Health and Social Care Board

Public Health Agency

Learning Report

Serious Adverse Incidents

April – September 2013

September 2013

CONTENTS

SECTION 1

1.0 BACKGROUND AND INTRODUCTION

Commissioners and Providers of health and social care must ensure that when a serious event or incident occurs, there is a systematic process in place for safeguarding services users, staff, and members of the public, as well as property, resources and reputation. One of the building blocks for doing this is a clear, regionally agreed approach to the reporting, management, follow-up and learning from serious adverse incidents (SAI).

On 1 May 2010 the responsibility for the management and follow up of Serious Adverse Incidents (SAIs) transferred from Department of Health, Social Services and Public Safety (DHSSPS) to the Health and Social Care Board (HSCB) working jointly with Public Health Agency (PHA) and collaboratively with Regulation Quality Improvement Authority (RQIA). In response, the HSCB issued the Procedure for the Reporting and Follow up of SAIs (the Procedure) to all HSC organisations and Special Agencies, which set out the process to be followed when a SAI occurred during the course of their normal business or commissioned service

2.0 REVISED PROCEDURE FOR THE REPORTING AND FOLLOW UP OF SAIS

During 2012/13 the HSCB, working with the PHA, undertook a review of the procedure issued in 2010. This involved meetings with colleagues from across the HSC to identify ways in which the current arrangements could be further strengthened. As a result of these discussions, a revised draft procedure was issued for consultation during August. Further amendments were made to reflect comments received during this exercise, with a final version being issued to all Departmental Arm's Length Bodies in September 2013

2.1 NOTABLE CHANGES TO PROCEDURE

A number of changes to the procedure including the following:

- **SAI criteria**

An additional criterion has been included - "*any death of a child in receipt of HSC Services (up to eighteenth birthday). This includes hospital and community services, a Looked After Child or a child whose name is on the Child Protection Register".*

In addition, the timescale for reporting serious self-harm, serious assault *(including suspected suicides, homicides and sexual assaults)* SAIs, by a service user known to/referred to mental health services, has been revised from 24 months to 12 months prior to the incident.

- **Investigation levels**

The single investigation process for all SAIs has been replaced by three levels of investigation to reflect the complexity of the incident and to ensure the timely identification of learning.

- **Timescales**

Timescales for conducting investigations have been revised in line with the level of investigation to be undertaken.

2.2 IMPLEMENTATION OF THE REVISED PROCEDURE

In order to ensure a smooth transition from the current arrangements to the revised Procedure, it was agreed the implementation of the procedure should be phased as follows:

- From 1 October 2013, the revised SAI reporting criteria will be adopted along with the associated reporting documentation;

- The introduction of the revised investigation levels and associated timescales will be implemented by individual organisations over the next six months, to be fully operational from 1 April 2014. This is to provide sufficient time for all organisations to provide training for staff and put in place local operational protocols to support the Procedure.

2.3 AIM OF THE REVISED PROCEDURE

The main aim of the revised procedure is to:

- Provide a mechanism to effectively share learning in a meaningful way, with a focus on safety and quality, ultimately leading to service improvement for service users;

- Provide a coherent approach to what constitutes a SAI, to ensure consistency in reporting across the HSC and Special Agencies;

- Clarify the roles, responsibilities and processes relating to the reporting, investigation, dissemination and implementation of learning arising from SAIs which occur during the course of the business of a HSC organisation / Special Agency or commissioned/funded service;

- Ensure the process works simultaneously with all other statutory and regulatory organisations that may require to be notified of the incident or be involved the investigation;

- Keep the process for the reporting and review of SAIs under review to ensure it is fit for purpose and minimises unnecessary duplication;

- Recognise the responsibilities of individual organisations and support them in ensuring compliance, by providing a culture of openness and transparency that encourages the reporting of SAIs;

- Ensure trends, best practice and learning is identified, disseminated and implemented in a timely manner, in order to prevent recurrence;

- Maintain a high quality of information and documentation within a time bound process.

2.4 TRAINING TO SUPPORT PROCEDURE

In order to ensure organisations are equipped to commence the full operational implementation of the procedure, a number of regional training programmes are being arranged. This training will provide staff with the necessary information and guidance to enable them to carry out significant event audits and route cause analysis investigations.

3.0 MANAGING SERIOUS ADVERSE INCIDENTS REPORTED

The arrangements for managing SAIs reported to the HSCB/PHA include:

- Regional reporting system to the HSCB for all SAIs;
- The nomination of a DRO to review and scrutinise reports;
- SAI Review Group meetings to consider reports, identify themes and learning;
- Overarching HSCB-PHA Quality Safety and Experience (QSE) Group to consider the issues identified by the SAI Review Group and agree actions and assurance arrangements;
- Escalation if required in respect of:
  - timescales for receipt of SAI and Investigation reports
  - assurances for action being taken forward by reporting organisations following the investigation.

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

4.0 SAIs REPORTED DURING PERIOD APRIL – SEPTEMBER 2013

During the period 1 April 2013 to 30 September 2013, the HSCB received 183 SAI notifications. This represents a decrease on the previous six months (October 2012-March 2013) when 204 SAIs were reported to HSCB. A breakdown of these SAIs by reporting organisation and programme of care is detailed at Appendix B.

5.0 DE-ESCALATION OF SAIs

HSC organisations/Special Agencies or Commissioned Service Providers are encouraged to report SAIs, however, it is recognised that SAI reports can be based on limited information at the time of reporting and further investigation may identify that the incident no longer meets the criteria of a SAI.

In such instances a request can be submitted, by the reporting organization, to de-escalate the SAI, however, the decision to approve the de-escalation will be made by the HSCB/PHA Designated Review Officer.

During the reporting period eight (8) SAI notifications received were de-escalated.

6.0 DUPLICATE SAI REPORTING

On occasions a notification may be received from one or more organisations relating to the same incident. In such instances, a lead organisation will be identified to take forward the investigation and follow and the duplicate notification will be closed.

SECTION 2

1.0 LEARNING FROM SERIOUS ADVERSE INCIDENTS

It is important that when a serious event or incident occurs that there is a systematic process for investigating and learning from incidents. The key aim from this process is to improve patient safety and reduce the risk of recurrence, not only within the reporting organisation, but across the HSC as a whole.

NIAO[1](2012) reinforced the need for robust reporting and learning systems and the current process has evolved with the implementation of a new SAI process in October 2013.

Learning opportunities from SAIs can be identified by the reporting organisation, DROs and through the Regional SAI Review Group and learning can take the form of:

- Local organisation actions;
- Formal learning letter;
- Thematic Reviews: Commissioned by the Regional SAI Review Group, and more recently the QSE Group, to review trends, patterns and provide an in-depth analysis. Key learning points are disseminated across the HSC;
- Newsletter: HSCB-PHA are developing a newsletter to ensure that local incidents are shared regionally to drive improvements for patients and services across the HSC.

1 The Safety of services provided by Health and Social Care Trusts (23 October 2012) Northern Ireland Audit Office

2.0 DISSEMINATION OF LEARNING INITIATIVES

The following initiatives were identified as part of the SAI review process and relate to learning from trends, reviews and individuals cases. Some of these initiatives may relate to learning identified and reported in the previous report as part of ongoing work.

2.1. WRONG SITE SURGERY - (UPDATE FROM PREVIOUS REPORT)

A patient attending a Day Procedure (DPU) was consented for and underwent the wrong procedure. The patient had no identity checks undertaken until the procedure was complete. A number of opportunities were missed to check the patient's identity.

A Safety and Quality Learning Letter LL/SAI/2012/012 (AS) was issued to all HSC Trusts on 20 December 2012, identifying the learning to prevent recurrence of a patient undergoing the wrong procedure. Confirmation from Trusts was requested on the following:

All DPU and Theatre staff

- have been provided with formal written procedures to check a patient's identity and procedure prior to starting the procedure
- are trained to use the formal written procedure – adherence should be 100%

All HSC Trust have confirmed completion of required actions.

2.2. PATIENT SELECTION AND INTRAPARTUM CARE IN MATERNITY UNITS - (UPDATE FROM PREVIOUS REPORT)

In two recent SAIs where one baby died and another suffered harm. Some of the underlying issues were common to both incidents. Escalation and appropriate action was delayed due to:

- not taking account of the entire clinical picture of the woman and her baby. CTG tracings and risk factors for pregnancy and labour were not considered together;
- failure to recognise pathological CTG tracings and escalate appropriately;
- lack of clarity in communication between members of the multidisciplinary team.

A Safety and Quality Learning Letter LL/SAI/2012/013 was issued on 3 January 2013 which identified the following actions for HSC Trusts:

- immediate dissemination of learning letter to all relevant staff including students;
- if a Consultant obstetric unit in trusts does not meet the minimum medical staffing standard of at least ST3-level resident cover in obstetrics, paediatrics and anaesthetics, the trust must immediately review the inclusion/exclusion criteria for the unit and adjust those to ensure that only low risk women are booked for delivery.

In addition, Trusts were asked to confirm:

- that staff are trained at least annually in interpreting CTGs;
- that staff competence in CTG interpretation is checked annually;
- that maternity teams conduct regular audits of their adherence to local protocols/policies for induction of labour, and in case reviews of intrapartum care;
- the date of the last audit of induction of labour, or the date of the next planned audit;
- the date of the last case review of intrapartum care, or the date of the next planned review.

Responses have been received by all Trusts identifying further actions before compliance is achieved. Designated Leads in the PHA & HSCB are working in collaboration with AD commissioners and individual Trusts to secure agreement on revisions to the patient selection criteria that further reduces risk. Longer term changes will be addressed through the Maternity Strategy implementation process. A further update has been requested to provide an assurance regarding actioning the recommendations in the learning letter by 25 November 2013; an update will be available in the next SAI Learning Report.

2.3. LOSS OF DATA FROM THE TWINKLE PAEDIATRIC DIABETIC DATABASE

Analysis of a SAI identified that BSO ITS did not have a mandatory process in place to check all new systems for full readiness before going live. After a serious datacentre failure, it was discovered that the Twinkle database (Paediatric Diabetes records) had not been backed up since it went live several months before the system failure. A Safety and Quality Learning Letter LL/SAI/2013/016(CS) was issued on 23 May 2013 to HSC Trusts identifying the learning to prevent recurrence and requesting the following:

- all relevant ICT staff and managers are made aware of the identified learning;

- all Trusts to confirm that they either have robust processes in place to check that all aspects of system readiness for live running have been fully tested before a new system goes live, or that they have time limited plans to introduce such processes;

- all Trusts to confirm that they carry out regular checks on the integrity and completeness of all database backups.

All Trusts have confirmed that they are now compliant.

2.4. MANAGEMENT OF DATA IN COMMUNITY SERVICES

A reported SAI identified a breach of data security when an agency social worker left a notebook behind in a service user's home. The notebook contained synopses of service delivery information and details of professional and client contacts gathered from a number of different Trusts.

A Safety and Quality Learning Letter LL/SAI/2013/017(FCC) was issued on 23 May 2013, to all Trust managers and operational staff involved in delivering community services (across all programmes of care). The following learning was identified to prevent recurrence:

- Trusts to ensure guidance is developed to provide a comprehensive procedure for service staff on the management of portable personal data in community settings;

- provide training (or review existing training) in relation to data protection issues that specifically includes addressing the lessons learned from this incident;

- HR Departments in Trusts employing agency staff should seek assurance from the Employment Agency that staff have a competent understanding of Data Protection.

Assurances have been provided by all Trusts that appropriate arrangements are in place to address these issues.

2.5. HAEMOLYSIS DURING OR AFTER HAEMODIALYSIS

A regional learning letter LL/SAI/2013/018 (AS) was issued to HSC Trusts on 28 June 2013, following a serious adverse incident involving a patient who became unwell whilst undergoing routine hospital haemodialysis (HD). This was originally thought to be a cardiac event but was later found to be due to haemolysis.

Haemolysis is a recognised but uncommon complication during, or some hours after, haemodialysis.

This learning letter related to a single reported incident, however it was felt that GPs and Emergency Departments would benefit from a reminder of the symptoms and signs of haemolysis to prevent this being the first case of a new cluster. Information on haemolysis and its symptoms were issued to the full HD patient cohort in NI (more than 700 patients in 6 HD Units).

Although uncommon, isolated instances of haemolysis may occur in future. The learning actions identified in the learning letter were as follows:

All staff working in haemodialysis units should:

- ensure that all new HD patients and their carers, are provided with information on haemolysis, its symptoms and the actions to take should they arise.

All haemodialysis service managers should check that their HD Unit:

- have a system in place to record that all patients commencing HD and their carers, have received information on haemolysis symptoms.

- use the regional recording sheet agreed in 2011 to monitor line position during HD.

- records the position of dialysis lines hourly, as agreed regionally in 2011.

Trusts were required to:

- Disseminate the learning letter to staff highlighted in the Transferrable Learning Section and all other all relevant staff.

- Confirm that arrangements are in place in your HD Unit to:

    - Record that all new patients and their carers have been given information on haemolysis symptoms;

    - Audit case note samples at least 6 monthly to access adherence to regional guidance on recording of line position during HD.

All Trusts have provided assurance that they are compliant the required actions.

2.6. KNOW THE MASSIVE HAEMORRHAGE PROTOCOL

A SAI occurred during a diagnostic laparoscopic procedure in a standalone surgical day procedure unit which was remote from the main hospital site. The patient's common iliac vein was accidentally perforated during trocar introduction, creating the potential for massive blood loss. The patient underwent successful surgery, but this was a near miss as the response was slower than would have been expected as the protocol was not followed correctly.

A Learning Letter LL/SAI/2013/019(AS) was issued to all Trusts and RQIA on 9 July 2013, setting out the following learning actions:

Medical, nursing, and administrative staff in theatres, day procedure/surgery units and other areas where blood loss is a possible event should:

- know respective Trust policies and procedure for how to respond in massive blood loss situations. Know how to request blood products in an emergency;

- participate in practice drills and debriefing sessions on the massive blood loss protocol every 12 months.

Service Managers in theatres, day procedure/surgery units and other areas where blood loss is a possible event should:

- check the massive blood transfusion emergency contact numbers are clearly displayed in relevant clinical areas;

- arrange major blood loss protocol drills with debriefing sessions every 12 months in clinical units where major blood loss is a possible event. This should include reviewing and testing agreed protocols for contacting emergency assistance from other teams and that relevant staff have participated in a test drill in the last 12 months;

- ensure that Trust policies and procedures for dealing with massive blood loss in free standing units remote from main hospital sites are reviewed regularly, and disseminated to relevant staff. These should comply with Circular HSS(MD) 17/2011 Better blood transfusion 3 Northern Ireland http://www.dhsspsni.gov.uk/hss-md-17-2011.pdfn;

- inform a member of Haemovigilance staff when blood components are considered to be a key factor in an incident, and should involve them in the incident investigation. Regulations regarding mandatory external reporting should be followed (UK Blood Safety and Quality Regulation) http://www.transfusionguidelines.org.uk/index.aspx?Publication=REGS.

Trusts were required to:

- Confirm that the learning letter has been disseminated to the staff groups named in the Transferable Learning Section, and other relevant staff;

- Confirm that staff in areas where major blood loss is a possible event, participate annually in drills of your Trust's protocol(s) for massive blood transfusion;

RQIA were required to:

- Disseminate to Independent Sector Providers.

All Trusts have identified further actions before compliance is achieved and assurance is required by 25 November 2013 (an update will be available in the next SAI Learning Report).

2.7. CHILD CENTRED DECISION MAKING

Analysis of two SAIs:

- CASE (A) Children abducted while on supervised contact visit with parent. Case records demonstrate a long and fractious relationship between the parents and the Trust.

- Case (B) Death of young person from over dose of medication. A referral was received by the Trust Gateway Service, and a decision was taken to forward it to a local Family Support Hub. The young person died prior to this being received. The Trust had previous involvement with the young person.

A Safety and Quality Learning Letter LL/SAI/2013/020 (FCC) was issued on 13 August 2013 and the following issues were identified:

- Issues of conflict between the parents and the Trust overshadowed the needs of the children;

- Assessments/ decisions regarding the longer terms needs of the children were not reflective of the needs and ages of the children;

- Trust information systems were not checked to ascertain if the young person had been known previously;

- There was a lack of line management oversight in relation to the decision to ref to the Family Support HUB.

TRANSFERABLE LEARNING:

- *FOCUS OF WORK:* Professionals to ensure that the needs of children remain a clear priority.

- *ASSESSMENT AND DECISION MAKING:* Professionals to bear in mind the ages of children and their need for permanence and stability.

- *LOCAL GOVERNANCE ARRANGEMENTS:* Trusts should ensure robust governance arrangements are in place and that a written record is available to ensure that actions taken by social workers are appropriate.

- *BACKGROUND CHECKS:* Social Workers should undertake background checks in respect of all referrals. Senior Social Workers should ensure such checks are carried out.

Confirmation requested and received that learning letter was disseminated.

2.8. COMMUNICATION OF PATIENTS RISK STATUS FOR CJD

Variant or vCJD originated from BSE in cattle and consequently an unknown number of people in the UK have been exposed to the causative agent [prion]. The agent can be spread between patients through surgical instruments and endoscopes particularly for procedures involving 'high risk' tissue such as brain and spinal cord. Patients identified as being 'at risk' of vCJD are identified in a pre-operative assessment. Single use instruments can then be used or the instruments can be destroyed or quarantined for future use on the same patient.

During 2012, there were two incidents where a patient's CJD risk status was not adequately flagged to staff performing surgery/a procedure on the patient.

In the first, a patient had a surgical procedure and was subsequently discovered to be CJD 'at-risk' several hours post- surgery. However, when the patient returned to theatre for further surgery some days later, the theatre set was not discarded because the CJD 'at-risk' status had not been flagged adequately in the patient's notes. The error was detected a few days later, but it meant that the theatre set could have been used in the interim on other patients.

In the second incident, the 'at-risk' status was known, but was not recorded in the patient's notes.

A Safety and Quality Learning Letter LL/SAI/2013/021 (AS) was issued to HSC Trusts on 19 August 2013 and reissued on 2 September 2013 setting out the following learning actions:

Medical and Nursing staff involved in the pre-operative assessment of patients for surgery and/or endoscopy, GPs and Dentists:

- if the patient responds 'Yes' to the question 'Have you ever been notified that you are at increased risk of CJD or vCJD for public health purposes?' you must ensure that this information is included in the patient's notes in such a way that it will be seen by all who need to know;

- if the patient informs a dentist that they have CJD, or have been notified that they are 'at risk' of CJD, then the dentist should include this in the patient's dental records and any referral for surgery.

For Managers of surgery and/or endoscopy services should:

- discuss this Learning Letter with clinical and other relevant staff in the services for which you are responsible, and identify any changes you need to make or other Service Managers need to make, in light of these incidents and the Action Required;

- ensure that staff in services for which you are responsible, use the up-to-date CJD & vCJD guidance: https://www.gov.uk/government/publications/guidancefrom-the-acdp-tse-risk-management-subgroup-formerly-tse-working-group

Trusts were required to confirm the following:

- that this letter has been disseminated to the staff groups named in the Transferable Learning Section, and other relevant staff;

- that they are following the latest suite of guidance on minimising the transmission of CJD and vCJD;

- that they have a protocol for risk assessing patients preoperatively for CJD and notifying other staff of a patient's CJD 'at-risk' status;

- the date(s) of the last audit(s) of compliance with CJD risk-assessments, or the date(s) of the next audit(s), in relevant specialties.

Action required by RQIA

- disseminate to relevant independent sector providers.

Action required by Directorate of Integrated Care, HSCB

- Disseminate to GPs and relevant non-Trust dentists.

HSC Trusts are to provide an assurance on actions by 30 November 2013; an update will be available in the next SAI Learning Report.

2.9. CARE PLANNING FOR ADULT MENTAL HEALTH PATIENTS

Consideration of the final review report of a SAI, regarding a mental health service user involved in a homicide, identified problems associated with care planning.

A review of the care and treatment of the patient, identified that the individual's care plan was not based on a multi-disciplinary comprehensive assessment but was lifted directly from a Clozapine Care Pathway. Whilst this addressed the individual's medication needs it did not address the wider needs.

A Safety and Quality Learning Letter LL/SAI/2013/022 (MH) was issued on 28 August 2013 to all Trusts identifying the learning and requesting confirmation of the following:

- that the Learning Letter be disseminated to all relevant staff – immediate effect and

- that by 7 October 2013 confirmation that the circulation of the letter and any relevant action has been taken.

Confirmation of both requirements from all Trusts was received by 21 October 2013.

2.10. SAFE USE OF INTRAVENOUS (IV) MAGNESIUM SULPHATE

Following a SAI involving IV magnesium sulphate the regional secondary care Medicines Governance Team were approached, by the Trust involved, to identify measures to minimise risks with prescribing, preparation and administration of IV magnesium sulphate. To do this, the Medicines Governance Team facilitated a multi-disciplinary Failure Modes and Effect Analysis (FMEA).

The FMEA report was issued via a Safety and Quality Learning Letter LL/SAI/2013/023 (AS) on 9 September 2013 to all HSC Trusts. In order to minimise the risks of further medication incidents involving magnesium sulphate from occurring, Trusts were requested to do the following:

- High-light to staff that bolus dose(s) of IV magnesium sulphate must never be administered from an infusion preparation where both a bolus and infusion are to be given and that they read the FMEA report and consider the application of its recommendations to their area of practice.

Trusts were also requested to review the complete FMEA report and risk assess their organisation against its recommendations. In particular, Trusts were asked to ensure that the following recommendations from the report are implemented:

- Any existing electronic prescribing and dispensing systems should be amended to express magnesium sulphate injections and pre-prepared infusion strength, in both mmol and grams to reduce the potential for confusion in dosing.

- Clinical guidelines should be in place to support the safe prescribing of IV magnesium sulphate in all relevant settings (for example, but not limited to, hypomagnesaemia, asthma, arrhythmias, severe pre-eclampsia, eclampsia, neuroprotection of the fetus in the management of preterm labour). The guidelines should express the dose required in both gram and mmols and the required rate of infusion.

In addition, Trusts were informed that the NI Secondary Care Medicines Governance Team is leading regional work to make pre-prepared IV magnesium sulphate infusions available and this work should be supported by other Trust staff. When pre-prepared infusions become available, all other magnesium sulphate injections should be removed from ward stock and replaced with the pre-prepared products.

HSC Trusts have been asked to confirm by 2 December 2013 that the letter has been disseminated to all relevant Trust staff for shared learning and the FMEA

report has been reviewed by their Trust and current practice risk assessed against its recommendations.

SECTION 3

NEXT STEPS

1.0 REVIEW OF COMPLAINTS AND SAIs REPORTED IN RELATION TO CARE AND TREATMENT OF OLDER PEOPLE

Following a thematic review of SAIs and complaints relating to the care and treatment of older people, a workshop was held on 17 May 2013 to agree actions in response to regional learning identified. *(An Older Person is defined as someone 65 years and over).*

The workshop was attended by lead clinicians and managers of older people services across Northern Ireland. Expert speakers from across health and social care N.I., as well as other agencies interfacing with older peoples services, led the discussions and action planning.

The following themes were discussed at the learning event:

- Advocacy (*recognising that most complaints are not made by older people themselves*)
- Falls
- Privacy and Dignity
- Misdiagnosis and delay in commencement of treatment
- Staff attitude and behaviour and staff communication with patients, service users and families.

An action plan is currently being developed, to ensure that learning from this review and the workshop is used to inform the improvement of services for older people by identifying existing streams of work or establishing where a new focus of work is required.

2.0 THEMATIC REVIEWS

Thematic Reviews are commissioned by the HSCB/PHA SAI Review Group, and more recently the QSE Group, to review trends and patterns. This in-depth analysis ensures that local patterns are considered within the regional and national context and ensuing recommendations and key learning points are disseminated across the HSC.

Following an in-depth analysis of the SAI reports, the Regional SAI Review Group requested that the following thematic reviews be undertaken:

- ***PATIENT FALLS IN HOSPITALS***

The Regional In-Patient Falls Group was established to provide multidisciplinary advice and support in preventing harm to patients who fall whilst in hospital. To support the work of this group a review of all serious adverse incidents (SAIs) reported to the Health and Social Care Board (HSCB) was commissioned by the Regional Serious Adverse Incident Review Group.

The aim of this review was to identify safety themes and learning to inform the development of an evidence based care bundle for falls prevention in hospitals in Northern Ireland. The review identified ten (10) SAIs relating to patients who fell whilst in hospital. In all of these incidents the patients sustained a head injury and subsequently died. Given the small number and the similarities of the injuries it was decided to conduct a further review of adverse incidents reported in HSC Trusts.

HSC Trusts routinely report to the Department of Health Social Services and Public Safety (DHSSPS), the number of falls incidents classified as causing moderate to severe harm. A request was made to HSC Trusts to provide additional information in relation to reported incidents in Quarter 1 and 2 of 2012/13 and to include the narrative account of the incident.

The purpose of the review is to identify any further learning about safety themes and causative factors to inform a phased approach to the implementation of an evidence based falls bundle of interventions.

This review has been completed and will be shared with HSC Trusts by the end of October 2013; the recommendations from this review will be implemented by the Multi-professional Regional In Patient Falls Group.

- ***PATIENT MIS-IDENTIFICATION IN HOSPITALS***

'Misidentification of Patients/ Clients' in HSC services was identified as a theme through SAI analysis, following several reported incidents. The aim of the review is to identify recurrent themes found within the reported SAIs and to consider regional actions which could reduce the incidence of such events. The review will be completed and issued to HSC Trusts by the end of December 2013.

- ***FAILURE IN REFERRAL OR FOLLOW UP PROCESS***

The Regional SAI Review Group commissioned this review following reported incidents of patients/clients not being referred or not receiving follow-up of care. The purpose of this review is to analyse SAI reports, identify regional learning and consider implementation of actions to improve systems.

This review will be completed and issued to HSC Trusts by the end of February 2014.

3.0 NEWSLETTER – LEARNING MATTERS

An essential element of improving services is the dissemination of information and a variety of methods are used to ensure learning is shared such as learning letters, alerts and reports. In addition the PHA/HSCB are developing a newsletter to compliment the other methods and to provide a forum where local learning from Serious Adverse Incidents, reviews and complaints can be shared regionally.

The title of this newsletter is 'Learning Matters' and will be issued by December 2013.

SECTION 4

CONCLUSION

The NIAO Report October 2012[2] recognised that a regional process for reporting, managing, analysing and learning from serious adverse incidents is in place and alluded to the benefits in highlighting risks and identifying good practice through the regular reporting of SAIs. This report highlighted that in NI we "enjoy high standards of care", however there is recognition that Adverse incidents can and do cause harm to patients and clients with consequential costs to the HSC system, however the biggest consequence is harm to patients. Therefore robust reporting systems, dissemination of learning and assurances that actions have been implemented are essential to a culture of improvement.

In this past six months eight learning letters have been disseminated and each of these have identified learning and there is a mechanism in place through the HSCB/PHA to gain assurances regarding the identified actions for these. In addition the HSCB/PHA is developing a newsletter to ensure local issues are shared regionally.

One of the key aims of the SAI reporting and learning process is to reduce the risk of recurrence, the timely and appropriate dissemination of learning for SAIs is essential to achieving this and to ensuring that these lessons are embedded into everyday practice.

A key requirement for health and social care organisations is to manage, report, analyse and implement learning from all patient safety incidents. A proactive risk management approach, together with a reactive process of patient safety incident management will promote increased awareness and identification of things that could go wrong.

The HSCB/PHA have a planned a programme of training for Significant Event Audits, Designated Review Officer roles and responsibilities and Root Cause Analysis (RCA) to ensure all involved in SAIs have the expertise, knowledge, tools and techniques to enable them to analyse and identify underlying causes of incidents. This comprehensive approach will promote learning from incidents and determine actions to prevent or reduce the likelihood of re-occurrence.

Through the SAI process the HSC is committed to learning from adverse incidents to improve quality, safety and the patient experience.

2 The Safety of services provided by Health and Social Care Trusts (23 October 2012) Northern Ireland Audit Office

APPENDIX A

REVISED CRITERIA FROM 1 OCTOBER 2013

DEFINITION OF AN ADVERSE INCIDENT AND SAI CRITERIA

'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 a 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 of:
  - a service user (including those events which should be reviewed through a significant event audit)
  - a staff member in the course of their work
  - a member of the public whilst visiting a HSC facility;

- any death of a child in receipt of HSC services (up to eighteenth birthday). This includes hospital and community services, a Looked After Child or a child whose name is on the Child Protection Register;

- 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 self-harm or serious assault (*including attempted suicide, homicide and sexual assaults*) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;

- serious self-harm or serious assault *(including homicide and sexual assaults*)
  - on other service users,
  - on staff or
  - on members of the public

  by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and known

[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

to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

- suspected suicide of a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

- serious incidents of public interest or concern relating to:
    - any of the criteria above
    - theft, fraud, information breaches or data losses
    - a member of HSC staff or independent practitioner.

ANY ADVERSE INCIDENT WHICH MEETS ONE OR MORE OF THE ABOVE CRITERIA SHOULD BE REPORTED AS A SAI.

APPENDIX B

ANALYSIS OF SAI ACTIVITY APRIL 2013 – SEPTEMBER 2013

The HSCB has **received 183 SAI Notifications** from across Health and Social Care (HSC) for the above period. The information[4] below has been aggregated into summary tables with commentary to prevent the identification of individuals.

Table 1 below provides an overview of all SAIs reported by organisation and includes **year on year comparison** of activity for the same **reporting period 1 April to 30 September**.

TOTAL ACTIVITY	Apr – Sep 2012	April- Sept 2013
BHSCT	44	35
HSCB	2	0
BSO	0	1
NHSCT	29	56
NIAS	3	2
PCARE	5	15
PHA	1	0
SEHSCT	23	19
SHSCT	15	28
VOL	1	0
WHSCT	18	27
Totals:	**141**	**183**

SAI DE-ESCALATION

SAI reports submitted 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 **eight (8) SAI notifications** received were subsequently **de-escalated**.

TOTAL DE-ESCALATED	Apr – Sep 2012	April- Sept 2013
BHSCT	5	2
NHSCT	2	2
NIAS	1	1
PCARE	1	1
SEHSCT	1	0
SHSCT	0	1
WHSCT	1	1
Totals:	**11**	**8**

[4] Source- HSCB DATIX Information System

DUPLICATE SAI NOTIFICATIONS

A notification may be received from one or more organisation but relating to the same incident.

TOTAL DUPLICATE	Apr – Sep 2012	April- Sept 2013
BHSCT	0	1
PCARE	0	1
Totals:	**0**	**2**

SAI ANALYSIS BY PROGRAMME OF CARE

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-escalated and duplicate SAI notifications have been **excluded** from the analysis in the remainder of this report.

ACUTE SERVICES

ORGANISATION	April – Sep 2012	April- Sept 2013
BHSCT	19	9
NHSCT	7	18
NIAS	2	1
SEHSCT	3	4
SHSCT	1	4
WHSCT	1	6
Totals:	**33**	**42**

Current period: Forty two (42) incidents were reported. The top four groups related to the following classifications/categories. Seven (7) incidents being the most reported in any one category.

Classification/category

- Diagnosis failed or delayed
- Treatment, procedure
- Clinical assessment (investigations, images and lab tests)
- Accident that may result in personal injury

The largest groups (n=7) associated with this category was relating to 'Cancer – Diagnosis failed or delayed'

MATERNITY & CHILD HEALTH

ORGANISATION	April – Sep 2012	April- Sept 2013
BHSCT	1	4
NHSCT	1	4
SEHSCT	1	0
SHSCT	1	2
WHSCT	4	2
Totals:	**8**	**12**

Current period: Twelve (12) SAIs relating to maternity and child health were reported.

FAMILY & CHILD CARE

ORGANISATION	April – Sep 2012	April- Sept 2013
NHSCT	6	5
SEHSCT	1	1
SHSCT	3	0
WHSCT	0	2
Totals:	**10**	**8**

Current period: Eight (8) SAIs were reported relating to the following categories. The largest group (n=5) related to 'Abusive, violent, disruptive or self-harming behaviour'.

OLDER PEOPLE SERVICES

ORGANISATION	April – Sep 2012	April- Sept 2013
BHSCT	2	2
NHSCT	2	5
SEHSCT	3	1
SHSCT	1	4
WHSCT	1	1
Totals:	**9**	**13**

Current period: Thirteen (13) SAIs were reported relating to older people services relating to the following categories/classifications:

- Abusive, violent, disruptive or self-harming behaviour
- Accident that may result in personal injury

The largest group (n=7) related to 'Abuse by staff to the patient'

MENTAL HEALTH

ORGANISATION	April – Sep 2012	April- Sept 2013
BHSCT	12	13
NHSCT	4	17
SEHSCT	14	12
SHSCT	9	14
VOL	1	0
WHSCT	10	14
Totals:	**50**	**70**

Current period: Seventy (70) SAIs relating to adult mental health services were reported.

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

The remaining reported incidents related to the following classifications:

- **Classification/category:**
  - Suspected Homicide
  - Abuse - other
  - Attempted suicide, whether proven or suspected
  - Absconder/missing patient

**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

ORGANISATION	April – Sep 2012	April- Sept 2013
BHSCT	0	2
NHSCT	1	2
SHSCT	0	1
WHSCT	1	0
Totals:	**2**	**5**

Current period: Five (5) SAIs relating to learning disability services were reported.

PHYSICAL DISABILITY AND SENSORY IMPAIRMENT

ORGANISATION	April – Sep 2012	April- Sept 2013
SEHSCT	0	1
Totals:	**0**	1

Current period: One SAI relating to physical disability and sensory impairment services was reported.

PRIMARY HEALTH AND ADULT COMMUNITY (INCLUDING GENERAL PRACTICE)

ORGANISATION	April – Sep 2012	April- Sept 2013
BHSCT	0	1
NHSCT	0	1
PCARE	5	13
SHSCT	0	2
Totals:	**5**	**17**

Current period: Seventeen (17) SAIs relating to Primary Health and Adult Community were reported. The top three groups related to the following classifications/categories:

- **Classification/category:**
  - Medication
  - Patient information (records, documents, test results, scans)
  - Infrastructure or resources (staffing, facilities, environment)
  - Test results / reports

The largest group (n=3) related to the administration or supply of a medicine from a clinical area.

CORPORATE BUSINESS

ORGANISATION	April – Sep 2012	April- Sept 2013
BHSCT	5	1
BSO	0	1
HSCB	1	0
NHSCT	6	2
PHA	1	0
WHSCT	0	1
Totals:	**13**	**5**

Current period: Five (5) SAIs were reported relating to the following classifications:

- Classification/category:
  - Patient's case notes or records
  - Information Technology
  - Test results / reports

HEALTH PROMOTION AND DISEASE PREVENTION

No reported incidents