

Learning Report

Serious Adverse Incidents

October 2014 – March 2015

June 2015

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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 MANAGING SERIOUS ADVERSE INCIDENTS REPORTED

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

- Regional reporting system for all SAIs;
- SAIs are reviewed by senior professional officers; in addition, the HSCB senior management team receives and considers all SAIs on a weekly basis;
- SAIs are allocated to a nominated professional officer, who is the Designated Review Officer (DRO) responsible for reviewing and scrutinising reports;
- SAI Review Sub Group (SAIRSG) meetings to consider reports, identify themes and learning;
- Overarching HSCB-PHA Quality Safety and Experience (QSE) Group to consider the issues identified by the SAIRSG and agree actions and assurance arrangements;
- The Safety and Quality Alerts (SQA) Team provide an assurance mechanism for any actions to be taken forward as a result of regional learning;
- 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.

3.0 WORK TAKEN FORWARD IN 2014- 2015

SERVICE USER AND FAMILY INVOLVEMENT IN SAIS

The HSCB and PHA SAI procedure makes clear the need for appropriate communication and involvement of service users, relatives and carers and from 1 April 2014, all SAI Investigation reports submitted to HSCB/PHA have a Service User/Family Carer Engagement Checklist attached.

APPENDIX C provides an analysis of service user/family/carer engagement for the period 1 April 2014 to 23 February 2015 for HSC Trusts. A further update to this information will be provided in the next edition.

In addition, and in line with DHSSPS communication, the HSCB and PHA have worked with the Patient Client Council, RQIA, and Trust Governance Leads to develop guidance for HSC organisations when involving service users/families throughout the relevant stages of the SAI process (issued in February 2015).

The purpose of the guidance is to ensure that communication with service users/families/carers, following a SAI, is undertaken in an open, transparent, informed, consistent and timely manner; thereby promoting a culture that effectively leads to improved service user and staff acceptance of the event. The guidance should be read in conjunction with the revised SAI Procedure in order ensure the engagement process is closely aligned to the required timescales, documentation, investigation levels etc. A leaflet has also developed to provide information for patients/families on the process.

DRO PROFESSIONAL GROUPS

During 2014/15 a pilot exercise was undertaken in relation to the process undertaken by DROs when reviewing SAI investigation reports. The pilot involved the following Programmes of Care (POC):

- Paediatrics and Child Health
- Maternity
- Mental Health (including Prison Health)
- Acute

A number of DROs from each of the above groups have met on a monthly basis to review SAI investigation reports, in order to close and/or identify any issue that requires consideration by the SAI Review Sub Group. The DRO professional groups benefit from:

- Multi-professional input / wider circle of experience,
- Group sign off , decisions not focused on one individual
- More complete understanding of the range of SAI issues within these service areas leading to the identification of regional trends

Consideration to extending this process to other POCs will be reviewed during 2015/16.

MEETINGS WITH HSC TRUSTS

During the reporting period the Chair and Co-chair of the RSAISG conducted a round of meetings with each of the HSC Trust Governance Leads to discuss issues relating to the Procedure for the Reporting and Follow up of SAIs and the more recent inclusion of the process for engaging with service user/ family and carers.

LAY PERSONS

In line with the current Complaints Procedure, the HSCB have established and continue to maintain of a list of lay persons for use by the HSC in the resolution of complaints. During the investigation of a complaint, a layperson can be used by an HSC organisation to provide an independent perspective and can, therefore, be adopted as one of the methods where HSC organisations could achieve 'enhanced' local resolution as part of the new single tier approach.

During 2014/15, and following consultation Trust Governance leads, it was agreed the current remit of lay persons could be extended to include their involvement in the SAI review process. This would provide support to HSC organisations who are routinely involved in the review of more complex SAIs, particularly when a degree of independence is required.

A number of lay persons expressed an interest in taking forward this role and attended a training event in March 2015 which provided an overview of the SAI process and included a session from a Trust Governance lead on the role of a Layperson in a Trust SAI Review.

Training on Root Cause Analysis for lay persons is scheduled for April and May 2015, after which, Trusts and HSCB Directorate of Integrated Care (HSCB) will be notified on the process to access lay persons to participate in SAI Reviews.

TRAINING

During the reporting period, a number of regional training programmes were undertaken to support staff in the implementation of the SAI procedure:

- Regional root cause analysis training (April and May 2014)
- Lay Persons training (March 2015)

4.0 SAIs REPORTED DURING PERIOD OCT 2014 – MAR 2015

During the period 1 October 2014 to 31 March 2015, the HSCB received 366 SAI notifications. This represents a decrease on the previous six months (April 2014 – September 2014) when 434 SAIs notifications 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 six (6) 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.

During the reporting period one duplicate SAI notification was received.

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 Alerts 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 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 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 had on the individuals involved.

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. MONITORING FOR TWIN-TO-TWIN TRANSFUSION SYNDROME (TTTS) – (Update from previous report)

Review of the antenatal care of some twin pregnancies has shown that:

- The mothers of these babies were not monitored during pregnancy for TTTS in line with the schedule recommended by NICE Clinical Guideline 129 'Multiple Pregnancy: the management of twin and triplet pregnancies in the antenatal period'. The NICE guideline recommends that in monochorionic twin pregnancies diagnostic monitoring with ultrasound for fetofetal transfusion syndrome (including to identify membrane folding) should start from 16 weeks and be repeated fortnightly until 24 weeks;
- There was a lack of clarity as to whether monitoring for TTTS was done at the same time as the ultrasonographer carried out the fetal anomaly ultrasound scan at 20 weeks; or whether a separate appointment with an obstetrician should have been arranged at that time to ensure that the mother was monitored for TTTS fortnightly between 16-24 weeks in addition to having a fetal anomaly ultrasound scan;
- The respective roles and responsibilities of obstetricians and ultrasonographers for monitoring TTTS were unclear;
- Obstetric staff of varying levels of seniority were involved in monitoring for TTTS.

A Safety and Quality Learning Letter LL/SAI/2014/027 was issued on 17 June 2014 setting out transferable learning and identified the following actions for HSC Trusts:

- Development of a clear policy that sets out the local arrangements for monitoring multiple pregnancies in line with the schedule recommended by

NICE (including a fetal anomaly scan). The NICE CG 129 is available at: <http://publications.nice.org.uk/multiple-pregnancy-cg129>;

- The Trust policy should be developed by a multidisciplinary team, including ultrasonographers, and must make it clear whose responsibility it is to monitor for TTTS fortnightly from 16-24 weeks in monochorionic multiple pregnancies, and remove all ambiguity regarding the respective roles of obstetricians and ultrasonographers;
- Trusts should ensure that those carrying out monitoring for TTTS are appropriately trained to do so. As far as possible, there should be continuity of staff who carry out the scans. Junior doctors should not be carrying out monitoring scans in multiple pregnancies unless directly supervised by an experienced consultant as part of their training;
- Trust policy should be reviewed and updated once the regional service model/care pathway is in place.

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

1. The Learning Letter is shared with obstetricians, ultrasonographers, midwives, service managers, and other relevant staff;
2. A clear policy is developed that sets out the local arrangements for monitoring multiple pregnancies in line with the schedule recommended by NICE;

HSC Trust responses have been reviewed by the Safety and Quality Alerts team and all HSC Trusts have provided satisfactory responses indicating substantive action.

2.2. PRESCRIBING AND DISPENSING INCIDENTS INVOLVING BUCCAL MIDAZOLAM PRODUCTS – (Update from previous report)

Buccal midazolam may be considered as an alternative to rectal diazepam for the treatment of prolonged seizures. Several buccal midazolam products are available, as prefilled syringes (PFS) and a multi-dose bottle, with a range of strengths and volumes, which leads to increased risk. A number of adverse incidents have been reported where patients have received the incorrect buccal midazolam product. Whilst no harm has been reported in these cases, there was potential for serious harm to occur. HSCB previously issued a Medicines Safety Alert to GPs and Community Pharmacist in June 2012 highlighting 'Actions to Minimise the Risks with Buccal Midazolam Preparations'¹.

Contributory factors to the incidents included:

- Change in buccal midazolam product prescribed

¹ <http://www.medicinesgovernance.hscni.net/primary-care/medicines-safety-alerts/>

- Poor communication between GP, Community Pharmacist and Trust Specialist Epilepsy Nurse/Consultant
- Lack of knowledge of the range and strengths of products available and how these are administered
- Generic prescribing, which is contrary to HSCB generic exemptions list
- Insufficient patient/carer education and counselling.

A Safety and Quality Learning Letter LL/AI/2014/028 was issued on 20 June 2014 and identified the following actions that:

HSC Trusts should:

1. Share the Learning Letter with all staff involved in recommending, prescribing or dispensing buccal midazolam products;
2. Review and as necessary, update processes for managing patients who require buccal midazolam products, taking account of the suggestions in the Transferable Learning section of the letter.
3. Review all patients currently receiving buccal midazolam to ensure the recommendations included in the learning letter are implemented.
4. Confirm by 15 September 2014 to alerts.hscb@hscni.net that actions 1 and 2 have been completed and action 3 is underway.

GP practices should:

1. Share the Learning Letter with all staff involved in recommending, prescribing or dispensing (dispensing practices only) buccal midazolam products;
2. Review and as necessary, update your processes for managing patients who require buccal midazolam products, taking account of the suggestions in the Transferable Learning section of the letter.
3. Review all patients currently receiving buccal midazolam to ensure the recommendations included in the learning letter are implemented.

Community Pharmacies should:

1. Share the Learning Letter with all staff involved in recommending, prescribing or dispensing buccal midazolam products;
2. Review and as necessary, update your processes for managing patients who require buccal midazolam products, taking account of the suggestions in the Transferable Learning section of the letter.

All HSC Trusts have confirmed that they are implementing the actions required. Further work is being taken forward regionally in relation to a pathway for epilepsy and by the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) Regional work

2.3. SYSTEMS TO CHECK THE INTEGRITY AND STERILITY OF PACKS OR INSTRUMENTS PRIOR TO USE – (Update from previous report)

Several Serious Adverse Incidents across different HSC Trusts have highlighted process failures within Sterile Services, resulting in instruments / packs being available for clinical use when they had not completed the full sterilization process.

The instruments / packs were used even though the indicator tape, which changes colour to show sterilization is complete, had NOT changed colour. Adequate processes to check the sterility of the instruments / packs prior to leaving Sterile Services and at point of use had not been implemented.

A Safety and Quality Learning Letter LL/SAI/2014/029 was issued on 1 October 2014 and identified transferrable learning:

HSC Trusts were asked to:

- Discuss this Learning Letter with acute and community medical and nursing staff who use sterile instruments/packs, service managers for those areas, and other relevant staff;
- Review and update their systems for checking the integrity and sterility of instruments/packs prior to use to minimize the risk of individual error.

All HSC Trust have confirmed actions are complete or processes are underway to achieve actions.

THE FOLLOWING ITEMS ARE NEW LEARNING ISSUED SINCE LAST REPORT

2.4. EMERGENCY CALL ARRANGEMENTS IN OBSTETRIC UNITS

Two serious adverse incidents involving neonatal deaths have highlighted the need for Trusts to ensure that they have robust arrangements to summon the appropriate staff to be present at delivery in a timely way.

In one case, the Trust's investigation report highlighted that on-site staff were bleeped individually to attend the emergency incident at delivery. The investigating team recommended that to ensure there are no delays in accessing appropriate staff; consideration should be given to a baton bleep emergency system to include all team members necessary for the delivery and resuscitation of the mother and baby.

In the other case, there was a delay in calling the paediatric registrar to a preterm baby who required neonatal resuscitation after delivery. The bleep system was not used to contact the paediatric registrar, but rather, a verbal message was conveyed to the registrar who was working on a ward. The investigating team recommended that consideration is given to the grade of paediatric staff called in emergencies, particularly when there are known risk factors.

A Safety and Quality Learning Letter LL/SAI/2015/030 was issued on 12 January 2015 setting out the following transferrable learning for Trust Service Directors responsible for Maternity Services:

- In an emergency situation at delivery in an obstetric unit, all relevant members of staff should be called through the equivalent of the 'crash-call' system in cardiology services (sometimes referred to as a 'baton system'). A baton system simultaneously calls all team members necessary for the delivery and resuscitation of the baby/mother rather than bleeping or ringing individual members of staff to attend.
- In cases where it is anticipated in advance that neonatal resuscitation is likely to be required after delivery, an appropriately senior member of the neonatal/paediatric team should be called to attend as soon as it is apparent that delivery is imminent.

The reminder of best practice guidance letter identified the following actions for HSC Trusts:

- Share this Learning Letter with relevant staff;
- Take account of this Learning Letter and ensure that emergency-call arrangements in maternity units in your Trust are:
 - The functional equivalent of a crash-call system
 - Explained to new and existing staff
 - Tested/rehearsed regularly;

NIMDTA were asked to action the following:

- Disseminate this letter to doctors in training in relevant specialties.

HSC Trusts were asked to provide a response by 27 February 2015 to confirm actions have been completed. All HSC Trusts have confirmed actions are complete.

2.5. DISCHARGE PLANNING AND RECORDING LEGAL STATUS UNDER THE MENTAL HEALTH ORDER - Reminder of best practice

This incident related to the discharge of a patient detained under the Mental Health legislation. Trust findings emphasized the importance of discharge planning in respect of all young people admitted to mental health inpatient provision which should commence at the time of admission as required under Trusts' current Admission and Discharge Protocol & Procedures for mental health services (CAMHS & AMHS).

The incident also highlighted the need to ensure that care plans are documented fully, and reasons for decisions (including any revisions to the care plan and changes in legal status under the mental health legislation) recorded clearly in keeping with best practice and current protocol and procedures.

A Safety and Quality Best Practice Reminder letter SQR/SAI/2015/001, was issued on 14 January, highlighting the following requirements under current guidance:

For care professionals working in mental health services:

- You are responsible for documenting your assessment of a patient and the rationale for your care decisions including those relating to a patient's legal status under mental health legislation.

For HSC Trust Directors of Mental Health Services:

- Trusts are reminded to ensure that:
 - Current admission and discharge protocols and procedures are adhered to and any updates or revisions are highlighted and discussed at staff meetings, and circulated to all relevant staff
 - File records should be audited quarterly to ensure compliance with requirements to document mental health status and the reasons for any changes fully and clearly. The audit results should be communicated to all staff.

The reminder of best practice guidance letter identified the following actions for

HSC Trusts:

- Please share this reminder letter with all relevant staff, including discussing it in appropriate team meetings and professional forums;
- Please review and as necessary, update relevant training and procedures to incorporate requirements in this letter.
- Ensure file audits are conducted quarterly to quality assure practice against the issues highlighted in this letter.

NIMDTA was asked to action the following:

- Please disseminate this reminder letter to doctors in training in relevant specialties.

Director of Integrated Care, HSCB was asked to action the following:

- Please disseminate this reminder letter to all General Practitioners.

RQIA was asked to action the following:

- Please disseminate this reminder letter to all relevant Independent Sector providers.

HSC Trusts were asked to confirm by 28 February 2015, that actions 1-2 have been completed, and that the date of the last quarterly audit, or the date the next audit will begin. All HSC Trusts confirmed they have completed the required actions.

2.6. AVOIDANCE, RECGONITION AND MANAGEMENT OF ANAPHYLAXIS

Reminder of best practice

A pregnant woman was prescribed intravenous co-amoxiclav even though the patient was known to have an allergy to penicillin and she was wearing an alert wristband. A midwife questioned the decision to prescribe co-amoxiclav in light of the known allergy, but was instructed to go ahead and administer the co-amoxiclav. The patient developed an anaphylactic reaction which was not immediately recognised. She eventually recovered after several days in ICU. The Trust's investigation report also found that the Trust did not have a protocol for the management of anaphylaxis in the hospital setting.

A Safety and Quality Best Practice Reminder letter SQR/SAI/2015/002, was issued on 3 February 2015, highlighting the following requirements under current guidance:

For medical midwifery, nursing, pharmacy and equivalent staff in primary care:

- If you feel that a patient is being put at risk by another member of staff, and you remain concerned after speaking to that staff member, you should contact a more senior member of the team or organisation.
- Regarding this specific incident, you should not supply or administer medication to a patient who is known to be allergic to that medication.
- You should be prepared to listen to colleagues who question your treatment decisions, and reconsider them, as necessary – to err is human and it may protect you and your patients.

For Trust Service Directors responsible for any health care staff involved in prescribing, supplying or administering medication

- Trusts should have an open organisational culture which emphasizes the safety benefits of teamwork and encourages staff to give and accept respectful challenge, particularly of decisions of more senior staff. Staff should feel able to escalate concerns to a more senior member of staff when necessary.
- Trusts should have a protocol for the management of anaphylaxis in both hospital and community settings, and should ensure that staff have immediate access to the protocol. Suitable algorithms for the management of anaphylaxis are available from many bodies including the UK Resuscitation Council, Royal College of Physicians (London) and the Association of Anaesthetists of Great Britain & Ireland.
- Trusts should ensure that all staff have up-to-date training in the identification and management of anaphylaxis.

The reminder of best practice guidance letter identified the following actions that:

HSC Trusts should:

1. Share this letter with relevant staff, and discuss it at team meetings/safety briefings;
2. Ensure that you have a protocol for anaphylaxis in both hospital and community settings and that staff have immediate access to the protocol;
3. Ensure that all staff are provided with regular update training in the management and treatment of anaphylaxis.

HSC Trusts were asked to confirm by 13 April 2015, that actions 1-2 have been completed, and that training under action 3 is available. An update will be provided in the next report.

Director of Integrated Care, HSCB should:

- Disseminate this letter to GPs, dentists and community pharmacists.

NIMDTA should:

- Disseminate this letter to doctors in training in relevant specialties.

RQIA should:

- Disseminate this letter to relevant Independent Sector Providers.

2.7. RESIDUAL ANAESTHETIC DRUGS IN CANNULAE AND INTRAVENOUS LINES – Reminder of best practice

A woman who had an emergency caesarean section under general anaesthetic experienced a sudden respiratory arrest two hours later. The patient had 3 intravenous lines in place, two of which had 'octopus' (2 line) extensions. The respiratory arrest occurred minutes after intravenous fluids were started on one of the lines. The likely cause was that a residual amount of muscle relaxant drug, present in the line, had been administered inadvertently to the patient when intravenous fluids were run through on that line, causing muscle paralysis. A neuromuscular blocking reversal agent was administered and the patient recovered quickly.

The staff, who were involved in this case, are to be commended for their prompt recognition of the cause of the respiratory arrest and taking the appropriate action.

A Safety and Quality Best Practice Reminder letter SQR/SAI/2015/003, was issued on 13 March 2015, highlighting the following requirements under current guidance:

On 24 July 2014, a Patient Safety Alert from NHS England (NHS/PSA/W/2014/008 attached) was issued to Trusts, RQIA and NIMDTA for dissemination to relevant staff.

This local case reinforces the need to implement the actions set out in the Patient Safety Alert.

For anaesthetists and all other theatre and recovery staff

- For each patient under your care, you need to ensure that all cannulae and extensions have been flushed through with saline, or another solution that does not contain anaesthetic drugs, before the patient leaves recovery or the department where the procedure/investigation was undertaken.
- You also need to ensure that any intravenous lines or extensions that are no longer required are removed before the patient leaves your care.

For Directors with responsibility for anaesthetic/theatre services

- You must have robust systems in your Trust that help staff to ensure that before the patient leaves recovery or the department where the procedure/investigation was undertaken:
 - All cannulae and extensions have been flushed through with saline, or another solution that does not contain anaesthetic drugs, and
 - Any intravenous lines or extensions that are no longer required are removed.

You should consider using the post-operative 'sign out' section of the WHO surgical safety checklist as part of your system.

The reminder of best practice guidance letter identified the following actions that:

HSC Trusts should:

- Share this Reminder of Best Practice Letter and attached Patient Safety Alert with all relevant staff;
- Review and as necessary, update your Trust's systems in light of the information in the Requirements under Current Guidance section;

Trusts were asked to confirm by 29 May 2015, that the actions above have been completed. An update will be provided in the next report.

NIMDTA should:

- Disseminate this letter to doctors in training in relevant specialties.

RQIA should:

- Disseminate this letter to relevant Independent Sector Providers.

2.8. REDUCED FETAL MOVEMENTS - Reminder of best practice

A woman who was 35 weeks pregnant attended a GP out-of-hours service as she was concerned she had not felt fetal movements for the previous 36 hours. The GP listened to the fetal heart with a sonicaid, reassured the mother, and she went home. The next day she contacted the maternity ward as she still felt no fetal movement. She was asked to attend the maternity unit immediately and an intrauterine death (stillbirth) was diagnosed.

In another case, a pregnant woman who was past her due date contacted the maternity assessment unit on two successive days with concern about reduced fetal movements. She was given telephone advice by a midwife on each occasion. There was no access to the patient's records during the telephone consultations, a full risk assessment was not performed and details of the advice given were not documented. During the first telephone contact the woman was asked to count fetal movements over a period of time, but despite having a lower than expected number of fetal movements, she was given inappropriate reassurance. On the second occasion the midwife was unaware that the mother had contacted the assessment unit the previous day, and the mother was again advised to count fetal movements over a period of time. The mother reported feeling no fetal movements and was asked to attend the hospital where an intrauterine death (stillbirth) was diagnosed.

A Safety and Quality Best Practice Reminder letter SQR/SAI/2015/004, was issued on 16 March 2015, highlighting the following requirements under current guidance:

The Royal College of Obstetricians & Gynaecologists has produced good practice guidance on reduced fetal movements. This is available at:

<https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg57>

Key points from the RCOG guidance will be incorporated to the Pregnancy Book and the next version of the Maternity Hand Held Record.

A patient information leaflet is also available at:

<https://www.rcog.org.uk/en/patients/patient-leaflets/your-babys-movements-in-pregnancy>

For general practitioners, community midwives, practice nurses and GP out of hours services

- If a pregnant woman contacts you with concern about fetal movements you should refer her to a maternity unit without delay.

For Emergency Department staff

- If a pregnant woman has concern about fetal movements you should contact the maternity team and arrange for them to assess her without delay.

For midwifery and obstetric staff

- In line with the RCOG guidance, you should advise women of the need to be aware of fetal movements up to and including the onset of labour, and you should tell them to contact their maternity unit without delay if they notice any decrease or cessation of fetal movements.
- You should follow the RCOG guideline on the risk assessment, investigation and management of women who have reduced fetal movements.
- You should ensure that you have sufficient information on the mother's history to make an informed judgment on the appropriate course of action.
- You should clearly document your assessment and management decisions.

For Trust Maternity Service Directors

- You should ensure that robust arrangements are in place in your Trust so that women with concerns about fetal movements are assessed appropriately.

The reminder of best practice guidance letter identified the following actions that:

HSC Trusts should:

1. Share this Reminder of Best Practice Letter with relevant staff.
2. Review and as necessary, revise your Trust's protocols to ensure that they are in line with the RCOG guideline on reduced fetal movements.
3. Send your local GPs and GP out of hours services details of how to refer women for assessment of reduced fetal movements, including the relevant contact telephone numbers.
4. Have in place an agreed referral pathway from ED to the maternity service. Ensure ED and maternity staff know that pathway, including how to access the relevant contact telephone numbers.
5. Review telephone triage protocols within maternity units to ensure that the relevant history is obtained from women who contact the unit with concern about fetal movements, and the appropriate advice is given, in line with the RCOG guideline.
6. Put in place a system for recording previous contacts/attendances at maternity assessment (day obstetric) units and ensure that this information is readily available to relevant staff.

Trusts were asked to confirm by 17 July 2015, that all actions above have been completed. An update will be provided in the next report.

OTHER LEARNING INITIATIVES TAKEN FORWARD

There are a range of other initiatives across the HSC where learning from SAIs changes practice to reduce the risk of recurrence. There has been a range of learning communications issued to family practitioner services relating to:

- Adverse incidents involving Rivaroxaban dosing
- Security of prescription pads
- Newer Oral Anticoagulant dosing
- Transdermal Fentanyl Patches

The following is a link to the Medicines Governance Website where these resources are available: <http://www.medicinesgovernance.hscni.net/primary-care/medicines-safety-advice-letters/>

Other examples of learning include:

Establishment of a Multi-agency Regional Practice Network - following Learning relating to a SAI involving a young female, with Portuguese citizenship, who came to the attention of Social Services following a referral from health professionals. The young person subsequently disappeared and was located in Wales.

Learning emerging from the SAI included the need for timely age assessment, active and robust information sharing between PSNI and other lead agencies throughout case management, escalation of any concerns about the effectiveness of multi-agency working and information sharing, analysis of the legal powers available to Trusts where a separated young person refuses a voluntary care arrangement and the inclusion of separated children within the revision of the Runaway and Missing from Home or Care Guidance.

To support the integration of learning to practice a regional practice learning network has been established comprising of representation from PSNI, Border Force, UKVI, VOYPIC, Trusts, RESWS, DHSSPS and HSCB to provide a vehicle for sharing learning and harnessing collaborative multi-agency working.

Regional Healthcare Associated Infection (HCAI) Forum - following learning from a SAI where a patient who had Carbapenemase Producing Organism (CPO) isolated, substantial regional work was carried out. The guidance, case summary and risk assessment relating to CPO was highlighted at a recent HCAI Learning Event.

In addition the Chief Medical Officer (CMO) issued a Carbapenemase Producing Enterobacteriaceae (CPE) Tool kit for Acute Trusts HSS(MD)11/2914. The PHA currently maintain a core dataset for CPE cases, reported through the Health Protection Duty Room, as part of routine case assessment and risk management.

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.

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 has been finalised and issued to relevant parties.

Five main themes were identified and as a result, the action plan outlines on-going work streams in which the themes will be addressed and will be taken account of in future work.

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 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 has been finalised and will be issued in the coming weeks to the HSC along with the regional poster (designed in partnership with the five HSC Trusts) for display throughout Trust wards and departments to raise staff awareness of the importance of patient verification processes at every stage of care.

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.

Learning Matters Newsletter provides a new method of sharing learning relating to serious adverse incidents, complaints, reviews and patient experience across Northern Ireland. The **third edition was issued in December 2014** and covers the following topics:

- Avoiding Computer Confusion: Log In, Check And Log Out.
- National Patient Safety Alerts
- Masking Challenging Behaviours
- Share to Learn: Lesson of the Week
- Wrong Site/Wrong Procedure

This edition of the newsletter can be viewed at:

[http://www.hscboard.hscni.net/publications/Learning%20Matters/08%20Learning_Matters_Issue_3-December_2014.pdf#search="learning matters"](http://www.hscboard.hscni.net/publications/Learning%20Matters/08%20Learning_Matters_Issue_3-December_2014.pdf#search=)

<http://www.publichealth.hscni.net/sites/default/files/Issue%203%20final.pdf>

The Learning Matters Newsletter editorial team are currently developing a ‘**Special Maternity Edition**’ of the Learning Matters Newsletter and will cover the following topics:

- Care of pregnant women who have had a previous caesarean section
- Antenatal fetal growth monitoring
- Maternity Early Warning Scores
- Operative vaginal delivery
- Human Factors

This special edition of the newsletter will be issued in the coming weeks.

Family Practitioner Services (FPS) Newsletters

During the reporting period, a number of learning newsletters were issued relating to FPS. Two in particular made reference to learning from SAIs i.e.

- GMS Newsletter
- Medicines Safety Matters for Prescribers and Community Pharmacists

The newsletters can be accessed on the GP intranet site using the following links:

GMS

- http://primarycare.hscni.net/gms_newsletter_main.htm
- <http://primarycare.hscni.net/3582.htm>

Medicines Safety Matters for Prescribers and Community Pharmacists

<http://niformulary.hscni.net/PrescribingNewsletters/MedicinesSafetyMattersGPs/msmgpvol4.1/Pages/default.aspx>

4.0 SAI LEARNING EVENT

The HSC Safety Forum will be hosting a Regional SAI Learning Workshop on the 14 April 2015 at Mossley Mill, Newtownabbey.

The aim of the event is to provide an opportunity to share learning from Serious Adverse Incidents regionally. To facilitate this, HSC Trusts have agreed to present a number of case studies for discussion and a relative of a patient involved in a SAI will share their experience of the process and the impact it had on their family.

5.0 IMPACT OF DONALDSON REPORT RECOMMENDATIONS

A number of recommendations contained within the Donaldson Report 'The Right Time, The Right Place' refer to the current system of incident reporting and some that are specific to the current SAI process.

Following its publication, the Department launched a consultation on 24 February 2015. The HSCB/PHA are preparing a response to the consultation questionnaire which will be approved by HSCB Board prior to submission to DHSSPS on 22 May 2015.

SECTION 4

CONCLUSION

The HSCB and PHA want patients, carers and their families to feel confident about the quality and safety of health and social care services in Northern Ireland. There is a continued commitment to learn from SAIs, to improve services and to reduce the risks of recurrence, both within the reporting organisations and across the HSC as a whole. The dissemination of learning following SAIs and ensuring that quality improvements are embedded into practice remains a key priority for the HSCB/PHA.

To support this, the Safety Forum is hosting a workshop in April 2015 which will provide an opportunity to share the learning from SAIs and to gain the patient/family experience by listening to a relative of a patient involved in an SAI and the impact it had on their lives.

This report demonstrates actions planned and achieved in the period from October 2014 – March 2015. It also highlights the broad range of work that is routinely undertaken and reaffirms our commitment to safety, effectiveness and patient and client focus.

Since the last report, five learning letters/reminders of best practice have been disseminated to the relevant HSC organisations. Additionally the “Learning Matters” newsletter was published in December 2014, 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 has continued to work with HSC Trust Colleagues in relation to enhancing service users/families involvement in the SAI process.

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.

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

ANALYSIS OF SAI ACTIVITY OCTOBER 2014 – MARCH 2015

The HSCB has **received 366 SAI Notifications** from across Health and Social Care (HSC) for the above period. The information³ 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 October 2014 to 31 March 2015**.

Total Activity	Oct 13 - Mar 14	Oct 14 – Mar 15
BHSCT	70	84
BSO	0	2
HSCB	0	1
NHSCT	98	71
NIAS	1	2
NIBTS	1	0
PCARE	14	13
PHA	0	1
SEHSCT	38	59
SHSCT	47	86
WHSCT	31	47
Totals:	300	366

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 **six (6) SAI notifications** received were subsequently **de-escalated**.

TOTAL DE-ESCALATED	Oct 13 - Mar 14	Oct 14 - Mar 15
BHSCT	4	0
NHSCT	3	3
PCARE	0	2
SEHSCT	2	0
SHSCT	1	0
WHSCT	0	1
Totals:	10	6

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 was one duplicate notification received.

TOTAL DUPLICATE	Oct 13 - Mar 14	Oct 14 - Mar 15
BHSCT	0	1
Totals:	0	1

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 13 - Mar 14	Oct 14 - Mar 15
BHSCT	17	23
NHSCT	36	18
NIAS	1	2
NIBTS	1	0
SEHSCT	7	16
SHSCT	7	26
WHSCT	8	14
Totals:	77	99

Current period: Ninety nine (99) SAIs were reported. The top five groups related to the following classifications/categories. Twenty-two (22) incidents being the most reported in any one category.

Classification/category

- Diagnosis failed or delayed
- Treatment, procedure
- Accident that may result in personal injury
- Implementation of care or on-going monitoring/review
- Medication

Since the revised SAI criteria (see Appendix A) were introduced (October 2013), there has been an increase in the number of reported incidents relating to falls; within the above classification/ category: accident that may result in personal injury, 15% of the reported SAIs (n=15) for this programme of care relate to slip, trips, falls and collisions in an acute setting.

MATERNITY & CHILD HEALTH

ORGANISATION	Oct 13 - Mar 14	Oct 14 - Mar 15
BHSCT	37	40
HSCB	0	1
NHSCT	8	6
SEHSCT	8	10
SHSCT	12	14
WHSCT	7	16
Totals:	72	87

Current period: Eighty seven (87) 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)'. 84% of the reported SAIs (n=73) for this programme of care relate to HSC Child Death Notifications.

FAMILY & CHILD CARE

ORGANISATION	Oct 13 - Mar 14	Oct 14 - Mar 15
BHSCT	3	3
NHSCT	4	8
SEHSCT	5	5
SHSCT	1	1
WHSCT	0	2
Totals:	13	19

Current period: Nineteen (19) SAIs relating to family and childcare were reported. The largest classification/category group (n=14) related to 'Abusive, violent, disruptive or self-harming behaviour'.

OLDER PEOPLE SERVICES

ORGANISATION	Oct 13 - Mar 14	Oct 14 - Mar 15
BHSCT	0	0
NHSCT	22	18
SEHSCT	3	1
SHSCT	12	32
WHSCT	2	4
Totals:	39	55

Current period: Fifty five (55) SAIs reported related to older people services. The largest classification/category group (n=44) related to slips, trips, falls and collisions.

MENTAL HEALTH

ORGANISATION	Oct 13 - Mar 14	Oct 14 - Mar 15
BHSCT	8	11
NHSCT	17	13
PHA	0	1
SEHSCT	10	26
SHSCT	13	12
WHSCT	10	9
Totals:	58	72

Current period: Seventy two (72) SAIs relating to adult mental health services were reported. 63% (n=46) related to suspected / attempted suicides* or unexpected deaths.

**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 13 - Mar 14	Oct 14 - Mar 15
BHSCT	0	4
NHSCT	4	2
SEHSCT	2	0
SHSCT	0	0
WHSCT	1	0
Totals:	7	6

Current period: Six (6) SAIs relating to learning disability services were reported.

PHYSICAL DISABILITY AND SENSORY IMPAIRMENT

ORGANISATION	Oct 13 - Mar 14	Oct 14 - Mar 15
BHSCT	0	0
NHSCT	1	0
SEHSCT	0	0
Totals:	1	0

Current period: No incidents relating to physical disability and sensory impairment services were reported.

PRIMARY HEALTH AND ADULT COMMUNITY (INCLUDING GENERAL PRACTICE)

ORGANISATION	Oct 13 - Mar 14	Oct 14 - Mar 15
PCARE	14	11
Totals:	14	11

Current period: Eleven (11) SAIs relating to Primary Health and Adult Community were reported. The largest classification/category group (n=7) was 'Medication'.

CORPORATE BUSINESS

ORGANISATION	Oct 13 - Mar 14	Oct 14 - Mar 15
BHSCT	1	2
BSO	0	2
NHSCT	3	3
SEHSCT	1	1
SHSCT	1	1
WHsCT	3	1
Totals:	9	10

Current period: Ten (10) SAIs were reported relating to corporate business. The largest classification/category group (n=3) related to 'Consent, Confidentiality or Communication'.

HEALTH PROMOTION AND DISEASE PREVENTION

No reported incidents

APPENDIX C

Analysis of Checklist received 1 April 2014 to 23 February 2015

Table 1 a- Analysis of Engagement with patient /family/carer	BHSCT		NHSCT		SEHSCT		SHSCT		WHSCT		TOTAL	
Checklists received	61	100%	167	100%	80	100%	88	100%	78	100%	474	100%
Patient / Service User / Family Notified <u>not informed</u> incident was being investigated as an SAI	6	9.8%	6	4%	10	12.5%	5	5.7%	13	16.7%	40	8.4%
Patient / Service User / Family <u>informed</u> incident was being investigated as an SAI	55	90.2%	161	96%	70	87.5%	83	94.3%	65	83.3%	434	91.6%

Table 1b - Analysis of Rationale for patient /family/carer <u>not informed</u> that incident was being investigated as an SAI	BHSCT		NHSCT		SEHSCT		SHSCT		WHSCT		TOTAL	
Not Informed	6	100%	6	100%	10	100%	5	100%	13	100%	40	100%
No Contact details or NOK	1	16.7%	3	50.0%	3	30.0%	1	20.0%	1	7.7%	9	22.5%
Not applicable	3	50.0%	1	16.7%	1	10.0%	0	0.0%	1	7.7%	6	15.0%
Other rationale provided	2	33.3%	1	16.7%	6	60.0%	4	80.0%	11	84.6%	24	60.0%
Declined involvement	0	0.0%	1	16.7%	0	0.0%	0	0.0%	0	0.0%	1	2.5%

Table 2 - Analysis of Investigation Reports shared/not shared	BHSCT		NHSCT		SEHSCT		SHSCT		WHSCT		Total	
Checklists received	61	100%	167	100%	80	100%	88	100%	78	100%	474	100%
Investigation Report shared	32	52.5%	121	72.5%	33	41.3%	70	79.5%	32	41.0%	288	60.8%
Report not shared	29	47.5%	46	27.5%	47	58.8%	18	20.5%	46	59.0%	186	39.2%

Table 2b - Analysis of Investigation Reports not shared	BHSCT		NHSCT		SEHSCT		SHSCT		WHSCT		Total	
Report not shared	29	100%	46	100%	47	100%	18	100%	46	100%	186	100%
Plan to share report	4	13.8%	8	17.4%	9	19.1%	2	11.1%	9	19.6%	32	17.2%
Withdrew from process prior to finalisation of report	6	20.7%	10	21.7%	4	8.5%	0	0.0%	4	8.7%	24	12.9%
Declined report	3	10.3%	2	4.3%	14	29.8%	0	0.0%	3	6.5%	22	11.8%
No response to correspondence	3	10.3%	16	34.8%	5	10.6%	6	33.3%	13	28.3%	43	23.1%
Other rationale provided	11	37.9%	6	13.0%	10	21.3%	9	50.0%	15	32.6%	51	27.4%
No rationale provided	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	2.2%	1	0.5%
No contact details or NOK	2	6.9%	3	6.5%	5	10.6%	1	5.6%	1	2.2%	12	6.5%
Not applicable	0	0.0%	1	2.2%	0	0.0%	0	0.0%	0	0.0%	1	0.5%