Scottish Ambulance Service
Adverse Event Review Framework
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Scottish Ambulance Service
Adverse Event Review Framework

Flowchart for Adverse Event Management  V1.1

All Staff

Ensure each adverse event report is reviewed to an appropriate level and commenced within 10 working days identifying any corrective actions required to prevent a reoccurrence and enter details onto the DATIX system including all relevant documents eg reflective accounts, photographs, RIDDOR, SBAR’s etc as electronic attachments.

If incident meets CAT 1—eg Significant Adverse Event please refer to process at following link and complete SBAR—http://www.scottish.nhs.uk/PoliciesAndProc/Pages/SAER.aspx

Inform H&S Department of all RIDDOR reportable incidents within 24hrs. Follow link for RIDDOR explanations http://www.hse.gov.uk/riddor/ and pass details to the Regional H&S Officer * Implement any identified corrective actions

Ensure Staff and managers are given the time to report and review adverse events as required

Analyze incidents to identify local trends. Senior managers may also identify reported incidents, which due to their potential seriousness require and in depth investigation (SAER).

Review and analyse incidents to identify trends and learning opportunities. These departments will also identify reported incidents, which due to their potential seriousness require and in depth investigation (SAER).

Consider all adverse events and near misses for local learning

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Version: 1.00  Page 3 of 98
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## Frequently Asked Questions

<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th>ANSWERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is an adverse event / incident?</td>
<td>An adverse event is defined as an event that could have caused, or did result in, harm to people or groups of people or damage to equipment or property. Harm is defined as an outcome with a negative effect. Please refer to Part 2 of this document for further definitions.</td>
</tr>
<tr>
<td>What is a significant adverse event (SAE)?</td>
<td>A SAE is any event that resulted in the unexpected death or serious harm (harm includes negative physical and emotional impact) to a patient. Please see appendix 6 for SAER Framework which outlines process and definition.</td>
</tr>
<tr>
<td>When do I report an adverse event and how do I record it?</td>
<td>All adverse events are reported onto the electronic reporting system, Datix, and you should inform your line manager. You do not need a password to do this, the link can be found on the front page of @SAS under the applications section or can be found here: <a href="http://datixweb/datix/live/index.php">http://datixweb/datix/live/index.php</a> Guidance on how to do this can be found in this document in Appendix 1.</td>
</tr>
<tr>
<td>How soon should you report?</td>
<td>The adverse event should be reported as soon after the event as possible and no more than 48 hours. If you are struggling for time, contact your line manager or ACC to ensure they are aware of the event, although events can be reported at any time.</td>
</tr>
<tr>
<td>Where will I get feedback from my adverse event?</td>
<td>You will get this from your line manager. Datix will also automatically feedback the outcome of the review to the reporter.</td>
</tr>
<tr>
<td>What if I feel upset by the adverse event, how will I be supported?</td>
<td>Firstly let your manager know how you feel. You will be advised by your manager what support is available for you and will help to arrange support. You can also self-refer to Occupational Health or to the Employee Counselling Service.</td>
</tr>
<tr>
<td>When would significant adverse events (SAE’s) be reviewed? And, who decides when a significant adverse event review (SAER) would be carried out?</td>
<td>Please see appendix 6 for SAER Framework which outlines process and definition.</td>
</tr>
<tr>
<td>If I was involved in the event, how will I know if a SAER is to be undertaken?</td>
<td>You should be notified by your line manager, informing you of the SAER team undertaking the review.</td>
</tr>
</tbody>
</table>

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| If I am asked to be part of a review team, will I have to have training and what am I expected to do? | As a member of a SAER Team, you will be given direction by the SAER Lead and are expected to attend meetings, review policies/procedures, visit the area where the SAE happened (if required), carry out reflections with staff, review documentation and participate in identifying the causes and making recommendations for improvement. All individuals required to carry out a review will have received Root Cause Analysis Training. |
PART 1: INTRODUCTION

1.1 Purpose

To define how adverse events and near misses shall be reported and reviewed within the Scottish Ambulance Service, in order to prevent or minimise the likelihood of recurrence.

1.2 Scope

All Directorates / Divisions and Departments.

This procedure applies to all adverse events and near misses that could have caused, or did result in, harm to people or groups of people, or damage to equipment or property by the work carried out by the ambulance service throughout Scotland.

1.3 Aims

The aims of the adverse event reporting framework are to:

- ensure the safety of patients and staff
- learn from adverse events locally and nationally to make service improvements that enhance the safety of our Service for everyone
- set out a standardised approach to adverse event management across the Service, including consistent definitions and the establishment of measures to monitor implementation
- ensure a consistent and co-ordinated approach to the identification, reporting and review of adverse events to allow best practice to be actively promoted across the Service
- present an approach that allows reflective review of events, seeking out root causes, identifying human factor failings, and that can be adapted to different settings, and
- develop the skills, culture and systems required to effectively learn from adverse events to improve services across SAS

This document now supersedes

HS 004 - Accident and Incident reporting procedure
Significant Adverse Event Review Framework v3

And is underpinned by

Risk Management Strategy and Policy
Health and Safety Strategies and Policies
Clinical Governance and Patient Safety Policies and Procedures
PART 2: DEFINITIONS (as defined by Healthcare Improvement Scotland, 2013)

2.1 What is an adverse event?
An adverse event is defined as an event that could have caused, or did result in, harm to people or groups of people or damage to equipment or property.

2.2 Harm is defined as an outcome with a negative effect. Harm to a person or groups of people may result from worsening of a medical condition, the inherent risk of an investigation or treatment, system failure, provider performance issues, service disruption, financial loss or adverse publicity.

2.3 All harm is not avoidable, for example the worsening of a medical condition or the inherent risk of treatment. However, it is often not possible to determine if the harm caused was avoidable until a review is carried out.

2.4 People are defined as:
- members of staff
- patients
- service users
- carers
- family members
- members of the public
- visitors, and
- contractors
- volunteers
PART 3: OVERARCHING PRINCIPLES
(as defined by Healthcare Improvement Scotland, 2013)

3.1 The 2020 Workforce Vision re-affirms NHSScotland’s key values, which are care and compassion; dignity and respect; openness, honesty and responsibility; quality and teamwork. The principles of the SAS Framework approach to learning from adverse events support and build on these values.

i. **Emphasis on learning and promoting best practice across the Service** – the system is focused on learning, locally and nationally, and makes extensive use of improvement methodology to test and implement the necessary changes. Near misses are reviewed regularly to promote learning and system improvements.

ii. **System approach** – adverse events act as a ‘window’ on the healthcare system allowing a systems analysis. This is important to allow a reflection on the weaknesses of the system, or in the case of near misses, the strengths, and prevent future events.

iii. **Openness about failures** – errors are identified, reported and managed in a timely manner, and patients and their families are told what went wrong and why. Reviews of events happen frequently and quickly following their occurrence. We expect adverse event reporting to increase as we move to a more open culture.

iv. **Just culture** – individuals are treated fairly. Organisational culture is based upon the values of trust, openness, equality and diversity which encourages and supports staff to recognise, report and learn from adverse events.

v. **Positive safety culture** – avoidance, prevention and mitigation of risks is part of the organisation’s approach and attitude to all its activities and is recognised at all levels of the organisation. Decisions relating to the management of adverse events are risk-based, informed and transparent to allow an appropriate level of scrutiny.

vi. **Personal, professional and organisational accountability** – everyone is responsible for taking action to prevent adverse events, including speaking up when they see practice that endangers safety, in line with the whistle-blowing policy. Roles and responsibilities will be explicit and clearly accepted with individuals understanding when they may be held accountable for their actions. The principal accountability of all NHS care providers is to patients, their families and carers.

vii. **Teamwork** – everyone who works for SAS is an essential and equal member of the team and needs to be valued, treated well and empowered to work to the best of their ability. Teamwork is recognised as the best defence of system failures and is explicitly encouraged and fostered within a culture of trust, mutual respect and open communication.
PART 4: MANAGING AN ADVERSE EVENT

4.1 The circumstances surrounding each adverse event will vary in terms of:

- Levels of harm
- Numbers of people involved
- Risk exposure
- Financial loss
- Media interest, and
- The need to involved other stakeholders

Therefore, the response to each adverse event should be proportionate to its scale, scope and complexity. This section outlines steps to manage adverse events.

4.2 Six stages of adverse event management

1. Risk assessment and prevention
2. Identification and immediate actions following an adverse event
3. Initial reporting and notification
4. Analysis and categorisation
5. Review (See Appendix 5 for aide memoires)
6. Improvement and monitoring
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Flow chart of actions to be taken to effectively manage adverse events

Stage 1: Risk Assessment and prevention—risk assessment should identify the hazards present in the SAS systems by evaluating the likelihood of potential harm from the hazard occurring, and evaluating the potential severity of that harm. Mitigating actions should be in place, that are proportionate to the risk to prevent it occurring.

Stage 2: Immediate actions following an adverse event

Adverse event occurs

Make person area safe and attend to any medical requirement

Implement any immediate operational actions to reduce risk of re-occurrence eg removal of trip hazard or faulty equipment

Stage 3: Initial reporting and notification

Report onto Service Incident reporting systems—DATIX can be found on @SAS

Grade Adverse event using impact definitions

Email Notification sent to Line manager for review

Email notification to Subject matter experts depending on categories selected

Stage 4: Analysis and categorisation

Identification of level of review required to be undertaken—dependant on category

If CAT 1 ie SAER follow the SAER process

If Cat 2 or 3 Follow Guidance contained within Appendix XX

Independent team carrying out review as per SAER process

Line Manager conducts review

Stage 5: Review

Develop action plan, if required

Submit review report and action plan via the appropriate governance mechanism

Governance mechanism quality assurance and closure of review

Share learning and implement key learning points

Implement action plan

Review of implementation of actions

Adverse event framework flowchart V1 Oct 2014
4.3 Stage 1: Risk assessment and prevention

Adverse event management is one part of effective risk management. Avoidance, prevention and reduction of risks should be the primary defence to prevent adverse events occurring. It is therefore important that risk assessment and prevention is seen as the first step in effective adverse event management.

The Risk assessments process should identify the hazards present in the workplace, evaluate the likelihood of potential harm from that hazard occurring, evaluate the potential severity of that harm and evaluate the number of people that might be affected. Mitigating controls should then be put in place that are proportionate to the risk to prevent it occurring or to mitigate the consequence. Please refer to the Services Intranet for Service risk assessments.

Dynamic risk assessment, (previously Crew Patient Safety) should be carried out on approach, arrival and during and work being conducted. The purpose of dynamic risk assessment is the continuous assessment of risk in the rapidly changing circumstances of an incident, in order to implement the control measures necessary to ensure an acceptable level of safety.

As part of an integrated risk management approach, the governance structures for the management of adverse events should also be aligned with the organisation’s risk management strategy and governance processes, including complaints and claims.

4.4 Stage 2: Identification and immediate actions following an adverse event

In all instances, the first priority is to ensure the needs of individuals affected by the adverse event are attended to, including any urgent clinical care which may reduce the harmful impact. A safe environment should be re-established, all equipment or medication retained and isolated, and relevant documentation copied and secured to preserve evidence and facilitate review and learning.

The first consideration following an adverse event is that patient and staff safety is paramount.

The Service should give early consideration to the provision of information and support to staff, patients, relatives and carers involved in the adverse event, including information on support systems which are available to staff, patients, relatives, visitors and contractors. Please refer to the Services Being Open policy.

4.5 Stage 3: Initial reporting and notification

When an adverse event (including near misses) occurs, this must be reported onto the Services Incident reporting system (Datix). Please refer to guidance on how to report adverse events in Appendix 1 of this document. Continual misuse or deliberate over categorisation of events should be managed appropriately by the local manager.

The Service operates an On Call process which Ambulance Control Centres should follow in the event of a significant adverse event in the Out of Hours period.

4.6 Reporting to external agencies

Specific events must be reported to external regulators at a national or UK level. This includes:

Please Note- This document is uncontrolled once printed.
i. reporting to the Health and Safety Executive (HSE) as set out in the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)
Hyperlink to website http://www.hse.gov.uk/riddor/

ii. reporting all adverse events involving health, social care, estates and facilities equipment to the Incident Reporting and Investigation Centre (IRIC) within Health Facilities Scotland as set out in CEL 43 (2009), carried out by risk manager

iii. reporting of sudden or unexpected deaths as a result of an adverse event to the Police and HSE

iv. reporting information governance incidents to the Information Commissioners Office

v. reporting of Adverse Drug Reactions via the Yellow Card Scheme to the MHRA

This system has been expanded since July 2012 to include medication errors due to a change in the European Transposition of Pharmacovigilance legislation, and reporting of Ionising Radiation adverse events to the Warranted Inspector for IR(ME)R.

Road Traffic Collisions also require to be reported to the Services Insurers. Guidance on how to do this can be found on Datix.

4.7 Stage 4: Analysis and categorisation

Following initial reporting of an adverse event or near miss, the relevant manager will assess the adverse event reporting form to consider whether a more in-depth review of the event is required. It is important the level of review is proportionate to the severity and frequency of the adverse event.

The decision to proceed, or not, to an adverse event review should be clearly documented. The decision as to whether a full review should take place will depend on the characteristics of the event and the potential for learning. If an initial review of a near miss suggests that there could be defects or failures in systems and processes then this could trigger a more extensive review.

Information, communications, outcomes and associated actions should be stored within Datix, so that an audit trail is evident.

The risk management team should quality assure the categorisation of events and appropriate actions taken if the original categorisation is inappropriate.

4.8 Categorisation of adverse events

The following categories should be used to group adverse events.

- **Category I – Events that may have contributed to or resulted in permanent harm**, for example death, intervention required to sustain life, severe financial loss (£>1m), ongoing national adverse publicity (likely to be graded as major or extreme impact on NHSScotland risk assessment matrix). Please see appendix 2.

- **Category II – Events that may have contributed to or resulted in temporary harm**, for example initial or prolonged treatment, intervention or monitoring required, temporary loss of service, significant financial loss, adverse local publicity (likely to be graded as minor or moderate impact on NHSScotland risk assessment matrix). Please see appendix 2.
• Category III – Events that had the potential to cause harm but
  i) an error did not result,
  ii) an error did not reach the person
  iii) an error reached the person but did not result in harm (near misses) These results can occur either by timely intervention or due to good fortune. Please see appendix 2.

The table below provides a guide to timescales and level of review.

<table>
<thead>
<tr>
<th>Adverse event category</th>
<th>Level of review</th>
<th>Review team</th>
<th>Improvement plan</th>
<th>Guidance timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category I</td>
<td>Level 1 Comprehensiv e adverse event analysis and review</td>
<td>Full review team – commissioning manager to agree review lead and Terms of Reference</td>
<td>Improvement plan to be developed and put through governance structures</td>
<td>Commence local review within 10 working days and complete within 3 months</td>
</tr>
<tr>
<td>Major or Extreme Grade</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category II</td>
<td>Level 2 Local management review in consultation with Associate Medical Director/Nurse Director or General Manager</td>
<td>Manager in charge of the department or area in consultation with staff</td>
<td>Improvement/action plan to be developed and reported through service management structures</td>
<td>Commence local review within 10 working days and complete within 4-6 weeks</td>
</tr>
<tr>
<td>Moderate or Minor Grade</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category III</td>
<td>Level 3 Further inquiries/questions Trends should be considered for further review</td>
<td>Managers/staff locally If further review required then local management review process</td>
<td>Not applicable unless trends require a review then a plan should be developed to address the outcomes</td>
<td>Adverse event approved and closed within 10 working days of being reported</td>
</tr>
<tr>
<td>Negligible or Near Miss Grade</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.9 Stage 5: Review

The purpose of the review is to determine what happened, how it happened, why it happened, and whether there are learning points for the service. It should follow the principles of a just culture and take a systems approach. For further reading on just culture, human factors and systems approach you can refer to Getting to grips with the human factor: Strategic actions for safer care, Sidney Decker 2013 or use the following links
http://www.justculture.eu/publications3.html
Category 1 – Major or Extreme

Please refer to SAER Process at Appendix 6 of this document.

Category 2 and Category 3

Depending on the type of incident, i.e. manual handling, RTC etc please see appendices 5 of this document for guidance on how to review the adverse event.

4.10 Stage 6: Improvement planning and monitoring

Level 1 and level 2 adverse event reviews may have an improvement plan developed in response to the findings and recommendations. All actions should identify owners and timescales for completion. Final plans should be shared with those who reported and were involved in the original adverse event and monitored centrally to ensure completion of actions.

Reports relating to thematic learning are collated to assist and inform wider service and organisation improvement. These themes are reported widely throughout the Service and redacted reports are published on the Services Intranet.
## PART 5: ROLES AND RESPONSIBILITIES AND GOVERNANCE STRUCTURE

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Staff, including specialist support services like ACC, ScotSTAR etc</strong></td>
<td>To report all adverse / near miss incidents onto Services Incident Reporting system (Datix). Ensure escalation to line manager or ACC in the Out of Hours period. Attend any training or complete e-learning package. Follow policy and procedures including adhering to timescales. Participate in reviews. Implement recommended actions and learning points.</td>
</tr>
<tr>
<td><strong>Line Managers</strong></td>
<td>Ensuring staff awareness and compliance with adverse event policies and procedures. Support staff following adverse event. Ensure adverse event is escalated appropriately in and out of hours. Manage adverse events including review, progress of actions, dissemination and implementation of learning. Review local themes and trends.</td>
</tr>
<tr>
<td><strong>Management Teams</strong></td>
<td>Ensure compliance with adverse event policies. Ensure compliance with procedures for reviewing and managing adverse events. Progression of action plans and follow-up. Dissemination of learning. Engagement with patient and families. Staff and Management support.</td>
</tr>
<tr>
<td><strong>Governance Committees</strong></td>
<td>Delegated responsibility from the Board to ensure incidents are reviewed and assurance requested to confirm improvements and actions have been taken to minimise risk.</td>
</tr>
</tbody>
</table>
PART 6: KEY PERFORMANCE MEASURES

5.1 The table below sets out the standards and indicators for the management of adverse events.

<table>
<thead>
<tr>
<th>Description of Measure</th>
<th>KPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Incidents reported within 2 days</td>
<td>&gt; 90%</td>
</tr>
<tr>
<td>% of Cat 1 Incidents (SAER) completed within 3 months</td>
<td>&gt; 90%</td>
</tr>
<tr>
<td>% of Cat 2 Incidents (minor or moderate) completed within 1 month</td>
<td>&gt; 90%</td>
</tr>
<tr>
<td>% of Cat 3 Incidents (negligible) completed within 10 days</td>
<td>&gt; 90%</td>
</tr>
<tr>
<td>% of Cat 1 Incidents where family engagement is appropriate and engagement has occurred</td>
<td>100%</td>
</tr>
<tr>
<td>% of high priority actions completed within set timescale</td>
<td>&gt; 90%</td>
</tr>
<tr>
<td>% of RIDDOR compliance</td>
<td>Greater than or equal to 90%</td>
</tr>
</tbody>
</table>

PART 7  POLICY REVIEW AND COMMUNICATION PLAN

This policy will be reviewed triennially or following any significant Organisational change.

The policy will be posted onto the Services Intranet for all staff to access and launched by the Communications team through the Services Intranet. Communication of the policy will take place through @SAS, team talk and regular bulletins within the Service.
APPENDIX 1 - GUIDANCE FOR STAFF ON WHAT TO REPORT ONTO DATIX

All staff within the organisation have a responsibility to report adverse and near miss incidents they witness, are involved in or are informed of on to the Services incident reporting system Datix as soon as possible after the event. Datix can be found on @sas by scrolling down to useful applications and tools and selecting E-reporting of incidents (Datix) under the applications section.

This short guide outlines the types of incidents that should be reported and what happens next.

Definitions

The NHS Scotland national framework for learning from adverse events through reporting and review defines an adverse incident as “an event that could have caused, or did result in, harm to people or groups of people”. This also includes damage to equipment or property.

Harm is defined as an outcome with a negative effect. Harm to a person or groups of people may result from worsening of a medical condition, the inherent risk of an investigation or treatment, system failure, provider performance issues, service disruption, financial loss or adverse publicity.

All harm is not avoidable, for example the worsening of a medical condition or the inherent risk of treatment. However, it is often not possible to determine if the harm caused was avoidable until a review is carried out.

Examples of the type of incidents that must be reported are as follows:

- **Patient Safety (Clinical Care) Issue:**
  Any event or omission arising during clinical care that resulted, or could have resulted, in unexpected physical or psychological harm to a patient. Examples include, incorrect patient assessment or treatment, medication / drug errors, Intubation related incidents, ACC dispatch and coding of calls, slips/trips/fall of patient.

- **Personal Accident (Non Clinical):**
  Slips/trips/falls, cuts, moving and handling incidents, needle stick injuries, electrocution, etc.

- **Road Traffic Collisions:**
  All vehicle accidents including driver’s error or someone else’s error.

- **Business Continuity Issue:**
  An event that prevents the SAS delivering normal services i.e. ACC systems failure, estates issues, severe weather and capacity issues.

- **Violence/Abuse:**
  Assault (physical, verbal or sexual); violent, aggressive or severely disruptive behaviour by patients, staff, visitors, relatives, or member of the public.
Security (including Information Governance):
Break-in, vandalism, damage to property, theft. Any breach of information security involving the confidentiality, integrity or availability of data (both hard copy and electronic data).

Equipment:
Equipment failures, malfunctions etc. of medical and non-medical equipment, unavailability of equipment.

Fire:
Actual fires, (whether by arson or unintentional) and incidents where the fire alarm has been activated.

Public Protection (Vulnerable Adults and Children):
Where a concern has been raised which indicates that a patient has been abused either by family, carers, other healthcare providers, members of staff or public.

Infection Control:
Healthcare acquired infections.

Significant Adverse Events Framework
If any of the above reported incidents meet the definition of a significant adverse event, i.e. that there was death or serious harm caused then the above framework will be implemented.

The examples provided above are not an exhaustive list. If a staff member is uncertain whether to report an incident they should refer to their line manager in the first instance and contact can be made with the Risk Management, Health and Safety or Clinical Governance Teams within the Service for further advice.

Other supporting tools available on @sas are:
Accident / Incident reporting procedure (Health and Safety Pages of @sas)
Datix step by step guide on how to report an incident (Risk & Resilience Pages of @sas)
Significant Adverse Event Review Framework (Clinical Pages of @sas)

What Happens Next?

Once you complete an incident report form the incident is automatically emailed to your line manager for review. You may often see that there are a number of other people within the Organisation who are emailed the incident and this is just so that topic specialists are aware of the event and can support the line manager to review. They will also assist with determining the level of review required for the incident, for example significant adverse event etc.

Once your line manager has completed the review of the incident it is included into the findings section of the report and sent through to the Risk Team for final approval. It is the responsibility of your line manager to provide you with feedback following the reporting of
your incident and you can also ask for this feedback if not automatically given. The Risk Team check all sections are complete and accurate so that once all the information is collated for reporting through various committees and groups, i.e. local and national health and safety committees, clinical groups etc the information is accurate.

These groups discuss the severity and frequency of incidents and pick out themes and trends to ensure the chance of them being repeated is reduced as much as possible, this ultimately reduces risk to patients and staff within the Organisation.
### Appendix 2 - NHS Scotland risk assessment matrix (produced by NHS QIS)

#### Table 1 – Impact/Consequence Definitions

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Negligible</th>
<th>Minor</th>
<th>Moderate</th>
<th>Major</th>
<th>Extreme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objectives / Project</strong></td>
<td>Barely noticeable reduction in scope, quality or schedule.</td>
<td>Minor reduction in scope, quality or schedule.</td>
<td>Reduction in scope or quality of project; project objectives or schedule.</td>
<td>Significant project over-run.</td>
<td>Inability to meet project objectives; reputation of the organisation seriously damaged.</td>
</tr>
<tr>
<td><strong>Injury (physical and psychological) to patient/visitor/staff</strong></td>
<td>Adverse event leading to minor injury not requiring first aid.</td>
<td>Minor injury or illness, first aid treatment required.</td>
<td>Agency reportable, e.g. Police (violent and aggressive acts).</td>
<td>Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling.</td>
<td>Incident leading to death or major permanent incapacity.</td>
</tr>
<tr>
<td><strong>Complaints / Claims</strong></td>
<td>Locally resolved verbal complaint.</td>
<td>Justified written complaint peripheral to clinical care.</td>
<td>Below excess claim.</td>
<td>Claim above excess level.</td>
<td>Multiple claims or single major claim Complex justified complaint</td>
</tr>
<tr>
<td><strong>Service / Business Interruption</strong></td>
<td>Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service.</td>
<td>Short term disruption to service with minor impact on patient care.</td>
<td>Some disruption in service with unacceptable impact on patient care.</td>
<td>Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.</td>
<td>Permanent loss of core service or facility. Disruption to facility leading to significant “knock on” effect</td>
</tr>
<tr>
<td><strong>Staffing and Competence</strong></td>
<td>Short term low staffing level temporarily reduces service quality (&lt; 1 day).</td>
<td>Ongoing low staffing level reduces service quality.</td>
<td>Late delivery of key objective/service due to lack of staff.</td>
<td>Uncertain delivery of key objective/service due to lack of staff.</td>
<td>Non-delivery of key objective/service due to lack of staff. Loss of key staff. Critical error due to ineffective training/ implementation of training.</td>
</tr>
<tr>
<td><strong>Financial (including damage / loss / fraud)</strong></td>
<td>Negligible organisational/personal financial loss. (£&lt;1k).</td>
<td>Minor organisational/personal financial loss (£1-10k).</td>
<td>Significant organisational/personal financial loss (£10-100k).</td>
<td>Major organisational/personal financial loss (£100k-1m).</td>
<td>Severe organisational/personal financial loss (£&gt;1m).</td>
</tr>
<tr>
<td><strong>Inspection / Audit</strong></td>
<td>Small number of recommendations which focus on minor quality improvement issues.</td>
<td>Recommendations made which can be addressed by low level of management action.</td>
<td>Challenging recommendations that can be addressed with appropriate action plan.</td>
<td>Enforcement action. Low rating. Critical report.</td>
<td>Prosecution. Zero rating. Severely critical report.</td>
</tr>
</tbody>
</table>
### Table 2 – Likelihood Definitions

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Rare</th>
<th>Unlikely</th>
<th>Possible</th>
<th>Likely</th>
<th>Almost Certain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probability</td>
<td>Can’t believe this event would happen – will only happen in exceptional circumstances.</td>
<td>Not expected to happen, but definite potential exists – unlikely to occur.</td>
<td>May occur occasionally, has happened before on occasions – Reasonable chance of occurring.</td>
<td>Strong possibility that this could occur – Likely to occur.</td>
<td>This is expected to occur frequently / in most circumstances – more likely to occur than not.</td>
</tr>
</tbody>
</table>

### Table 3 - Risk Matrix

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Impact/Consequences</th>
<th>Impact/Consequences</th>
<th>Impact/Consequences</th>
<th>Impact/Consequences</th>
<th>Impact/Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Negligible</td>
<td>Minor</td>
<td>Moderate</td>
<td>Major</td>
<td>Extreme</td>
</tr>
<tr>
<td>Almost Certain</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>V High</td>
<td>V High</td>
</tr>
<tr>
<td>Likely</td>
<td>Medium</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>V High</td>
</tr>
<tr>
<td>Possible</td>
<td>Low</td>
<td>Medium</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Unlikely</td>
<td>Low</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>High</td>
</tr>
<tr>
<td>Rare</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Medium</td>
<td>Medium</td>
</tr>
</tbody>
</table>
INTRODUCTION

Scottish Ambulance service (SAS) is committed to continually and systematically reviewing and improving our incident reporting processes and working practices to prevent or reduce the risk of harm both to patients and staff. It is vital that incidents are reviewed in a timely manner in order to capture learning and implement measures to ensure the highest quality of patient care and staff safety is achieved.

It is essential reviewers/line managers provide feedback to staff members reporting incidents and explain what actions have now been taken and the lessons learned as a result.

As a line manager and designated reviewer for a group of incidents you will be notified by email that an incident has been reported and will advise you to review the incident. Clicking the link on the email or logging into Datix through the homepage of @SAS will allow access to do so. Please follow the steps below to review the incident appropriately.

STEP BY STEP GUIDE

1. Click the E-reporting of Incidents (Datix) link on the homepage of @SAS under useful Applications & Tools

![Useful Applications & Tools]

2. Login is at the top left of the page:

![Login]

Enter your username and password. Username will be the beginning of your email address i.e. wilma.mackie or wmackie. If you require access and permissions to view incidents within your division/department please contact Wilma Mackie on 07920 271 807 or wmackie@nhs.net.

3. When logged in the screen below will appear detailing the status of the incidents, the number of incidents and the number of incidents that are overdue.
Click on:
Status: New Incidents Requiring Review
Or
Status: Incidents Being Reviewed by Line Manager

4. Click on a number, this will take you to the list of incidents and you can click anywhere on the incident to open the details.

5. Top left of the screen allows you to navigate between areas of the incident after the details have been checked.

6. Please ensure you complete all the relevant sections of the form. The fields marked with a red asterix MUST be completed.

7. In order to ensure the incident has been accurately recorded the manager should ensure the incident details are accurate by checking all categories selected, this may involve speaking with the staff members involved. By ensuring the details are accurate allows national themes and trends to be identified.
INCIDENT DETAILS – Ensure these are accurate.

- Incident Date
- Time
- Details
- Action Taken
- RIDDOR Reportable?

LOCATION – Ensure these are accurate

- Station
- Division
- Health Board Area
- Service
- Location exact

INCIDENT CODING - Ensure these are accurate/appropriate.

- Incident type – ‘Clinical’ – patient safety or ‘Non-clinical’ – staff safety.
- Category
- Sub Category
- Result – ‘Adverse Incident’ – actual harm OR ‘Near Miss’ – potential for harm
- Severity of Incident – this will have been completed by the staff.

If there is any Medication or Equipment involved in the incident there will be a drop down section further down with more detail. Please ensure this is recorded accurately.

8. INVESTIGATION

The manager should detail in this section what actions have been taken as a result of the incident and lessons learned. The incident may require further investigation and analysis therefore this should be escalated through the Patient Safety Significant Adverse Event process will be invoked as per the patient safety learn and improve policy.

Areas to enter:
- Date the investigation started
- Investigator - Advise who is investigating it by clicking the green plus icon and adding as many people as appropriate.
- Action Taken Report - what action was taken as a result of the incident.
- Lessons Learned - the lessons that have been learned either on an individual or organisation wide basis. Please advise the Risk Management Department if there are organisation wide issues involved so this can be co-ordinated centrally.
- Outcome of Investigation – please select the appropriate outcome for the incident. If there is national learning please select appropriate field.
Risk Grading

The classification of incidents is scored using a simple risk matrix. The matrix used by SAS is the Healthcare Improvement Scotland matrix which was adapted from an International Risk Management Standard (Australian Standard / New Zealand Standard 4360:1999).

All incidents will be graded in order to determine the actions to be taken at local and national level. The grading of the incident is determined by two factors:

- The actual consequence, outcome or severity of the incident
- The probability or likelihood of the incident occurring/reoccurring

Please refer to Appendix 2 of this document for the Services Risk Matrix.

- **Was the Incident a Significant Adverse Event**
  See Service Significant Adverse Event Framework) A Significant Adverse Event requiring review is defined as an incident that occurred in relation to Service operations and results in one or more of the following:
  - Unexpected or avoidable death;
  - Serious harm, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm;
  - A scenario that prevents or threatens to prevent the Service’s ability to continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or IT failure;
  - Allegations of abuse
- Adverse media coverage or public concern about the organisation or the wider NHS;
- One of the core set of Never Events that results in death or serious harm.

If the incident has been declared a SAE by the Services SAER Group then please select ‘yes’ if not select ‘no’

**Date Investigation Completed**
Please complete the date you completed the investigation.

**ACTION PLAN**
This enables any actions to be undertaken as a result of the incident/investigation to be tracked. They can be assigned to a manager within the service who has Datix permissions. To do this, select ‘create a new action’ and will take you to the actions form, shown below on page 6.
DOCUMENTS
You are able to attach documents to the incident by clicking the 'Attach a Document' link. This is the section you can attach a written report or a RIDDOR report for example.

NOTEPAD
This allows notes to be added to the review as it’s ongoing. It also creates a log of the notes for future reference.

PEOPLE INVOLVED
This section highlights the people that have been involved in the incident either the patient, staff member person affected etc.

EMAIL COMMUNICATION
Should there be a need to communicate to staff regarding the review of the incident please use this section. Please also use this section to feedback the outcome of the review to staff to ensure the Service can evidence staff are receiving feedback. Instructions are below

- Click on the drop down menu in the Recipients section and select the appropriate staff members involved in the incident. Then click for each staff member.
- To add additional staff enter their nhs.net email address in the ‘Additional Recipients’ section followed by a comma. E.g. skilday@nhs.net, wmackie@nhs.net

This will ensure that appropriate staff are included in any discussions/review regarding the incident

PERSON AFFECTED, EMPLOYEE, MATCHING CONTACTS
If the people involved in the incident are not added or linked link the contacts to the incident.
Click the Create a new Person Affected or Create a New Employee link then type in the persons name and Click Check for matching contacts, Click ‘Choose’ the person. Then ‘Create New Link’ button
To approve the contacts. Click ‘unapproved’ next to the name, then check the contact select approved then check for matching contacts, if the same person appears select ‘create new link’. If not do not approve.

**APPROVAL STATUS**

Then scroll to the top of the form to the approval status section.

- If you have completed the review of the incident select ‘awaiting final approval’ or if you require more information and are not yet finished select, ‘incident being reviewed by line manager’.

Scroll down to bottom and Click ‘Save’. Incident complete!

If you have any trouble completing this form please contact Wilma Mackie on 07920 271 807.
SEARCHING FOR AN INCIDENT

In the event that you require access to a previous incident as a reviewer or a manager, you are able to search previous Datix incidents.

When logged in click on the Incidents’ link and then New Search’. See below.

This will then bring up a blank Incident form where you can fill in specific details including: please put a * in first.

Reference
ID
Date
Name
Division
Incident Coding

Click Search and this will narrow the search to the particular incidents within the criteria you have searched. Please note the more information the search criteria the less incidents you will have.

Please note that it will only show incidents that as a manager you have permission to view.

ACTIONS
In some cases there may be incidents that following an investigation Actions are assigned to managers. These actions can be viewed by clicking on the actions tab at the top of the screen.
If you have any questions please contact wmackie@nhs.net.
Appendix 4 – RIDDOR Flowchart

Reporting of Injuries, Diseases and Dangerous Occurrence (RIDDOR) Flowchart Oct 2014

- Accident or Incident Occurs
  - Was anyone hurt or Killed?
    - No
    - Yes
      - Employee
      - Patient, Public or Visitor
  - Was this a dangerous Occurrence?
    - No
    - Yes
      - Injury from a sharp KNOWN (not suspected) to be contaminated with BBV is reportable as a dangerous occurrence
      - More than 7 days lost time?
        - No
        - Yes
          - Complete a Service DATIX form on @SAS
          - Complete RIDDOR Report On Line. As soon as possible but within timelines outlined in section 6.3 (Keep a copy of the pdf file)
          - Telephone HSE immediately to inform of incident

- Suicide and or Self harm is not reportable

NOTE: IF block shape is RED
Check definitions on http://www.hse.gov.uk/riddor/ Or contact H&S team for advice

In both cases immediate advice should be sought from the Health and Safety team.
## APPENDIX 5 – Guidance for Completing Investigations

The list below is not exhaustive but provide pointers to areas that should be covered when completing the Investigation - Familiarise yourself with relevant Policies, Risk Assessments, SSOW and Training Records.

### RTC – Considerations During Investigation

<table>
<thead>
<tr>
<th>Drivers Full Name:</th>
<th>Date of Incident:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job Role of Driver:</td>
<td>SAS Start Date:</td>
</tr>
<tr>
<td>Location of Incident:</td>
<td>Driving under Blue Light conditions: Yes/No</td>
</tr>
<tr>
<td>Type of Rd (M/Way/A/B/Unclassified):</td>
<td>Going through Traffic Lights: Red/Amber/Green</td>
</tr>
<tr>
<td>Registration No of SAS Vehicle:</td>
<td>Registration of any Third Party Vehicles involved:</td>
</tr>
<tr>
<td>Estimated speed of vehicle on impact:</td>
<td>Speed of Road:</td>
</tr>
<tr>
<td>Was vehicle - going forward/reversing/stationary/parked:</td>
<td>If reversing was a banksman used: Yes/No</td>
</tr>
</tbody>
</table>

### In Drivers opinion who is at fault

| Own Fault | Did the individual consider the risk/hazard prior to the incident? Dynamic Risk Assessment completed? Driving Training completed (Date)? |
| Third Party | Was training followed? |
| Combination of both | Is further training required/recommended? |

### Distractions

<table>
<thead>
<tr>
<th>Contributory factors</th>
<th>Was Weather a contributory factor?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Snow/sleet</td>
<td>Rain</td>
</tr>
<tr>
<td>Fog/mist</td>
<td>Cloudy</td>
</tr>
<tr>
<td>Sun/Glare</td>
<td>Windy</td>
</tr>
</tbody>
</table>

### Ground conditions

<table>
<thead>
<tr>
<th>Was the Road Surface?</th>
<th>Ground conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level/bad camber</td>
<td>Icy</td>
</tr>
<tr>
<td>Sloping/gradient</td>
<td>Wet/Dry</td>
</tr>
<tr>
<td>Even/Uneven</td>
<td>Muddy</td>
</tr>
<tr>
<td>Rough Terrain/Rural tracks</td>
<td>Oily</td>
</tr>
<tr>
<td>Potholes/raised manhole covers</td>
<td>Greasy</td>
</tr>
</tbody>
</table>

### Light/Good

<table>
<thead>
<tr>
<th>What were the Lighting conditions?</th>
<th>Visibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good Natural Daylight</td>
<td>Good Clear</td>
</tr>
<tr>
<td>Night/Dark</td>
<td>Poor</td>
</tr>
<tr>
<td>Dusk/Getting Dark</td>
<td>Obstructed</td>
</tr>
<tr>
<td>Dull/Overcast</td>
<td>Audible and Visual Warning Systems</td>
</tr>
<tr>
<td>Light/Good</td>
<td>Indicators On/Off</td>
</tr>
<tr>
<td>Dazzlingly bright</td>
<td>HeadLights On/Off</td>
</tr>
<tr>
<td>Poor or No artificial lighting</td>
<td>Beacons On/Off</td>
</tr>
<tr>
<td>Poor or No artificial lighting</td>
<td>Horn Sounded Yes/No</td>
</tr>
</tbody>
</table>

### Injuries Sustained

| To Whom - Describe Injury and outcome: |
| In the injured persons opinion what caused the accident? |
| In Your opinion what caused the accident? Root Cause? Contributory factors? |
### Manual Handling Considerations During Investigation

The list below is not exhaustive but provide pointers to areas that should be covered when completing the investigation

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of accident:</th>
</tr>
</thead>
</table>

**Was the Load**

<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excessively heavy.</td>
<td></td>
</tr>
<tr>
<td>Bulky or unwieldy.</td>
<td></td>
</tr>
<tr>
<td>Difficult to grasp/hold.</td>
<td></td>
</tr>
<tr>
<td>Unstable, or with content that moved.</td>
<td></td>
</tr>
<tr>
<td>Sharp, hot or otherwise dangerous.</td>
<td></td>
</tr>
</tbody>
</table>

**The Working Environment**

<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the lack of space prevent the person from maintaining a good posture.</td>
<td></td>
</tr>
<tr>
<td>Uneven, slippery or unstable floor or ground. (Consider Slip, Trip and Fall hazards)</td>
<td></td>
</tr>
<tr>
<td>Variations in floor or ground conditions</td>
<td></td>
</tr>
<tr>
<td>Extreme of temperature or humidity (e.g. causing fatigue or lack of grip)</td>
<td></td>
</tr>
<tr>
<td>Conditions caused by poor ventilation or excessive wind</td>
<td></td>
</tr>
</tbody>
</table>

**Did the Task Involve**

<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holding or manipulating loads at a distance away from the body.</td>
<td></td>
</tr>
<tr>
<td>Unsatisfactory bodily movements or twisting, (e.g. Twisting the trunk, stooping, reaching.)</td>
<td></td>
</tr>
<tr>
<td>Excessive movement of the load, (e.g. excessive lifting - lowering, carrying excessive distance, etc.)</td>
<td></td>
</tr>
<tr>
<td>Excessive pushing or pulling. If pushing a trolley cot, vehicle etc (make and model) and describe environment they were pushing in - eg on incline, gravel, snow/ice</td>
<td></td>
</tr>
<tr>
<td>Sudden movements of load.</td>
<td></td>
</tr>
<tr>
<td>Frequent or prolonged physical effort, (e.g. either weight or repetitions)</td>
<td></td>
</tr>
<tr>
<td>A rate of work imposed by a process.(rushing)</td>
<td></td>
</tr>
</tbody>
</table>

**Other Factors**

<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was movement or posture hindered by Personal Protective Equipment.</td>
<td></td>
</tr>
<tr>
<td>In the injured persons opinion what caused the accident</td>
<td></td>
</tr>
</tbody>
</table>

**The Individual**

<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had they had adequate rest/recovery periods between previous exertion and the cause of the injury?</td>
<td></td>
</tr>
<tr>
<td>Consider the physical attributes of the individual, (eg. Age, height, weight, strength, etc.)</td>
<td></td>
</tr>
<tr>
<td>Consider any health issues the individual may have (not just back related), eg. Angina, diabetes, thyroid, etc, that could affect their ability to manually handle.</td>
<td></td>
</tr>
<tr>
<td>Consider previous injuries, (eg. Leg or ankle weakness, back problems, hernias, etc.)</td>
<td></td>
</tr>
<tr>
<td>If previously injured,</td>
<td></td>
</tr>
<tr>
<td>Have they had any Individual Risk Assessments carried out and been issued with any ‘alternative’ equipment/light or restricted duties etc if so what?</td>
<td></td>
</tr>
<tr>
<td>When did the individual last have a full medical examination (GP) or been to OH?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>In your opinion what caused the accident</td>
<td></td>
</tr>
<tr>
<td>Contributory factors?</td>
<td></td>
</tr>
</tbody>
</table>
### Slip, Trip, Fall Considerations During Accident Investigation

The list below is not exhaustive but provide pointers to areas that should be covered when completing the investigation.

**Review the relevant Risk Assessment for STF and environment depending on type/location of incident.**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of Accident:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>Weather</td>
</tr>
<tr>
<td>Urban</td>
<td>Snow/sleet</td>
</tr>
<tr>
<td>Rural</td>
<td>Rain</td>
</tr>
<tr>
<td>Description of location</td>
<td>Fog/mist</td>
</tr>
<tr>
<td>Roadside with kerb</td>
<td>Cloudy</td>
</tr>
<tr>
<td>Roadside without kerb</td>
<td>Sun</td>
</tr>
<tr>
<td>Car park</td>
<td>Light conditions</td>
</tr>
<tr>
<td>Forecourt</td>
<td>Night</td>
</tr>
<tr>
<td>Driveway</td>
<td>Dull/overcast</td>
</tr>
<tr>
<td>Other - give details</td>
<td>Light/good</td>
</tr>
<tr>
<td>Where did the incident happen</td>
<td>Dazzlingly bright</td>
</tr>
<tr>
<td>Accessing/egressing Service Vehicle</td>
<td>Good artificial lighting/white/orange</td>
</tr>
<tr>
<td>Area surrounding Service Vehicle</td>
<td>Poor artificial lighting</td>
</tr>
<tr>
<td>Other - give details</td>
<td>No artificial light</td>
</tr>
<tr>
<td>Ground</td>
<td>Accessing/egressing the vehicle</td>
</tr>
<tr>
<td>Level</td>
<td>Assisting a mobility impaired patient</td>
</tr>
<tr>
<td>Sloping</td>
<td>Manual handling equipment eg pushing chair/trolley/cot</td>
</tr>
<tr>
<td>Even</td>
<td>Related to working at Height</td>
</tr>
<tr>
<td>Rough</td>
<td>Other - give details</td>
</tr>
<tr>
<td>Pothole</td>
<td>If at height was anything being stood on?</td>
</tr>
<tr>
<td>Surface</td>
<td>What was the height of the object being stood on?</td>
</tr>
<tr>
<td>Icy</td>
<td>Up to 0.5 mtr</td>
</tr>
<tr>
<td>Wet</td>
<td>0.5 to 1 mtr</td>
</tr>
<tr>
<td>Muddy</td>
<td>1.0 to 1.5 mtr</td>
</tr>
<tr>
<td>Oily</td>
<td>Greater than 1.5 mtr</td>
</tr>
<tr>
<td>Other - give details</td>
<td>If &quot;height related&quot; what task was being carried out (e.g. Replacing beacon bulb, stepping from vehicle step/ramp)</td>
</tr>
<tr>
<td>Hazard</td>
<td>Was “time pressure” a contributory factor?</td>
</tr>
<tr>
<td>Did any hazard contribute to the incident</td>
<td>Good</td>
</tr>
<tr>
<td>eg trailing cable?</td>
<td>Yes? Why?</td>
</tr>
<tr>
<td>In the injured persons opinion what caused the accident?</td>
<td>No</td>
</tr>
<tr>
<td>In Your opinion what caused the accident? Detail root cause, contributory factors</td>
<td>-</td>
</tr>
</tbody>
</table>

---

Scottish Ambulance Service

Adverse Event Review Framework

**Please Note-** This document is uncontrolled once printed.

Version: 11

Release Date: May 2015

Owner: Medical Director
## Contact or Struck by Stationary/Moving Object or Vehicle - Considerations During Investigation

For guidance in investigations of:  - Contact with Vehicle Part, Struck Against Something, Struck by Moving Vehicle, Struck by Moving Object

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of accident</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Voluntary

- Is there any suggested equipment/tools that would have prevented the incident?
- Did the individual consider the risk/hazard prior to the incident? DRA completed? Training completed?
- Was long hair, jewelry or something else insecure contributory to the incident?

### Involuntary

- Was the incident caused due to a persons attention being distracted?
- If not, would any resulting injuries been less severe if it had been worn?
- Was the distraction reasonably foreseeable?
- Was the PPE being worn in good condition and fitted the wearer well?

### Person/Object contact

- Was approved PPE being worn at the time?
- Was the weather a contributory factor?

#### Driver/Passenger

- Rain
- Fog/mist

#### Customer

- Fog/mist
- Sun

#### Third Party

- Sun
- Cloudy

#### Other

- Sunny
- Cloudy
- Fog/mist

### Equipment/Fixed/Stationary Object

- What precautions were taken to prevent the item/vehicle from moving?
- Were Ground conditions a contributory factor?
- Level
- Sloping
- Pothole
- Uneven
- Wet
- Dizzy

### Weather

- Snow/sleet
- Driver/Passenger
- Rain
- Customer
- Fog/mist
- Third Party
- Sun

### Surface

- Icy
- Wet
- Muddy
- Oily
- Dry

### Equipment

- Was the equipment assembled correctly?
- Was the equipment a "Handtool"?
- Was the equipment faulty or defective?
- Was equipment/tools being used for it's designed purpose?
- Was equipment/tools being used for it's designed purpose?
- Was the Surface?

#### Equipment failure

- Was equipment/tools being used for it's designed purpose?
- Was the equipment faulty or defective?
- Was equipment/tools being used for it's designed purpose?
- Was the Surface?

#### Weather

- Snow/sleet
- Driver/Passenger
- Rain
- Customer
- Fog/mist
- Third Party
- Sun

#### Ground conditions

- Snow/sleet
- Driver/Passenger
- Rain
- Customer
- Fog/mist
- Third Party
- Sun

#### Equipment failure

- Weather
- Equipment
- Ground conditions

#### In the injured persons opinion what caused the accident?

### Contributory factors

- In Your opinion what caused the accident? Root Cause? Contributory factors?
APPENDIX 6: Significant Adverse Event Review Framework
Section 1: Policy
Introduction

Ensuring patients are treated safely is our top priority. Effective reporting and analysis of Significant Adverse Events (SAE) allows the organisation, you and your team to highlight and learn from both strengths and weaknesses in the care we provide. Improving the quality and safety of patient care is a key clinical governance priority in healthcare and SAE reporting has an important role in contributing to this aim. This guidance on identifying, reporting and learning from SAEs will help us to focus on reliable, safe and effective systems of care allowing you and your team to provide the best care every time for patients and their families or loved ones.

A SAE is any event that resulted in the unexpected death or serious harm (harm includes negative physical and emotional impact) to a patient. All SAEs will be reviewed in accordance with Scottish Ambulance Service agreed process. Current thinking suggests that the causes of incidents cannot simply be linked to the actions of individual people, but are usually the result of system-wide issues. The Scottish Ambulance Service wants to encourage and support staff to do the right thing, first time and every time. The process is not designed to apportion blame, indeed no-one should be disciplined for making an honest mistake. But it is important for both individuals and organisations to learn from these mistakes, especially so when they are significant in nature. All staff have a responsibility to report incidents onto Datix and take appropriate remedial action where necessary (please refer to the Services Incident Reporting procedure).

Scope

This policy and process document applies to all activities conducted by the Scottish Ambulance Service whether conducted by employees, volunteers or contracted services.

Purpose

The purpose of this policy is to communicate the process of dealing with a SAE to all Service staff so that they can be safe, responsive and take control of a SAE if it occurs. Once implemented this will support:

- Safeguarding people (patients, public and staff), property, the service’s resources and its reputation;
- Understanding why the event occurred;
- Ensuring that steps are taken to reduce the chance of a similar incident happening again;
- Reporting to other bodies where necessary; and
- Sharing the learning with other organisations
Commitments to patients and families involved in a Significant Adverse Event

The Scottish Ambulance Service is committed to ensuring that when a SAE occurs immediate, appropriate and effective action will be taken to ensure:

- The patient and their family are safe and supported;
- Staff members are safe and supported; and
- The organisation learns from the event and ensures any required improvements are made.

The Scottish Ambulance Service recognises the considerable impact that such an adverse event will have on patients and/or their carers/family. The organisational response to such an event will be:

- Compassionate;
- Transparent;
- Honest;
- Timely; and
- Consistent

with a focus on the needs of the patient and/or carers/family.

The Scottish Ambulance Service has agreed what patients and/or carers/families can expect to happen every time a SAE occurs. When an event occurs patients and/or their carers/families can expect the following:

- We will keep them informed of our actions from the time that the adverse event happens through to the point when we have identified the learning, if appropriate and improvements to be made;
- We will communicate with them respectfully and honestly, in a way that compassionately acknowledges and recognises the emotional impact of the adverse event on the patient and their family;
- We will support them by providing a consistent named contact person;
- We will work with them to involve them in the review process, taking account of their preferences and providing them with the opportunity to share details of their experiences with staff, if appropriate to support their learning; and
- We will provide them with a sincere and honest apology for identified failings.
Our commitments to staff

The Scottish Ambulance Service has agreed what staff can expect to happen every time a SAE occurs and what the organisation expects from staff.

The Scottish Ambulance Service is committed to developing and shaping our organisational culture with values, beliefs and behaviours that:

- Recognise the importance of our staff in delivering quality services;
- Support our managers and leaders to value staff, their health, safety and wellbeing; and
- Support an honest, fair and just culture underpinned by respect and dignity.

This requires every member of staff to play their part; and to understand their roles, responsibilities and commitments. For the NHS Board, the revised Staff Governance Standard sets out what it must achieve in order to continuously improve the fair and effective management of staff. The Scottish Ambulance Service recognises the importance of staff governance as a feature of high performance which ensures that all staff have a positive employment experience in which they are fully engaged with both their job, their team, and their organisation. Achieving such an outcome will not only have a positive impact on organisational performance (and therefore on the quality of the services we provide), it is also an important component in providing all employees with dignity at work. For staff, the Staff Governance Standard, together with existing staff Codes of Conduct, sets out the responsibilities, standards of performance and behaviours expected.

Our approach to supporting staff through SAEs will reflect these aims and has been agreed in partnership with staff through the National Partnership Forum.

Supporting staff

The Board recognises the impact that a SAE may have on staff and has listened to feedback from staff. Our commitment to staff is that the Board’s revised approach will be:

- Fair and thorough;
- Supportive and compassionate;
- Transparent;
- Honest;
- Timely and consistent;

while all the time being focussed on the needs of the patient, their family and staff.

The Board’s commitments to staff when a SAE occurs are:
• We will ensure that you are safe and fully supported throughout the process;
• We will communicate with you respectfully and honestly, in a way that compassionately acknowledges and recognises the emotional impact the event may have had on you. This communication will be provided by a named contact person;
• We will involve you in the review process, listening to your experience and ensuring this informs the process and the resultant learning;
• We will ensure that the review is completed thoroughly, openly, fairly and as quickly as possible;
• We will keep you informed of progress of the SAE review, through your named contact, from the time that the event happens through to the point when we have identified the learning and improvements to be made; and
• We will ensure you receive feedback on the findings, recommendations and wider learning.

In return, the Board’s expectations from staff are:

• Ensure that you seek to fully understand the revised process and support its implementation within your area of work.

If you are required to participate in a review process we will need you to:

• Fully and actively engage throughout the process from initial review to developing and delivering improvement plans and identifying learning;
• Communicate openly, respectfully and honestly with everyone involved;
• Operate within all relevant professional code of conducts as well as the Board’s code of confidentiality;
• Fully implement any learning and education relevant to your role or sphere of practice; and
• Identify if you need help and support and accept this when it is offered

Definitions

To minimise ambiguity and ensure consistency of approach the Service framework provides a definition of the term SAE. A SAE requiring review is defined as an incident that occurred in relation to Service operations and results in one or more of the following:

• Unexpected and avoidable death of one or more patients, staff, visitors or members of the public, i.e. Category 1 Events as identified in the National Framework for the management of SAEs;
• Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm;
• A scenario that prevents or threatens to prevent the Service’s ability to
continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or ICT failure;

- Allegations of abuse (definition provided later in the document under “supplementary definitions”);  
- Public concern about the organisation or the wider NHS;
- One of the core set of Never Events that results in death or serious harm
  1. Opioid overdose of an opioid-naïve patient  
  2. Failure to recognise a misplaced or displaced ETT  
  3. Failure to monitor and respond to SPO2 or EtCO2 saturation  
  4. Misidentification of patients  
  5. Patient left at home outwith see and treat and no safeguarding in place  
  6. Patient falls or jumps from a moving vehicle  
  7. Patient falls from an ambulance trolley, patient chair or wheelchair  
  8. Ambulance involved in a fatal collision  
  9. Wrong medication given leading to adverse patient outcome  
  10. A patient suffering an immediately life-threatening condition does not receive a paramedic response  
  11. Non reported medication administration error  
  12. Preventable death in our care

A list of supplementary terms is provided within the National Patient Safety Agency (NPSA) guidance and provided later in the document under “supplementary definitions”

**Definition of Significant Adverse Events Requiring Further Review – Further Guidance**

The Service acknowledges that SAEs are not necessarily all clinical in nature and will include incidents such as data loss and serious breaches in confidentiality.

Any consideration of whether an incident meets the definition of Significant should consider the spirit of Service policy and the gravity of each incident. The definition of what constitutes a significant adverse event is not exhaustive and should not inhibit awareness of items which, although not listed specifically as SAEs, are SAEs.

It is assumed that any event involving death or serious harm will always be treated as a Significant Adverse Event Review (SAER) incident.
Supplementary Definitions:

- **Adverse Event** - An adverse event is defined as an event that could have caused, or did result in, harm to people or groups of people.

- **Unexpected death** – where natural causes are not suspected. Local organisations should review these to determine if the incident contributed to the unexpected death.

- **Permanent harm** – directly related to the incident and not to the natural course of the patient’s illness or underlying conditions, defined as permanent lessening of bodily functions, including sensory, motor, physiological or intellectual.

- **Prolonged pain and/or prolonged psychological harm** – pain or harm that a service user has experienced, or is likely to experience, for a continuous period of 28 days.

- **Serious harm** – a patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.

- **Major surgery** – a surgical operation within or upon the contents of the abdominal or pelvic, cranial or thoracic cavities or a procedure which, given the locality, condition of patient, level of difficulty, or length of time to perform, constitutes a hazard to life or function of an organ, or tissue (if an extensive orthopaedic procedure is involved, the surgery is considered major).

- **Abuse** – a violation of an individual’s human and civil rights by any other person or persons. Abuse may consist of single or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in serious harm or exploitation of the person subjected to it. This is defined in No Secrets for adults and in Care Quality Commission (CQC) guidance about compliance. Working together to safeguard children (2006) states that “abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm or by failing to act to prevent harm”.

- **Opioid Overdose of an opioid naïve patient** - Death or serious harm as a result of an overdose of an opioid given to a patient who was opioid naïve. Specifically this means:
  - Where a dose is used that is not consistent with the dosing protocol agreed by the healthcare organisation, or the manufacturer’s recommended dosage for opioid-naïve patients:
• Where the prescriber fails to ensure they were familiar with the therapeutic characteristics of the opioid prescribed:
• Excluded are cases where the patient was already receiving opioid medication.
Section 2: Procedure / Process
**Procedure**

The Significant Adverse Event Group (SAER Group) is directly responsible for overseeing the SAE process from inception to completion of recommendations as outlined in the action plan and to monitor and provide Board assurance in relation to the reporting and reviewing of SAEs involving the Service. The SAER Group will also:

- Provide strategic leadership and direction on all matters relating to the SAE;
- Ensure robust systems are in place and operating effectively for the identification, assessment and reviewing of all potential SAEs, both within the organisation and for independent contractor services;
- Be responsible for the decision and subsequent grading or down grading of all potential SAEs (must be Senior member of Medical Directorate, 1 non-clinical and any other Group member);
- Ensure process flow chart is followed;
- Receive and approve the final review report and associated action plan and be assured that the root cause of the Adverse Event has been established and learning has been realised;
- Sign off final reports and action plans (must be Senior member of Medical Directorate, 1 non-clinical and any other Group member);
- Monitor the progress and timely completion of the action plan;
- Identify themes and allocate them to appropriate owners to progress.

Incidents are reported to the SAER Group for consideration as to whether such incidents meet the definition of Significant. Incidents that may require additional review could come to the Service’s attention via a number of formal and informal routes including:

- Datix Reports
- Patient Concern
- Freedom of Information Request
- Central Legal Office
- Commendations process
- Never Event
- Whistle Blowing
- Exec Team
- ACC
- Patient Complaint
- Press Enquiry / Report
- Other NHSScotland body
- Scottish Government
- Trigger Tool
- Informal Conversations

The SAER group will use the initial incident review guidance (appendix 1) and the SBAR provided by Divisional Management (appendix 2) to determine if the incident is significant.

If the incident is a SAE, the SAER group members will inform the Chief Executive and launch a SAER.
**Review Process**

On receipt of information that an incident has occurred that may be a SAE, the SAER group will use the initial incident review guidance and an SBAR from the Division (appendix 2) to identify if the incident is a SAE. They will convene to decide if the incident is a SAE and if appropriate will invite local management. If it is classed as a SAE the SAER group will launch the SAER process and inform the CEO.

The incident will be assigned to a named member of the SAER Group who will act as the co-ordinator for the review. The SAER Group will assign two trained reviewers from the list of staff trained in Root Cause Analysis to carry out the review.

Once the reviewing officers have completed the review and developed an action plan they will forward these to the review co-ordinator who will quality control and present to SAER Group, the reviewing officers may also be asked to present to SAER Group.

The SAER Group will ensure that all completed reports are reviewed, redacted and forwarded to the National Clinical Governance Group and Staff and Clinical Governance Committees for information.

The Director of Health Professions & Nursing Care will share the completed SAER with the Chief Executive.

**Detailed process for reviewing officers when conducting a review**

This policy aims to establish a clear pathway for dealing with issues of adequacy of performance and competency of clinical staff, and any variations relating to clinical practice. It will establish a clear separation between these issues and those that pertain to matters of personal misconduct and capability.

The purpose of the policy is to encourage employees to openly discuss patient care issues in a supportive environment within the boundaries of justifiable accountability and to improve clinical practice for the future which will provide real benefits for patients and staff.

The policy is not intended to prevent issues of staff conduct and performance being dealt with by other appropriate service policies. Whilst no disciplinary sanctions are to be considered as part of this policy, there may be occasions whereby during the patient safety review or patient safety reflective meetings that issues come to light where it is deemed appropriate to invoke the Services Disciplinary Policy (Managing Conduct and Performance) rather than continue with this process.

This policy will allow the service to manage clinical performance issues without always having the need to refer to professional/registration bodies.
However, there may be cases, for example, those where poor patient care was deemed to put the public at risk or the individual was deemed unfit to practice through lack of clinical competency. In these instances, the service would have a duty to refer the matter to the relevant professional/registration body.

This process is divided into 2 levels; Patient Safety Reflective (PSR) meetings and Root Cause Analysis (RCA).
**Patient Safety Reflection Process**

The appointed reviewing officers will have been given a set of terms of reference from SAER Group.

The first stage of the review is to conduct the Patient Safety Reflective Meeting. The reviewing officers should consider incorporating additional expert assistance within the debrief if it is deemed necessary. The members of staff will be invited to attend and be advised that they can be accompanied.

The reflective meeting should be conducted in an informal and relaxed atmosphere with the emphasis placed on learning lessons and improving clinical practice.

An action plan, if appropriate should be agreed with the individual at the end of the meeting, and recorded in writing on the Reflective Meeting Form.

The next stage of the process is to conduct the Root Cause Analysis. If at any point during the reflective meeting or the subsequent analysis of the incident it is considered more appropriate to deal with the matter under the Service’s Disciplinary Policy (Managing Performance and Conduct) the process will stop, this will be decided by the DHP&NC in conjunction with the Divisional Management. The employee will be informed in writing of the reason why and the more appropriate pathway will be followed.

The recording forms for the PSR are in Appendix 3 and the Root Cause Analysis template is in Appendix 4.

**Root Cause Analysis Process**

Root Cause Analysis investigation is a problem solving methodology for discovering the real, or root cause(s) of problems, or difficulties identified via a range of activities, including adverse incident management. It is a retrospective analysis of the sequence of events leading to an adverse incident and will sometimes include the way the incident has been managed. Please refer to Maria Dineen’s Six Steps to Root Cause Analysis guidance which was issued to trained reviewers within SAS.
Transfer to Disciplinary / Conduct Process

When considering whether an issue should be managed / controlled by the SAER framework or by the Service disciplinary / conduct process the following questions should be asked:

1. Is it alleged that there was a deliberate breach of a sound Service policy?
2. Is there concern about the health of the individual(s)?
3. Is the main concern about a clear lack of knowledge, skills, or significant unprofessional conduct?

If the answer to all of these questions is NO then the significant adverse event group process should be the first choice, if the answer is YES to any of the questions then the Service’s disciplinary or conduct processes should be used. In the latter case a patient safety exercise can be conducted after the conclusion of the formal process.

The NPSA decision support tree is attached in appendix 5, this tool can be used to support the decision to move into the disciplinary process.

There may be occasions where both processes need to run concurrently due to the severity of the incident, in such cases the Director of Health Professions and Nursing Care, or deputy shall approve the running of concurrent processes after discussion with the Director of HR, or deputy. In these cases appropriate processes will need to be in place to ensure information from either process does not adversely prejudice the other.

Monitoring SAER Group reviews and Action Plans

Once completed, reviews and action plans are passed to the review co-ordinator by the reviewing officers and the review co-ordinator shall pass all information to SAER Group.

The SAER Group will formally review the incident review and action plan at the next scheduled meeting.

On a quarterly basis the SAER Group shall compile reports for Service governance committees statistically detailing the status of all reviews and their subsequent action plans. In addition to this an executive summary for all completed reviews will be provided to the Staff and Clinical Governance committees.

Process for monitoring action plan effectiveness and implementation

To ensure the Board obtains adequate assurance that the SAE process is being followed, the SAER Group will regularly monitor the recommendations for improvement to ensure they have been implemented and sustained.
Failure to sustain improvements could give rise to increased risk in relation to patient safety and further work may be necessary to re-communicate previously identified improvements.

Assurance will be provided to the Service that all procedures in respect of identifying and managing SAEs have been effectively implemented when the following have been evidenced:

- Full compliance with this policy has been achieved and evidenced;
- It is demonstrated that contributory factors of a SAE have been identified, action taken and recommendations communicated, implemented and reviewed in accordance with the Service Risk Management Policy;
- There is evidence that recommendations previously implemented have been sustained and maintained;
- There is evidence of public and patient involvement in the SAE process; and
- There is evidence that support offered reasonably met the needs and requirements of all those involved, including cultural and religious requirements.

**Sharing Lessons Learnt**

- The Director of HP and Nursing Care will ensure that all learning from Significant Adverse Events is published;
- The Director of HP and Nursing Care will liaise with managers and professional leads to ensure that any learning identified in the action plan is appropriately reflected in training and in policies and procedures;
- The Director of HP and Nursing Care shall provide a formal update to the Clinical Governance Committee at each meeting and to the Senior Management Team;
- Action plans will reflect any learning identified as part of the review and Heads of department / General Managers will ensure that action plans are fully implemented;
- Heads of department / General Managers will ensure that learning is appropriately discussed at team meetings, professional forums etc;
- If appropriate specific training / awareness sessions will be organised; and
- If considered appropriate the Service may decide to carry out audits to ensure that changes in practice have been embedded into the every day working practices of the organisation.

Examples of appropriate learning include:

- Solutions to address incident root causes that may be relevant to other teams, services and provider organisations;
Identification of the components of good practice that reduced the potential impact of the incident, and how they were developed and supported;

Potential impact of the incident;

Lessons from conducting the review that may improve the management of reviews in future;

Documentation of identification of the risks, the extent to which they have been reduced, and how this is measured and monitored; and

An executive summary should be published and circulated for each incident containing learning points.

Document control and Retention

The SAER group will be responsible for maintaining a records database recording all significant decision points. In addition to this the SAER group shall maintain all records associated with this process in a secure environment appropriate for patient records.
Roles and Responsibilities

The roles and responsibilities of Service personnel and governance groups are briefly outlined below:

**Chief Executive:** Has overall responsibility for Service activities, and for the final approval of SAER.

**Medical Director:** Has overall responsibility for Clinical Governance and Patient Safety.

**Director of Health Professions and Nursing Care:** Has overall responsibility for health and safety, infection control and significant adverse events. The DHPNC chairs the SAER Group.

**Director of Finance:** Has overall responsibility for ensuring funding is available to support this policy.

**Director of Service Delivery:** Has the responsibility of ensuring action plans are implemented.

**General Managers (GM):** To release staff to conduct the review processes.

**Medical Directorate:** Contribute to SAER group and review processes.

**Team Leaders (TL) / Area Service Managers (ASM):** To complete SBARs and where appropriate patient safety reflections.

**All Service employees:** To report all incidents whether Significant or not onto Datix.

**Significant Adverse Event Group:** To receive signed off reviews and action plans at all stages and to confirm review has identified root causes and appropriate learning. To assist with developing action plans for national/regional themes that emerge from SAER, complaints, concerns, etc.

**Clinical Governance Committee:** To receive quarterly reports from the SAER group and to assure the board that appropriate reviews are taking place.

**Staff Governance Committee:** To receive quarterly reports from the SAER group.

**National Clinical Governance Group:** To receive signed off reviews and action plans at all stages and to confirm review has identified root causes and appropriate learning. To assist with developing action plans for national/regional themes that emerge from SAER, complaints, concerns, etc.
Health and Safety Committee; and Infection Control Committee: To receive quarterly statistical reports from the SAER group and where appropriate review signed off reviews and action plans in order to modify Service policy or procedures as required.
Appendices: Forms, records and decision tools
### Appendix 1 – SAER GROUP – Initial Incident Review Record

| Date: |  |
| Date of Incident: |  |
| Datix Number: |  |
| SAER Group members |  |
| Summary of Incidents (Note based on currently available information) |  |
| Division Occurred in: | North | EC | SE | WC | SW | SORT | FLEET | ACC | AIR | Other |
| Is the incident a SAE | Yes | No |
| Is a SAER recommended | Yes | No |
| Date Passed to Exec Team |  |
| Did Chief Executive approve SAER | Yes | No |
| Date Exec Team Approved/Rejected |  |

### Description / Question

**With regard to incidents not directly involving staff, patients or visitors**

<table>
<thead>
<tr>
<th>Description / Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Is the Service exposed to significant media interest (at the extreme level on Service risk matrix) due to the incident?</td>
<td>Yes</td>
</tr>
<tr>
<td>B</td>
<td>Is the ability of the Service to deliver core services threatened due to the incident</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**With regard to incidents involving staff, patients or visitors,**

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Has a “never event” occurred?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>Has “Unexpected or avoidable death” occurred?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>Was “Serious Harm” been caused?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>Are there allegations of “abuse”?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Note: Any answer involving a yes response should lead to a recommendation to the Exec team that a SAER process is launched. The SAER group may recommend a SAER subject to Exec approval for incidents where no “yes” answer is provided.

If SAER process is approved for this incident complete the following details:

<table>
<thead>
<tr>
<th>Description</th>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAER Group co-ordinator appointed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reviewing Officer appointed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date PSR required by</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date PSRev required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date PSEA required</td>
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<td></td>
</tr>
</tbody>
</table>
Appendix 2 – SBAR Guidance for Managers

Significant Adverse Event Group

SBAR - Datix Web Number: IMMEDIATE ACTION

**Situation**

What happened?
When did it happen?
Where did it happen?
Who was involved?
Who reported it?
To whom did they report it?
Include patient outcome if known.

Give a concise statement of the incident.

**Background**

Pertinent background information related to the situation.

Information may include but not limited to that obtained from C3, Sequence of Events, Patient Report Form, Datix, Viewpoint, written and verbal communications, ACC voice recordings (It may not be necessary to use all these elements).

**Assessment**

Is there a problem that requires further review?
Has there been a failure in relation with compliance with policy, procedure or system?
What is the severity of the incident using the risk matrix definitions?

- Negligible – No impact to Organisation or Injury
- Minor – Minor impact or injury requiring first aid
- Moderate – Moderate impact to Organisation or injury requiring further treatment
- Major – Major impact to Organisation or long term incapacity / disability (e.g. loss of limb), requiring extensive rehabilitation and support
- Extreme – Extreme impact to Organisation or death or major permanent incapacity where rehabilitation will not improve outcome

**Recommendation**

Apart from further consideration by Significant Adverse Event Group, are there any other recommendations?
Appendix 3 – Patient Safety Reflection Process

Patient Safety Reflection *
Please refer to human factors framework

This template should be used to help you “reflect-on-action”, i.e. to think about what you (and others) did, how successful this was, and whether or not if any changes were made this would have resulted in any different outcomes.

### Report Author and Distribution

<table>
<thead>
<tr>
<th>Report Author</th>
<th></th>
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<tbody>
<tr>
<td>Report Date</td>
<td></td>
</tr>
<tr>
<td>Report Issued to SAER GROUP Date</td>
<td></td>
</tr>
<tr>
<td>SAER GROUP Ref Number (eg:WebXXXX)</td>
<td></td>
</tr>
<tr>
<td>Incident Number:</td>
<td></td>
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</tbody>
</table>

### Description

What happened?
Consider the entire event/patient journey not just a specific incident within it. For clinical incidents try and break this down into the component parts of the call i.e. dispatch, en-route, arrival, on scene, en-route/hospital/discharge etc.

### Feelings
<table>
<thead>
<tr>
<th>What were you thinking about in terms of people, activity, environment?</th>
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**Evaluation**

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<tr>
<th>What do you think worked well and what didn’t work as well in terms of people, activity, environment?</th>
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</table>

**Analysis**

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<tr>
<th>Why do you think this happened in terms of people, activity, environment?</th>
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</table>
What other influences might there have been? Is there information that is missing?

Conclusion

What else could you have done?
**Patient Safety Reflection Action Plan**

<table>
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<tr>
<th>Ref No</th>
<th>Recommendation</th>
<th>Completion by whom</th>
<th>Completion Due Date</th>
<th>Complete and Completion Date</th>
</tr>
</thead>
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<td></td>
<td>Yes / No</td>
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<td>Yes / No</td>
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<td>Yes / No</td>
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<td></td>
<td></td>
<td></td>
<td>Yes / No</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td>Yes / No</td>
</tr>
</tbody>
</table>

*based on Gibbs (1988) Reflective Cycle*
Patient Safety Reflection Report Template

Summary

Findings from Significant Adverse Event Group, Terms of Reference

Conclusion

Recommendations
Appendix 4 – Root Cause Analysis Report Template

Scottish Ambulance Service
Significant Adverse Event Review

Review in relation to: Datix Reference xxx
Author(s) and Role: xxx
Date submitted: xxx
## Executive Summary

### Incident Details

<table>
<thead>
<tr>
<th>Incident Details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

## Main Findings and Conclusions of Review

<table>
<thead>
<tr>
<th>Main Findings and Conclusions of Review</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

## Good Practice Identified

<table>
<thead>
<tr>
<th>Good Practice Identified</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

## Recommendations

<table>
<thead>
<tr>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
Full Report

Methodology, Terms of Reference, Detection of Incident, Patient and Family Involvement, Review Timescales

Please detail below the methods you used to conduct the review and all sources of data and information used to conduct this review. Also identify the terms of Reference. As a minimum this will usually include:

<table>
<thead>
<tr>
<th>Information</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic Patient Report Form</td>
<td>ACC call recording to dispatch</td>
</tr>
<tr>
<td>Philips MRx Defibrillator Printout</td>
<td>ACC call recording to hospital</td>
</tr>
<tr>
<td>999 call recording – Incident number</td>
<td>Statements from</td>
</tr>
<tr>
<td>Sequence of Events – Incident number</td>
<td>Transcripts of interviews</td>
</tr>
</tbody>
</table>

Patient Safety Reflection Form

Methodology

Outline the methods used to conduct the review.

Terms of Reference

Outline the terms of reference for review.

Detection of Incident

How the Adverse Event was detected.

Patient and Family Involvement

Record all contacts made with the patient and family. To include dates they were informed of the event, any communications with them and how they participated in the review. Detail the reasons for not involving them if appropriate.

Review Timescales

Outline the review start and finish dates.
<table>
<thead>
<tr>
<th>Incident Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please summarise the incident description and consequences</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using a human factors approach insert your evidence based findings in this section. Please refer to Contributory Factors Classification Framework on page 74.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>People</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Activity</th>
</tr>
</thead>
</table>

| Environment |
## Conclusions

Insert the conclusions you have made from all of the evidence gathered

### Areas Where It Can Be Demonstrated That The Care And Treatment Of The Patient Met With Local And National Practice Standards

### Areas Where It Can Be Demonstrated That The Care And Treatment Of The Patient did not meet With Local And National Practice Standards

### Learning Opportunities Identified, But Which Do Not Constitute Significant / Serious Lapses In Care And Treatment.
<table>
<thead>
<tr>
<th>Actions already completed following incident</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insert all recommendations in this section</td>
</tr>
</tbody>
</table>
### Timeline / Chronology

| Date | Time | Staff member involved | Event / step in chronology | Contextual Information e.g. Relevant background information, the detail of what is written in the clinical record, information obtained from staff statements but which is not in the records) | Were expected policy/practice standards met - if yes what is this evidence to support this assertion? | Are there significant concerns regarding care and treatment / standard/policy compliance. If yes what are they? | Questions that need to be asked about the patient's care and treatment (also identify to whom the question needs to be posed) these should be focusing on exploring the concerns identified and adhere to the principles of a human factors analysis framework | Questions that need to be asked about systems, policies, supervision, training etc (also identify to whom the question needs to be posed) these should be focusing on exploring the concerns identified and adhere to the principles of a systems analysis framework. |

---

Please Note- This document is uncontrolled once printed.
### Contributory Factors Classification Framework

<table>
<thead>
<tr>
<th>Patient Factors</th>
<th>Components</th>
</tr>
</thead>
</table>
| Clinical condition | - Pre-existing co-morbidity  
|                  | - Complexity of condition  
|                  | - Seriousness of condition  
|                  | - Limited options available to treat condition  
|                  | - Disability  |
| Physical Factors | - Poor general physical state  
|                  | - Malnourished  
|                  | - Dehydrated  
|                  | - Age related issues  
|                  | - Obese  
|                  | - Poor sleep pattern  |
| Social Factors | - Cultural / religious beliefs  
|                | - Language  
|                | - Lifestyle (smoking/ drinking/ drugs/diet)  
|                | - Sub-standard living accommodation (e.g. dilapidated)  
|                | - Life events  
|                | - Lack of support networks / (social protective factors -Mental Health Services)  
|                | - Engaging in high risk activity  |
| Mental/Psychological Factors | - Motivation issue  
|                | - Stress / Trauma  
|                | - Existing mental health disorder  
|                | - Lack of intent (Mental Health Services)  
|                | - Lack of mental capacity  
|                | - Learning Disability  |
| Interpersonal relationships | - Staff to patient and patient to staff  
|                | - Patient engagement with services  
|                | - Staff to family and family to staff  
|                | - Patient to patient  
|                | - Family to patient or patient to family  
|                | - Family to family (Siblings, parents, children)  |

<table>
<thead>
<tr>
<th>Staff Factors</th>
<th>Components</th>
</tr>
</thead>
</table>
| Physical issues | - Poor general health (e.g. nutrition, hydration, diet, exercise, fitness)  
|                  | - Disability (e.g. eyesight problems, dyslexia)  
|                  | - Fatigue  
|                  | - Infected Healthcare worker  |
| Psychological Issues | - Stress (e.g. distraction / preoccupation)  
|                          | - Specific mental illness (e.g. depression)  
|                          | - Mental impairment (e.g. illness, drugs, alcohol, pain)  
<p>|                          | - Lack of motivation (e.g. boredom, complacency, low job satisfaction)  |
| Social | - Domestic problems (e.g. family related issues)  |</p>
<table>
<thead>
<tr>
<th>Domestic</th>
<th>Lifestyle problems (e.g. financial/housing issues)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cultural beliefs</td>
</tr>
<tr>
<td></td>
<td>Language</td>
</tr>
<tr>
<td>Personality Issues</td>
<td>Low self confidence / over confidence (e.g. Gregarious, reclusive, interactive)</td>
</tr>
<tr>
<td></td>
<td>Risk averse / risk taker</td>
</tr>
<tr>
<td></td>
<td>Bogus Healthcare worker</td>
</tr>
<tr>
<td>Cognitive factors</td>
<td>Preoccupation / narrowed focus (Situational awareness problems)</td>
</tr>
<tr>
<td></td>
<td>Perception/viewpoint affected by info. or mindset (Expectation/Confirmation bias)</td>
</tr>
<tr>
<td></td>
<td>Inadequate decision/action caused by Group influence</td>
</tr>
<tr>
<td></td>
<td>Distraction / Attention deficit</td>
</tr>
<tr>
<td></td>
<td>Overload</td>
</tr>
<tr>
<td></td>
<td>Boredom</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Task Factors</th>
<th>Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guidelines, Policies and Procedures</td>
<td>- Not up-to-date</td>
</tr>
<tr>
<td></td>
<td>- Unavailable at appropriate location (e.g. Lost/missing/non-existent/not accessible when needed)</td>
</tr>
<tr>
<td></td>
<td>- Unclear/not useable (Ambiguous; complex; irrelevant, incorrect)</td>
</tr>
<tr>
<td></td>
<td>- Not adhered to / not followed</td>
</tr>
<tr>
<td></td>
<td>- Not monitored / reviewed</td>
</tr>
<tr>
<td></td>
<td>- Inappropriately targeted/focused (i.e. not aimed at right audience)</td>
</tr>
<tr>
<td></td>
<td>- Inadequate task disaster plans and drills</td>
</tr>
<tr>
<td>Decision making aids</td>
<td>- Aids not available (e.g. CTG machine; checklist; risk assessment tool; fax machine to enable remote assessment of results)</td>
</tr>
<tr>
<td></td>
<td>- Aids not working (e.g. CTG machine, risk assessment tool, fax machine)</td>
</tr>
<tr>
<td></td>
<td>- Difficulties in accessing senior / specialist advice</td>
</tr>
<tr>
<td></td>
<td>- Lack of easy access to technical information, flow charts and diagrams</td>
</tr>
<tr>
<td></td>
<td>- Lack of prioritisation of guidelines</td>
</tr>
<tr>
<td></td>
<td>- Incomplete information (test results, patient history)</td>
</tr>
<tr>
<td>Procedural or Task Design</td>
<td>- Poorly designed (i.e. Too complex; too much info.; difficult to conceive or remember)</td>
</tr>
<tr>
<td></td>
<td>- Guidelines do not enable one to carry out the task in a timely manner</td>
</tr>
<tr>
<td></td>
<td>- Too many tasks to perform at the same time</td>
</tr>
<tr>
<td></td>
<td>- Contradicting tasks</td>
</tr>
<tr>
<td></td>
<td>- Staff do not agree with the ‘task/procedure design’</td>
</tr>
<tr>
<td></td>
<td>- Stages of the task not designed so that each step can realistically be carried out</td>
</tr>
<tr>
<td></td>
<td>- Lack of direct or understandable feedback from the task</td>
</tr>
<tr>
<td></td>
<td>- Misrepresentation of information</td>
</tr>
<tr>
<td></td>
<td>- Inappropriate transfer of processes from other situations</td>
</tr>
<tr>
<td></td>
<td>- Inadequate Audit, Quality control, Quality Assurance built into the</td>
</tr>
</tbody>
</table>
### Communication Components

<table>
<thead>
<tr>
<th>Verbal communication</th>
<th>Inappropriate tone of voice and style of delivery for situation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ambiguous verbal commands / directions</td>
</tr>
<tr>
<td></td>
<td>Incorrect use of language</td>
</tr>
<tr>
<td></td>
<td>Made to inappropriate person(s)</td>
</tr>
<tr>
<td></td>
<td>Incorrect communication channels used</td>
</tr>
<tr>
<td>Written communication</td>
<td>Inadequate patient identification</td>
</tr>
<tr>
<td></td>
<td>Records difficult to read</td>
</tr>
<tr>
<td></td>
<td>All relevant records not stored together and accessible when required</td>
</tr>
<tr>
<td></td>
<td>Records incomplete or not contemporaneous (e.g. unavailability of patient management plans, patient risk assessments, etc)</td>
</tr>
<tr>
<td></td>
<td>Written information not circulated to all team members</td>
</tr>
<tr>
<td></td>
<td>Communication not received</td>
</tr>
<tr>
<td></td>
<td>Communications directed to the wrong people</td>
</tr>
<tr>
<td></td>
<td>Lack of information to patients</td>
</tr>
<tr>
<td></td>
<td>Lack of effective communication to staff of risks (Alerts systems etc)</td>
</tr>
<tr>
<td>Non verbal communication</td>
<td>Body Language issues (closed, open, body movement, gestures, facial expression)</td>
</tr>
<tr>
<td>Communication Management</td>
<td>Communication strategy and policy not defined / documented</td>
</tr>
<tr>
<td></td>
<td>Ineffective involvement of patient/carer in treatment and decisions</td>
</tr>
<tr>
<td></td>
<td>Lack of effective communication to patients/relatives/carers of risks</td>
</tr>
<tr>
<td></td>
<td>Lack of effective communication to patients about incidents (being open)</td>
</tr>
<tr>
<td></td>
<td>Information from patient/carer disregarded</td>
</tr>
<tr>
<td></td>
<td>Ineffective communication flow to staff up, down and across</td>
</tr>
<tr>
<td></td>
<td>Ineffective interface for communicating with other agencies (partnership working)</td>
</tr>
<tr>
<td></td>
<td>Lack of measures for monitoring communication</td>
</tr>
</tbody>
</table>

### Equipment Components

<table>
<thead>
<tr>
<th>Displays</th>
<th>Incorrect information / feedback available</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inconsistent or unclear information</td>
</tr>
<tr>
<td></td>
<td>Illegible information</td>
</tr>
<tr>
<td></td>
<td>Interference/unclear equipment display</td>
</tr>
<tr>
<td>Integrity</td>
<td>Poor working order</td>
</tr>
<tr>
<td></td>
<td>Inappropriate size</td>
</tr>
<tr>
<td>Work Environment</td>
<td>Components</td>
</tr>
<tr>
<td>------------------</td>
<td>------------</td>
</tr>
</tbody>
</table>
| **Administrative factors** | - Unreliable or ineffective general administrative systems (Please specify e.g.: Bookings, Patient identification, ordering, requests, referrals, appointments)
- Unreliable or ineffective admin infrastructure (e.g. Phones, bleep systems etc)
- Unreliable or ineffective administrative support |
| **Design of physical environment** | - Poor or inappropriate office design (computer chairs, height of tables, anti-glare screens, security screens, panic buttons, placing of filing cabinets, storage facilities, etc.)
- Poor or inappropriate area design (length, shape, visibility, provision of space)
- Inadequate security provision
- Lack of secure outside space
- Inadequate lines of sight
- Inadequate/inappropriate use of colour contrast/patterns (walls/doors/flooring etc) |
| **Environment** | - Facility not available (failure or lack of capacity)
- Fixture or fitting not available (failure or lack of capacity)
- Single sex accommodation limitation/breach
- Ligature/anchor points
- Housekeeping issues – lack of cleanliness
- Temperature too high/low
- Lighting too dim or bright, or lack of
- Noise levels too high or low
- Distractions |
| **Staffing** | - Inappropriate skill mix (e.g. Lack of senior staff; Trained staff; Approp. trained staff)
- Low staff to patient ratio
- No / inaccurate workload / dependency assessment |
<table>
<thead>
<tr>
<th>Organisational Components</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organisational structure</strong></td>
</tr>
<tr>
<td>- Hierarchical structure/Governance structure not conducive to discussion, problem sharing, etc.</td>
</tr>
<tr>
<td>- Tight boundaries for accountability and responsibility</td>
</tr>
<tr>
<td>- Professional isolation</td>
</tr>
<tr>
<td>- Clinical versus the managerial model</td>
</tr>
<tr>
<td>- Inadequate maintenance</td>
</tr>
<tr>
<td>- Lack of robust Service level agreements/contractual arrangements</td>
</tr>
<tr>
<td>- Inadequate safety terms and conditions of contracts</td>
</tr>
<tr>
<td><strong>Priorities</strong></td>
</tr>
<tr>
<td>- Not safety driven</td>
</tr>
<tr>
<td>- External assessment driven e.g. Annual Health checks</td>
</tr>
<tr>
<td>- Financial balance focused</td>
</tr>
<tr>
<td><strong>Externally imported risks</strong></td>
</tr>
<tr>
<td>- Unexpected adverse impact of national policy/guidance (from Department of Health / Health authorities /Professional colleges)</td>
</tr>
<tr>
<td>- Locum / Agency policy and usage</td>
</tr>
<tr>
<td>- Contractors related problem</td>
</tr>
<tr>
<td>- Equipment loan related problem</td>
</tr>
<tr>
<td>- Lack of service provision</td>
</tr>
<tr>
<td>- Bed Occupancy levels (Unplanned bed opening/closures)</td>
</tr>
<tr>
<td>- PFI related problems (Private Finance Initiative)</td>
</tr>
<tr>
<td><strong>Safety culture</strong></td>
</tr>
<tr>
<td>- Inappropriate safety / efficiency balance</td>
</tr>
<tr>
<td>- Poor rule compliance</td>
</tr>
<tr>
<td>- Lack of risk management plans</td>
</tr>
<tr>
<td>- Inadequate leadership example (e.g. visible evidence of commitment to safety)</td>
</tr>
<tr>
<td>- Inadequately open culture to allow appropriate communication</td>
</tr>
<tr>
<td>- Inadequate learning from past incidents</td>
</tr>
<tr>
<td>- Incentives for 'at risk'/'risk taking' behaviors</td>
</tr>
<tr>
<td>- Acceptance/toleration of inadequate adherence to current practice</td>
</tr>
<tr>
<td>- Ignorance/poor awareness of inadequate adherence to current practice</td>
</tr>
<tr>
<td>- Disempowerment of staff to escalate issues or take action</td>
</tr>
</tbody>
</table>

### Education and Components
### Training

<table>
<thead>
<tr>
<th>Components</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competence</td>
<td>Lack of knowledge&lt;br&gt;                    Lack of skills&lt;br&gt;                    Inexperience&lt;br&gt;                    Inappropriate experience or lack of quality experience&lt;br&gt;                    Unfamiliar task&lt;br&gt;                    Lack of testing and assessment</td>
</tr>
<tr>
<td>Supervision</td>
<td>Inadequate supervision&lt;br&gt;                     Lack of / inadequate mentorship&lt;br&gt;                     Training results not monitored/acted upon</td>
</tr>
<tr>
<td>Availability / accessibility</td>
<td>Training needs analysis not conducted/acted upon&lt;br&gt;                     On the job training unavailable or inaccessible&lt;br&gt;                     Emergency Training unavailable or inaccessible&lt;br&gt;                     Team training unavailable or inaccessible&lt;br&gt;                     Core skills training unavailable or inaccessible&lt;br&gt;                     Refresher courses unavailable or inaccessible</td>
</tr>
<tr>
<td>Appropriateness</td>
<td>Inappropriate content&lt;br&gt;                     Inappropriate target audience&lt;br&gt;                     Inappropriate style of delivery&lt;br&gt;                     Time of day provided inappropriate</td>
</tr>
</tbody>
</table>

### Team Factors

<table>
<thead>
<tr>
<th>Components</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role Congruence</td>
<td>Lack of shared understanding&lt;br&gt;                    Role + responsibility definitions misunderstood/not clearly defined</td>
</tr>
<tr>
<td>Leadership</td>
<td>Ineffective leadership – clinically&lt;br&gt;                    Ineffective leadership – managerially&lt;br&gt;                    Lack of decision making&lt;br&gt;                    Inappropriate decision making&lt;br&gt;                    Untimely decision making (delayed)&lt;br&gt;                    Leader poorly respected</td>
</tr>
<tr>
<td>Support and cultural factors</td>
<td>Lack of support networks for staff&lt;br&gt;                    Inappropriate level of assertiveness&lt;br&gt;                    Negative team reaction(s) to adverse events&lt;br&gt;                    Negative team reaction to conflict&lt;br&gt;                    Negative team reaction to newcomers&lt;br&gt;                    Routine violation of rules/regulations&lt;br&gt;                    Lack of team openness/communication with colleagues&lt;br&gt;                    Inadequate inter-professional challenge&lt;br&gt;                    Failure to seek support&lt;br&gt;                    Failure to address/manage issues of competence (whistle blowing)</td>
</tr>
</tbody>
</table>
Please use the Glasgow Grid Below to examine all of the evidence gathered to reach a root cause.

For each of the columns ask a different “why question” derived from the previous question. Example below. Please replicate your questions in each column and the learning points from each question. These should be included in the action plan if one is required.

<table>
<thead>
<tr>
<th>Q1. Why did HV (A) draw up the wrong vaccination?</th>
<th>Q2. Why did HV (A) administer the wrong vaccination?</th>
<th>Q3. Why did both HVs fail to double-check the vial or inform the guardians prior to vaccination?</th>
<th>Q4. Why was there no formal standard immunisation protocol in the practice?</th>
<th>Q5. Why did the practice make this assumption?</th>
</tr>
</thead>
</table>

**Increasing Depth of Analysis**

Superficial In-Depth

|-----|-----|-----|-----|-----|

**Answers / Root Causes**

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

**Identified Learning Points/Needs**

---

Please Note- This document is uncontrolled once printed.

Version: 1.00
Page 80 of 98
Release Date: May 2015
Owner: Medical Director
<table>
<thead>
<tr>
<th>Five Whys Tool / Glasgow Grid</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
**Action plan**

What could be done differently next time? Is there any wider organisational learning that can be taken from this event? How will this be shared? Who will be responsible? What are the timelines?

(Consider Incident Decision Tree)

<table>
<thead>
<tr>
<th>Ref No</th>
<th>Recommendation</th>
<th>Completion by whom</th>
<th>Completion Due Date</th>
<th>Complete and Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes / No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Yes / No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Yes / No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Yes / No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Yes / No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Yes / No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Yes / No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Yes / No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Yes / No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Yes / No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 5: Incident Decision Tree

INCIDENT DECISION TREE*
Work through the tree separately for each individual involved

**Start Here**

Deliberate Harm Test

- Were the actions as intended?
  - NO
  - YES

  - Were adverse consequences intended?
    - NO
    - YES

    Consult NCAA or relevant regulatory body
    Advise individual to consult Trade Union Representative
    Consider:
    ● Suspension
    ● Referral to police and disciplinary/regulatory body
    ● Occupational Health referral

    Highlight any System Failures identified

  - NO

Incapacity Test

- Does there appear to be evidence of ill health or substance abuse?
  - NO
  - YES

  - Were the protocols and safe procedures available, workable, intelligent, correct and in routine use?
    - NO
    - YES

    Consult NCAA or relevant regulatory body
    Advise individual to consult Trade Union Representative
    Consider:
    ● Occupational Health referral
    ● Reasonable adjustment to duties
    ● Sick leave

    Highlight any System Failures identified

  - YES

Foresight Test

- Did the individual depart from agreed protocols or safe procedures?
  - NO
  - YES

  - Were there any deficiencies in training, experience or supervision?
    - NO
    - YES

    Consult NCAA or relevant regulatory body
    Advise individual to consult Trade Union Representative
    Consider:
    ● Referral to disciplinary/regulatory body
    ● Reasonable adjustment to duties
    ● Occupational Health referral
    ● Suspension

    Highlight any System Failures identified

  - NO

Substitution Test

- Would another individual coming from the same professional group, possessing comparable qualifications and experience, behave in the same way in similar circumstances?
  - NO
  - YES

  - Were there any significant mitigating circumstances?
    - NO
    - YES

    Consult NCAA or relevant regulatory body
    Advise individual to consult Trade Union Representative
    Consider:
    ● Referral to disciplinary/regulatory body
    ● Reasonable adjustment to duties
    ● Occupational Health referral
    ● Suspension

    Highlight any System Failures identified

  - NO

System Failure

Review system

* Based on James Reason’s culpability model

Please Note- This document is uncontrolled once printed.

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Appendix 6

BEING OPEN POLICY AND PROCEDURE

This procedure applies to all significant adverse events as defined within the framework.

Guiding principles for being open (adopted from NPSA 2005)

The Principles

The following set of principles has been developed to help the SAS create and embed a culture of being open:

1. Acknowledgement
2. Truthfulness, timeliness and clarity of communication
3. Apology
4. Recognising patient and carer expectations
5. Professional support (for patients, carers their families and for staff?)
6. Risk management and systems improvement
7. Multidisciplinary responsibility
8. Clinical governance
9. Confidentiality
10. Continuity of care

Key Principles

Acknowledgement

All patient safety incidents should be acknowledged and reported as soon as they are identified through the Service’s incident reporting system, Datix. In cases where the patient and/or their carers inform staff when something untoward has happened, it must be taken seriously from the outset. Any concerns should be treated with compassion and understanding by all staff. Denial of a patient’s concerns will make future open and honest communication more difficult.

Truthfulness, Timeliness and Clarity
Information about a patient safety incident must be given to patients and/or their carers in a truthful and open manner by an appropriately nominated officer. Patients should be given a step-by-step explanation of what happened, which takes into account their individual needs, and is delivered openly.

Communication should be timely, please refer to timeline within the SAER GROUP framework. Patients and/or their carers should be provided with information about what happened as soon as this is practical. It is also essential that any information given is based solely on the facts known at the time. Staff should explain that new information may emerge as an incident review is undertaken, and the patient and/or carers should be kept up-to-date with the progress of the review. Patients and/or their carers should receive clear, unambiguous information and be given a single point of contact within the Service, for any questions or requests they may have. They should not receive conflicting information from different members of staff, and the use of medical jargon, which they may not understand, should be avoided. Staff should check that patients and/or their carers understand what is being said to them.

**Apology**

Patients and/or their carers should receive a sincere expression of sorrow or regret for the harm that has resulted from a patient safety incident. This should be in the form of an appropriately worded and agreed manner of apology, as early as possible. Both verbal and written apologies should be given. Based on local circumstances, senior managers should decide on the most appropriate member of staff to issue these apologies to patients and/or their carers. The decision should consider seniority, relationship to the patient, and experience and expertise in the type of patient safety incident that has occurred.

Verbal apologies are essential because they enable face-to-face contact between the patient and/or their carers and SAS staff. This should be given as soon as staff are aware an incident has occurred. It is important not to delay for any reason, including: setting up a more formal multi-disciplinary discussion with the patient and/or their carers; fear and apprehension; or lack of staff availability. Delays are likely to increase the patient’s and/or their carers’ sense of anxiety, anger or frustration.

A written apology must also be given. This should clearly state that the Service is sorry for the suffering and distress resulting from the incident must also be given. Depending on the needs of the patient, carer or family members, alternative forms of communication may need to be considered and offered.

**For Information / Guidance see SPSO Guidance on Apology on page 60**

**Recognising Patient and Carer Expectations**

Patients and/or their carers can reasonably expect to be fully informed of the issues surrounding a patient incident, and its consequences, in a face-to-face
meeting with representatives from the Service. They should be treated sympathetically, with respect and consideration. Confidentiality must be maintained at all times. Patients and/or their carers should be provided with support in a manner appropriate to their needs. This involves consideration of special circumstances that can include a patient requiring additional support, independent advice, advocacy and support including communication support, such as foreign language or BSL interpretation. For further information please contact the Services Equalities Manager, Ann Tobin.

**Professional Support**

The Service encourages its staff, whether directly employed or independent contractors, to report patient safety incidents. Staff should feel supported throughout the incident review process because they too may have been affected by being involved. They should not be unfairly exposed to punitive disciplinary action, increased medico-legal risk or any threat to their registration.

Where there is reason for the Service to believe that a member of staff has committed a punitive or criminal act, steps will be taken to preserve its position, and the member(s) of staff will be so advised at an early stage to enable them to obtain separate legal advice and/or representation.

The Service encourages staff to seek support from their relevant regulatory / professional body such as the Healthcare Professions Council of Paramedics.

**Risk Management and Systems Improvement**

Patient Safety Reflection, Patient Safety Review and Root Cause Analysis (RCA) are the tools used within the Service to uncover the underlying causes of a patient safety incident, please refer to the PSL & I framework. The reviews and analysis should focus on improving systems of care, which will then be reviewed for their effectiveness by the Significant Adverse Event Group.

**Multi-Disciplinary Responsibility**

This policy on openness applies to all staff that have key roles in the patient’s care. Most healthcare provision involves multi-disciplinary teams and communication with patients and/or their carers following an incident that led to harm should reflect this. This ensures consistency with the philosophy that incidents usually result from system failures and rarely from the actions of an individual.

**Clinical Governance**

Being open is supported through the Service’s Significant Adverse Event Group, with accountability to the Executive Team to ensure required changes are implemented and their effectiveness reviewed. Findings will be disseminated to staff so that they can learn from patient safety incidents. Continuous learning
programmes and audits will be developed to allow the Service to learn from the patient’s experience of the policy of being open. The information used to share learnings will be treated appropriately, which may mean the incident and/or findings will be anonymised before being disseminated.

Confidentiality

The privacy and confidentiality of the patient and/or carer and staff privacy will be fully considered and respected. Details of a patient safety incident should at all times be considered confidential. It is good practice to ask the individual concerned for their consent prior to disclosing information beyond the clinicians involved in treating the patient. Where this is not practicable or an individual refuses to consent to the disclosure, disclosure may still be lawful if justified in the public interest or where those investigating the incident have statutory powers for obtaining information. Communication with those outside the clinical team should also be on a strictly need-to-know basis and, where practicable, records should be anonymous. In addition, it is good practice to inform the patient and/or their carers about who will be involved in the review before it takes place, and give them the opportunity to raise any objections.

Continuity of Care

Patients are entitled to expect that they will continue to receive high standards of care and will continue to be treated with respect and compassion.
Being Open Process

Being open is a process rather than a one-off event. There are a number of stages in the process. The duration of the process depends on the incident, the needs of the patient, their family and carers, and how the investigation into the incident progresses. Please see the diagram and further detail below.

Overview of the Being open process

<table>
<thead>
<tr>
<th>Incident detection or recognition</th>
<th>Preliminary team discussion</th>
<th>Initial Being open discussion</th>
<th>Follow-up discussions</th>
<th>Process completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detection and notification through appropriate systems</td>
<td>Initial assessment</td>
<td>Verbal and written apology</td>
<td>Provide update on known facts at regular intervals</td>
<td>Discuss findings of investigation and analysis</td>
</tr>
<tr>
<td>Prompt and appropriate clinical care to prevent further harm</td>
<td>Establish timeline</td>
<td>Provide known facts to date</td>
<td>Inform on continuity of care</td>
<td>Inform on continuity of care</td>
</tr>
<tr>
<td></td>
<td>Choose who will lead communication</td>
<td>Offer practical and emotional support</td>
<td>Share summary with relevant people</td>
<td>Share summary with relevant people</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identify next steps for keeping informed</td>
<td>Monitor how action plan is implemented</td>
<td>Monitor how action plan is implemented</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Respond to queries</td>
<td>Communicate learning with staff</td>
<td>Communicate learning with staff</td>
</tr>
</tbody>
</table>

Documentation: Provide written records of all Being open discussions

Record investigation and analysis related to incident

Being Open Procedure

Step 1: Incident Detection and Recognition

Please refer to the SAER framework for information regarding this stage.

Stage 2: Preliminary team discussion

The SAER Framework identifies the level response for each type of incident.

1. Timing

The initial being open discussion with the patient, their family and carers should occur as soon as possible after recognition of the patient safety incident. Factors to consider when timing this discussion include:
The content of the initial being open discussion with the patient, their family and carers should cover the following:

- An expression of genuine sympathy, regret and a meaningful apology for the harm that has occurred
- The facts which have been established to date, which have the consensus of the multi-disciplinary team reviewing the incident. Where there is disagreement on which facts have been established, communication relating to these should be deferred until after the investigation has been completed. This means that early dialogue can still be opened with the
patient, carers and family members concerned, while further work is done to obtain clarity.

- The patient, their family and carers are informed that an incident investigation is being carried out and more information will become available as it progresses.
- Consideration is given of the understanding which the patient, family members and carer may have of what happened, as well as any questions they may have.
- Consideration and formal noting of the views and concerns of the patient, their family and carer and demonstration that these are being heard and taken seriously.
- Appropriate language and terminology are used when speaking to patients, their families and carers. For example, using the terms ‘patient safety incident’ or ‘adverse event’ may be meaningless or even insulting to some patients, their families and carers. If a patient’s first language is not English, it is also important to consider their language needs – if they would like the being open discussion to be conducted in French or Urdu, for example via a sign language should be arranged.
- An explanation about what will happen next in terms of the short through to long-term treatment plan and incident analysis findings.
- 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.
- In addition to direct assistance, an offer of practical and emotional support for the patient, their family and carer. This may involve getting help from third parties such as charities and voluntary organisations. Information about the patient and the incident should not normally be disclosed to third parties without consent.

Stage 4: Follow-up discussions

Follow-up discussions with the patient, their family and carers are an important step in the being open process. Depending on the incident and the timeline for the investigation, there may be more than one follow-up discussion. The following guidelines will assist in making the communication effective:

- The discussion occurs at the earliest practical opportunity.
- Consideration is given to the timing of the meeting, based on both the patient’s health and personal circumstances, as well as family commitments: e.g. a family member who is key to the meeting may have work commitments.
- Consideration is given to the location of the meeting, for example at the patient’s home.
- Feedback is given on progress to date and information provided on the investigation process.
- 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.
The patient, their family and carers should be offered an opportunity to discuss the situation with another relevant professional, where appropriate.

A written record of the discussion is kept and shared with the patient, their family and carers.

All queries are responded to appropriately. If the query is likely to take more than a few days to collate a response, an acknowledgement of receipt of the query should be sent to the originator of the query.

If completing the process at this point, the patient, their family and carers should be asked if they are satisfied with the investigation and a note of the response made in the patient’s records.

The patient is provided with contact details so that if further issues arise, it is straightforward for the patient to get back in touch with the relevant healthcare professionals or an agreed alternative contact.

Stage 5: Process completion

1. Communication with the patient, their family and carers

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

- the chronology of clinical and other relevant facts
- details of the concerns and complaints of the patient, their family and carers
- a repeated apology for the harm suffered and any shortcomings in the delivery of care that led to the patient 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.

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

2. Communication with the GP

Wherever possible, it is advisable to send a brief communication to the patient’s GP advising them of the events.

3. Monitoring

Any recommendations for systems improvements and changes implemented should be monitored for effectiveness in preventing a recurrence.
The risk manager or equivalent should develop a plan for monitoring the implementation and effectiveness of changes.

4. Communicating changes to staff
Effective communication with staff is a vital step in ensuring that the recommended changes are fully implemented and monitored. It will also facilitate the move towards increased awareness of patient safety issues and the value of being open. Being open fits well with the Service’s own set of values, helping embed a culture of patient safety and continuous improvement in standards of clinical care. It will be important to ensure that communications channels are two-way, in order to for staff to feed back their views on patient safety.

5. Documentation
Throughout the Being open process it is important to record discussions with the patient, their family and carers as well as the incident review process. Required patient safety incident documentation includes:

- a copy of the Patient Report Form
- incident report(s)
- records of the incident review and analysis process.

The incident report and record of the investigation and analysis process should be filed separately to the patient’s medical records as a patient safety incident record, and kept as part of the healthcare organisation’s clinical governance reports.

Written records of the Being open discussions should include:

- the time, place and date, as well as the name and relationships of all attendees;
- the plan for providing further information to the patient, their family and carers;
- offers of assistance and the patient’s, their family’s and carers’ response;
- questions raised by the patient, 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 patient, their family and carers;
- copies of letters sent to the patient, their family and carers, and the GP;
- copies of any statements taken in relation to the patient safety incident;
- a copy of the incident report.

A summary of the being open discussions should be shared with the patient, their family and carers.

Conclusion
It is vital that the Service is open and honest with any patient involved in a significant adverse event, as defined within the framework. It is also vital that the Service apologises for any errors made in the treatment of the patient.
**SPSO** guidance on

apology

When the Scottish Public Services Ombudsman (SPSO) investigates a complaint and finds unremedied fault, the Investigation Report will recommend what an organisation needs to do to put things right. A common recommendation is that an apology should be offered by the offending organisation. This guidance note sets out what is meant and what is required for an apology to be meaningful.

**SPSO** advice leaflet 2
what is an apology?

The SPSO’s preferred definition is: ‘an encounter between two parties at which one party, the offender, acknowledges responsibility for an offence or grievance and expresses regret or remorse to a second party, the aggrieved’.

Whatever the definition, it is clear that an apology is much more than an expression of regret. An apology is an interactive exchange between two parties, so getting the process right is as important as saying the right things. However, in all cases, it is for the recipient to decide whether or not to accept the apology.

why apologise?

Not everyone finds it easy to apologise. However, a meaningful apology can have a powerful effect for both parties in diffusing emotion and moving forward to a new phase where resolution is possible. It is often the first step to repairing a damaged relationship. It can help to restore dignity and trust. It says that both parties share values about appropriate behaviour towards each other and that the offending party has regrets when they do not behave according to those values.

what do complainants want?

The experience of the SPSO is that complainants want and expect many different things from an apology, including:

- An acknowledgement of the wrong done;
- Confirmation that they were right;
- An understanding of why things went wrong;
- An acceptance of responsibility;
- A reassurance that the problem has been addressed and will not happen again;
- A reconciliation of a relationship, and;
- The restoration of their reputation.

what is a meaningful apology?

First and foremost, it is one which gives the complainant what he or she wants. Lazare¹ and other authors consider that an apology has a number of integral and essential elements. Although their inclusion may not guarantee success, their absence is likely to result in failure. The importance and necessity of each element will vary depending on the nature of the offence and the overall apology should be proportionate to the harm done.
elements of a meaningful apology are:

- An acknowledgement of the wrong done. This is the naming of the offence. Whether or not it was intentional, an apology must correctly describe the offending action or behaviour. The description must be specific in order to demonstrate an understanding of the offence. It must also acknowledge the resulting impact on the aggrieved.

- Accepting responsibility for the offence and the harm done. This includes identifying who was responsible for the offence.

- A clear explanation as to why the offence happened. This should show that the offence was not intentional or personal. Although most people will want or need an explanation, it should be recognised that this is not always the case. Also, if there is no valid explanation, then one should not be offered. The offender may wish to say that there is no excuse for the offending behaviour.

- Expressing sincere regret. This demonstrates that the offender recognises the suffering of the aggrieved and is remorseful. It can be difficult to communicate sincere regret in writing. The nature of the harm done and needs of the aggrieved will determine whether the expression of regret should be made in person as well as being reinforced in writing.

- An assurance that the offence will not be repeated. This may include a statement of the steps that have or will be taken to address the complaint and, wherever possible, to prevent a recurrence of the harm.

- Actual and real reparations (or redress). This is making amends. The SPSO deals with this element in a separate Policy on Redress.

how should an apology be delivered?

When offering an apology, it is essential to understand how and why the complainant believes that they were wronged and what they want in order to put things right. It is impossible to construct a meaningful apology without this understanding.

The SPSO recommends that an organisation asks a complainant directly what they want and involves them in deciding the form and content of the apology.

Each complaint is unique and each apology needs to be tailored individually. There is no ‘one size fits all’, but here is some generic good practice:

1. The timing of an apology can be crucial. Once wrongdoing has been established, an apology delayed may be an opportunity lost.

2. A meaningful apology should be owned, active and unconditional (i.e. ‘It was my fault’ rather than ‘If mistakes have been made’).

3. The language used should be clear, plain and direct.

4. The apology should sound natural and sincere.

5. The apology should not question whether the aggrieved had been harmed (i.e. ‘I am sorry if you were offended’)

6. The apology should not minimise the offence (i.e. ‘no-one else has complained’).

7. It is also essential to apologise to the right person(s).
who should apologise?

As a general rule, where the person who committed the offence is willing and able to apologise, they should be enabled and supported to do so.

If a personal or official apology is delivered by a third party on behalf of an organisation, then it should be delivered by the leader i.e. the person considered by the complainant to be the most accountable.

the benefits of apologising

Properly delivered, a meaningful apology can benefit the organisation as well as the complainant. It can take some heat out of the situation, dissolve anger and reduce stress for both the complainant and the staff dealing with the complainant. It can also help to repair the relationship between the complainant and the organisation.

It is important to remember that an apology is not a sign of weakness or an invitation to be sued. It can be a sign of strength and it can demonstrate a willingness to learn when something has gone wrong. It can also demonstrate a commitment to putting things right. To apologise is good practice and a vital part of any effective complaints management culture.


October 2006
# Scottish Ambulance Service
## Significant Adverse Event Review Framework

### Review History

<table>
<thead>
<tr>
<th>Issue No</th>
<th>Reason for review and brief description of changes made</th>
<th>Effective Date</th>
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<tr>
<td>1</td>
<td>Initial Issue</td>
<td>May 13</td>
</tr>
<tr>
<td>2</td>
<td>Reviewed policy in consultation with trained reviewers</td>
<td>April 14</td>
</tr>
<tr>
<td>3</td>
<td>Reviewed policy in line with National Framework</td>
<td>November 14</td>
</tr>
</tbody>
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**Owner:** DHPNC  
**Version No:** 2  
**Doc & page:** SAER Framework  
**Review arrangements:** 2 yearly  

- **PFPI Checklist (available from W Mason):** Assessed as meeting the National Standards for Community Engagement checklist (Communities Scotland)  
- **Risk and Equality & Diversity Impact Assessment (available from A Tobin and Risk Manager):** No adverse impact has been detected - but under continuous review.  
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