

Serious incident investigation procedure

SOP | SIR-SOP-001

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Title	Serious incident investigation procedure
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Prepared by	{{roles.quality_lead.name}}, Quality lead
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Effective date	{{document.effective_date}}
Next review	{{document.review_date}} (12 months, or sooner after any incident or change)
Replaces	None (new document)
Standards and criteria supported	Basis B2.6 (Serious Incidents Are Investigated)
Evidence basis	E-006, E-009
Status of this document	Recommended best-practice model. A hospital may adopt, adapt or replace it with an equivalent that meets the same criteria.

At a glance: what to do

1. Every serious incident is reported to the clinical director the same day, and the patient is kept safe and supported.
2. A named investigator is appointed within 5 working days, and the investigation follows a recognised root cause analysis method.
3. The investigation findings and an action plan with owners and dates are approved by the governing body.
4. The patient and family are told the outcome, through the disclosure process (CAN-POL-001).

Stop and get help straight away if: a serious incident is not reported the same day, or no investigation is started.

1. Purpose

To make sure every serious incident is reported, investigated thoroughly, and turned into action that prevents it happening again (B2.6).

2. Scope

Applies to	Clinical and support staff in the hospital
Locations	All wards, clinics and departments of {{facility.legal_name}}
When	Whenever the activity described is carried out
Does not apply to	Activities covered by another document listed in section 15

3. Definitions and abbreviations

Term	Meaning in this SOP
Serious incident	An unexpected event that causes, or could cause, death, serious injury or serious harm to a patient, a member of staff or a visitor, or a major loss of service.
Root cause analysis	A structured method that looks at the system factors behind an event, rather than

Term	Meaning in this SOP
	blaming an individual.
Action plan	The list of changes agreed from the investigation, each with an owner, a due date and a way of checking it has worked.

4. Background and rationale

To make sure every serious incident is reported, investigated thoroughly, and turned into action that prevents it happening again (B2.6).

5. Responsibilities

Role	Duties in this SOP	Competence needed
Clinical director	Receives every serious incident the same day, appoints the investigator, and reports to the governing body	Governing body
Investigator	Leads the investigation, interviews those involved, and writes the report with the action plan	Clinical director
Governing body	Approves the report and action plan, and checks progress each quarter	Owner or board
All staff	Report any serious incident the same day and keep evidence safe	Ward or department lead

6. Equipment, materials and resources

Item	Specification or standard	Check before use
Records and forms named in this document	Current version	Checked before use

7. Safety and infection prevention

- Stop and call for help if a patient is at immediate risk. Do not delay urgent care to complete paperwork.

8. Before you start

- Confirm the forms and equipment named in this document are available and current.

9. Procedure

Follow the steps in order. Where a step says "If", take the action for the case that applies. Do not skip a step. If a step cannot be done, use section 11 and section 12.

Step	Action	How to do it	Key point
1	Report.	- Report the incident to the clinical director the same day, using the incident form. - Keep the patient safe and supported, and preserve the records and equipment involved.	Incident reported the same day.
2	Appoint.	The clinical director appoints an investigator with no direct involvement in the event, within 5 working days.	Investigator appointed.
3	Investigate.	- Collect the records, interview those involved, and map the events and system factors using a recognised root cause analysis method. - Complete the report within the timescale set by the governing body (a draft of 45 working days is suggested).	Report completed.
4	Act and close.	- Agree an action plan with an owner and due date for each action, and check each action when it is due. - Tell the patient and family the outcome through the	Actions agreed and outcome shared.

Step	Action	How to do it	Key point
		disclosure process (CAN-POL-001), and record it in the register (SIR-REG-001).	

Decision points

- No decision points in this procedure.

10. Special situations

Situation	What to do
Out of hours	Follow the same steps. Use the on-call contact on the wall of the area.

11. Problems and escalation

- Any serious problem goes to the duty clinical lead at once and to the clinical director the same day.

12. Monitoring and compliance

What is checked	Target	How often	Who	If the target is missed
Serious incidents reported the same day	100%	Quarterly	Clinical director	Escalate to the governing body
Investigations completed within the set timescale	90% or more	Quarterly	Clinical director	Review the investigator workload and timescales
Action plans with owner and due date	100%	Quarterly	Clinical director	Escalate to the governing body

13. Records

Record	Where it is kept	Kept for
Record named in this document	Patient record or the area file	{{facility.records_retention_years}} years

14. Training and competence

- Investigators complete root cause analysis training before their first investigation, and refresh it every three years.
- All staff are told how to report a serious incident at induction.

15. Related documents

ID	Title	Relationship
SIR-REG-001	Serious incident register (existing)	Register
CAN-POL-001	Duty of candour and disclosure policy (existing)	Policy

16. Evidence

ID	Source and status
E-006	ASF Policy Framework v1.2. Adapted.
E-009	ASF Expert Committee consensus.

EC = ASF Expert Committee consensus. Items marked EC are reviewed by the Committee each year.

17. Change history

Version	Date	What changed	Approver and signature
1.0	{{document.effective_date}}	First version	Pending Expert Committee approval