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

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	

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.*
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.*
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)

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.

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.

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:

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:

For Category 1 Incidents Senior Accountable Officer (SAO) Details

Name:

Signature:

Date:

For Category 2 Incidents Local Accountable Officer (LAO) Details

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.

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

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.

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.

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 ☐

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.

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:

Staff Liaison Person

Name:

Email:

Telephone: