### Preliminary Assessment Form

### Note: Guidance in italic font should be deleted on completion.

**Part A – to be completed in advance of the SIMT/Review decision making meeting**

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| **A. 1. Incident Details** |  |
| NIMS Reference No: | Date entered on NIMS: |
| Date of Incident: |  |
| Incident Type: (brief description) |  |
| Date Notified to SAO/LAO |  |
| Date of SIMT/Review decision meeting: | |
| Date Report Completed |  |

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| **A.2 Background**  **to Incident** | *Include detail of:*  *The background to the service user e.g. their health status and reason for admissions/attendance*  *A brief chronology of the events leading up to the incident.* |

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| **A.3 Actions taken to date** | *Include detail of the current status of the service user affected and assurance that the following have been addressed:*   * *The immediate care needs of the service user and that, if required, a plan for further care is in place.* * *An assessment to identify any immediate actions required to prevent harm to others as a consequence of the incident.* * *The immediate supports needs of persons affected i.e. service users,*   *-relevant person(s) and staff*   * *Detail of any meetings held with the service user/-relevant person(s)* * *That Open Disclosure has been initiated or if not that an explanation of why not, is provided.* * *That a named service user/-relevant person(s) and staff designated support persons have been appointed* * *Detail of any questions or issues raised by the relevant person(s) that require consideration by the SIMT/Review decision making meeting.* * *That the incident has been factually documented in the service user’s healthcare record.* * *That any equipment or drugs implicated in the incident have been taken out of service and retained for examination.* * *That the incident has been reported onto NIMS and to any other bodies/agencies external to the service.* |

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| **A.4 Name and title of Person completing Part A** |  |

**Part B – Record of Decision (to be completed at the SIMT/or review decision making meeting)**

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| **B.1 Management of Incident to date** |
| *Based on Part A and discussions at the meeting include here an assessment of the adequacy of actions taken or planned in relation to the incident. Include also details of any further actions required.* |

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| **B.2 Appropriate Pathway for Review of Incident Reported** |
| Having considered Part A is the SIMT/Review decision making meeting satisfied that the Incident Management Framework is the appropriate pathway for the management of this issue?  🞎 Yes 🞎 No |
| If No, please indicate which alternative review/investigation route is most appropriate. (See making decisions about appropriate reviews/investigations pathways guidance – IMF Guidance Section 3) |
| If Yes, AND it is also decided appropriate to also conduct a review/investigation using an alternative pathway, please document below the alternative pathway and recommendation in relation to scheduling of the two processes. |

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| **B.3 Information required for decision making in relation to review under the IMF** |
| Is further information required to assist a decision to review? Please select one option below: 🞎 Yes 🞎 No |
| If Yes, please indicate the type of information required |
| Healthcare Record Review 🞎 |
| Other Specify: |

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| **B.4 Approach to review** |
| Please indicate the decision as to the approach of review to be conducted. Please select one option below: |
| |  |  |  |  | | --- | --- | --- | --- | | Comprehensive Review |  |  | If Comprehensive Review is selected, proceed to Part C | |
| |  |  |  |  | | --- | --- | --- | --- | | Concise Review |  |  | If Concise Review is selected, proceed to Part C. | |
| |  |  |  |  | | --- | --- | --- | --- | | No further Review |  |  | If No Further Review selected complete Section B.5 and refer to relevant Quality and Safety Committee for completion of B.6. | |  |  | |  |  |  |  | |
| **B.5 Sign off of decisions where No Further Review Required** |
| If the decision is NOT to commission a Comprehensive Review or Concise Review, please set out below the reason or rationale for this decision and the evidence upon which it was based,  **Reason:** |
| Please outline below, any learning opportunities identified along with the arrangements required to ensure that these inform relevant care or management practice. |
| **Date:** |

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| **For Category 1 Incidents Senior Accountable Officer (SAO) Details** |
| Name:  Signature: |
| Date: |
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| Name:  Signature:  Date: |

Decisions where No further Review required must be:

* Submitted for review and ratification by the relevant Quality and Safety Committee or other equivalent committee
* Communicated to persons affected i.e. service user, relevant person(s) and staff.
* Entered onto NIMS and this should include the reason and rationale for same.

These incidents should be incidents in an Aggregate Review process.

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| **B.6 No Further Review Required – Ratification of Decision** |
| Ratified by Quality and Safety Committee or equivalent committee Please select one option below: 🞎 Yes 🞎 No  If No is chosen please outline the reason for this below and submit this form to the SAO/LAO (as appropriate)  **Reason:** |
| Date: |

**Part C – for Incidents where a decision to further Review has been taken, please complete this section**

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| **C.1 Comprehensive Review** |
| A decision has been taken to commission a Comprehensive Review 🞎 Yes 🞎 No |
| Note: The Final Report of the Comprehensive Review must be accepted by the Review Commissioner within 125 days of occurrence of the incident. |

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| **C.2 Concise Review** |
| A decision has been taken to commission a Concise Review 🞎 Yes 🞎 No |
| If the decision is to commission a Concise Review, indicate whether this will be by way of any option below.  Please select one below:  Multidisciplinary Team Approach (Tick appropriate box for methodology to be used)  *Systems Analysis* 🞎  *After Action Review* 🞎  Incident Specific Review Tool 🞎  Desktop Review 🞎 |
| The Final Report of the Concise Review must be accepted by the Review Commissioner within 125 days of occurrence of the incident. |

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| **C. 3 Level of Independence attaching to the review.** |
| Please select one option below   1. Membership of Team internal to the team/department/NAS Operational Region 🞎 2. Membership of Team internal to the service/hospital/NAS Operational Area 🞎 3. Membership of Team external to the service/hospital but internal to the CHO/HG/NAS Corporate Area 🞎 4. Membership of Team involve persons external to the CHO/HG/NAS Directorate 🞎 |

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| **C.4 Scope of the Review** |
| *This should set out the timeframe to be reviewed e.g. from admission to incident occurrence, from referral to incident, from X date to Y date.* |
| **C. 5 Composition of the Review Team** |
| *Whilst it is not necessary to identify by name members of the Review Team at this stage the composition by title/profession should be listed.* |

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| **C. 6 Contacts in relation to the review process** |
| **Review Commissioner (SAO – Category 1 Incidents or LAO – Category 2 Incidents)**  Name:  Email:  Telephone: |

**Service User Designated Support Person**

Name:

Email:

Telephone:

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**Staff Liaison Person**

Name:

Email:

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