Health and Social Care Board

Public Health Agency

Learning Report

Serious Adverse Incidents

April 2011 – September 2011

October 2011

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SECTION 1

Introduction

A Serious Adverse Incident is defined as, any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation,[1] arising during the course of the business of an HSC organisation / Special Agency or commissioned service.

These incidents occur in all health systems and can be the result of system failures, human error, intentional damaging act, rare complications or other causes.

An organisation with a culture of safety will not only report these incidents but will have a process by which learning from these incidents is shared both locally and regionally.

This report aims to identify key regional learning, action taken and proposed from SAIs reported during the period to September 2011.

The aim is to improve the care and treatment of patients and clients, to improve safety and ensure respectful management of the incident.

Background

Responsibility for management of Serious Adverse Incident (SAI) reporting transferred from the DHSSPS (Department) to the Health and Social Care Board (HSCB) working in partnership with the Public Health Agency (PHA), with effect from 1st May 2010.

In April 2010, following consultation with key stakeholders, the HSCB issued the procedure for the 'Reporting and Follow up of Serious Adverse Incidents' for full implementation on 1 May 2010. The procedure sets out the arrangements for reporting, managing, investigating and reviewing of all SAIs occurring during the course of business of an HSC organisation, special agency or commissioned service. It also sets out the arrangements of how SAIs are managed within Primary Care Services in conjunction with the adverse incident system in place within the Integrated Care Directorate in the HSCB.

The procedure details arrangements for internal management of SAIs by HSCB and PHA staff which are supported by an additional internal protocol in relation to the nomination and role of a HSCB/PHA Designated Review Officer (DRO).

Appendix A of this report sets out the definition of an adverse incident and the criteria of an SAI.

[1] Source: DHSSPS How to classify adverse incidents and risk guidance 2006
www.dhsspsni.gov.uk/ph_how_to_classify_adverse_incidents_and_risk_-_guidance.pdf

Current Arrangements to manage the SAI Process

The arrangements to manage the SAI process by the HSCB and PHA include:

1. Regional reporting system to the HSCB for all SAIs.

2. The nomination of a Designated Review Officer (DRO) to review and scrutinise reports.

3. Regional SAI Group meeting held on a bi-monthly basis to consider reports, identify learning and agree actions.

4. Escalation process through normal performance management arrangements if required in respect of:
    a. deadlines for Investigation reports
    b. assurances for action being taken forward by Trusts following the investigation

In addition, the HSCB Senior Management Team receives and considers all SAIs on a weekly basis.

SAIs Received April 2011 – September 2011

During the period 1 April to 30 September 2011, the HSCB received 145 SAIs. A breakdown of these by Trust and programme of care is detailed at Appendix B.

SAI Categories

SAIs are categorised by Programmes of Care as follows:

- Mental Health
- Acute Services
- Family and Child Care
- Learning Disability
- Corporate Business / other
- Maternity and Child Health
- Primary Health and Adult Community (Including General Practice)
- Elderly
- Physical Disability and Sensory Impairment
- Health Promotion and Disease Prevention

De-escalation

Trusts are encouraged to report SAIs but it is accepted that SAI reports can be based on limited information at the time of reporting. This can result in occasions where following further investigation the incident does not meet the criteria of an SAI. If this happens a request can be submitted by the reporting organisation to de-escalate the report. This information is considered by the HSCB/PHA Designated Review Officer who advises on approval for any de-escalation.

During the reporting period five SAI notifications received were de-escalated.

SECTION 2

Learning from Serious Adverse Incidents

The purpose of any adverse incident reporting system is to improve patient safety. Reporting is only of value if it leads to a constructive response therefore each organisation has a role in identifying learning.

The Regional SAI Group has a role in meaningful analysis, identifying learning between organisations, making recommendations for change and informing the development of solutions.

Learning opportunities can be identified in a number of ways:

- Through individual investigations and root cause analysis.
- Aggregation of similar incidents over time identifying common underlying causes.
- Systematic reviews of areas of concern.

When learning is identified, both Providers and the Regional SAI Group have a role in identifying actions which will makes changes to practice through, for example, prioritisation, training or dissemination of information and in the implementing and sustaining these changes in practice.

In taking forward this work, the Regional Group recognises that there are many barriers to learning as identified in 'An Organisation with a Memory'.[2]

- An undue focus on the immediate event rather than on the root cause of problems
- A tendency towards scapegoating and finding individuals to blame rather than acknowledging and addressing deep rooted organisational problems
- Lack of corporate responsibility
- Organisational culture

In meeting its objectives the Regional Group will be exploring new methods of learning to maximise the impact on patient safety.

[2] An Organisation with a memory (2000) Department of Health England.

Current Learning Initiatives

These current initiatives were identified as part of the SAI review process and relate to both learning for trends, reviews and individuals cases. Some of the learning identified may relate to SAIs reported in the previous period as part of ongoing work.

Mental Health

During this reporting period there have been 64 SAIs reported in Mental Health Services, the majority associated with suicides or unexpected deaths. (Appendix B)

The Regional SAI group commissioned an independent consultant through the Beeches Management Centre to analyse all SAIs related to suicides over a period.

The review was asked to complete an analysis from a regional perspective of:

- Trends emerging from the reports submitted
- Areas were practice could be improved
- Issues which require a regional approach
- Lessons regarding the SAI process from both a HSCB/PHA and HSC Trust perspective.

The report was considered by the Regional SAI group in June 2011 and key priority learning issues agreed.

A Professional Practice Workshop was held on the 13 October 2011, to share key findings and agree actions. The Programme is included in Appendix C. This event was attended by approximately 130 participants, including Directors of Mental Health, Executive Medical and Nursing Directors, Clinical Governance Leads and Front Line Practitioners.

The outcome of the workshop and follow up actions will be included in the next SAI report.

Early Warning Scores

Trusts have made significant progress with the introduction of Early Warning Scores and systems of early clinical alerts. These Early Warning Scoring Systems (EWS) are evidence based tools designed to assist with the detection of changes in clinical deterioration at an early stage, making it easier to intervene and correct.

The Regional SAI Group, in partnership with the DHSSPS, felt that good practice needed to be reinforced as a number of SAIs have been associated with a failure to recognise a deteriorating patient, resulting in a delay of failure to act.

The regional learning focuses on the careful observation and monitoring of individual patients to detect signs of clinical deterioration.

The PHA in collaboration with the DHSSPS, have organised a PEWS (Physiology Early Warning Scores) Workshop targeting an audience of Chief Executives, Lead Clinicians and Governance Officers. The programme will be delivered by expert clinicians from the other UK Countries and will also include local solutions. This event will be followed with a "rolling" training programme of half day workshops targeted at front line staff.

The event was scheduled for 5 October but has had to be rescheduled due to the industrial action. The programme for the workshop is attached at Appendix D.

Breathing Masks

A small number of SAIs highlighted an issue related to the use of breathing masks in the acute hospital sector. This issue was highlighted to the Regional SAI Group by the DRO. Concerns were raised about the product and the potential for users error in application.

The Regional SAI Group convened a working group to consider the issue and identify the action required.

The outcome of this work was:

- A revised specification for procuring specific masks, including a revised training programme.
- The learning arising from reviewing this incident was disseminated regionally via the Resuscitation Officers Forum (R.O.F.) and the DHSSPS were requested to issue an Alert letter.
- This Alert letter was issued jointly by the DHSSPS and the Northern Ireland Adverse Incident Centre (NIAIC).
- Arrangements were made to recall all masks that did not have the required safety vents. Regional Supplies Service has implemented the recall.

Syringe Drivers

An SAI was received which highlighted an issue of concern related to variations in equipment used between the statutory sector and voluntary sector. This issue was discussed by the Regional SAI Group with the DRO.

Actions following the Regional Group include:

- Advice and guidance should be issued regionally on the need to check types, brands, and specification of similar type equipment.

- Plans are being progressed to move to standardisation of syringe drivers, thus reducing, or if possible, eliminating risks. The PHA are progressing this work through the Regional Palliative and End of Life Care Steering Group in partnership with BSO colleagues.

Maternal & Child Health

An SAI was reported relating to the care and treatment of an individual with diabetic ketoacidosis (DKA). This was highlighted to the Regional SAI Group by the DRO as having regional implications for the delivery of services.

The Regional Group considered this and recommended that the CMO issue a letter to the service on this issue, which has now been actioned.

Primary Care

General Medical Services (GMS)

Learning is disseminated via the circulation of Alert letters across the 4 professions. Some services such as community pharmacy also produce newsletters. The development of trend analysis will enable Primary Care to focus on specific areas with the aim of disseminating learning.

Pharmacy

A small number of SAIs involving community pharmacy have been reported to the HSCB. These include:

- Prescriptions not being received by a community pharmacy from a GP practice;

- A pharmacy prescribing medication in the absence of prescriptions being supplied by the patient's GP**.**

As a result of these incidents, the HSCB has issued letters to GPs and community pharmacists reminding them of their legal obligation regarding written prescriptions and the supply of medicines.

SECTION 3

Next Steps

The management and review of SAIs is an ongoing process with the following identified as key actions for the Regional SAI Review Group.

Review of SAIs related to Care of Older People

Following discussions at the Regional SAI Group and subsequently with the chair of the Regional Complaints Group, it has been agreed to conduct an analysis of SAIs and complaints relating to care of older people.

This review will commence in December 2011.

Review of SAI Procedure

Following a number of stakeholder events to monitor the effectiveness of the current regional procedure, plans are in place to introduce amendments and consult upon the revised procedure prior to full implementation. This will include a review of the SAI process as it related to integrated care.

Review of the role of the DRO

A DRO workshop has been planned for November 2011. The aim of the workshop is to review the role and function of a DRO, following which revised guidance for DROs will be issued. The workshop will also assist in informing the review of the SAI procedure.

Regional Adverse Incident and Learning (RAIL) System

The PHA working closely with the HSCB and all other HSC organisations have a responsibility to ensure the Regional Adverse Incident Learning System is successfully designed and implemented and evaluated. The overall aim of the project is to implement agreed proposals for an integrated system that will support a culture of learning from adverse incidents and the effective implementation of that learning across the HSC and Primary Care services.

The established project team have a responsibility to:

- Develop a work plan to achieve the delivery of the projects aims and objectives, supported by a business case.
- Take agreed action to support the delivery of the projects aims.
- Quality assures all deliverables in line with the projects terms of reference.

Considerable progress has already been made:

- Project structure has been put in place;

A project team has been established to take forward the preparation of an outline business case with options which will be submitted to the Project Board by December 2011.

Appendix A

Definition of an Adverse Incident

'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation, [3] arising during the course of the business of an HSC organisation / Special Agency or commissioned service.

The following criteria will determine whether or not an adverse incident constitutes a SAI.

SAI Criteria

- serious injury to, or the unexpected/unexplained death (*including suspected suicides and serious self harm*) of :
    - A service user
        - A service user known to Mental Health services (including Child and Adolescent Mental Health Services (CAMHS) or Learning Disability (LD) within the last two [4] years)
    - A staff member in the course of their work
    - A member of the public whilst visiting an HSC facility.

- Unexpected serious risk to a service user and/or staff member and/or
    - member of the public

- Unexpected or significant threat to provide service and/or maintain business
    - continuity

- Serious assault (*including homicide and sexual assaults*) by a service user
    - on other service users,
    - on staff or
    - on members of the public

  Occurring within a healthcare facility or in the community (where the service user is known to mental health services including CAMHS or LD within the last two years).

- Serious incidents of public interest or concern involving theft, fraud, information breaches or data losses.

[3] Source: DHSSPS How to classify adverse incidents and risk guidance 2006
www.dhsspsni.gov.uk/ph_how_to_classify_adverse_incidents_and_risk_-_guidance.pdf

[4] Mental Health Commission 2007 UTEC Committee Guidance

Appendix B

Total SAI Activity April 2011 – September 2011

The HSCB has received 145 SAIs from across Health and Social Care (HSC) for the above period. The information below has been aggregated into summary tables / commentary to prevent the identification of individuals.

Table 1 below gives an overview of all SAIs reported by organisation.

Table 1 – Trust

SAIS REPORTED	BHSCT	NHSCT	PCARE	SEHSCT	SHSCT	WHSCT	NIAS	HSCB	Total
Totals:	**50**	**27**	**1**	**29**	**25**	**12**	**0**	**1**	**145**

SAI De-escalation

SAI reports can be based on limited information at the time of reporting. If on further investigation the incident does not meet the criteria of an SAI, a request can be submitted by the reporting organisation to de-escalate. In line with the HSCB Procedure for the reporting and follow up of SAIs the reporting organisation provides information on why the incident does not warrant further investigation under the SAI process. This information is considered by the HSCB/PHA Designated Review Officer prior to approving any de-escalation. During the reporting period 5 SAI notifications received were subsequently de-escalated.

SAIs by Programme of Care

Acute Services

Table 2 – Acute Services

SAIS REPORTED	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total
Totals:	**19**	**2**	**1**	**3**	**1**	**26**

26 incidents relating to Acute Services were reported during the period under the following categories, with less than 5 incidents being reported in any one category.

Categories:

- Slips, trips and falls
- Diagnosis
- Medication error
- Equipment failure
- Treatment / Procedure
- Failure to act / monitor

- Cardiac arrest
- Controlled drugs missing / unaccounted
- Healthcare acquired infection
- Physical abuse, assault or violence
- User error
- Other

- There were no major themes emerging from the SAIs. The largest group (n=4) were associated with the category, 'trips, slips and falls.'
- SAIs related to diagnosis were identified in 3 SAIs

Maternity & Child Health

Four SAIs relating to maternity and child health were reported during the period.

Family & Child Care

Table 3 – Family & Child Care

SAIS REPORTED	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total
Totals:	**6**	**3**	**1**	**7**	**0**	**17**

17 SAIs relating to family and childcare were reported during the period.

10 SAIs were related to suspected cases of abuse. The remaining seven SAIs were reported under the following categories with less than five incidents being reported in any one category.

Categories:

- Access, admission, transfer, discharge other
- Documentation (including records, identification) other
- Other
- Self harm
- Suicide (completed), whether proven or suspected
- Unexpected/Unexplained death

Older People Services

Table 4 – Older People Services

SAIS REPORTED	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total
Totals:	**1**	**1**	**2**	**2**	**1**	**7**

Seven SAIs relating to older people services were reported during the period under the following categories, with less than five incidents being reported in any one category.

Categories:

- Falls from a bed or chair
- Alleged abuse/assault
- Proven, alleged or suspected theft
- Transfer – delay/failure
- Fire - accidental

Mental Health

Table 5 – Mental Health

SAIS REPORTED	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total
Totals:	**16**	**19**	**22**	**9**	**9**	**75**

75 SAIs relating to mental health were reported during the period

- 64 related to suspected/attempted suicides* or unexpected deaths

The remaining eleven SAIs were reported under the following categories, with less than five incidents being reported in any one category.

Categories:

- Self harm
- Homicide (whether proven or suspected)
- Violence / aggression
- Sexual abuse
- Missing patient
- Access, admission, transfer, discharge to/from service
- Other / Other medication incident
- Fire – Accidental

**Suspected suicide – suicide (completed) whether suspected or proven. It should be noted that in the absence of knowledge of the inquest verdict, all of these cases have been classified as "suspected suicides" regardless of the circumstances in which the individual was reported to have been found.*

Learning Disability Services

Seven SAIs relating to learning disability services were reported during the period under the following categories, with less than five incidents being reported in any one category:

- Asphyxiation
- Sexual Abuse
- Lifting or moving a patient or other person
- Homicide (whether proven or suspected)
- Accident
- Other

There were no specific trends noted

Primary Care

One SAI relating to primary health was reported during the period

Physical Disability and Sensory Impairment

One SAI relating to physical and sensory impairment was reported during the period

Appendix C

Professional Practice Event

"Sharing the Learning .....SAIs and Suicides in Mental Health"

THURSDAY 13 OCTOBER 2011 9AM -1.30PM

KNOCKBRACKEN HALL, KNOCKBRACKEN HEALTHCARE, BELFAST

Time	Item
9.00 – 9.30 am	**Registration & refreshment**
9.30 – 9.45 am	Setting the scene "Purpose of new review process" - Mrs Mary Hinds, Public Health Agency
9.45 – 10.10 am	"Serious Adverse Incidents – identifying the common causes and learning the lessons" Key Speaker – Dr Colin Dale, Caring Solutions
10.10 – 10.30 am	"Learning from PSNI Experience" – Sharon Beattie & Alison Conroy PSNI
10.30 – 10. 50 am	Mental Health Order & Role of RQIA in Serious Adverse Incidents – Mr Patrick Convery, RQIA
10.50 – 11.10 am	**Refreshments**
11.10 - 11.30 am	Report on Review of Mental Health Serious Adverse Incidents within Health & Social Care Trusts – Mr Brendan Mullan, Independent Consultant
11.30 – 11.55 pm	"What makes a good review?" – Dr Gerry Waldron, Public Health Agency
11.55 – 12.15 pm	Trust Perspective on SAI Review process – **To be confirmed**
12.15 – 12.20 pm	Issues Log
12.20 – 1 pm	Group work and discussion
1 - 1.20 pm	Feedback , Summary & Close – Mrs Mary Hinds
1.20 pm	**Lunch**

Appendix D

EARLY WARNING SCORES

AND THE

MANAGEMENT OF THE DETERIORIATING PATIENT – WORKSHOP

5 OCTOBER 2011, 9.30 – 4.00

CASTLEVIEW SUITE, THE PAVILION, STORMONT ESTATE, BELFAST

PROGRAMME

8.30	Registration Tea / Coffee	
Co Chairs	**Dr Michael McBride, Chief Medical Officer, DHSSPSNI**	
	Mrs Mairead McAlinden, Chief Executive, Southern HSCT	
9.30	Welcome and Opening Remarks	Dr Michael McBride
9.40	Purpose of the day	Mrs Mary Hinds
9.50	GAIN - The N.I. Perspective	Dr John Trinder, GAIN
10.10	The Salford Experience Mr David Dalton, CEO Mr Peter Murphy, DNS Salford Royal NHS Foundation Trust	
10.40	Why quality improvement in healthcare is hard and how to get it work? Professor Mary Dixon-Woods, Leicester University	
11.00	**COFFEE**	
11.20	Identifying patient deterioration – which track and trigger system should I use? Professor Gary Smitm	
11.40	Local Solutions	

- Children — Ms Bernie McGibbon
- Critical Care Outreach: Working with wards to benefit patients — Joanna McCormick
- E Learning Programme for PEWS — Mr Padraig Dougan

	• Assisted Technology ?	Mr Roy Harper
12.40	Panel Discussion	Mrs Mairead McAlinden
1.00	**LUNCH**	
Co Chairs	**Mrs Angela McLernon, Chief Nursing Officer (Acting), DHSSPSNI**	
	Mr Sean Donaghy, Chief Executive, Northern HSCT	
1.45	Introduction to afternoon session	Sean Donaghy
1.50	Regional Learning Case Scenarios Gavin Lavery/Mary McElroy • Complexity in Care • Maternity / Obstetrics • General	
2.50	Group work and Feedback - Gavin Lavery / Mary McElroy	
3.50	Summary and Key Learning	Angela McLernon
4.00	Closing remarks	Sean Donaghy
	Way Forward	