Health and Social Care Board

Public Health Agency

Learning Report

Serious Adverse Incidents

October 2013 – March 2014

June 2014

CONTENTS

SECTION 1

1.0 BACKGROUND AND INTRODUCTION

From 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.

During 2012/3 the HSCB, working with the PHA, undertook a review of the Procedure, issued in 2010, and issued revised guidance in September 2013 for implementation on 1 October 2013 and with full operational implementation on 1 April 2014.

2.0 REVISED PROCEDURE FOR THE REPORTING AND FOLLOW UP OF SAIS (October 2013)

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

The notable changes to the procedure are:

- **SAI criteria**

  - An additional criterion has been included - "*any death of a child in receipt of HSC Services (up to eighteenth birthday).*
  - SAIs involving a service user known to/referred to mental health services has been revised from 24 months to 12 months

- **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  - The single investigation process for all SAIs has been replaced by three levels of investigation to reflect the complexity of the incident and to ensure the timely identification of learning.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. However to date, there have been a number of investigation reports that are outstanding beyond their

submission date. This issue has been raised during 2013/14 and further steps are being taken to improve the timeliness of these reports

2.2 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;

- Ensure the process works simultaneously with all other statutory and regulatory organisations;

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

- provide 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.

2.3 SERVICE USER / FAMILY INVOLVEMENT IN SAIS

The revised SAI Procedure makes clear the need for and importance of, appropriate communication and involvement of service users, relatives and carers. However, in light of recent communications with DHSSPS, and in order to further assist Trusts, the HSCB and PHA have reviewed the SAI Notification Form and developed a SAI Investigation Report Checklist which should accompany all SAI Investigation Reports regardless of the investigation level. This will ensure a consistent approach is afforded to the level of service user / family engagement across the region. The checklist also contains a section in relation to those SAIs that have been notified to the Coroner (*where there is a requirement to do so*).

The revised forms were issued to all DHSSPS Arm's Length Bodies and Special Agencies to be implemented with immediate effect (April 2014) for all newly reported SAIs and for on-going SAIs for which investigations have not yet been completed. In addition, and in line with DHSSPS communication, the HSCB and PHA are working with the Patient Client Council and RQIA to develop guidance

for HSC organisations when involving service users/families throughout the relevant stages of the SAI process.

The HSCB/PHA are currently developing the HSCB DATIX risk management system to record the additional level of detail in relation to service user/family involvement, and reporting to the Coroner. This will enable analysis of this information to be reported on in future learning reports.

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 were arranged. This training provided staff with the necessary information and guidance to enable them to carry out significant event audits (SEA) and route cause analysis (RCA) investigations.

A number of regional training programmes were delivered during 2013/14:

- SEA Training (December 2013)
- Designated Review Officer (DRO) Workshop (December 2013)
- RCA Training (January – March 2014)

This RCA training was delivered by the Royal College of Nursing (RCN) and the evaluation from these training sessions was very positive. A further two sessions have been arranged for DROs new to the SAI process or for those who were unable to attend the other sessions.

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 Sub 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 Sub 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 OCT 2013 – MAR 2014

During the period 1 October 2013 to 31 March 2014, the HSCB received 300 SAI notifications. This represents an increase on the previous six months (April 2013 - September 2013) when 183 SAIs notifications were reported to HSCB.

It should be noted that that this is the first reporting period since the revision of the Procedure and the revised SAI reporting criteria (refer to Appendix A), heightened awareness of the revised procedure (following the consultation and implementation), the HSC training programmes for SEA and RCA along with recent Thematic Reviews undertaken will account for some of the increases in reporting.

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

HSCB/PHA STRUCTURE FOR LEARNING FROM SAIS

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.

The HSCB, working closely with the PHA, is responsible for identifying and disseminating regional learning from its monitoring role in relation to SAIs, complaints and patient client and experience.

- **Quality Safety and Experience (QSE) Group**

  The HSCB and PHA recently established a jointly chaired QSE Group to provide an overarching, streamlined approach in relation to how the HSCB and PHA meet their statutory duty of Quality. This multi-disciplinary group meet on a monthly basis to consider learning, patterns/trends, themes or areas of concern, and agree appropriate actions to be taken, from all sources of safety and quality information received by the HSCB and PHA.

  A Regional SAI Review Subgroup reports to, and supports the work of the QSE Group.

- **Safety Quality and Alert Team (SQAT)**

  The work of the QSE group is closely aligned to SQAT, which is responsible for overseeing the implementation and assurance of Regional Learning Letters/Guidance issued by HSCB/PHA in respect of SAIs

SAI LEARNING MECHANISMS

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

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

services across the HSC. The first edition was issued across the HSC in December 2013 with the second due to be issued in May 2014.

- The SAI Bi-annual Learning Report provides an overview on all learning letters / thematic reviews carried out and/or reported on during the period of reporting.

2.0 DISSEMINATION OF LEARNING INITIATIVES

Learning from SAIs is a significant element to improving practice. However the HSCB and PHA are cognisant that each and every SAI has an impact on individuals and families. Therefore, whilst for the purposes of this report patient identifiable information has been removed this is not intended to diminish the personal impact that these incidents have.

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 on-going work.

2.1. PATIENT SELECTION AND INTRAPARTUM CARE IN MATERNITY UNITS - (update from previous report)

In two SAIs where one baby died and another suffered harm, there were some underlying issues which 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 and HSCB are continuing to work 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 will be available in the next SAI Learning Report.

2.2. KNOW THE MASSIVE HAEMORRHAGE PROTOCOL (update from previous report)

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 considered 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:

Trusts were required to:

- disseminated the learning letter to the staff groups named in the Transferable Learning Section, and other relevant staff;
- ensure staff in areas where major blood loss is a possible event, participate annually in drills of their Trust's protocol(s) for massive blood transfusion;

All HSC Trusts have confirmed compliance has been achieved in meeting these requirements.

2.3. COMMUNICATION OF PATIENTS RISK STATUS FOR CJD (update from previous report)

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 identifying the learning and requested confirmation of the following:

HSC Trusts were required to confirm the following:

- the learning 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.

HSC Trusts have confirmed that all actions are now complete or have confirmed a date for actions to be completed.

2.4. SAFE USE OF INTRAVENOUS (IV) MAGNESIUM SULPHATE (update from previous report)

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).

A Safety and Quality Learning Letter LL/SAI/2013/023 was issued on 9 September 2013 and HSC Trusts were asked to:

- review the complete FMEA report and risk assess current practice its recommendations. Three of these recommendations were highlighted in the learning letter. These included:
    - 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.
    - 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.

- Share the content of the learning letter and the FMEA report with medical, nursing, midwifery and pharmacy staff and specific direction was provided to them stating that they should:

    - Never administer a bolus dose(s) of IV magnesium sulphate from an infusion preparation where both bolus and infusion are to be given.

    - Read the FMEA report so that you are aware of the risks associated with prescribing, dispensing, administration and monitoring of IV magnesium sulphate. The FMEA report provides a complete list of recommendations and you should consider their application to your own practice.

- Trusts were requested to provide confirmation of the following:

    - that this letter has been disseminated to the staff groups named in the Transferrable Learning Section and other relevant staff;
    - that the FMEA report has been reviewed by each HSC Trust and current practice risk assessed against its recommendations.

HSC Trust have confirmed that all actions are now complete or have confirmed a date for actions to be completed.

In addition:

- The NI Medicines Governance Team is progressing with the purchase of pre-prepared IV magnesium sulphate infusions.

THE ITEMS BELOW ARE NEW LEARNING ISSUED SINCE LAST REPORT

2.5. SAFE MANAGEMENT OF LOWER BOWEL DYSFUNCTION INCLUDING DIGITAL RECTAL EXAMINATION AND DIGITAL REMOVAL OF FAECES

Two SAIs were reported where an inappropriate method to manually remove faeces from patients occurred. These incidents involved members of staff who were employed within the Independent Sector across two Trust areas.

A Safety and Quality Learning Letter LL/SAI/2013/024 was issued to all HSC Trusts and RQIA on the 16 December 2013, setting out the following actions:

For Frontline Nursing Staff:

- Do not use implements to remove faeces from patients.

- It is your responsibility to make sure you follow your organisation's policy/procedure when performing digital removal of faeces from patients.

- If your organisation does not yet have a policy/procedure for digital removal of faeces from patients, you should follow the Royal College of Nursing guidelines on "Management of lower bowel dysfunction, including DRE and DRF" (digital rectal examination/digital removal of faeces) published 15 November 2012 and available at *www.rcn.org.uk/publications*.

Directors of Nursing and Managers of Nursing and Residential Homes *were asked* to ensure that:

- Their organisation has a policy/procedure for the assessment, treatment and management of patients/clients who require digital removal of faeces. The Royal College of Nursing has produced guidelines on "Management of lower bowel dysfunction, including DRE and DRF" (digital rectal examination/digital removal of faeces) (published 15 November 2012 and available at www.rcn.org.uk/publications). These guidelines should be used as a reference for your own policy/procedure;

- All relevant staff are aware of their organisation's policy/procedure;

- Staff who require additional training in the policy/procedure, receive training.

HSC Trusts were asked to confirm by the 14 February 2014:

- That the learning letter had been disseminated to the Trust staff groups named in the Transferable Learning Section, and other relevant Trust staff – timescale – immediate;

- That their Trust has a policy/procedure that covers digital removal of faeces and that it reflects Royal College of Nursing guidelines on "Management of lower bowel dysfunction, including DRE and DRF" (digital rectal examination/digital removal of faeces) (published 15 November 2012 and available at www.rcn.org.uk/publications

Confirmation of all requirements from all HSC Trusts was received by 14 February 2014.

2.6. HEAD INJURY IN PATIENTS ON WARFARIN – TREAT AS A MEDICAL EMERGENCY

Two recent SAIs related to patients who had presented at the Emergency Department (ED) with head injury, who were also on warfarin. In the first case the patient confirmed that they were taking warfarin. The patient was triaged as Category 3, which meant they should have had a medical assessment with 1 hour; however the waiting time for Category 3 patients at the time was over 3 hours. Following a CT scan the patient was diagnosed with a subdural haemorrhage. Prothrombin Complex Concentrate (PCC) was ordered (by then 5 hours after the patient arrived in ED), but this was not administered until almost 2 hours later i.e. almost 7 hours after the patient arrived in ED. The frequency of neurological observations was not increased to the recommended 'every 15 minutes'. A repeat CT scan showed a dramatic increase in the subdural haemorrhage and midline shift; palliative care was given and the patient subsequently died.

The second case had similar circumstances. An elderly patient was brought by Ambulance to ED following a fall and with a visible head injury. Triage staff did not use the Trust's head injury proforma and therefore did not identify that the patient was on warfarin. The patient was triaged as Category 4; they had a medical

assessment almost 4 hours later and at that point, noted to be on warfarin. A CT scan was ordered but not performed until 1.5 hours later. PCC was ordered when the CT scan showed a subdural haematoma but not administered for a further 45 minutes and therefore almost 8 hours after the patient first presented to ED. The patient subsequently deteriorated and died.

Head injury in patients on warfarin has a significant mortality rate, but patient outcomes are improved when warfarin is reversed quickly. In these cases there were a number of factors which contributed to the delays in administration of Prothrombin Complex Concentrate (PCC):

- There was no advance warning to ED staff that a patient with a head injury and on warfarin was being brought to ED. ED staff therefore did not have an opportunity to prepare for immediate medical assessment of the patient;

- The NI Electronic Care Record (NIECR) was not used to check the patient's medications and staff were therefore unaware that the patient was on warfarin;

- Head injury in patients on warfarin was not recognised as a medical emergency and patients were therefore not fast-tracked for assessment and treatment;

- In both cases, PCC was given after the CT scan rather than in advance on a precautionary basis despite signs of possible intracranial bleeding;

- PCC was not stored in the ED so immediate administration of PCC was not possible;

- ED escalation plans did not maintain the ED waiting time for Category 3 & 4 patients within the College of Emergency standards, so the patients' assessment by a doctor was delayed by 3-4 hours. This suggests that the ED Escalation Plan was not adequate or was not activated sufficiently.

A Safety and Quality Learning Letter LL/SAI/2014/025 was issued to all Trusts, NIMDTA, Directorate of Integrated care and RQIA on the 8 January 2014, setting out transferable learning for various personnel:

Trusts were asked to provide a response by the 30 April 2014 that the identified learning was actioned. They were asked to confirm the following:

a. That the learning letter has been disseminated to the Trust staff groups named in the Transferable Learning Section, and other relevant Trust staff;

b. That their Trust ED protocol(s) for managing head injury has been amended as necessary to reflect the content of the Transferable Learning section of this letter;

c. That their Trust protocol(s) for managing head injury in-patients in hospital or Trust nursing/residential settings has been amended to reflect the content of the Transferable Learning section;

d. That the protocols in b) and c) above have been disseminated to relevant staff;

e. That their Trust ED Escalation Plan has been amended to reflect the content of the Transferable Learning section;

f. That key ED staff know the procedure to increase staffing levels in response to increased numbers of patients registering at ED and/ or other escalation triggers.

HSC Trust responses will be reviewed by the Safety and Quality Alerts team on 23 June 2014 and an update will be provided in the next SAI Learning Report.

2.7. DISPENSING BETA BLOCKERS – SELCTION ERRORS

Over the past year, a small number of adverse incidents have been reported to the HSCB where beta blockers have been inadvertently supplied to patients as a result of a selection error at the point of dispensing in a community pharmacy. Some of these resulted in patients coming to serious harm. The three most common beta blockers that have been supplied in error were atenolol, bisoprolol and propranolol. Contributory factors to these errors included:

- Similar names
- Similar drug strengths
- Similar packaging
- Close proximity of a beta blocker to the intended drug on the shelf.

It should be noted that inadvertent administration of beta blockers can have potentially serious side effects, especially in vulnerable patients such as the elderly or those with other serious co-morbidities. Side effects include:

- Bradycardia
- Hypotension
- Acute cardiac insufficiency
- Bronchospasm.

A Safety and Quality Learning Letter LL/SAI/2014/026 was issued on 9 April 2014 which identified the following transferable learning for HSC Trusts:

There are a range of practical steps that can be taken to reduce the risk of this type of error occurring. These include:

- For all prescriptions, ensure that there is a double-check built into your dispensing process where possible. This may be by another pharmacist or member of dispensary staff and should be included in your Standard Operating Procedures (SOPs). All staff who dispense should be trained in and signed up to the SOPs.

- The Royal Pharmaceutical Society of Great Britain suggested some principles to be followed when carrying out the final accuracy check on a dispensed medicine. The mnemonic ‘HELP’ may be useful:

H How much has been dispensed
E Expiry date check
L Label checks for the correct patient's name, drug name, dose, and warnings
P Product check, i.e. the correct medication and strength have been supplied.

Consider:

- Moving beta blockers to a separate storage area

- Marking stock or shelf edges clearly to highlight beta blockers

- Adding an alert to the computer to highlight drugs which have the potential to be mis-selected

- When procuring medicines, look for packaging designs that assist accurate product selection, e.g. consider different generic manufacturers for different generic products, or generic manufacturers whose packaging is sufficiently different between preparations to allow them to be distinguished easily.

In secondary care, robotic dispensing should help prevent this type of selection error. However, where 'broken bulk' of medicines is used, measures such as those listed above should be put in place to avoid selection of a beta blocker when another medicine is intended.

Extra care should *be taken to check prescriptions for high risk drugs.*

Extra care should be taken where three or more tablets or capsules of the same medication are either prescribed or required to make up the prescribed dose.

As outlined in the Pharmaceutical Society of Northern Ireland's Professional Standards and Guidance for the Sale and Supply of Medicines[1], the pharmacist must ensure that the patient receives sufficient information and advice to enable the safe and effective use of the prescribed medicine. It is therefore good practice that when pharmacists or dispensary staff are handing out medication to patients, they should check the patient's or carer's understanding of the medicine they are expecting to receive, where possible. This will help verify the accuracy of the prescription and dispensed medication. The name and appearance of the dispensed item should also be verified where possible.

For further suggestions, please see please see Medicines Safety Matters, Prescribers & Community Pharmacists Vol 2 Issue[2]

Incorrect selection may also occur at ward level and nursing staff should be aware of the potential to select a beta blocker and the possibility of harmful effects should it be administered in error.

[1]http://www.psni.org.uk/documents/313/Standards+on+Sale+and+Supply+of+Medicines.pdf
[2]http://www.medicinesgovernance.hscni.net/primary-care/newsletters/medicines-safety-matters-prescribers-community-pharmacists/

Community Pharmacies and HSC Trusts were asked to confirm by the 30 May 2014 that the following actions had been taken:

- This Learning Letter was shared with all staff involved in either dispensing or the administration of medicines to patients;

- Review and as necessary, update your SOPs and arrangements for managing beta blockers, taking account of the suggestions in the Transferable Learning section of this letter.

An update will be provided in the next SAI Learning Report.

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 was 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. A report giving an overview of both pieces of work is currently being finalised and will be issued in the near future.

2.0 THEMATIC REVIEWS

Thematic Reviews are commissioned by the HSCB/PHA Quality Safety and Experience (QSE) Group, to review trends and patterns. These in-depth reviews ensure 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 review of SAI reports, the following thematic reviews were 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 SAIs reported to the HSCB was commissioned by the Regional Serious Adverse Incident Review Group.

This information will inform the established regional quality improvement work that is being undertaken. The 'Fallsafe' bundle, which is being implemented regionally, recommends multiple interventions for those people vulnerable to falls, and a phased approach to its introduction is required. Information from this review will also assist the Regional In-patient Falls Prevention Group to prioritise those elements which provide the greatest opportunity for improvement. In particular, the management of delirium and confusion.

There has been an increase in reported SAI incidents relating to falls, since 1st October 2013. The introduction of the new SAI procedure in October 2013, which includes SEA's, the report on the Regional Review of Patient Falls in Hospital and the improvement work by the Regional falls group and the Regional Governance leads group, have all contributed to the increase in awareness of reporting of serious harm from falls.

A further piece of work has been recommended by the SAI Review Sub Group, to commence at the end of May 2014. This was requested following significant increase in incidents relating to falls resulting in fractured femurs and an update will be provided in the next learning report.

The Thematic Review of In-Patient Falls has been completed and has been shared with HSC Trusts and other relevant HSC organisations.

- ***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 this thematic review was to identify recurrent themes found within reported SAIs and to consider any regional actions that could be implemented to reduce the incidence of "Misidentification of Patients and Clients".

This review is currently being finalised and a number of recommended actions in relation to the findings have already commenced these include:

- Visual aids, such as posters will be designed and displayed throughout Trust wards and departments to raise awareness across all HSC staff of the importance of patient verification processes at every stage of care.

- A newsletter article "Right Patient Right Care" has been published in the PHA newsletter "Learning Matters" (no1, December 2013).This newsletter is disseminated Trust wide and its purpose is to provide service users and health service staff access to important learning.

- The Patient Safety Forum and the Royal College of Nursing (RCN) who are currently responsible for the delivery of Leadership Training to nursing staff are exploring the possibility of including a topic based on Quality improvement in Leadership for Safety with theatres and procedural areas.

The review will be issued to HSC Trusts and relevant organisations in the coming weeks.

- ***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 was to analyse SAI reports, identify regional learning and consider implementation of actions to improve systems.

This review provides a detailed analysis of SAIs relating to where a Failure in the Referral or Follow-up Process has occurred across all programmes of care, for the period 1 May 2010 to 19 July 2013. The majority of these SAIs were identified within the Acute Services Programme of Care.

From the conclusions of this review it is clear that there are multi- faceted reasons for failure in the referral or follow-up process and this learning will inform future quality improvement work. The main themes identified related to: communication, ownership and handover of documentation. Work is progressing to address the main issues from the themes identified within this report and these will be addressed through the Regional Electronic Care Record (ECR), the HSCB review of Red Flag guidelines, NICaN workplan and the Regional Hospital at Night Group.

The Thematic Review of SAIs relating to where a Failure in the Referral or Follow-up Process has been completed and shared with HSC Trusts and other relevant HSC organisations.

- ***VENOUS THROMBOEMBOLISM (VTE)***

In December 2013 a review of reported SAIs in which patients suffered venous thromboembolism (VTE) was requested by the HSCB/PHA QSE Group.

A review of all SAIs reported to the HSCB for the Acute Services Programme of Care from 1 May 2010 to 22 November, 2013 was conducted. This review identified three reported SAIs relating to VTE. In conclusion all three reports show that either risk assessment was not undertaken, or appropriate prophylactic treatment was not prescribed in line with NICE Guidelines.

PHA monitors HSC Trusts compliance with VTE risk assessment quarterly, through Quality Improvement Plan (QIP) reporting. The issues and learning from this review will be considered within a number of work streams as the PHA continues to provide support and leadership to quality improvement in prevention of VTE in hospital patients.

The Thematic Review of SAIs relating to where patients suffered VTE has been completed shared with HSC Trusts and other relevant HSC organisations;

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 has developed a newsletter to compliment the other methods and to provide a forum where local learning from SAIs, reviews and complaints can be shared regionally.

The title of this newsletter is ‘Learning Matters’ and the first edition was issued in December 2013.

www.publichealth.hscni.net/publications

www.hscboard.hscni.net/publications/index.html

The second edition will be issued in May 2014.

SECTION 4

CONCLUSION

The HSCB/PHA are committed to learning from SAIs, improving services and reducing the risks of recurrence, both within the reporting organisation and across the HSC as a whole. The dissemination of learning following SAIs ensures that quality improvements are embedded into practice.

The NIAO Report (October 2012)[1] recognised that a regional process for reporting, managing, analysing and learning from SAIs is in place within Northern Ireland and alluded to the benefits in highlighting risks and identifying good practice through the regular reporting of SAIs..

The SAI procedure was revised in October 2013 following engagement with staff across the HSC. Since the last report three learning letters, and three thematic reviews have been disseminated to the relevant HSC organisations. Additionally the "Learning Matters" newsletter was published in December 2013, to compliment the other methods of learning and to provide a forum where local learning from SAIs, reviews and complaints can be shared regionally.

HSCB/PHA have recognised a need to enhance service users/families involvement in the SAI process. As a result, the HSCB and PHA have revised the SAI documentation to include a checklist to identify service users / family and, the statutory reporting to the HM Coroner (where there is a requirement to do so). The revised forms have been issued to HSC organisations for immediate use.

Quality, Safety and Patient Experience are a significant focus for the HSCB and PHA and both organisations will work in partnership with the HSC to improve the quality of care by learning from incidents and improving standards regionally.

1 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'.[2] 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 to/referred to mental health and related services *(including CAMHS,*

[2] 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

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 OCTOBER 2013 – MARCH 2014

The HSCB has **received 300 SAI Notifications** from across Health and Social Care (HSC) for the above period. The information[3] 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 Oct to 31 Mar**.

Total Activity	Oct 12 - Mar 13	Oct 13 - Mar 14
BHSCT	49	70
HSCB	1	0
NHSCT	48	98
NIAS	4	1
NIBTS	2	1
PCARE	15	14
SEHSCT	34	38
SHSCT	25	47
WHSCT	26	31
Totals:	**204**	**300**

This is the first reporting period since the revised SAI reporting criteria was introduced in October 2013 (refer to Appendix A). Heightened awareness of the revised procedure (following the consultation and implementation), the HSC training programmes for SEA and RCA along with recent Thematic Reviews undertaken will account for some of the increases in reporting.

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 **ten (10) SAI notifications** received were subsequently **de-escalated**.

TOTAL DE-ESCALATED	Oct 12 - Mar 13	Oct 13 - Mar 14
BHSCT	3	4
NHSCT	3	3
PCARE	2	0
SEHSCT	1	2
SHSCT	0	1
WHSCT	2	0
Totals:	**11**	**10**

[3] Source- HSCB DATIX Information System

DUPLICATE SAI NOTIFICATIONS

A notification may be received from one or more organisation but relating to the same incident. During the reporting period there were no duplicate notifications received.

TOTAL DUPLICATE	Oct 12 - Mar 13	Oct 13 - Mar 14
NHSCT	2	0
WHSCT	1	0
Totals:	**3**	0

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	Oct 12 - Mar 13	Oct 13 - Mar 14
BHSCT	16	17
NHSCT	8	36
NIAS	3	1
NIBTS	0	1
SEHSCT	8	7
SHSCT	5	7
WHSCT	2	8
Totals:	**42**	**77**

Current period: Seventy seven (77) SAIs were reported. The top five groups related to the following classifications/categories. Eighteen (18) incidents being the most reported in any one category.

Classification/category

- Treatment, procedure
- Accident that may result in personal injury
- Diagnosis failed or delayed
- Medication
- Access, Appointment, Admission, Transfer, Discharge

Since the revised criteria (see Appendix A) were introduced, there has been an increase in the number of reported incidents relating to falls; within the above classification/ catergory: accident that may result in personal injury, 16 SAIs related to slip, trips, falls and collisions.

MATERNITY & CHILD HEALTH

ORGANISATION	Oct 12 - Mar 13	Oct 13 - Mar 14
BHSCT	4	37
NHSCT	1	8
NIAS	1	0
NIBTS	1	0
SEHSCT	0	8
SHSCT	2	12
WHSCT	0	7
Totals:	**9**	**72**

Current period: Seventy-two (72) SAIs relating to maternity and child health were reported. The revised criteria (Appendix A) included an additional requirement to report 'any death of a child in receipt of HSC services (up to eighteenth birthday)'. 85% of the reported SAIs (n=61) for this programme of care relate to HSC Child Death Notifications.

FAMILY & CHILD CARE

ORGANISATION	Oct 12 - Mar 13	Oct 13 - Mar 14
BHSCT	2	3
NHSCT	10	4
SEHSCT	1	5
SHSCT	3	1
WHSCT	1	0
Totals:	**17**	**13**

Current period: Thirteen (13) SAIs relating to family and childcare were reported. The largest classification/category group (n=10) related to 'Abusive, violent, disruptive or self-harming behaviour'.

OLDER PEOPLE SERVICES

ORGANISATION	Oct 12 - Mar 13	Oct 13 - Mar 14
BHSCT	1	0
NHSCT	3	22
SEHSCT	4	3
SHSCT	3	12
WHSCT	2	2
Totals:	**13**	**39**

Current period: Thirty-nine (39) SAIs reported related to older people services. The largest classification/category group (n=30) was 'Accident that may result in personal injury' of which 87% (n=26) related to slips, trips and falls.

MENTAL HEALTH

ORGANISATION	Oct 12 - Mar 13	Oct 13 - Mar 14
BHSCT	21	8
NHSCT	19	17
SEHSCT	17	10
SHSCT	12	13
WHSCT	15	10
Totals:	**84**	**58**

Current period: Fifty-eight (58) SAIs relating to adult mental health services were reported. 79% (n=46) related to suspected/attempted suicides* or unexpected deaths.

The remaining reported incidents related to the following classifications:

- Abuse
- Attempted suicide, whether proven or suspected
- Accident that may result in a personal injury

**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	Oct 12 - Mar 13	Oct 13 - Mar 14
BHSCT	1	0
NHSCT	1	4
SEHSCT	2	2
SHSCT	0	0
WHSCT	0	1
Totals:	**4**	**7**

Current period: Seven (7) SAIs relating to learning disability services were reported.

PHYSICAL DISABILITY AND SENSORY IMPAIRMENT

POC7	Oct 12 - Mar 13	Oct 13 - Mar 14
BHSCT	1	0
NHSCT	0	1
SEHSCT	1	0
Totals:	**2**	**1**

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

PRIMARY HEALTH AND ADULT COMMUNITY (INCLUDING GENERAL PRACTICE)

ORGANISATION	Oct 12 - Mar 13	Oct 13 - Mar 14
HSCB	1	
PCARE	13	14
Totals:	**14**	**14**

Current period: Fourteen (14) SAIs relating to Primary Health and Adult Community were reported. The largest classification/category group (n=9) was 'Medication'.

CORPORATE BUSINESS

ORGANISATION	Oct 12 - Mar 13	Oct 13 - Mar 14
BHSCT	0	1
NHSCT	1	3
NIBTS	1	0
SEHSCT	0	1
SHSCT	0	1
WHSCT	3	3
Totals:	**5**	**9**

Current period: Nine (9) SAIs were reported relating to corporate business. The largest classification/category group (n=3) was 'Patient information (records, documents, test results, scans)'

HEALTH PROMOTION AND DISEASE PREVENTION

No reported incidents