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SAFETY FIRST:

A Framework for Sustainable Improvement in the HPSS

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POLICY STATEMENT ON SAFETY

The Department of Health, Social Services and Public Safety, together with the Health and Personal Social Services (HPSS), is committed to the ongoing development of a safer service, as part of its drive to improve clinical and social care, service user experience and outcomes.

No health and social care environment will ever be absolutely safe and without risk; however, more can always be done to improve the safety and quality of care provided.

High safety standards are key indicators of a high quality service. Over the next few years, the policy focus will be on linking quality and safety. Particular attention will be on:

- Creating an informed, open and fair safety culture within the HPSS;
- Raising awareness of risk and promoting timely reporting of adverse incidents;
- Investigating serious incidents;
- Sharing the learning across HPSS environments;
- Implementing change;
- Developing skills, knowledge and expertise; and
- Involving and communicating with the public.

In support of the policy, an action plan has been developed, which places “Safety First” as the philosophy which all organisations, practitioners and staff should promote and adopt.

The action plan will be reviewed in 2007.

SECTION 1 – AIM OF FRAMEWORK

1.1 INTRODUCTION

Safety has to be the first concern of everyone who works in or manages the Health and Personal Social Services (HPSS) in Northern Ireland. It is an integral part of quality in health and social care - diminished standards of safety reflect poor quality of service for people. Effective care, therefore, has to place an emphasis on efforts to improve safety processes in order to prevent adverse outcomes, and to improve the service user and carer experience. Safety is, therefore, an integral part of clinical and social care governance.

This document aims to draw together key themes to promote service user safety in the HPSS. It intends to build on existing systems and good practice, to bring about a clear and consistent DHSSPS policy and action plan, which can be reviewed in light of advances and developments. It does not aim to identify or replace existing policies and procedures, particularly those relating to statutory health and safety functions, or staff or visitor safety, but rather focuses on safety in terms of improvement of quality of care through enhanced clinical and social care governance.

The major policy focus and action will be on:

- creating an informed, open and fair safety culture across HPSS organisations;
- raising awareness of risk and promoting timely reporting of adverse incidents;
- sharing the learning across HPSS environments;
- implementing change;
- investigating serious incidents; and
- involving and communicating with the public.

Appendix A sets out the Terms of Reference and scope of this safety document. The action plan (section 5) will be reviewed in 2007, to determine progress and map future priorities.

1.2 ERROR – A PART OF THE HUMAN CONDITION

No health and social care environment is one hundred percent safe. Some adverse incidents which occur may be the inevitable complication of treatment or care. Many treatment decisions are made in a busy working day, using a range of technologies and

activities (e.g. medicines, medical devices, equipment, procedures) and in different environments, which can, in themselves, be the subject of error. The factors which influence quality and safety of care, include:

- the context, e.g. HPSS, regulatory frameworks;
- the organisation and its management e.g. financial resources, priorities, policies, safety culture;
- the work environment e.g. staffing levels, skill mix, workload;
- the team e.g. structure, communication, supervision arrangements;
- the individual (staff) e.g. knowledge and skills, motivation, health;
- the task e.g. task design, use of protocols, accuracy of test results; and
- patient characteristics e.g. complexity of condition, language and communication, personality and social factors.[1]

Given the multiplicity of factors which influence the care of an individual, health and social services will never be totally error-free. But what can be achieved is the minimisation of risk, a greater knowledge and understanding of why human error and systems failures occur and the fostering of a culture which supports learning in order to prevent reoccurrence.

1.3 DEFINITION OF AN ERROR OR INCIDENT

It is important to have a common understanding of what constitutes an error or incident, regardless of the source. Errors can occur at all stages of the process of care, from diagnosis to treatment, to preventive care. Not all errors result in harm; these errors are often described as “near misses”. These too, represent an opportunity to identify systems improvements and have the potential to prevent adverse incidents in the future. All types of errors and incidents should be included in a common definition - social care, clinical, health and safety, fire, infection control etc., as they could potentially impact on the health and social care of service users, staff and visitors.

For the purposes of the Department and the HPSS, the regional definition of an error or incident is as follows:

[1] Adapted from; Vincent, Taylor-Adams and Stanhope 1998

"Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation".

The definition acts as a common working definition for HPSS organisations. It acknowledges that not all errors result in harm to patients and service users, but some do. Where the potential for harm/loss/damage is detected and the incident is prevented thus resulting in no harm to the individual, it is considered a "near miss" and can yield valuable learning.

The definition also supports the view that damage to property, environment or reputation can have both a direct and indirect impact and cost on health and social care. For example, faulty equipment may require tests to be repeated, potential for mis-diagnosis and concern for service users and staff. In addition, an incident may lead to loss of trust on behalf of the public and reduced satisfaction and morale among staff, with consequent negative impact on workforce recruitment and retention. More generally, employers and society may pay because of loss of worker productivity, school attendance, and a reduction in population health status. So, the human, social and economic costs resulting from adverse incidents are potentially high, but especially when a death occurs which may have been preventable.

1.4 THE HUMAN, SOCIAL AND ECONOMIC COSTS

The National Patient Safety Agency in England and Wales has produced its first report based on findings of the National Reporting and Learning System from November 2003 to March 2005. It shows a rate of five adverse incidents reported per 100 admissions in acute hospitals. In acute hospital settings, about three in every 1,000 reported incidents resulted in death[2].

Although many HSS Trusts and Boards have local incident reporting systems, the health and social services in Northern Ireland do not have a common reporting or data analysis system for adverse incidents; therefore, neither the number of adverse incidents in health and social care environments is known nor can the order of magnitude of untoward deaths be estimated. However, as with other developed healthcare systems, it can be reasonably assumed that the problem exists in our health and social care environment.

[2] Building a Memory: preventing harm, reducing risks and improving patient safety – The first report of the National Reporting and Learning System and the Patient Safety Observatory – July 2005 – www.npsa.nhs.uk

What is known is the fact that any adverse incident, whether or not it results in injury, harm or death, has the potential to cause considerable distress not just to service users and carers but also to health and social care staff. For the families of those who have suffered the loss of a loved one, that loss can be made worse by the knowledge that death may have been preventable and that past lessons may not have been learnt.

The human, social and economic costs to individuals and families, the Health and Social Services and society are enormous. For example, in the HPSS:

- in 2004, via the Northern Ireland Adverse Incident Centre[3], 166 adverse incidents reports were received with 4 relating to circumstances involving fatalities;

- in 2004/05, a total of 10,107 medication-related patient safety incidents[4] were reported by staff in eight of Northern Ireland hospitals alone, although 89% of these were considered not to have caused harm (i.e. a near miss);

- in 2004/05, the frequency of MRSA[5] among hospital patients has shown a first and significant annual downturn during four years of monitoring, 242 patients were recorded as having MRSA in 2004/05 a decrease of 21% when compared to the same period in 2003/04;

- 15 suspected suicides and 3 suspected homicides occurred involving people in or who had just been discharged from mental health settings in the HPSS and were reported to the Department in 2004/05[6]; and

- in 2003/04, £15 million was paid in settlement of clinical negligence claims (HSS Boards and Trusts) with a future potential liability of around £100 million for current claims[7].

[3] Northern Ireland Adverse Incident Centre records and investigates, as appropriate, reported adverse incidents involving medical devices, non medical equipment, plant and building items used in the HPSS

[4] Source – Northern Ireland Medicines Governance Team

[5] Source - Communicable Disease Surveillance Centre – Northern Ireland – www.cdscni.org.uk

[6] Source – DHSSPS – Circular HSS (PPM) 06/2004. Reporting and follow-up of serious adverse incidents

[7] Source - DHSSPS

1.5 LEADERSHIP AND ORGANISATIONAL CULTURE

The culture of an organisation is about "how we do things around here" and this is significantly influenced by the leadership of senior management. But for senior management to demonstrate leadership, it has to have the knowledge, skills and information to promote a safety culture.

An informed safety culture has four major sub-components[8]:

- *a reporting culture* - in which people are prepared to report their errors and near misses;
- *a just culture* – where an atmosphere of trust and fairness is created in which staff are encouraged to engage in safety related activities;
- *a flexible culture* - which respects the skills, abilities and limitations of frontline staff; and
- *a learning culture* – the willingness and competence to draw the appropriate conclusions from its safety information systems and to implement major reforms.

The DHSSPS endorses the approach that all organizations should have an informed safety culture, which should be given the highest priority at senior management level and promoted throughout as "everyone's business".

1.6 AN INFORMED SAFETY CULTURE

At present, there is no internationally accepted definition of patient safety incidents. Different definitions, information sources and methods of collection and analysis will affect findings. Appendix B provides examples of potential sources of information about the frequency of patient safety incidents and some of the strengths and weaknesses of each system. These include incident reporting systems, medical records review, surveys of patients and staff, and routine data collection. These illustrate the potential breadth of information sources, which contribute to knowledge of safety incident rates. However, for health and social care, the sources of reporting and data collection are even wider. What is needed is the systematic approach to data analysis and intelligence gathering from a range of sources, building on local, national and international capacity and capability, for example:

[8] Reason, J. Managing the risks of organisational accidents. Ashgate. Aldershot 1997

- published literature for health and social care environments e.g. NICE, SCIE and NPSA;
- National Inquiries - e.g. Confidential Inquiries: CEMACH, NCISH, NCEPOD;
- statutory and voluntary reporting systems - e.g. local medicines and devices reporting, MHRA, child protection, Mental Health Commission;
- hospital and social care episode statistics;
- health and social care complaints;
- local and national Inquiries, e.g., Lewis, Ombudsman, Hyponatraemia, Climbié, Shipman and Bristol Inquiry Reports;
- regional and local audit findings;
- Regulation and Quality Improvement Authority (RQIA) reviews and reports;
- Social Services Inspectorate reports;
- claims and litigation findings;
- coroner's findings; and
- death certification data.

Building a comprehensive picture on safety as part of improved quality of care can be complex. However, given the relatively small population size in Northern Ireland and the integrated nature of health and social care services, this provides us with a unique opportunity to draw together the different strands of learning and disseminate it in a positive way - to improve quality of health and social care, rather than in a punitive way to blame and shame individuals or organisations.

Yet being a small region also has its disadvantages in that incidents may occur relatively infrequently here to make their detection and monitoring meaningful. We must also learn from errors detected nationally; we cannot "reinvent the wheel" in terms of national and international expertise and resources when trying to draw together all the variety of sources of information to enhance learning. So, a balance has to be struck between the need for local intelligence mechanisms and expertise, and building on national and international capacity and capability. Hence the need for links with national organisations such as the National Patient Safety Agency (NPSA), Social Care Institute For Excellence (SCIE) and the National Institute for health and Clinical Excellence (NICE) - to enhance both quality and safety in health and social care.

KEY POINTS

- No health and social care service will ever be 100% error-free but what we can do is reduce the risk, enhance systems and expertise, and learn from adverse incidents and near misses.
- Strong leadership, a focus on systems and on organisational safety culture will reduce error.
- A regional definition of an adverse incident is identified covering health, social care, people, property, environment and reputation.
- A systematic approach to information gathering and data analysis is needed locally, which builds on national and international capacity and capability.
- No single source of information will provide all the data that is needed for safety analysis. For example, complaints, litigation, and death certification, together with adverse incidents reporting systems, audit and performance data need to be linked to enhance quality of care and be linked to evidence of effectiveness.

SECTION 2 – CURRENT SYSTEMS TO PROMOTE SUSTAINABLE IMPROVEMENT IN THE HPSS

2.1 INTRODUCTION

Sustainable improvement is at the forefront of the development of health and social care services in Northern Ireland. This is being undertaken through a multi-faceted approach to modernising and reforming organisational structures and delivery of care, together with a greater emphasis on quality, safety and accountability for the commissioning and delivery of that care.

Although healthcare systems from around the world vary considerably, many developed countries, such as the United States of America, Australia and the United Kingdom are leaders in the field of patient safety initiatives. Last year the UK European Union Presidency had a major focus on patient safety.

This section of the Safety Framework recognises that quality and safety are part of the continuum of local service improvement and are integral to good governance of an organisation. It sets out:

- the local commitment to quality and service improvement;
- safety and risk management systems underpinning good governance;
- local examples of organisational cultural change;
- links to national standard-setting bodies;
- examples of learning from local serious adverse incidents;
- changes to HPSS complaints procedures;
- serious adverse incident interim reporting arrangements; and
- the need for education, workforce development and regulation.

2.2 A COMMITMENT TO QUALITY AND SERVICE IMPROVEMENT

In 2001 the Northern Ireland Executive gave a commitment in the first Programme for Government to put in place a framework for raising the quality of services delivered and for tackling poor performance in the HPSS. Since then, much work has been undertaken to bring forward this programme.

The consultation document "Best Practice – Best Care"[9], issued in April 2001, was the first step towards fulfilling this commitment. It set out proposals to put in place a framework to raise the quality of services provided to the community and tackle issues of poor performance across the HPSS. The aim was to provide a high quality system of health and social care, which was easy and convenient to use, was responsive to people's needs and provided a service that instilled confidence in those who used it.

The quality improvements in "Best Practice – Best Care" are centred on five main areas:

- setting of standards: to improve services and practice;
- improving governance in the HPSS: in other words, the way in which organisations manage their business;
- improving the regulation of the workforce, and promoting staff development through life-long learning and continuous professional development;
- changing the way HPSS organisations are held to account for the services they commission and/or provide: the Duty of Quality; and
- establishing a new, independent body to assess the quality of health and social care - the Regulation and Quality Improvement Authority (RQIA).

From 1 April 2003, a statutory duty of quality was placed on HSS Boards and Trusts. Under this duty, each Board/Trust is required to[10] "*put and keep in place arrangements for the purpose of monitoring and improving the quality of the health and personal social services which it provides to individuals and the environment in which it provides them*". This requirement to deliver on the quality of services is similar to the requirements already placed on the HPSS to ensure financial probity.

RQIA came into operation from April 2005. RQIA's principal role includes the registration, regulation and inspection of a wide range of services delivered by the independent sector and the HPSS, and to report to the Department on the quality of care provided by the HPSS. In addition, it has a general role to promote and facilitate quality improvement in health and social care.

[9] Best Practice – Best Care: a framework for setting standards, delivering services and improving monitoring and regulation in the HPSS

[10] Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (S.I. 2003 No.431 (N.I.9))

In order to provide greater consistency and accountability in the quality of care provided, and to facilitate the RQIA in its role, a range of standards have been developed, including:

- controls assurance standards[11], to assist HPSS organisations to demonstrate that they are doing their reasonable best to manage risk effectively;
- minimum care standards[12], applicable to agencies and establishments in the independent, voluntary and statutory sectors and to certain HPSS services; and
- generic quality standards[13], applicable to primary, secondary and tertiary care in the HPSS.

The above developments all contribute to good governance within the HPSS.

2.3 SAFETY AND RISK MANAGEMENT AS PART OF GOOD GOVERNANCE

All HPSS organisations are required to have a system of internal control to help facilitate the flow of information about risk both up and down and across the organisation. Part of this system is the recording of risks on risk registers. These are held at key points within the organisation depending on its size and structure. When most effective, a system of risk management involves every member of staff, and the organisation as a whole being aware of the key risks that affect them.

The function of risk registers is to inform key decision-makers of the risks they need to know about in order to fulfill their role in the commissioning and delivery of care. The recently-produced "Establishing an Assurance Framework: a practical guide for management boards of HPSS organisations[14]" is written to help HPSS board members, directors and senior managers within the HPSS to further improve their systems of internal control and to embed the principles of whole-organisation risk management as an integral part of quality health and social care. It acknowledges

[11] Controls assurance standards available on: http://www.dhsspsni.gov.uk/index/health_and_social_services/governance/governance-controls.htm

[12] Draft care standards available on: http://www.dhsspsni.gov.uk/index/consultations/previous_consultations.htm

[13] The Quality Standards for Health and Social Care: supporting good governance and best practice in the HPSS available on: http://www.dhsspsni.gov.uk/qpi_quality_standards_for_health_social_care.pdf

[14] Establishing an Assurance Framework: a practical guide for management boards of HPSS organisations – http://www.dhsspsni.gov.uk/publications/2006/assurance_framework.pdf

that decisions by individuals, managers and directors can positively or negatively affect the delivery of care to the individual.

Knowledge and skills in the assessment and appropriate management of risk in an often rapidly changing environment of care are essential to organisational health, to ensure safety and to improve outcomes in clinical and social care. Clear roles, policies, procedures and systems will help facilitate appropriate risk decisions and minimise inappropriate and potentially damaging decisions. This includes a system for assuring that each organisation has available information about key elements of risk:

- at the right time;
- in the right way; and
- to the right person(s).

This enables the most appropriate decisions to be made and facilitates the promotion and delivery of improvements in care.

2.4 SUPPORTING CULTURAL CHANGE

Having appropriate procedures to identify, assess and manage risk is central to organisational health, but this has to be complemented by cultural change in order to demonstrate a commitment to good practice, drive quality and enhance organisational performance. The following four initiatives are all examples which support cultural change:

The Clinical and Social Care Governance Support Team (CSCG) was established by the DHSSPS in 2004. In establishing the CSCG Support Team, the Department's aim was to promote the longer-term cultural change and organisational development that it considered necessary to ensure that the statutory duty of quality could be implemented successfully and consistently in the HPSS. In turn, this would lead to a continuous improvement in health and social care services in Northern Ireland. A decision to link with the NHS Clinical Governance Support Team in developing these local arrangements was taken on the basis that the HPSS would have access to the experience, knowledge and tools already developed in the NHS. The CSCG Team has developed an extensive work programme across primary, community and secondary care. This programme has included specific training initiatives and topic specific programmes, such as in elderly care, to facilitate a multidisciplinary approach to learning and to champion

quality improvement. It complements the many other local initiatives, some of which have been ongoing for a number of years, such as the Clinical Resource Efficiency Support Team (CREST) which aims to drive up standards in clinical practice by the production of specific guidance.

Regional Governance and Risk Management Adviser - The post of Regional Governance and Risk Management Adviser, sponsored by the Department from October 2003, was initially focused on supporting the HPSS in embedding the fundamental structures and processes of risk management. The post promotes a joined-up approach to governance arrangements in HPSS organisations. Integral to this is the involvement of the adviser in a range of safety, quality and risk management initiatives. A major project is underway relating to the standardisation of definitions and coding to enhance incident management (see Appendix D).

The Northern Ireland Medicines Governance Team aims to improve medication-related patient safety by a systematic regional approach to medication risk management through the deployment of six senior pharmacists dedicated to medicines risk management in Northern Ireland hospitals. Beginning in August 2002, the team has addressed three main areas: the development of the risk management process itself, including identification, analysis and evaluation of risk, the development of 'good practice' initiatives and risk education. In November 2004, the Team was awarded the Health Service Journal Award for Patient Safety. As part of the Pharmaceutical Services Improvement Projects currently underway, funding has been secured to extend the Medicines Governance Team, with the aim of enhancing medicines governance arrangements in the primary care sector of the HPSS.

The Safer Patient Initiative, promoted and funded by The Health Foundation Trust, in collaboration with the Institute for Healthcare Improvement (IHI) in the USA, aims at making hospitals safer for patients in the UK. Following rigorous assessment of applications, Down Lisburn Trust was one of four UK Trusts selected to start work on the safety initiative in October 2004. This provides the Trust with an opportunity to work with an expert team from IHI and world experts to promote safety and quality. The four UK Trusts were selected for this prestigious project on the basis of their exceptionally high level of commitment to improving patient

safety. The project will last for two years; the selected trusts are expected to become exemplars in patient safety so that other hospitals can learn from their success.

2.5 LINKING WITH NATIONAL BEST PRACTICE

Whilst HSS Boards and Trusts in Northern Ireland have the capacity to be leaders in the field of quality and safety, given our relatively small size and limited resources, we must draw on the wide range of skills, knowledge and expertise that is available at national and international level. The establishment of appropriate links with national best practice and standard setting bodies is a key element in the framework for raising the quality of health and social services in Northern Ireland. These links are necessary to secure access to independent evidence-based guidance to promote safe, effective and efficient care.

It is recognised that guidance developed in Great Britain should generally have universal application and that local duplication is unnecessary.

Current progress on the Department's links with national bodies is outlined below.

- **National Patients Safety Agency (NPSA)** - A formal agreement with NPSA to extend its services to Northern Ireland is planned from April 2006. This will provide access to the whole range of NPSA's training material, tools and guidance to promote and facilitate safety in the HPSS. This will include access to the NPSA's *Seven Steps to Safety* programme for both primary and secondary care, adapted to meet the need of our integrated health and social care environment. In addition, the HPSS will eventually join with the National Reporting and Learning System, to facilitate an integrated approach to reporting and learning from adverse events (see section 3). The NPSA's Patient Safety Observatory will bring together many sources of information and facilitate benchmarking on safety across the HPSS with other regions.

- **National Clinical Assessment Service (now part of NPSA but previously the autonomous National Clinical Assessment Authority)** - Since October 2004, NCAS provides advice, support, and assessment for HPSS organisations where a doctor's or dentist's performance is called into question (see section 3). This was one of the key

recommendations in *Confidence in the Future for Patients, and for Doctors*[15]. This document set out proposals for the prevention, recognition and management of poor performance of doctors.

- **Social Care Institute for Excellence (SCIE)** – SCIE was developed to identify and promote dissemination of knowledge about what works in social care. A service level agreement was established with SCIE in June 2004 extending the Institute's remit to cover Northern Ireland. Local social care practitioners and academics are now actively involved in SCIE projects and the development of best practice guidelines.

- **National Institute for health and Clinical Excellence (NICE)** - Whilst NICE guidance has no formal status in Northern Ireland, many parts of the HPSS draw on the material produced by the Institute. The Department has had negotiations with NICE on formal links and is represented, in observer capacity, on the committee that provides advice on the selection of topics for NICE appraisal and guidance programmes. A process for reviewing the applicability of NICE guidance to Northern Ireland and, where appropriate, endorsing it for uptake in the HPSS is being put in place. In addition, the HPSS will link with NICE new interventional procedures programme to ensure that new procedures used for diagnosis and treatment are safe enough and work well enough for routine use in the HPSS.

2.6 LEARNING FROM LOCAL ADVERSE INCIDENTS

The provision of health and social care will never be error free due to the complexity of factors which contribute to that care. It is acknowledged that the majority of errors do not lead to any harm for patients, staff or service users, but unfortunately some will. Recent examples of adverse incidents which continue to receive much attention, because of potential severity of outcome are:

- **The Independent Review of Endoscope Decontamination,** was established in June 2004, following concerns about the effectiveness of decontamination of endoscopes in some locations in Northern Ireland. This was chaired by Dame Deirdre Hine. It examined the systems and processes in Trusts to ensure the effective cleaning and

[15] www.dhsspsni.gov.uk/publications/archived/2000/confuture.pdf

high-level disinfection of flexible endoscopes before and after their use on patients, and found a number of areas in which procedures could be improved. Implementation of the recommendations is currently underway.

- **Inquiry into Hyponatraemia – Related Deaths[16].** In November 2004, the Department appointed Mr John O'Hara QC to hold an Inquiry into the events surrounding and following the deaths of three young children, with particular reference to their care and treatment in relation to fluid balance, and the role that individuals and organisations played following their deaths.

- **The Management of Hyperkalaemia in Adults.** Following recent serious adverse incidents relating to blood electrolyte abnormalities involving potassium, the Clinical Resource Efficiency Support Team (CREST) produced guidelines and wall charts for every local organisation to provide clear and concise information to enable clinicians to safely and effectively manage patients presenting with hyperkalaemia.

- **Post operative care following laparoscopic abdominal surgery.** An independent review team produced a report on lessons arising from the death of Mrs Janine Murtagh. It contained a number of recommendations covering consent, patient care, leadership and communication, and the implementation of policies and procedures.

2.7 ARRANGEMENTS FOR MONITORING AND LEARNING FROM SERIOUS ADVERSE INCIDENTS

In July 2004, interim guidance was issued to the HPSS, including family practitioner services, on the circumstances where particular serious adverse incidents or near misses must be reported to the DHSSPS (Circular HSS (PPM) 06/04). These are where the episode is considered:

- to be serious enough for regional action to be taken to ensure improved care or safety for patients, clients or staff;
- to be of such seriousness that it is likely to be of public concern; or
- to require independent review.

[16] www.ihrdni.org

The guidance complements existing local and national reporting systems, both mandatory and voluntary, which have been established over the years. These provide for specific incidents relating to, for example, medical devices, equipment, medicines, mental illness, child protection, communicable disease and the safety of staff to be reported to various points in the DHSSPS.

The new interim reporting arrangements on serious adverse incidents (SAI) were developed to try and ensure that lessons are learned across the HPSS and that serious local incidents are not repeated. The DHSSPS plans to collate learning from reported SAIs and produce an annual report. DHSSPS will also hold SAI briefings for the HPSS at regular intervals. HPSS directors and senior officers responsible for safety and quality will attend these meetings in order to gain information on the emerging current picture of SAIs across the HPSS. This will present an opportunity for the service to share learning and discuss possible improvements to the current reporting mechanisms in order to facilitate further sharing and learning.

It is recognised that different sources and types of data on adverse incidents all contribute to our knowledge of adverse incidents. Examples include “near misses”, complaints, social care inspections, litigation, audit, records review, confidential inquiries etc., together with information about relatively infrequent incidents, which occurred in other health and social care systems. Through the NPSA’s National Learning and Reporting System, and Patient Safety Observatory, the triangulation of data sources and analysis will be facilitated. However, there will remain a need to have some local reporting arrangements to ensure timely dissemination of local adverse incidents and near misses. Work will be done to clarify arrangements and avoid duplication.

2.8 EDUCATION, WORKFORCE DEVELOPMENT AND REGULATION

Staff and HPSS organisations must be able to justify the trust that the public places in them. For this to happen, the DHSSPS and the HPSS need to be able to demonstrate that good standards of practice and care are being maintained and that respect for service users is being shown. It is recognised that when safety and quality are introduced early into educational programmes, this has a positive impact on the future delivery of safe and effective care. Consequently, the content of this framework will be of use to educational providers.

The maintenance of good standards of practice and care requires individuals and organisations to have a learning culture, and one which supports training and development of staff. Training and development needs analyses, linked to regional, local, organisational and individuals' priorities and objectives, are essential for the ongoing enhancement of quality and safety within the HPSS. The introduction of quality assured appraisal systems which facilitate review of performance and the identification of development needs have the capacity to improve treatment and care and reduce error.

The regulation of the workforce has a major part to play in the promotion of quality and safety. Regulation and responsibility should take place at different levels[17], for example:

Personal level – based on a commitment to quality of care that puts the safety and care of the patient and service user first;

Team level – based on the concept of the importance of team working and the requirement to take responsibility for the performance of the team, and to act if an individual's conduct, performance or health is placing the public at risk;

Workplace level – which reflects the responsibility that HPSS organisations have for ensuring that staff, equipment and facilities are fit for purpose in the commissioning and provision of care. This is expressed through the Duty of Quality, clinical and social care governance, performance management systems and compliance with legislation; and

Professional level – which is undertaken by statutory regulators, for example, working through the development of standards, education, registration and licensing, and fitness to practise procedures.

Examples of professional regulators include the General Medical Council, General Dental Council, Nursing and Midwifery Council, Pharmaceutical Society of Northern Ireland, the Health Professions Council, General Optical Council and the Northern Ireland Social Care Council. All of these organisations have a major part to play in the promotion of quality of care and in the identification and management of fitness to practise. The Council for Healthcare Regulatory Excellence was formed in April 2003 to

[17] Adapted from Developing Medical Regulation: A Vision for the Future – April 2005 - GMC

ensure consistency of approach and good practice among nine "health" regulators. Several of the professional regulatory organisations identified above are undergoing development and change. Many of the drivers for change in the regulation of the workforce are as a consequence of national inquiries such as, the Bristol, Shipman, and Climbié Inquiry Reports.

Locally, a number of organisations also promote best practice and enhanced clinical and social care performance, including:

Northern Ireland Social Care Council (NISCC) – As part of the Northern Ireland Assembly's commitment to raising the status of the whole social care workforce, raising the standards of social care practice and ensuring proper protection of the public against persons who are unsuitable to carry out the work, NISCC was established in 2001 to regulate the social care workforce and to regulate the training of social workers.

Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) – In 2002, NIPEC was established to shape practice, education and performance within the professions of nursing and midwifery in Northern Ireland and to equip nurses and midwives in such a way as to enable them to provide better care for patients and service users.

KEY POINTS

- Sustainable improvement in health and social care requires a multifaceted approach, including service reorganisations and reform, and an emphasis on safety and quality as part of good governance.
- Systems and procedures for the identification, assessment and management of risk are important but have to be supported by organisational cultural change to promote sustainable quality improvements.
- Much work had already been undertaken locally to support quality and safety.
- National links are an important way of gaining access to knowledge, skills and best practice.
- Linkage with the National Patient Safety Agency, National Institute for health and Clinical Excellence, and the Social Care Institute for Excellence are pivotal to the promotion of quality and safety.
- Education, workforce development and regulation occur at individual, team, organisational, regional, and national levels; it is part of the drive to promote quality and protect the public.
- Recent local adverse incidents emphasise the need to put *safety first.*

SECTION 3 – PROMOTING SERVICE USER AND STAFF SAFETY

3.1 INTRODUCTION

Section 2 identified the progress that has been made to date to promote and embed quality and safety within HPSS environments. This section builds on this work and identifies other key elements to promote service user and staff safety. These include:

- creating an informed, open and fair safety culture across the HPSS;
- raising awareness of risk and promoting timely open reporting of adverse incidents;
- sharing the learning across HPSS environments and implementing solutions; and
- investigating serious incidents.

To facilitate implementation of these key elements requires co-ordinated action involving individuals, the HPSS including family practitioner services and the DHSSPS. Actions to promote and support a safer service are identified in section 5. This section is written for managers, educationalists and practitioners to clearly document high level work which needs to occur between 2006 and 2007. The action plan is outcome focused and attributes responsibilities.

3.2 CREATING AN INFORMED, OPEN AND FAIR SAFETY CULTURE ACROSS ORGANISATIONS

An informed organisational culture that promotes safety and quality should be at the centre of every stage of prevention, treatment and care. Section 1 identified four main components of an informed safety culture as:

- a reporting culture;
- a just culture;
- a flexible culture; and
- a learning culture.

A just culture is one that is seen to be open and fair to staff. Creating such a culture encourages the reporting of incidents, which is essential to the success of data collection and subsequent improvement in activity, systems, and care.

An “open and fair” organisation can be defined as a one where staff are not blamed, criticised or disciplined as a result of a

genuine slip or mistake that might have lead to an incident. Disciplinary action would, however, follow an incident that occurred as a result of misconduct, gross negligence or an act of deliberate harm. In determining 'blameworthiness', a 'fair' approach is one that separates the actions of individuals involved from the patient outcomes. A 'fair' culture advocates the systems approach, recognising that accidents may occur as a result of a series of system failures rather than through a deliberate malicious act on the part of an individual. Moving to the systems approach will be an important challenge. Research has shown that currently 85% of health care incidents are caused by systems failures yet, 98% of remedial action focuses on the person or people involved in the incident[18].

Organisations that operate a 'fair' culture are more likely to gather useful information about their organisation that can be used to further improve safe practice and pre-empt future incidents. In this way the organisation can acknowledge mistakes, learn from them and take action to put things right. This is an integral part of what the public wants the HPSS to achieve.

But being "open and fair" also means that the organisation should encourage staff to be open and fair when communicating with patients, service users and carers. This is a part of the redress that people can and should expect when things go wrong and where harm has been caused. This includes an organisational commitment to providing an explanation of what happened, an apology, a reassurance of speedy remedial treatment and, where appropriate, financial compensation.

Any change in culture requires sustained commitment at the most senior level in the organisation. Frank and open discussion needs to occur within senior management and agreement reached on what an open and fair culture will mean in practice for their organisation and this needs to be cascaded throughout the organisation as part of an overarching policy on safety. There are many tools which can assist HPSS organisations in assessing organisational safety culture in terms of underlying beliefs, attitudes and behaviours. In addition, tools such as root cause analysis and NPSA's Incident Decision Tree can assist in distinguishing between poor performance of the individual and a systems failure.

[18] Overveit J. Health Service Quality. Brunel University, 1998

3.3 RAISING AWARENESS OF RISK AND PROMOTING TIMELY REPORTING

Raising awareness of risk implies that all members of an organisation should have a good understanding of the factors that contribute to human and organisational error. In addition, there is a need for individuals to recognise that no-one is perfect; that there is always the capacity to reflect on one's work and to improve. Key tools to enhance this reflection are, for example, professional appraisal, audit and significant event analysis, and multidisciplinary team discussion and analysis.

Raising awareness of risk has to happen at all levels within an organisation. Whilst much work has been done to promote risk assessment and risk management within HPSS organisations within recent years, there remain opportunities which the HPSS will have, in the near future, including access to all NPSA material, tools and guidance.

Recent HPSS adverse incidents, highlighted through the coroner's service, have emphasised the need to pay particular attention to risk awareness and action within undergraduate and post graduate training programmes, newly appointed staff and at vulnerable interfaces such as the transfer of patients to different parts of the HPSS or at the interface between secondary, community and primary care. Specific action to raise awareness in these vulnerable areas needs to be undertaken. In particular, risk awareness should be incorporated into education and training programmes; there should be mandatory training for all newly recruited staff on basic organisational risk awareness, policies and procedures, risk within their specific areas of work, and on incident reporting systems. This should be seen by senior management as an integral part of a new recruit's induction into the organisation. In addition, all existing staff should have in-service education and training to support the continual awareness of risk. Appendix C provides an example of a training programme to promote risk awareness.

It must be explicit in all training and incident reporting and management policies that a staff member's responsibility for patient and service user safety comes before any responsibility to other staff, for example, in their own team or profession. This is supported by the codes of conduct for each profession and must be observed regardless of the severity of the incident(s) concerned.

Promoting a reporting culture is an important challenge for all sections of the HPSS and one which is essential if organisations and individuals are to learn from errors. Timely and open reporting is part of individual and organisational responsibility to quality improvement and learning. Whilst it is acknowledged that the majority of incidents do not lead to harm, valuable lessons can be learnt from these and "near misses" – where an error was detected and stopped before it resulted in harm. Research has shown that the more incidents and near misses that are reported then the more information there is about what is going wrong and the more action that can be taken to make health and social care safer both locally and nationally[19].

It is essential that commitment from senior management within the organisation is evident and that clear lines of accountability and communication are defined. It is equally important to ensure that policies and procedures are not simply 'for show' and that staff experiences reflect the ethos agreed by senior management. For example, the ways in which the reporting, investigation and subsequent management of medication incidents have been handled to date, indicates that cultural change is possible and, as a consequence, staff are willing to report incidents. But for staff, the benefits of reporting are not always made clear, particularly when there is a fear of blame, no noticeable change and no feedback. In addition, reporting can seem time-consuming and complicated.

The benefits of reporting need to be cascaded throughout the HPSS. These include:

- improvement in care of patients, clients, service users and staff;
- resources targeted more effectively;
- increased responsiveness;
- pre-empting complaints; and
- reducing costs.

3.4 REGIONAL REPORTING SYSTEMS PROJECT

In order to promote consistency of approach to reporting, in January 2005, the DHSSPS commissioned a project to be carried out across the HPSS to standardise definitions, reporting forms and the coding of incidents. A summary of the first phase of this project is included in Appendix D. This work should help facilitate

[19] Seven Steps to Patient Safety – NPSA - 2004

the sharing of learning between HPSS organisations as data can be shared and analysed more easily across Trusts, Boards and relevant Agencies that comprise Northern Ireland's HPSS. This project's remit encompasses all adverse incidents, inclusive of clinical incidents, social care, staff incidents and any other adverse event that may affect the operation of the HPSS, including the family practitioner services. The work will further facilitate a future link with the National Patient Safety Agency's National Reporting and Learning System.

Whilst local reporting mechanisms will always be important, there is some potential duplication in current reporting systems at local, regional and national level. This is because reporting systems serve different purposes and may have different specialist audiences. In order to provide a greater understanding of where the links are at local, regional and national level will require the Department to work with the HPSS and the NPSA to promote a consistent approach. Of particular importance is the incorporation of all health (both clinical and non clinical) and social care incidents.

The Regional Reporting Systems Project is part of the work to provide greater consistency of approach locally. This Project is part of the phased implementation plan to join with the NPSA's National Reporting and Learning System (NRLS). Joining the NRLS will mean that the HPSS will receive comprehensive reports on patient safety incidents, tailored to the needs of Northern Ireland, but it will also facilitate comparisons with other regions in England and Wales on the frequency of reporting and type of incident. In addition, through the Patient Safety Observatory, the Department and HPSS will have access to the learning that will emerge from other reporting systems and sources, such as, MHRA for medicines and medical devices, professional bodies and National Confidential Enquiries. Use of computerised data analysis tools will help identify potential clusters, patterns and trends across these reporting systems.

Comparisons between regions are important; however, there remains a need within each HPSS organisation to ensure that a reporting culture is fostered and that tools such as the Heinrich ratio are used to regularly assess the "health" of the organisation's reporting system and, where appropriate, ask area/sections which are not reporting for a "nil return" to confirm that incidents have not occurred.

3.5 SHARING THE LESSONS ACROSS THE HPSS

Section 1 provided examples of the many and varied data sources from which learning on safety and quality issues can occur - for example, audits reports, incidents reporting systems, complaints procedures and claims and litigation. When an incident occurs, a fundamental principle of a systems approach to error management is the understanding of how and why an incident occurred[19]. It is only then that learning can be shared and the lessons learnt used to prevent its reoccurrence. The sharing of learning can and should take place at different levels, for example:

- multidisciplinary team discussion within HPSS organisations;
- participation in personal and team education, training and development e.g. development of guidelines and solutions;
- training and participation in and use of investigative tools such as Root Cause Analysis;
- formal data collection and analysis procedures e.g. outcome statistics discussed at team, clinical and social care governance and senior management levels;
- formal communications pathways and networks e.g. urgent communications, newsletters, IT-based systems and discussion fora; and
- production and cascade of annual/ quarterly reports on adverse events.

Further consideration will be given to developing a single information gateway to bring together all departmental publications and guidance in an accessible format and on a monthly basis. In addition, the DHSSPS and the HPSS will consider how the extranet could be used to disseminate the results of all root cause analysis between organisations.

The accountability for patient, service user and staff safety rests with the Chief Executive of an organisation. To facilitate discussion, analysis and feedback, an integrated governance approach should be encouraged within HPSS organisations. There is a need to ensure that there are clearly delineated relationships and communication pathways within the organisation. This is necessary so that front line staff and, in particular, clinical and social care governance leads and risk managers have access to up to date information and that there is a feedback loop to ensure that safety information is received and acted upon within an appropriate timeframe.

The Safety Alert Broadcast System (SABS) is an electronic system developed by the Department of Health in England, with the MHRA, NHS Estates and the NPSA. The aim of this system is to bring different types of alerts together into one electronic system thus ensuring that all urgent communications are received and implemented. Nominated leads in each Trust and Primary Care Trust are asked to disseminate it to those who need to take action. This role is similar to the current MHRA medical device liaison officer role but with the additional responsibility of providing feedback on action to implement the alert using a simple electronic form. The development of a Service Level Agreement with NPSA will provide an opportunity for the Department to explore with the Department of Health in England if appropriate links to the SABS system can be established.

3.6 INVESTIGATING SERIOUS INCIDENTS

Obtaining incident reporting data is just the first step towards a comprehensive approach to safety. Significant investment has been made locally and nationally in root cause analysis training to promote proper understanding of the cause(s) of an adverse incident. There should be a consistent approach to deciding which incidents need to be followed up and further investigated; these should follow best practice in the use of tools for root cause analysis. There are two main criteria, which the HPSS should use in determining further investigation of an incident:

- ***the level of severity/grade of the incident*** - e.g. an untoward death or permanent injury; and
- ***the potential for learning*** e.g. frequency of incident or near miss.

The Chief Executive of the organisation is responsible for investigating the cause of a serious incident as part of his/her commitment to quality of care, which is underpinned by the Duty of Quality. The immediate priority in this case should be to take all the necessary steps to secure the safety of services users, staff and other people involved. All HPSS organisations should have clear policies on incident reporting including a standard approach to investigation of each level of severity of incident. This will be facilitated by the Regional Reporting Systems Project (see Appendix D) and links with the NPSA.

Incidents involving unexpected death or serious harm and requiring investigation by the police and/or the Health & Safety Executive (HSENI) are rare but have increased in number in the

past few years. There is a statutory duty placed on individuals and organisations to report such incidents. When they happen, incidents need to be handled correctly for public safety reasons as well as the maintenance of confidence in the HPSS, Police, Coroner and Health and Safety Executive. To achieve this, it is important that these four arms of the public sector communicate and work with one another in a consistent and ordered manner. The DHSSPS has finalised a Memorandum of Understanding[20] between these four organisations in order to better facilitate these complex interactions. The Memorandum complements existing joint procedures in relation to the protection of children and vulnerable adults.

Special action must be taken in the event of a public health hazard such as a major incident, chemical contamination, or biological, radiological or nuclear emergency. Specific regional guidance governs arrangements for dealing with major incidents.

Regional guidance should be followed where incidents involve suicides or other serious events involving people who have a mental disorder, child protection issues or when an incident fitting the criteria of a National Confidential Enquiry has occurred.

Where an incident involving a medicine has occurred, which falls within the remit of the Medicines Act and the Pharmacy Inspectorate of the DHSSPS, organisations should comply with regional reporting arrangements and co-operate with the investigation.

3.7 ENHANCED ASSESSMENT OF CLINICAL AND SOCIAL CARE PRACTICE

In countries that have promoted safety and quality in healthcare, there is a link between institutional assessment, reviews, accreditation and safety and quality initiatives; the assumption being that quality and safety, to some extent, can be assured by a review, inspection or an accreditation process. All of these processes take account of recognised standards of care.

This inspection, review or accreditation can take place at different levels, for example at:

- national level – through professional bodies and national accreditation schemes;

[20] http://www.dhsspsni.gov.uk/mou_investigating_patient_or_client_safety_incidents.pdf

- regional level – though statutory inspection procedures and clinical and social care governance reviews;
- local level – through commissioning arrangements with providers of care; and
- individual level – through the organisational assessment of individual performance.

The RQIA will be reviewing clinical and social care governance within the HPSS using the five themes contained within the Quality Standards, with particular emphasis on Safe and Effective Care. This approach will assist RQIA and the HPSS in the future development of methodologies and the refinement of self-assessment processes.

RQIA will report on the quality of care provided by the HPSS following its governance reviews. This developmental approach will promote quality improvement across organisations.

In addition to RQIA's inspection and review functions, it also has the power to investigate serious incidents at the request of the Minister, Department or the public. It will report to the Department on the quality of care within all HPSS services. As the work of RQIA progresses, it will provide a rich source of learning for the HPSS, the DHSSPS and the public.

At national level, the impact of major inquiries such as Shipman, Kerr/Haslam and Climbié, will continue to have a major impact on organisational and professional practice locally. In addition, reviews[21], such as those currently being undertaken by Sir Liam Donaldson and Mr Andrew Foster will impact on clinical and social care governance arrangements locally, including how an individual practitioner's fitness to practise is assessed.

A formal link with the National Clinical Assessment Service has already been established to provide advice, support and, where appropriate, full assessment for HPSS organisations, where a doctor's or dentist's performance is called into question. In addition, annual appraisal of individuals is now a reality for many HPSS staff. Where performance of an individual is considered to put patients or service users at risk, then the organisation must have processes in place to facilitate action and prevent harm.

[21] CMO Review of Medical Revalidation: A Call for Ideas, 3 March 2005 – www.dh.gov.uk; Review of Non-Medical Regulation – Call for Ideas, 29 June 2005, Mr Andrew Foster – www.dh.gov.uk

New disciplinary procedures for HPSS-employed doctors and dentists have been introduced to promote the early and active assessment and resolution of concerns regarding clinical practice. In addition, primary legislation is being drafted for the family practitioners services, to further extend the function of the Health Service Tribunal and the powers of HSS Boards where there is a concern about professional or personal conduct or practice.

A local response to Shipman Inquiry recommendations will be produced, to cover:

- Shipman 3 – Recommendations on new death certification pathways and investigation;
- Shipman 4 – Recommendations on enhanced monitoring and inspection of controlled drugs; and
- Shipman 5 – Recommendations on complaints, whistle-blowing, appraisal and professional performance.

3.8 DESIGNING AND IMPLEMENTING SOLUTIONS

The HPSS does not, as yet, have good mechanisms to facilitate the sharing of solutions on quality and safety problems. There is often excellent work in progress across the HPSS but no clear forum for sharing this work to others in similar situations. This may lead to duplication and wasted resources and the reoccurrence of adverse incidents. The measures identified in paragraph 3.4 will facilitate the cascade of effective solutions. So too will links with national bodies specifically involved with solutions development such as the NPSA, MHRA and the NHS Purchasing and Supply Agency.

Whilst reporting systems are a pivotal part of the identification of trends and themes requiring solutions, they are not the only source of information at local or national level. There is a need, therefore, to promote partnership working within the HPSS and at national level to share resources in solutions development. However, where a solution needs to be developed and implemented locally, it should be specifically commissioned by the DHSSPS with the scope of the project clearly defined and resourced.

To facilitate implementation, where appropriate, a solution should be designed in toolkit format in order to promote consistency of approach across the HPSS. As identified in the Safety Alert Broadcast System (SABS), there should be a feedback loop to confirm that implementation is completed. New arrangements for regional audit should be linked to the wider quality and safety

agenda and used to facilitate implementation of solutions, where appropriate.

The development of a Service Level Agreement with the NPSA opens up the possibility for the HPSS to be selected to pilot new approaches to the delivery of care/improvements in patient safety. This is particularly appropriate in areas where the HPSS has carried out innovative work e.g. Medicines Governance and in areas where the HPSS presents a unique challenge, for example, the large and complex area of social care. Participation in the development of innovative work will stimulate the further development of a safety culture across the HPSS and will engage both health and social care professionals.

Effective design of health and social care facilities remains an important aspect of quality of care. This is because effective design thinking can deliver products, services, processes and environments that are simple to understand, to use, comfortable and convenient, and consequently less likely to lead to accidental misuse, error and accidents. The report, *Design for Patient Safety* [22] identifies opportunities for improving patient and service user safety through the more effective use of design.

[22] Design for patient safety: A system-wide design-led approach to tackling patient safety in the NHS Department of Health and the Design Council. February 2004. Available at : http://www-edc.eng.cam.ac.uk/medical/reports.html

KEY POINTS

- An **informed** organisational culture, that builds on many data sources, is necessary to promote safety and quality. This culture requires endorsement and agreement by senior management in order to promote a **reporting** culture, and one, which is seen to be **just**, **flexible** and has the capacity to **learn** from errors.
- A systematic approach to raising awareness of risk of the factors that contribute to human and organisational failures is essential for staff, especially new recruits.
- Promoting timely open reporting is a major challenge for all HPSS organisations; the benefits of reporting should be highlighted to staff with clear feedback mechanisms identified.
- The first step to a comprehensive approach to safety, is obtaining and analysing **all** incident data. Clear policies and procedures for the reporting and investigation of serious incidents are the responsibility of senior management.
- The NPSA's National Reporting and Learning System will facilitate a cohesive approach to data collection in Northern Ireland and will facilitate benchmarking against other regions.
- Links to the NPSA, through its "Seven Steps" Programme together with use of tools and guidance will promote reporting and investigation of serious incidents in secondary and primary care, and build on existing work.
- Designing and sharing the solution, should draw on national and local work; where appropriate, local organisations should lead in the piloting of such solutions.
- Enhanced assessment of clinical and social care practice through HPSS Regulation and Quality Improvement Authority will promote learning.
- Where individual performance is called into question, the National Clinical Assessment Service will provide advice and support to organisations, and formal assessment of the individual, if required.

SECTION 4 – INVOLVING AND COMMUNICATING WITH THE PUBLIC

4.1 INTRODUCTION

There is now good evidence that trusting and respecting the patient/user at a number of levels (e.g. individual and community) in the health and social care system improves health and well-being significantly[23]. Patients, service users and the public have a major part to play in the prevention and detection of errors in health and social care.

4.2 PUBLIC INVOLVEMENT IN PROMOTING HEALTH, WELL-BEING AND SAFETY

People are ultimately responsible for their own health and well-being, and that of their dependants. However, it is acknowledged that health and well-being are influenced by many factors, such as poverty, crime, violence, education and unemployment. HPSS service provision plays but one part in the overall health of the population. The HPSS needs to work in partnership with other agencies, communities and the media to seek to influence and improve the health, social well-being and safety of the public and their staff. In this regard the media have an important public health and safety role in tandem with their duty to responsibly hold public bodies to account.

The Quality Standards for Health and Social Care set out the values and principles which all HPSS organisations and staff should adopt when engaging with the public and service users. These include the need to involve people in all stages of care and to provide timely and appropriate information to assist in decision-making.

Integration of service users, carers and local communities into all stages of planning, development, evaluation and review of health and social care services is an important part of continuous quality improvement and the open culture which should be promoted throughout the HPSS.

Through proactive involvement of the public in safety matters, it is hoped that:

[23] www.pickereurope.org

- risks will be identified;
- concerns and ideas for improvement will be shared; and
- solutions will be generated in partnership with service users and the public which will be more realistic and achievable.

4.3 PUBLIC EXPECTATION OF A QUALITY SERVICE

Understanding the expectations of the public, staff, media and an organisation can sometimes be difficult. But proactive involvement of the public and staff will lead to a mutual understanding of needs and drivers for change; for example, why certain HPSS services require development to ensure safe and effective care and others do not. In addition, it will promote an understanding of the complexity of factors which determine why health and social care services will never be error free, but minimisation of the risk of error is important for service improvement and health and social care outcomes. But when things go wrong, people have a right to feel let down by the Service, to make a complaint and to seek redress if harm has been caused. Some organisations and staff have a tendency to think of these actions in a negative light because of fear of litigation, adverse media coverage and potential for destruction of reputation and career pathway. Both service users and staff need open and fair processes to investigate and determine the cause of what went wrong. For this to happen means that there are special responsibilities placed on the media, the public, service users and staff. A system that does not support an open and fair process is to no-one's advantage in Northern Ireland, as it will not encourage open reporting, communication or learning.

4.4 CHANGING LOCAL COMPLAINTS PROCEDUES

The reporting and handling of complaints are also part of a learning culture. The public has a right to complain when concerned about their treatment or care. Complaints tend to be seen in a negative light, but nonetheless are a significant source of learning for individuals and organisations.

The Department is currently undertaking a review of the HPSS complaints procedures, with the aim of making complaints systems more effective for the public, staff and organisations. It is anticipated that a public consultation on the new procedures will commence in early 2006. This consultation will also incorporate some of the recommendations contained in the 5th Shipman Inquiry Report.

In reviewing the HPSS complaints procedures, the aim is to:

- make procedures easier to access;
- be fair to all parties;
- respond to complaints in a timely way;
- emphasise early resolution;
- ensure the process is aimed at satisfying the complainant's concerns; and
- promote learning across the HPSS.

4.5 A SYSTEM OF REDRESS

Errors will happen and although most do not lead to harm, some will. But what happens when things go wrong and a service user is harmed? Not all service users and carers are content with the current system and sometimes find it hard to engage with HPSS organisations to find out what happened to themselves or to their loved one.

Openness is fundamental to the partnership between the service user and those who provide care. In support of that openness, people should be given an explanation of what has happened, an apology, reassurance, remedial treatment and compensation, where appropriate. A unified approach to redress should be developed. Effective redress will be part of the regional and local goal to promote a timely response for the service user. It will also set "error" in the context of learning in order to promote quality improvements within the HPSS.

4.6 COMMUNICATING SERIOUS INCIDENTS

All organisations should have a clear policy on how to communicate a serious incident to individuals, families and carers, staff and to the media, where appropriate. This policy should comply with best practice relating to the confidentiality of information, human rights, and privacy for service users and staff. The six major parts of this policy should include:

- a unified approach to redress (as identified above) for the individual, their family and carers;
- support for service users and carers during the course of an investigation and/or further treatment;
- support for individuals within the organisation to cope with the physical and psychological impact of what has happened;
- a timely inter-organisational communication system;

- designated and trained key people within the organisation with responsibility for communication; and
- how and by whom the incident should be investigated.

KEY POINTS

- Individuals have responsibility for their own health, and that of their dependants.
- The HPSS, public and media need to work in partnership to promote public health and social well-being, and to enhance safety for service users and staff.
- Provision of information, in accessible format, to support decision-making in treatment and care, and to enhance safety, is essential for service users and carers.
- The public has a pivotal role in the prevention and detection of error.
- The public has a right to complain when concerned about their treatment or care. Complaints are a significant source of learning for HPSS organisations.
- The public and media have important responsibilities regarding the promotion of an open and fair culture, in order to prevent reoccurrence of incidents.
- Service users and staff need open and fair processes when a serious adverse incident is being investigated.
- Redress means having systems in place to offer an apology, reassurance, speedy remedial treatment, and compensation, if appropriate, when harm has been caused to an individual.
- All HPSS organisations should have an effective communication policy in place.

SECTION 5 – ACTION PLAN AND STEPS TOWARDS SUSTAINABLE IMPROVEMENT

5.1 INTRODUCTION

In this section, the action plan and steps underpinning sustainable improvement in the HPSS are brought together in five key themes:

- implementing evidence–based best practice and learning from adverse events;
- agreeing common systems for collection, analysis and management of adverse events;
- sharing the learning;
- building public confidence; and
- promoting education, training and support for health and social care staff.

The audience for this action plan is HPSS managers, staff, educationalists and practitioners, including those working within the family practitioner services. The plan also includes action which will be undertaken by the DHSSPS as part of its commitment to safe and effective care. Given the broad nature of the safety and quality agenda, the plan does not aim to be all-encompassing but rather to focus on high level actions which need to take place in order to prevent adverse outcomes, and to improve service user, carer and staff experiences. It is seen as complementary to the many other initiatives which are ongoing in the HPSS primary, secondary and community sectors to improve health and social care outcomes.

The vision for the future is a safer service, where there is a systematic and co-ordinated approach to safety and quality. This requires staff, organisations and the public to work in partnership to promote a culture of learning, which is open and fair to service users, carers and staff, and one which minimises errors.

The following action plan will be reviewed and updated in 2007 to take account of progress and local and national developments.

5.1.1 Implementing evidence based practice and learning from adverse events			
Responsibility	**Action**	**Outcome**	**Completion date**
DHSSPS	Links to the National Patient Safety Agency will be agreed and guidance issued to the HPSS	Access to training, tool and guidance for the HPSS and the Department	April 2006
DHSSPS	A phased implementation plan to support joining the National Reporting and Learning System (NRLS) will be put in place	Triangulation of data sources, benchmarking and cascade of learning	June 2006
DHSSPS	All HPSS organisations will be part of NRLS	Triangulation of data sources, benchmarking and cascade of learning	December 2007
DHSSPS	Guidance on the nature of links to NICE and local pathways will be cascaded to the HPSS	Promotion of evidence based best practice	February 2006
DHSSPS	Following links with NICE, specific guidance on the introduction of new interventional procedures into the HPSS will be produced	Safer introduction of new diagnostic equipment and treatments.	April 2006
DHSSPS, CREST	CREST together with the Department will agree and publish the process for development of its annual work programme	Better linkage of regional priorities and audit programmes	June 2006
DHSSPS, CREST, RMAG	The Review of Regional Audit Arrangements will be implemented. Regional audit programmes will be linked to the wider safety and quality agenda	Better linkage to regional priorities and audit programmes	April 2006 Ongoing
RQIA	Will commence evaluation of HPSS quality of care	Assessment quality of care	From April 2006 ongoing

5.1.2 Agreeing common systems for data collection, analysis and management of adverse events			
Responsibility	**Action**	**Outcome**	**Completion date**
DHSSPS, HPSS	All organisations will adopt the definition of an adverse incident as identified in Section 1	Standardisation of definition and local data collection in adverse incidents	March - 2006 ongoing
DHSSPS, HPSS	All organisations will recognise the need for an informed safety culture	Supports timely reporting and an open, fair, flexible and learning culture	March 2006
DHSSPS	Better linkage on quality and safety agenda within Departmental structures	Integration of quality and safety issues	April 2006
DHSSPS, HPSS	Safety and quality will be a standing agenda item at board meetings	Senior management commitment to quality and safety	February 2006 and ongoing
HPSS	Organisations will have incident reporting levels reviewed at least quarterly by senior management	Regular analysis of adverse incidents and near misses	March 2006 ongoing
HPSS	All organisations will have a designated lead to determine when a serious incident investigation should be instigated	Clarity and consistency in handing investigation of major incidents	April 2006
DHSSPS, HPSS	Algorithms on common and specific reporting systems will be designed and cascaded for use in HPSS	Avoidance of duplication and clarity of reporting arrangements	September 2006
DHSSPS	Develop and publish policy guidance to clarify the role and function of Interim Arrangements for the Reporting of Serious Adverse Incidents	Clarity for the HPSS and the Department in the Reporting of Serious Adverse Incidents	February 2006
DHSSPS	Review local Interim Arrangements for the Reporting of Serious Adverse Incidents, in light of links with the NPSA's Patient Safety Observatory	Clarification of purpose and avoidance of duplication	April 2007
DHSSPS, HPSS	Regional Reporting Systems Project for primary and secondary care will be completed, and linked to joining with NRLS	Standardisation of definitions, reporting forms and coding of incidents	April 2007

5.1.2 Agreeing common systems for data collection, analysis and management of adverse events			
Responsibility	**Action**	**Outcome**	**Completion date**
DHSSPS	A centralised database of clinical negligence claims will be developed	Enhanced data analysis and sharing the learning	December 2006
DHSSPS, in collaboration with PSNI, HSE, and Coroner's service	A Memorandum of Understanding will be published on the investigation of unexpected death or serious harm, which will complement existing procedures and processes for protection of children and vulnerable adults	Promoting communication and shared working between the public sector	March 2006
DHSSPS	Further guidance will be issued on how and when to investigate a serious adverse incident	Clarity and consistency in handling investigations	September 2006

5.1.3 Sharing the learning			
Responsibility	**Action**	**Purpose**	**Completion date**
HPSS, including FPS	Each organisation will have a policy on incident management which will be endorsed by senior management and will be regularly reviewed	Consistency of approach in incident management and learning throughout the organisation	March 2006
DHSSPS, HPSS including FPS	Each organisation will demonstrate a multidisciplinary team approach to reducing risk and improving reporting	Engagement with staff. Consistency of approach in incident management and learning throughout the organisation	April 2006
HPSS including FPS	Each organisation will have a feedback mechanism in place when an incident is reported by an individual or team	Facilitation of action, learning and service change	March 2006
DHSSPS, HPSS	Where a major incident has been identified locally, local solutions will be designed by convening a panel of experts and/or building into existing programmes e.g. CREST, NPSA	Facilitation of action, learning and service change	Ongoing
DHSSPS	An annual report on local serious adverse events will be issued to the HPSS	Sharing the learning and implementing change	March 2006 and Ongoing
RQIA	Following investigation of specific serious adverse incidents, RQIA will produce and cascade a report	Cascade of learning and prevention of reoccurrence of adverse incident	April 2006 and ongoing
DHSSPS, HPSS	A review of communication channels will be undertaken by the Department to include; - consideration of links with SABS, a gateway approach to provision of information, revision of departmental website “governance” pages and extranet access on the results of root cause analysis in the HPSS	Enhanced communication, timely distribution of urgent communications and sharing of learning	December 2006

5.1.4 Building public confidence			
Responsibility	**Action**	**Outcome**	**Completion date**
DHSSPS, HPSS	Organisations will recognise that health and social care will never be error–free, but patients, clients, service users and carers have an important partnership role to play in identification and reduction of errors	Better information to service users and acknowledgement of their role as partners in care	February 2006 Ongoing
DHSSPS, HPSS	Organisations will have a policy on how to communicate a serious adverse incident to individuals/families/staff and the media	Better information and coordination of communication with stakeholders	April 2006
DHSSPS in collaboration with NISCC	A programme for roll-out of registration for the social care workforce will be agreed and commenced in April 2006	Enhanced regulation of the workforce	April 2006
DHSSPS	A public consultation will be undertaken on a new HPSS complaints system	Improved openness, transparency and learning	April 2006
DHSSPS, in collaboration with HPSS	Guidance on redress, where harm is caused to service users, will be developed and implemented in the HPSS	Supporting openness, an apology, an explanation, remedial treatment and compensation, where appropriate	December 2006
DHSSPS, in collaboration with HPSS	A composite set of safety/quality performance indicators will be developed encompassing clinical and non-clinical care, and social care	Enhanced accountability and performance management on safety and quality	July 2006
DHSSPS	New Primary Care legislation will be introduced to enhance the role and functions of the Health Service Tribunal and powers of the HSS Boards	Improved procedures for considering the conduct or performance of family practitioners	November 2006
DHSSPS, HPSS Boards and Trusts	A specific project will be convened to consider key elements to enhance safety and communication at the interface of primary and secondary care	Enhanced safety and quality of care at the interface of primary and secondary care	February 2007
DHSSPS, HPSS Boards, Primary care	Medicines Governance Team Programme will extend into primary care	Promotion of medicines risk management and improvement in quality of	January 2006 Ongoing

5.1.4 Building public confidence			
Responsibility	**Action**	**Outcome**	**Completion date**
practitioners Medicines Governance Team		care	
DHSSPS	A Northern Ireland response to Shipman Inquiry Report Recommendations will be consulted upon and published	Improved professional practice and public protection	July 2006
DHSSPS	A review of existing appraisal systems (medical) will be undertaken	Improved professional practice and public protection	January 2006
DHSSPS	Following the outcome of Donaldson & Foster reviews on professional regulation, implementation of national recommendations will be implemented	Improved professional practice and public protection	Date to be determined
DHSSPS	The Department will publish guidance on Protecting Personal Information	Supports confidentiality and implementation of professional practice and legislation	January 2006
DHSSPS	Guidance on a new disciplinary framework for employed doctors and dentists will be published and implemented in the HPSS	Improved procedures for considering the conduct or performance of doctors/dentists in the HPSS	February 2006
CREST, DHSSPS, HPSS	All organisations will implement CREST guidance on Inter-hospital transfer of medical records	Reduction of risk to service user, when transferred in or between HPSS establishments	April 2006
HPSS	HPSS will complete implementation of the Hine Review on endoscope decontamination	Consistent approach to disinfection and decontamination of endoscopes	July 2006
DHSSPS, HPSS	A response to the O' Hara Inquiry Recommendations will be published and implemented	Safer care for sick children who require intravenous fluid	Date to be determined
DHSSPS, HPSS, in collaboration with Universities, CREST RMAG NIPEC,	The recommendations from the RQIA report on *Review of the lessons arising from the death of Mrs Janine Murtagh* will be implemented	Consistent and improved approach to consent, pre and post operative care, leadership and communication, and the implementation of policies and procedures	March 2007

5.1.4 Building public confidence			
Responsibility	**Action**	**Outcome**	**Completion date**
NIMDTA			
DHSSPS	A Regional Procurement Strategy, incorporating safety, will be published for the HPSS	Safer health service procurement, design and practice	January 2006

5.1.5 Promoting education, training and support for all health and social care staff			
Responsibility	**Action**	**Outcome**	**Completion date**
HPSS	All HPSS organisations will include risk awareness within induction programmes to the organisation, and in specific areas of care	Awareness of risk and of organisational reporting policies and procedures	April 2006 Ongoing
DHSSPS, in collaboration with NIMDTA	A project will be convened to consider the generic contents of an induction programme for new doctors, building on recent learning from adverse events	Standardisation of induction, for new doctors	February 2006
DHSSPS, in collaboration with Universities, NIPEC, NICPPET, NIMDTA NISCC NPSA	Discussion will be held with key stakeholders to incorporate risk awareness, and adverse incident policies and procedures into basic training modules, including specific high risk areas such as medicines, medical devices and child protection issues	Promotion of safety and quality and cascade of learning	December 2006

5.2 CONCLUSION

Safety First: A Framework for Sustainable Improvement in the HPSS sets out a clear policy direction to improve quality of care. This policy and action plan is part of the modernisation and reform agenda and places safety and quality at the heart of good governance.

It recognises that major steps are needed to promote partnership working and enhance public confidence in the services provided. Support, training and education of staff are vital to its success.

The action plan will be reviewed in 2007 to assess progress on implementation. Quality and safety are part of good governance and will be reported on by the HPSS Regulation and Quality Improvement Authority. In addition, the action plan will form part of the ongoing accountability review processes for HPSS organisations, including primary care practitioners. A number of quality and safety performance indicators will be developed as part of implementation of the action plan.

GLOSSARY

ACCREDITATION

Formal recognition or approval of a service or training programme from a recognised authority e.g. a royal college.

ADVERSE EVENT OR INCIDENT

Any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation.

CARER

A carer is an individual who looks after someone who is unwell and/or who requires special assistance to manage their complex needs or situation.

CLINICAL AUDIT

A quality assessment and improvement mechanism in which healthcare professionals peer review their practice, compare it to best practice and introduce improvement in line with their findings.

Clinical and social care audit is interpreted as multi-disciplinary or multi-professional audit, involving a wide range of clinical and social care professions, with inputs from all its constituent groups working together or in single disciplines.

CLINICAL AND SOCIAL CARE GOVERNANCE

A framework through which local organisations are accountable for the quality of service they provide.

CLINICAL NEGLIGENCE

Failure to exercise a reasonable standard of care appropriate to the circumstances, resulting in unintended injury, loss or death to another party.

CULTURE

The general customs and beliefs, of a particular organisation at a particular time. ‘How we do things around here.’

HEINRICH RATIO

A proactive check on a systems “vital signs”- The Heinrich ratio of one major injury to twenty nine minor injuries to three hundred no-injury incidents.

HOMICIDE

An act of murder.

HOSPITAL AND SOCIAL CARE EPISODE STATISTICS

Statistics on hospital and social care episodes of care, e.g. admissions, outpatients appointments, domiciliary care hours provided.

INTELLIGENCE MECHANISMS

The mechanisms for the collection and co-ordination of data.

MEDICINES GOVERNANCE

A focus on risk management involving the prescription, supply, dispensing administration and disposal of medicines. It aims to improve patient & client care through a programme of continuous improvement in medicines management.

NEAR MISS

An unexpected or unintended incident that was prevented, resulting in no harm.

RISK REGISTER

A record of residual risk which details the source, nature, existing controls, assessment of the consequences and likelihood of occurrence, action necessary to manage risk, person responsible for implementing action and timetable for completion.

SERVICE LEVEL AGREEMENT

A service level agreement is a document, which defines the relationship between two parties: the provider and the recipient.

SERVICE USER

Anyone who uses, requests, applies for, or benefits from health and social care services. They may also be referred to as clients, patients or consumers.

ABBREVIATIONS AND ACRONYMS

CEMACH

Confidential Enquiry on Maternal and Child Health.

CISH

Confidential Inquiry into Suicides and Homicides by people with mental illness.

CREST

Clinical Resource Efficiency Support Team.

CSCG

Clinical and Social Care Governance.

DHSSPS

Department of Health, Social Services and Public Safety (Northern Ireland).

DIS

Directorate of Information Systems (DHSSPS).

FPS

Family Practitioner Services- e.g. general medical practitioners, community pharmacists, general dental practitioners, and optometrists.

GB

Great Britain.

GDC

General Dental Council.

GMC

General Medical Council.

HPSS

Health and Personal Social Services commissioning and providing treatment and care in hospitals, communities and through family practitioner services.

HRD

Human Resources Directorate (DHSSPS).

HSENI

Health and Safety Executive Northern Ireland.

IHI

Institute for Healthcare Improvement in the United States of America.

MHRA

Medicines and Healthcare products Regulatory Agency.

MRSA

Methicillin-Resistant Staphylococcus Aureus.

NCAS

National Clinical Assessment Service now part of NPSA but previously the autonomous NCAA (National Clinical Assessment Authority)

NCEPOD

National Confidential Enquiry into Patient Outcome and Death.

NHS

National Health Service.

NI

Northern Ireland.

NIAIC

Northern Ireland Adverse Incident Centre.

NICE

National Institute for health and Clinical Excellence.

NIMDTA

Northern Ireland Medical and Dental Training Agency.

NIPEC

Northern Ireland Practice and Education Council for Nursing and Midwifery.

NICPPET

Northern Ireland Council for Pharmaceutical Postgraduate Education and Training.

NISCC

Northern Ireland Social Care Council.

NPSA

National Patient Safety Agency.

NRLS

National Reporting and Learning System.

PCD

Primary Care Directorate (DHSSPS).

PPMD

Planning and Performance Management Directorate (DHSSPS).

RMAG

Regional Multi-professional Audit Group.

RQIA

Health and Personal Social Services Regulation and Quality Improvement Authority.

SABS

Safety Alert Broadcast System.

SAI

Serious Adverse Incidents.

SCD

Secondary Care Directorate (DHSSPS).

SCIE

Social Care Institute for Excellence.

APPENDIX A - TERMS OF REFERENCE AND MEMBERSHIP OF GROUPS

The terms of reference for this project are as follows:

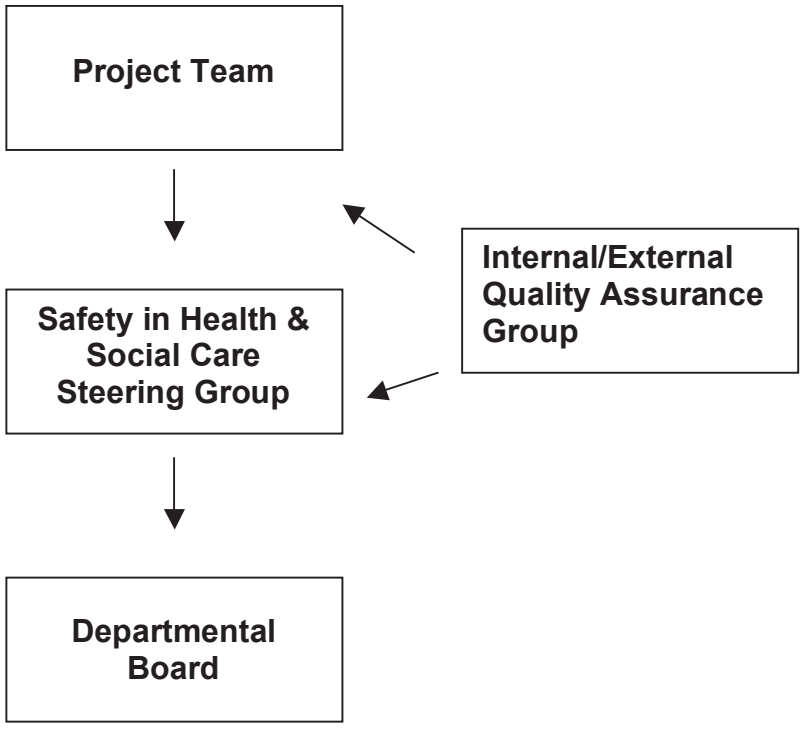
Service user and staff safety concerns everyone who uses or works in the HPSS. The safety policy framework will:

- identify the key components of a safety policy;
- consolidate good practice;
- promote and support an open and fair safety culture;
- link local objectives and priorities, with national developments;
- build capacity and capability at local level; and
- embed service user and staff safety in everyday practice, clinical and social care governance systems and health and social care environments.

The safety framework will be accompanied by an action plan, which will identify key tasks to be taken forward by the Department and the HPSS. This policy framework and action plan will be reviewed in early 2007.

Reporting arrangements

The Safety in Health and Social Care Steering Group will act as the steering group for this project. This Group will report to the Departmental Board by early September 2005.



Safety in Health and Social Care Steering Group

Chair: Dr Ian Carson – Deputy Chief Medical Officer, DHSSPS

Members: Mr Jonathan Bill, DHSSPS
Ms Tracey Boyce, RGH
Mr Brian Godfrey, DHSSPS
Dr Maura Briscoe, DHSSPS
Dr Glenda Mock, DHSSPS
Mr Don Hill, DHSSPS
Ms Irene Low, Ulster Community Hospitals Trust
Ms Nicola Kelly, Belfast City Hospital Trust
Ms Yvonne Kirkpatrick, Belfast City Hospital Trust
Mrs Nuala McArdle, DHSSPS
Dr Norman Morrow, DHSSPS
Mr Pat Newe, DHSSPS
Mrs Elizabeth Qua, DHSSPS
Mr Robert Sergeant, DHSSPS
Mrs Heather Shepherd, Regional Governance Adviser HPSS
Mrs Doreen Wilson, DHSSPS

The Project Team

The project team will comprise:

Mrs Heather Shepherd – Regional Governance Adviser, HPSS
Dr Maura Briscoe – Medical & Allied Group (lead), DHSSPS
Mr Jonathan Bill- Planning & Performance Management Directorate, DHSSPS
Ms Tracey Boyce – Medicines Governance Advisor, NI Medicine Governance Team, Royal Group Hospitals Trust
Mr Brian Godfrey – Health Estates Agency, DHSSPS
Mrs Liz Qua - Health Estates Agency, DHSSPS
Mr Pat Newe – Social Services Inspectorate, DHSSPS

Secretariat – Mr Jonathan Wright, Medical & Allied Group, DHSSPS

Quality Assurance Group

There will be a virtual QA Group comprising nominees from:

- Primary Care Directorate DHSSPS;
- Secondary Care Directorate DHSSPS;
- Community Care Directorate DHSSPS;
- Human Resources Directorate DHSSPS;
- Best Practice, Best Care Steering Group;
- Finance Management Directorate (Claims and Litigation) DHSSPS;
- Public Safety Unit DHSSPS;
- Planning and Performance Management Directorate DHSSPS;
- Professional Groups within the DHSSPS;
- Health and Personal Social Services Regulation and Quality Improvement Authority;
- Health Estates Agency DHSSPS;
- Northern Ireland Social Care Council;
- Mr Howard Arthur, CGST, Modernisation Agency
- HPSS Trusts & Boards; and
- HSS Councils.

APPENDIX B – EXAMPLES OF DATA SOURCES AND FINDINGS

Information Source	Examples of factors that will affect findings	Examples of findings
Incident reporting Systems	More likely to record near misses and errors which did not lead to harm. May be less likely to report known side effects and complications of treatment.	4.9 incidents reported for every 100 hospital admissions, and 1.2 incidents reported for every 100 bed days (England). 1.1 to 3.8 incidents for every 100 bed days (Regions, Pennsylvania, USA)[24]
Medical record review	The threshold that is used for including minor errors or deviations from standards of care. The threshold that is used for determining that harm to a patient was preventable.	Four to 17 adverse events in every 100 hospital admissions (studies in North America and Europe).
Routine data Collection	Recording of adverse events likely to be incomplete. Recording likely to improve with greater awareness of issues.	About two adverse events in every 100 hospital admissions in England[25]. 16 deaths from MRSA in every million men, and 8.5 deaths for every million women[26].
Surveys of patients and staff	Level of awareness of staff and patients. Patient's condition: for example, people with long-term conditions are more likely to be aware of errors than those receiving life-saving treatment.	35 in every 100 NHS staff reported seeing at least one error or near miss that could have harmed patients during the month before the survey[27]. 18 to 28 in every 100 patients with health problems from five countries believe a medical mistake or medication error affecting them had occurred in the two years before the survey[28].

Source:- *Building a memory: preventing harm, reducing risk and improving patient safety*. National Patient Safety Agency, July 2005.

[24] Department of Health. *Building a Safer NHS for Patients.* Available at www.doh.gov.uk/buildsafenhs (November 2003)
[25] Aylin P et al. How often are adverse events reported in English hospital statistics? *BMJ* 2004;329:369
[26] Office on National Statistics. *Health Statistics Quarterly.* Spring 2005:60-5
[27] Healthcare Commission. *NHS Staff Survey 2004: Summary Report.* March 2005
[28] Commonwealth Fund. *2002 International Health Policy Survey of Adults with Health Problems.* Available at: www.cmwf.org/surveys/surveys_show.htm?doc_id=228168

APPENDIX C

RAISING AWARENESS OF RISK, AS PART OF AN INDUCTION PROGRAMME FOR NEW RECRUITS, AND THE TRAINING OF IN-SERVICE STAFF

To improve patient and service user safety, the education and training of all HPSS staff must include risk awareness. Inclusion of "risk awareness" is an integral part of the risk management standard included in Controls Assurance Standards, the HPSS Quality Standards and the Care Standards.

Particular attention needs to be paid to the induction of temporary staff to ensure that key policies and procedures relevant to their level of competence are known prior to the commencement of practice.

Induction and in-service training programmes, should include:

- an overview on the organisation's safety culture, policies and procedures;
- basic awareness of the systems approach to patient and service user safety;
- awareness that health and social care is a high risk industry and the importance of being risk aware;
- awareness of their own personal responsibilities within their specific areas of work;
- the current incident statistics for health and social care within the organisation;
- examples of how things can go wrong;
- why incidents happen;
- how to report incidents;
- the importance of working within one's own ability; and,
- practical skills to practise safely.

APPENDIX D

How to Classify Adverse Incidents and Risk

Guidance for Senior Managers Responsible for Adverse Incidents Reporting and Management

Summary Version

The full version of this document will be subject to review and up-to-date versions will be available on the governance website.

http://www.dhsspsni.gov.uk/index/hss/governance.htm

Contents

1.0 Introduction

2.0 Stages of Adverse Incident Management

3.0 Flowchart One

1.0 Introduction

1.1 This is a shortened version of a document produced to assist Health and Personal Social Services organisations (HPSS) in developing or reviewing processes to assess incidents and their consequent risk implications. It has been written for senior managers responsible for reporting and overall management of adverse incidents and it is not intended as guidance for all staff. It does not provide detailed guidance for HPSS incident investigation, as this will be the subject of further work.

1.2 The following pages outline a tool to help managers classify incidents and risk, using the Australian / New Zealand Standard: Risk Management (AS/NZS 4360: 2004) and "Step 4 – Promote Reporting" from the National Patient Safety Agency (NPSA) publication "Seven Steps to Patient Safety" as primary sources.

1.3 The guidance should be used for all incidents not just those that involve patients / service users. This is in line with the current systems and processes that HPSS organisations use to manage incidents. The tool has been developed for use across the HPSS including the primary care sector and covers all incidents including clinical and social care incidents.

1.4 HPSS and primary care organisations should follow the principles of this guidance when developing, revising and implementing their own local policies and procedures. It is of key importance however that these principles are tailored to suit the objectives, nature and size of the particular organisation. The broad aim of this document is to facilitate better systems for sharing learning from adverse incidents across the HPSS and beyond. It provides a framework for appropriate and sufficient analysis of, and learning from events where there has been significant harm or potential harm to, and/or death of a patient, service user, staff member, visitor and/or significant damage to property or the environment.

1.5 One important principle is that all adverse incidents should be considered and recorded centrally within organisations so that any organisation-wide implications can be captured as early as possible. However, this must not negate the importance of local management responsibility for handling incidents in their area. All types of incidents should be included; for example; social care, clinical, health and safety, fire, infection control etc.

1.6 To help with capturing all incidents within similar processes an HPSS regional definition of an incident has been devised; an adverse incident within the HPSS context is therefore defined as;

"Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation"

1.7 Further associated work in this area will include a regional minimum dataset for recording incidents and a set of regional codes for the most prevalent types of incidents.

2.0 Stages of Adverse Incident Management (See Flowchart One)

Stage 1 – Incident occurs and is reported via the organisations' internal reporting mechanism to the organisations' central recording system. Incident details are communicated internally as necessary.

Stage 2 – Determine actual incident severity.

Stage 3 – Assess incident to determine immediate action required. Following initial assessment consider whether it is appropriate to report to external organisations (See flowchart for examples)

Stage 4 – Initiate incident investigation as appropriate. Consider whether it is appropriate to report to external organisations. (See examples of organisations requiring reports in Flowchart One)

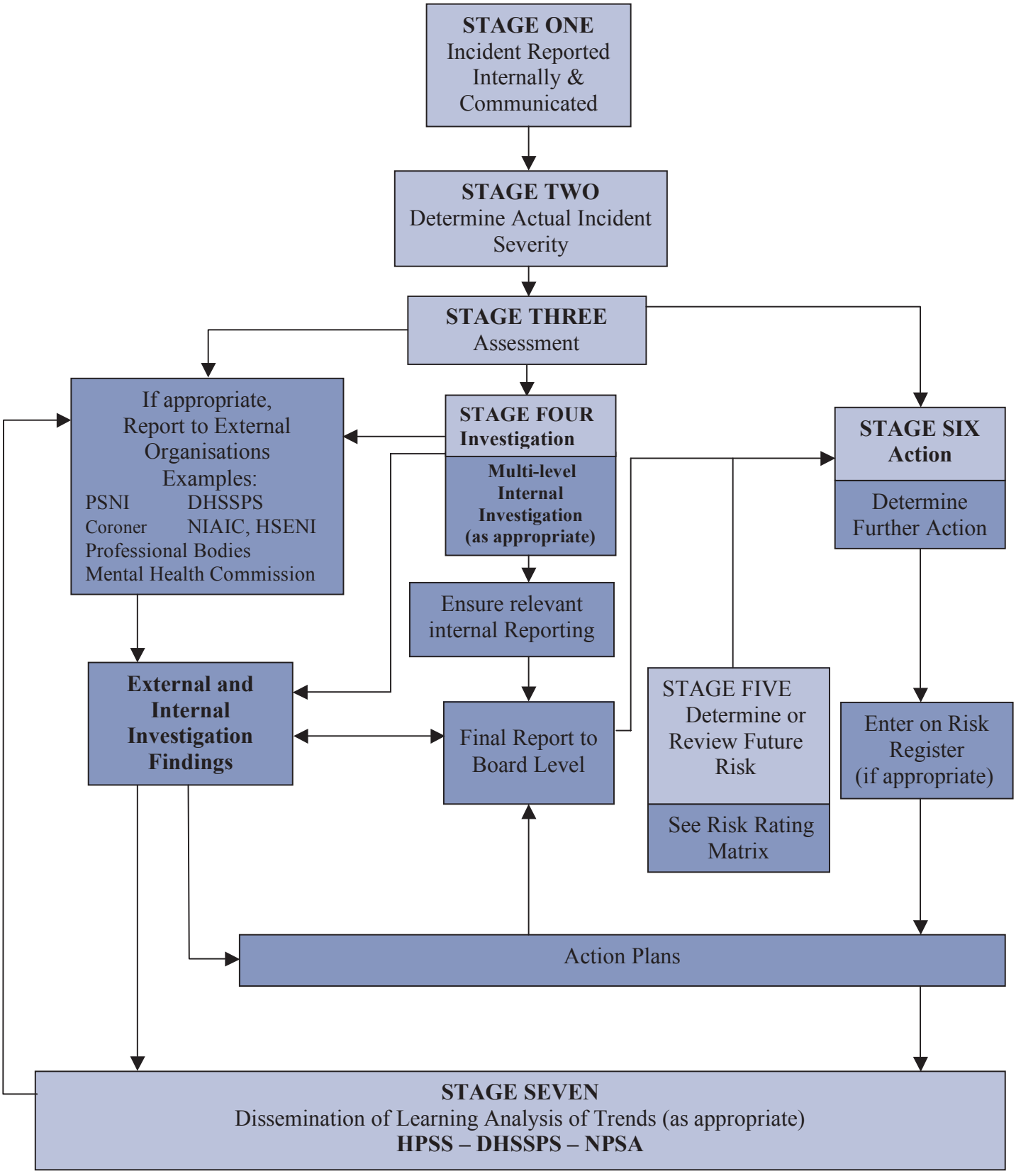
Stage 5 - This is a secondary classification mechanism for assessing ***potential future risks***. Use the following prompts:

(a) Think about the likely impact if the incident were to occur again without any intervening circumstances that made the incident less severe.
(b) Assess the likelihood of the incident occurring again.
(c) Use the Risk Rating Matrix (available in the full version of this document) to determine the risk severity.

Stage 6 – Use the Action Guidance to determine what further action should be taken. For example, consider whether this issue needs to be entered on the risk register.

Stage 7 – Determine any local and regional learning and communicate this within the organisation and with the appropriate regional / national bodies. Following the outcome and learning from investigations keep the future risk rating (Stage 5) under regular review.

STAGES OF ADVERSE INCIDENT MANAGEMENT FLOWCHART ONE



APPENDIX E

PROMOTING EQUALITY AND HUMAN RIGHTS

Section 75 of the Northern Ireland Act 1998 requires the Department, in carrying out its functions, powers and duties, to have due regard to the need to promote equality of opportunity:

- between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- between men and women generally;
- between persons with a disability and persons without; and
- between persons with dependants and persons without.

Members of the project team met to consider the equality and human rights implications of the safety framework and action plan. A screening exercise was undertaken, against four questions, which are identified below. The following text represents a summary of the discussion.

Is there any evidence of higher or lower participation or uptake by different groups?

The Group discussed the potential for greater integration of safety and quality policy development and action. It recognised that diminished standards on safety reflected a poor quality of treatment and care, for service users across the spectrum of care provided. Given the diverse nature of this framework, no one particular section 75 category would be disadvantaged. Indeed, the aim was to benefit all service users by promoting a safety culture, and a systematic approach to prevention, detection, reporting and management of adverse incidents. A part of this safety culture was the promotion of learning to prevent reoccurrence of incidents.

It was noted that whilst all people have the right to access HPSS services, greater use of these services are made by the very young, older people and those with complex needs and chronic conditions. The safety framework acknowledges the complexity of health and social care provision and environments. It advocates an open and fair culture which promotes involvement of all service users, particularly in relation to identification of risk and the part that service users, carers and the wider public have to play in the minimisation of that risk and in the development of solutions appropriate to their needs.

The safety framework links to the values and principles identified in the Quality Standards for the HPSS. These have been consulted upon;

these values include equality, diversity, choice, rights and respect for the individual.

Is there any evidence that different groups have different needs, experience, issues and priorities in relation to the particular policy?

No. It was considered that religion, political opinion, racial group, marital status, sexual orientation, gender or disability had no direct impact on this high level policy document or action plan. It was noted that there was a full section contained in the framework on involving and communicating with service users, carers and the public. This recognised that all people had a right to complain when concerned about their treatment or care, and that appropriate redress was an integral part of a quality system, when things go wrong. It was felt that the action plan was a relatively high level one which brought together many different strands of the quality and safety agenda. The action plan also attributed action to a number of organisations. In such circumstances, there would be a general need to consider equality and human rights implications when implementing specific actions.

Is there an opportunity to better promote equality of opportunity or good relations by altering policy or working with others in government or the community at large?

Equality of opportunity and good relations will be promoted through development of this policy. The policy and action plan recognise the need for:

- Enhanced promotion of health and safety for **all** service users, carers, staff, practitioners and visitors;
- Development of organisational communication policies and the training of staff to enhance engagement with service users and carers;
- Promotion of good relations through development and support of an informed safety culture;
- Increase in the reporting of adverse incidents and shared learning of experience;
- A more systematic approach to redress, when things go wrong;
- Enhanced communication across primary, secondary and community care, and with other agencies, for example, police, Health and Safety Executive and coroners;

- Increase in the availability of information and consultation on treatment and care with service users, carers and practitioners; and

- Enhanced education, training and development of staff.

How will this impact on complementary policy areas?

The safety framework and action plan complement other policy areas. It is part of the overall quality framework as set out in Best Practice Best Care (2001), which was subject to extensive consultation. Safety is an integral part of clinical and social care governance, care standards, controls assurance and quality standards. All of these developments are aimed at enhancing health and social care outcomes and the service user experience. The safety framework also supports other initiatives to promote continuous professional development, life-long learning and enhanced regulation of the workforce. The safety framework and action plan is underpinned by the Duty of Quality as outlined in the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

Conclusion

The safety framework is a high level document, which aims to bring together different strands of the wider safety and quality agenda. It draws on existing policy developments and identifies, in a single plan, actions which need to take place within the next two years to enhance safety within health and social care services. The project team concluded there was no adverse impact on equality or human rights arising from the safety framework. It was also noted that equality and human rights implications would be considered as part of the development and implementation of specific actions associated with the framework.

APPENDIX F

REFERENCES, CIRCULARS AND GUIDANCE

CIRCULARS

NIAIC Safety Notice MDEA (NI) 2004/01 Reporting Adverse Incidents and Disseminating Medical Device/Equipment Alerts. Health Estates, Northern Ireland Adverse Incident Centre.

Circular HSS (PPM) 3/2002 – Corporate Governance: Statement on Internal Control (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 6/2002 – AS/NZS 4360:1999-Risk Management (DHSSPS) http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 8/2002 – Risk Management in the Health and Personal Social Services (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM)10/2002 – Governance in the HPSS: Clinical and Social Care Governance – Guidance on Implementation (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS(PPM)13/2002 – Governance in the HPSS – Risk Management (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (F) 20/2002 – Clinical Negligence: Prevention of Claims and Claims Handling (DHSSPS)

Circular HSS (PPM) 5/2003 – Governance in the HPSS: Risk Management and Controls Assurance (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (FAU) 19/2003 – Statement of Internal Control: Transitional Statement 2002/03(DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM)6/2004 – Reporting and follow-up on serious adverse incidents: Interim Guidance (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM)8/2004 – Governance in the HPSS: Controls assurance standards – update
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (F) 2/2004 – Statement on Internal Control – Full Implementation for 2003/04 (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 5/2005 – Reporting of Serious Adverse Incidents within the HPSS
www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 2/2006 – Reporting and Follow-up on Serious Adverse Incidents
www.dhsspsni.gov.uk/hss/governance/guidance.asp

STANDARDS

Quality Standards – Consumer Involvement in Community Care Services (DHSSPS) 1999

Quality Standards for Health and Social Care: supporting good governance and best practice in the HPSS
http://www.dhsspsni.gov.uk/qpi_quality_standards_for_health_social_care.pdf

GUIDANCE

Guidance on Implementation of the HPSS Complaints Procedure, (DHSSPS), March 1996

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MAHI - STM - 089 - 5578

MAHI - STM - 089 - 5579

FROM THE ACTING CHIEF MEDICAL OFFICER
Dr Ian Carson

Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

HSS(MD) 12/2006

Castle Buildings
Stormont Estate
Belfast BT4 3SR
[redacted]

Your Ref:
Our Ref: iwc
Date: 24 April 2006

TO:- Chief Executives of:
HSS Trusts and Boards
NI Blood Transfusion Service
Central Services Agency
NI Postgraduate Education Council
NI Social Care Council
NI Medical and Dental Training Agency
NI Guardian ad Litem Agency and
NI Medical Physics Agency

For onward transmission by the Chief Executive to relevant staff including:

Executive Leads Governance / Clinical and Social Care Governance
Executive Leads Adverse Incident Management Governance / Clinical and Social Care Governance/ Risk Managers
Medical Directors
Directors of Nursing
Directors of Social Services
Directors of Pharmaceutical Services
Directors of Public Health
Directors of Primary Care

Dear Colleague

GUIDANCE DOCUMENT – "HOW TO CLASSIFY INCIDENTS AND RISK"

Introduction

I attach a copy of "*How to Classify Incidents and Risk*" as guidance to assist HPSS organisations in developing or reviewing processes to assess adverse incidents and their risk implications. The purpose of the guidance is to act as a model that can be adapted for local use. The target audience for this document is senior managers and those involved in adverse incident management.

Background

This guidance is the product of a wider project that was convened in 2005, under the auspices of the Safety in Health and Social Care Steering Group, to enhance systems and processes in the HPSS to better manage adverse incidents and risk arrangements. It is designed to promote greater consistency of approach within the HPSS and to make it easier for the HPSS to share learning from adverse incidents. The project also fits into the wider context of *HPSS Controls Assurance Standards (*in particular, the criteria concerning adverse incident management), *The Quality*

Standards for Health and Social Care (specifically the theme of "Safe and Effective Care") and the recently issued *Safety First: A Framework for Sustainable Improvement in the HPSS.*

The project team, lead by the Regional Governance and Risk Management Adviser, consists of clinical and social care governance managers and risk managers from across the HPSS. The project work is quality assured by HPSS Clinical and Social Care Governance Executive Leads.

Action
Organisations will have already set up a centralised system for collating and analysing all adverse incidents. The attached document provides a steer for how these incidents are defined and how they should be analysed; however, each HPSS organisation will need to tailor this advice to best suit their own organisational needs and requirements.

It is recommended that the content and applicability of this document be discussed at senior management level within your organisation. It is not intended that this guidance be used without adaptation to the specific requirements of each organisation. For example; the flowchart contained within the guidance (Page 3) can be used to review existing procedures and can be altered to suit the many different situations that exist across the HPSS.

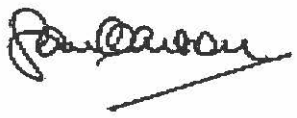
Future Pathway
This project has two further phases:-

- → Phase II will produce a Regional Minimum Dataset and will be completed within the next few months; and
- → Phase III will produce a set of regional codes for adverse incidents and will be completed in March 2007.

The above work is seen as complementary to any future link with the National Patient Safety Agency (NPSA).

I would like to take this opportunity to thank the project manager, Heather Shepherd, Regional Governance and Risk Management Adviser and her HPSS-wide project team for their effort in putting together this complex work.
The document will be kept under review with the most up-to-date version available from the departmental governance webpage on
http://www.dhsspsni.gov.uk/index/hss/governance.htm

Yours sincerely



DR IAN CARSON
Chair of the Safety in Health and Social Care Steering Group

This letter is available at www.dhsspsni.gov.uk and also on the DHSSPS Extranet which can be accessed directly at http://extranet.dhsspsni.gov.uk or by going through the HPSS Web at http://www.n-i.nhs.uk and clicking on DHSSPS.

How to Classify Adverse Incidents and Risk

Guidance for Senior Managers Responsible for Adverse Incident Reporting and Management

April 2006

This document will be subject to review and up-to-date versions will be available on the governance website.

http://www.dhsspsni.gov.uk/index/hss/governance.htm

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Introduction

1.1 This document has been produced to assist Health and Personal Social Services organisations (HPSS) in their clinical and social care governance arrangements. In particular to help develop or review processes to assess adverse incidents and their risk implications. It has been written for senior managers responsible for the reporting and overall management of adverse incidents and it is not intended as guidance for all staff. It does not provide detailed guidance for HPSS incident investigation, as this will be the subject of further work.

1.2 The following pages outline a tool to help managers classify incidents and risk, using the Australian / New Zealand Standard: Risk Management (AS/NZS 4360: 2004) and "Step 4 – Promote Reporting" from the National Patient Safety Agency (NPSA) publication "Seven Steps to Patient Safety" as primary sources.

1.3 The guidance should be used for all incidents not just those that involve patients / service users. This is in line with the systems and processes that HPSS organisations currently use to manage incidents. This document has been designed for use across the HPSS including the primary care sector and covers all incidents including clinical and social care incidents.

1.4 Organisations should follow the principles of this guidance when developing, revising and implementing their own local policies and procedures. It is of key importance however that these principles are tailored to suit the objectives, nature and size of the particular organisation. The aim of this document is to facilitate better systems for sharing learning from incidents across the HPSS and beyond. It provides a framework for appropriate and sufficient analysis of, and learning from incidents where there has been significant harm or potential harm to, and/or death of a patient, service user, staff member, visitor and/or significant damage to property or the environment.

1.5 One important principle is that all incidents should be considered and recorded centrally within organisations so that any organisation-wide implications can be captured as early as possible. However, this must not negate the importance of local management responsibility for handling incidents in their area. All types of incidents should be included: for example, social care, clinical, health and safety, fire, infection control etc.

1.6 To help with capturing all incidents within similar processes an HPSS regional definition of an incident has been devised; an adverse incident within the HPSS context is therefore defined as:

"Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation."

1.7 Further associated work in this area will include the development of a regional minimum dataset for recording incidents and a set of regional codes for the most prevalent types of incidents.

2.0 Stages of Adverse Incident Management (To be read in conjunction with Flowchart One)

This section provides further guidance to support Flowchart One overleaf and gives further detail relating to each stage in the process.

Stage 1 – Incident occurs and is reported via the organisation's internal reporting mechanism to the organisation's central recording system. Incident details are also communicated internally as necessary.

Stage 2 – Determine actual incident severity (using Table 1 and Table 2). An incident will often have multiple aspects – considering all these aspects (see Table 2) decide the level of severity.

Stage 3 – Assess incident to determine immediate action required. Following this initial assessment consider whether it is appropriate to report to external organisations (See examples of organisations requiring reports in Flowchart One). If the severity of the incident means that action must precede investigation – go straight to Stage 6.

Stage 4 – Initiate incident investigation as appropriate. Following investigation re-consider in the light of further information whether it is appropriate to report to external organisations. (See sample list of organisations that may require reports in Flowchart One).

Stage 5 - This is a secondary classification mechanism for assessing ***potential future risks***. Use the following prompts:

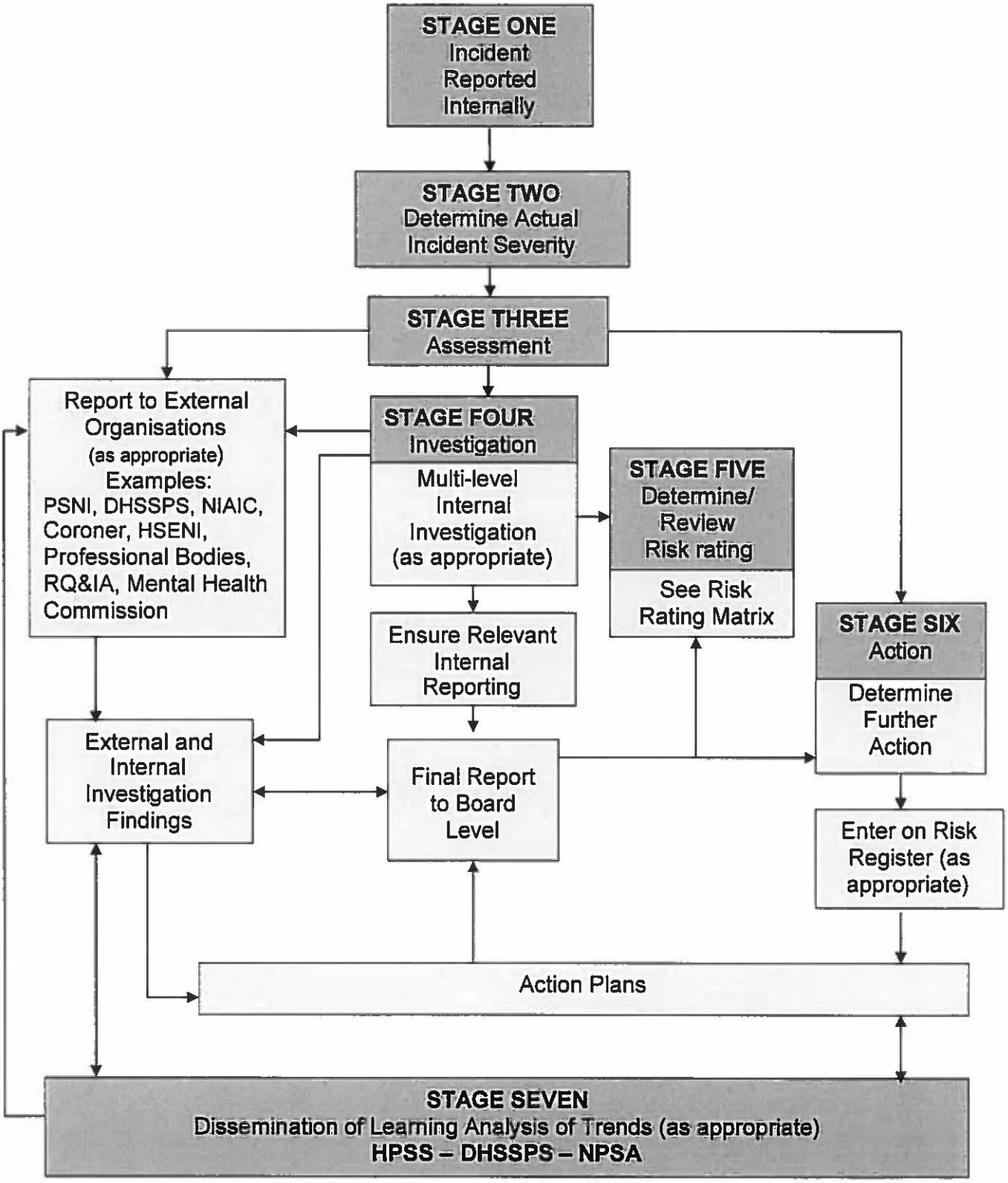
(a) Think about the likely impact if the incident were to occur again without any intervening circumstances that made the incident less severe. (Use the Impact Table – Table 2)
(b) Assess the likelihood of the incident occurring again.
(c) Use the Risk Rating Matrix (Page 6) to determine the overall risk rating.

Stage 6 – Use the Action Guidance (Table 3) to determine what further action should be taken. For example, consider whether this issue needs to be entered on the risk register and/or any organisation-wide action is required.

Stage 7 – Determine any learning from the adverse incident and communicate this within the organisation and with the appropriate regional / national bodies. Following the outcome and learning from investigations review the risk rating in Stage 5 and keep this under regular review.

STAGES OF ADVERSE INCIDENT MANAGEMENT FLOWCHART ONE

(please read in conjunction with commentary on Page 2)



3.0 Initial Grading of Incident Severity

The initial assessment of an incident should be performed quickly, even when all facts may not be available. There is always scope to re-grade as facts and issues emerge over time and following investigation. This guidance is primarily for internal reporting mechanisms but please note one particular external reporting route - Serious Adverse Incidents (most probably incidents from the Catastrophic and Major severity levels) should be reported to the DHSSPS (see Circular HSS (PPM) 02/06) - i.e. those incidents that meet the following criteria:

- Be serious enough to warrant regional action to improve safety or care;
- Be of public concern; or
- Require an independent review.

Table 1 - Actual Incident Severity (according to the facts available)

In determining the actual severity consider the outcome of the incident in terms of harm to people / resources / environment / reputation / quality.

Severity of incident	High Level Descriptors (see Impact Table 2 overleaf for a more detailed list)
Catastrophic	Incident with widespread implications to services
Major	Significant disruption to services
Moderate	Short term disruption to services
Minor	No interruption to services
Insignificant	No adverse outcome but risk potential evident

Impact Table 2 (based on facts available about the incident)

This table may also be used to assess the impact of risks in order to analyse future risks

	PEOPLE (Any person affected by an Incident: Staff, User, Visitor, Contractor)	RESOURCES (Premises, money, equipment, Business interruption, problems with service provision)	ENVIRONMENT (Air, Land, Water, Waste management)	REPUTATION (Adverse publicity, Complaints, Legal/Statutory Requirements, Litigation)	QUALITY AND PROFESSIONAL STANDARDS (including government priorities, targets and organisational objectives)
CATASTROPHIC	Incident that lead to one or more deaths	Severe organisation wide damage/ loss of services /unmet need	Toxic release affecting off-site with detrimental effect requiring outside assistance.	National adverse publicity. DHSSPS executive investigation following an incident or complaint. Criminal prosecution.	Gross failure to meet external standards, priorities
MAJOR	Permanent physical/emotional injuries/trauma/harm.	Major damage, loss of property / service /unmet need	Release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc)	Local adverse publicity. External investigation or Independent Review into an incident/complaint. Criminal prosecution /prohibition notice	Repeated failure to meet external standards.
MODERATE	Semi permanent physical/emotional injuries/trauma/harm (recovery expected within 1 year).	Moderate damage, loss of property / service /unmet need	On site release contained by organisation	Damage to public relations. Internal investigation (high level), into an incident/complaint. Civil action	Repeated failure to meet internal standards or follow protocols.
MINOR	Short-term injury/harm. Emotional distress. (Recovery expected within days /weeks.)	Minor damage, loss of property / service /Unmet need	On site release contained by organisation	Minimal risk to organisation. Local level internal investigation into an incident/complaint Legal challenge	Single failure to meet internal standards or follow protocol.
INSIGNIFICANT	No injury/harm or no intervention required / near miss	No damage or loss, no impact on service Insignificant unmet need	Nuisance release	Minimal risk to organisation, Informal complaint	Minor non compliance,

MMcG- 126

RISK RATING MATRIX (adapted from AS/NZ 4360, 2004 MODEL)

LIKELIHOOD	CONSEQUENCE (Potential Impact)				
	Insignificant	Minor	Moderate	Major	Catastrophic
Almost certain (will undoubtedly recur, a persistent issue)					
Likely (will probably recur, not a persistent issue)					
Possible (may recur occasionally)					
Unlikely (do not expect it to happen again)					
Rare (can't believe it will ever happen again)					

Risk Rating

Low	Medium	High	Extreme

Table 3 - Action Guidance

Risk Rating Level	Descriptors
Extreme	Identified risks which fall in the red area are deemed extreme risk to the organisation and must be reported to the appropriate Governance Group. These risks require immediate action to reduce the level of risk and the relevant Director / Officer will ensure they are forwarded to the Executive Management Board/Governance Committee. The appropriate Director / Officer will ensure the implementation of a time monitored action plan and provide regular reports to the Executive Management Board/Governance Committee.
High	Identified risks which fall in the orange area are deemed high risk to the organisation and require prompt action to reduce the risk to an acceptable level. These risks and agreed action plans should be considered by the local Governance Group. Risks that cannot be reduced locally should be forwarded for consideration by the Executive Management Board/Governance Committee.
Medium	Identified risks which fall in the yellow area are deemed medium risk to the organisation and require action to reduce risk to an acceptable level. Responsibility for taking action would normally remain at a local level within the appropriate Directorates/Programmes/Service Areas and monitored by the relevant Local Governance Group and entered on the Directorate Register.
Low	Identified risks which fall in the green area are deemed as acceptable risks and require no immediate action, but must be monitored regularly.

Appendices

APPENDIX A - TERMS OF REFERENCE AND MEMBERSHIP OF GROUPS

This project aims to create a standard method of adverse incident reporting across the Health and Personal Social Services including Trusts, Boards and across the Primary Care sector. This will include creating HPSS agreed standard incident definitions, a minimum dataset and recommended reporting form and regional coding of incidents.

Project Reporting Arrangements

The Project Team

The project team is multi-disciplinary and drawn from across the HPSS. The project has been able to access HPSS best practice in adverse incident management. A list of project team members is set out below:

Dr Kathryn Booth, Medical Adviser, EHSSB GP Unit / DHSSPS
Ms Tracey Boyce, HPSS Medicines Governance Project Manager, Royal Hospitals Trust
Mrs Therese Brown, Risk Management Director, Altnagelvin HSS Trust
Mrs Jacqui Burns, Risk Manager, NHSSB
Ms June Champion, Risk Manager, Royal Hospitals Trust
Dr Martina Hogan, Consultant Paediatrician, Craigavon Area Hospital Group Trust
Mrs Yvonne Kirkpatrick, Governance Manager, Belfast City Hospital Trust
Ms Irene Low, Risk Manager, Ulster Community and Hospitals Trust
Mr Alex Lynch, Governance Manager, Homefirst Community HSS Trust
Ms Marita Magennis, Social Services, Newry and Mourne HSS Trust
Mrs Mairead Mitchell, Assistant Director, Improvement and Governance, North and West Belfast Community Trust
Mr Brian Mullin, Acting APSW, Causeway HSS Trust
Ms Heather Shepherd, HPSS Regional Governance and RM Adviser
Mrs Roberta Wilson, Clinical and Social Care Governance Co-ordinator

Quality Assurance Group

Quality Assurance for the project was arranged via a virtual QA Group comprising governance leads from all HSS Trusts and HSS Boards.

APPENDIX B

REFERENCES, CIRCULARS AND GUIDANCE

The following is a list of useful documents providing further guidance in this area.

Being Open. Communicating patient safety incidents with patients and their carers. National patient safety Agency (2005) www.npsa.nhs.uk

Department of Health, Social Services and Public Safety Memorandum of Understanding

Department of Health, Social Services and Public Safety - Safety in Health and Social Care Project – Clinical and Social Care Governance - Deloitte, 31st March 2004

Circular HSS (PPM) 02/2006 – Reporting and Follow-Up on Serious Adverse Incidents within the HPSS
www.dhsspsni.gov.uk/hss/governance

Circular HSS (PPM) 5/2003 – Governance in the HPSS: Risk Management and Controls Assurance (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 6/2002 – AS/NZS 4360:1999-Risk Management (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 6/2004 – Reporting and follow-up on serious adverse incidents: Interim Guidance (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 8/2002 – Risk Management in the Health and Personal Social Services (DHSSPS) http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 8/2004 – Governance in the HPSS: Controls assurance standards – update http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 10/2002 – Governance in the HPSS: Clinical and Social Care Governance – Guidance on Implementation (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 13/2002 – Governance in the HPSS – Risk Management (DHSSPS) http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Creating the virtuous circle: patient safety, accountability and an open and fair culture, NHS Confederation 2003.

Doing Less Harm; Improving the Safety and Quality of Care Through Reporting, Analysing and Learning from adverse incidents, Department of Health and NPSA Draft August 2001.

Making it happen – A guide for risk managers on how to populate a risk register (CASU, Keele University) www.dhsspsni.gov.uk/hss/governance

National Patient Safety Agency. 2004 Seven Steps to Patient Safety www.npsa.nhs.uk/health/resources/7steps

NIAIC Safety Notice MDEA (NI) 2006/01 Reporting Adverse Incidents and Disseminating Medical Device/Equipment Alerts. Health Estates, Northern Ireland Adverse Incident Centre.
www.dhsspsni.gov.uk/index/hea/niaic

Patient Safety: Towards Sustainable Improvement, Fourth Report to Australian Health Ministers' Conference, Australian Council for Safety and Quality in Healthcare, July 2003

Shipman Inquiry Reports www.the-shipman-inquiry.org.uk/reports

The Bristol Royal Infirmary Inquiry
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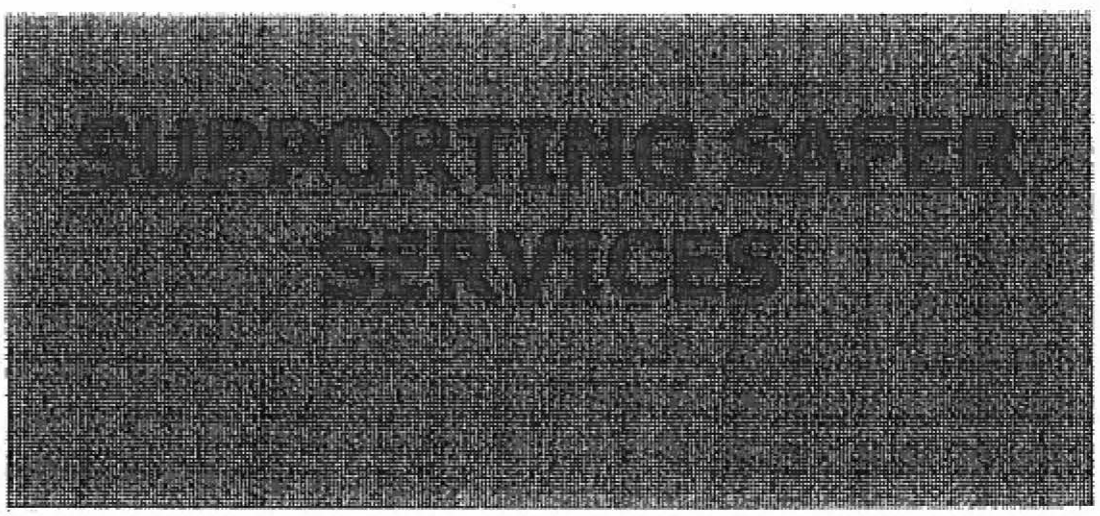

FEEDBACK ON LEARNING ARISING FROM CIRCULARS HSS (PPM) 06/04 AND 05/05 (JULY 2004 – DECEMBER 2005)

June 2006

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Foreword

Service user and staff safety has become a major priority for health and social services (HPSS) organisations in recent years. It is an issue which has received an increasingly high profile at local, national and international levels and is one that has to be considered in the context of a broader range of quality improvement, modernisation and reform programmes. The Department is committed to ensuring service users receive high quality treatment and care, delivered by motivated and skilled staff in modern settings where risks of an error or adverse incident are minimised.

Each year in Northern Ireland hundreds of thousands of people use the HPSS for a variety of reasons. In the course of one year, one million people attend A&Es, 740,000 inpatient and daycases are treated, 28 million prescription items are dispensed and two million people attend an outpatient appointment. It is inevitable that with such large scale and complex activity errors can and do occur. Some could have or did lead to harm, loss or damage to people, property, environment or reputation. These errors are not necessarily related to individual human error but are often linked to systems faults, work environments, technological failures or may be due to the complex characteristics of the individual patient's or client's condition or circumstances.

Promoting a reporting culture is just one element of a quality improvement programme which requires leadership and commitment of senior management and all staff who work in the

HPSS. Timely and accurate reporting of all adverse incident leads to a greater understanding of what went wrong and an assessment of potential future risk of reoccurrence within the organisation. Most significantly, it helps HPSS organisations and staff learn important lessons. By ensuring there are robust systems in place to identify, investigate and manage adverse incidents and, where appropriate, by taking positive action to ensure they are not repeated, we can all help to minimise future risks to service users.

The Department has established an interim system to report serious adverse incidents (SAIs) to it in a timely and standardised manner. This is just one of a number of local and national reporting systems which have been in place for some years. However, since July 2004, the Department has required the HPSS to report incidents which are serious enough to require regional action to improve safety, or be of major public concern or require an independent review. The fact that more serious adverse incidents have been reported in the last six months of this reporting period is proof of the willingness by HPSS organisations to report and share experiences. By doing so all HPSS organisations can learn from these incidents.

This Report highlights examples of SAI reports that have been the catalyst for change at regional level in areas such as clinical care, social care and mental health services. These changes have included HPSS organisations reviewing their procedures, promoting compliance with existing guidance and the development of new regional guidance. All of these changes have taken place to ensure that the risk of similar incidents occurring is minimised.

HPSS Boards and Trusts are accountable for the quality of care that they commission and provide, and for a continual drive for quality improvement. Much work is already underway at local and regional levels. The Regulation and Quality Improvement Authority, a new organisation set up from April 2005, will be publicly reporting on the quality of care provided by HPSS organisations through clinical and social care governance reviews, specific incident investigations and thematic reviews. Using the recently issued Quality Standards and, in particular, the safe and effective care theme, RQIA will assess how robust HPSS organisations' systems are in reporting, investigating, managing and learning from adverse incidents. As part of the overall assessment of quality of care, in the future, RQIA's report to the Department will cover how well organisations are preventing, detecting, communicating and learning from adverse incidents and near misses.

As part of a broader quality improvement programme, this Report also considers how the Department and the HPSS can further enhance incident reporting systems. In March 2006, further guidance on reporting, including a revised proforma, was issued by the Department. In addition, subject to Minister's approval, the Department is planning to enter into a formal agreement with the National Patient Safety Agency which will include links to their National Reporting and Learning System (NRLS). Once all HPSS organisations are part of the NRLS, the Department will review the need to continue with its current interim reporting arrangements.

The HPSS in Northern Ireland is facing a radical and unprecedented period of change. It is our duty to continue the progress we have made to improve the quality of the service we provide to service users during this transition period. I commend everyone in the HPSS for the efforts they have made to enhance the quality of service. But more can always be done to improve both safety and quality of care. This will require an integrated approach across the whole of the service, including the recognition that service users and the media have an important role in minimising risk and promoting an open and fair culture, which recognises the needs of both services users and staff. It is only in this way that we will be able to build a reporting culture which facilitates learning and promotes change.

Andrew McCormick
Permanent Secretary
DHSSPS

SECTION 1: The objectives and strategic context of the regional serious adverse incident reporting system

1.1 Introduction

The delivery of health and social care is complex. Many treatment and care decisions are made in a busy working day, using a range of technologies, procedures and activities, by many different staff and in a variety of settings. No health and social care environment will ever be one hundred percent safe. Some adverse incidents which occur may be the inevitable complication of treatment or care.

The Department of Health, Social Services and Public Safety(DHSSPS) is committed to ensuring that those who use health and social services are treated or cared for in a way that promotes high-quality care where risks are minimised. ***When adverse incidents occur, it is the responsibility of the HPSS organisations to ensure that the incident is appropriately investigated, managed and action taken to reduce the risk of reoccurrence.***

However, some incidents are of such significance that regional learning and/or action might be required. This interim mechanism of reporting serious adverse incidents to the Department, as described in this Report, is recognition by the Department that more can always be done to improve service user safety and to learn at a local and regional level. This Report will be accompanied by a HPSS workshop, in order to cascade learning and to discuss with HPSS staff how this system might be amended and improved.

In the longer term, the Department recognises that the triangulation of data sources at local and national levels, together with culture change, are necessary to inform quality improvements. These will be addressed through further linkages with the national reporting and learning systems and standard setting bodies, and through embedding quality and safety in the reform and modernisation agenda thus making "quality and safety" a central

role and function of new commissioning and provider organisations emerging from the Review of Public Administration[1].

1.2 Criteria for reporting Serious Adverse Incidents to the DHSSPS

This is the first report of serious adverse incidents (SAIs). It covers incidents reported to the DHSSPS by the HPSS, between July 2004 and December 2005. The reporting criteria was outlined in circular HSS (PPM) 06/04[2] and subsequently updated by HSS(PPM) 5/05[3]. These circulars required HPSS organisations, and family practitioners services (via HSS Boards), to report serious adverse incidents (including near misses) to the Department where the HPSS senior manager considered that the incident was likely to:

- Be serious enough to warrant regional action to improve safety or care within the broader HPSS;
- Be of major public concern; and/or
- Require an independent review.

1.3 Objectives of the Serious Adverse Incident Report

The three principle objectives of this Report are;

(i) to encourage an open and learning reporting culture, recognising that lessons need to be shared in order to improve service user and staff safety;

(ii) to provide feedback on high level analysis and themes arising from reported adverse incidents; and

(iii) to feedback high level emerging learning.

1.4 High levels of HPSS Activity

The Report needs to be set in context. During 2004/2005, the HPSS delivered high levels of treatment and care in a variety of settings[4]. For example, there were:

[1] http://www.dhsspsni.gov.uk/reviewpublicadmin
[2] http://www.dhsspsni.gov.uk/hssppm6-04.doc
[3] http://www.dhsspsni.gov.uk/hssppm05-05.doc
[4] Source: DHSSPS

- 1 million accident and emergency (A&E) attendances;
- 28 million prescription items dispensed in the community;
- 2 million out-patient attendances;
- 740,000 in-patient and day cases;
- 176,000 people in contact with Social Services;
- 2,500 looked after children;
- 18,000 children referred to Social Services; and
- 1,500 children on the Child Protection Register.

With complex activity taking place on this scale, it is inevitable that some serious adverse incidents occur.

1.5 Who is this Report for?

This Report has been produced to support learning from serious adverse incidents. It is, therefore, aimed at those who work in or manage the HPSS and at those who have an interest in improving the safety and quality of health and social care services.

1.6 Strategic Context

The Report on serious adverse incidents has to be set in the context of other major developments on quality and safety which have been undertaken locally, which have been informed by national and international developments on quality and safety. These include:

(i) A major focus on clinical and social care governance, including risk management processes within the HPSS and the DHSSPS;

(ii) A statutory Duty of Quality[5] on HSS Boards and Trusts;

(iii) Development of a range of standards, including care standards for regulated services, HPSS quality standards, and a suite of controls assurances, including core standards on governance, risk management and financial management;

[5] See Article 34 of the HPSS (Quality, Improvement and Regulation) (NI) Order 2003 (S.I. 2003/431 (N.I. 9))

(iv) Development of *Safety First*[6] (March 2006), a document which sets out the Department's policy on safety and is accompanied by a comprehensive action plan to promote quality and safety improvements;

(v) An extensive work programme by the NI Clinical and Social Care Governance Support Team[7], the Regional Governance and Risk Management Adviser[8] and the Medicines Governance Team[9] to assist HPSS organisations in sustainable quality improvements; and

(vi) Formation of the Regulation and Quality Improvement Authority[10] (April 2005) which registers and regulates a range of services and reports on the quality of care within the HPSS. This will include, where appropriate, thematic reviews of specific aspects of service provision. As the Regulation and Quality Improvement Authority develops its methodology for the reporting on the quality of care to the public and to the HPSS, this will include an assessment of the organisational systems within HPSS organisations and the investigation of specific serious adverse incidents, e.g. a breast screening programme. Under the Safe and Effective Care theme of the Quality Standards[11], produced by the Department and used by the HPSS and RQIA, HPSS organisations are required to have systems in place to prevent, detect, communicate and learn from adverse incidents and near misses.

In addition to the above, through the Regional Governance and Risk Management Adviser, the Department commissioned guidance on how to classify adverse incidents and risk (March 2006)[12]. This is part of a wider project to develop a regional dataset, codes and reporting forms for the HPSS.

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[6] http://www.dhsspsni.gov.uk/index/publications
[7] http://www.dhsspsni.gov.uk/index/hss/governance/governance-clinical.htm
[8] http://www.dhsspsni.gov.uk/index/hss/governance/governance-adviser.htm
[9] http://www.dhsspsni.gov.uk/pas-governance
[10] http://www.rqia.org.uk/
[11] **Quality Standards for Health and Social Care: supporting good governance and best practice in the HPSS (March 2006)**
http://www.dhsspsni.gov.uk/qpi_quality_standards_for_health__social_care.pdf
[12] **See Circular HSS(MD) 12/06, *How to Classify Adverse Incidents and Risk***
http://www.dhsspsni.gov.uk/ph_how_to_classify_adverse_incidents_and_risk_-_guidance.pdf

All of these developments will enhance systems approaches and culture change, with a view to improving service user outcomes and learning from adverse incidents. It will also facilitate linkage with other reporting systems such as the National Reporting and Learning System[13], designed by the National Patient Safety Agency[14] in England and Wales to encourage anonymised reporting, learn from adverse incidents and develop solutions in order to prevent reoccurrence.

1.7 Changing the Culture

Major strategic policy changes, as identified above, are designed to promote a safety and quality culture. But changing the culture of an organisation requires leadership and commitment at senior management level within an organisation. It also needs the proactive involvement of staff, the public and the media. Both service users and staff need open and fair processes to investigate and determine the cause of an adverse incident. For this to happen means that there are special responsibilities placed on the service users, staff media and the public. A system that does not support an open and fair process is to no-one's advantage in Northern Ireland, as it will not encourage open reporting, communication or learning.

[13] http://www.npsa.nhs.uk/display?contentId=2390
[14] http://www.npsa.nhs.uk/

SECTION 2: Frequency of reporting, variation and health and social care settings

2.1 Setting the Scene

An adverse incident is an event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation.

This definition represents the current working definition for adverse incidents in the HPSS, as outlined in the *Safety First: A Framework for Sustainable Improvement in the HPSS.* It recognises that not all errors result in harm to service users and/or staff, but some do. Where an incident is prevented, resulting in no harm, this is called a "near miss". This Report, therefore, includes all types of incidents which meet this criterion and those contained in circular (PPM 06/04).

It should be noted that:

- adverse incidents arise in a variety of settings;
- incident reporting systems are but one method that can be used to detect such events;
- when an incident reporting system is used, the success of it depends on individual/teams/organisations promoting its use in the interests of learning and sharing information;
- there are many local and national systems to which HPSS organisations report; and
- the Department's interim SAI system is dependent on the voluntary reporting by HPSS organisations; this "regional incident reporting" tool does not represent a complete picture of all adverse incidents occurring in organisations either in terms of the frequency or the severity of incidents.

In addition to the above, a number of other challenges emerge regarding the interpretation of the data provided by HPSS organisations which a reader of this report needs to keep in mind:-

(i) the reporting system was solely designed to provide feedback on the three criteria (as defined within the departmental circular); therefore, the data cannot be used for comparative purposes with other more comprehensive local, national or international systems;

(ii) the system is not designed to identify, for any specific incident, the degree of harm caused to the individual service user or the level of severity of the reported incident - this is the responsibility of the HPSS organisation to investigate;

(iii) the information supplied by HPSS organisations is usually limited to a one page proforma; therefore, it is not possible to ascertain whether a service user outcome (e.g. a death) was caused by the safety incident - this is the responsibility of the HPSS organisation to determine; and

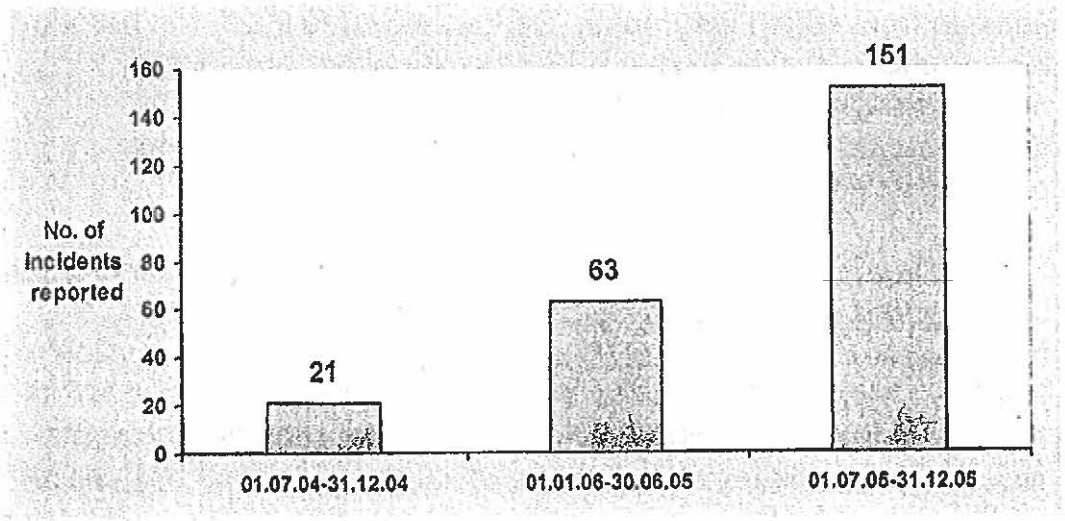
(iv) an organisation which reports many incidents, does not necessarily mean that this organisation is unsafe but rather the converse may be true i.e. the organisation may have achieved more in terms of supporting an open and learning culture, thus levels of reporting are higher than other similar organisations. Equally so, an organisation with low levels of reporting could be an unsafe organisation, as it may not support an open reporting and learning culture.

Within the identified constraints of the system, the following information on the frequency and variation of reporting of adverse incidents is supplied to promote discussion at local level on whether each HPSS organisation supports an open reporting and learning culture and whether individual organisations are assured that staff have knowledge of existing reporting pathways.

2.2 Frequency of reporting

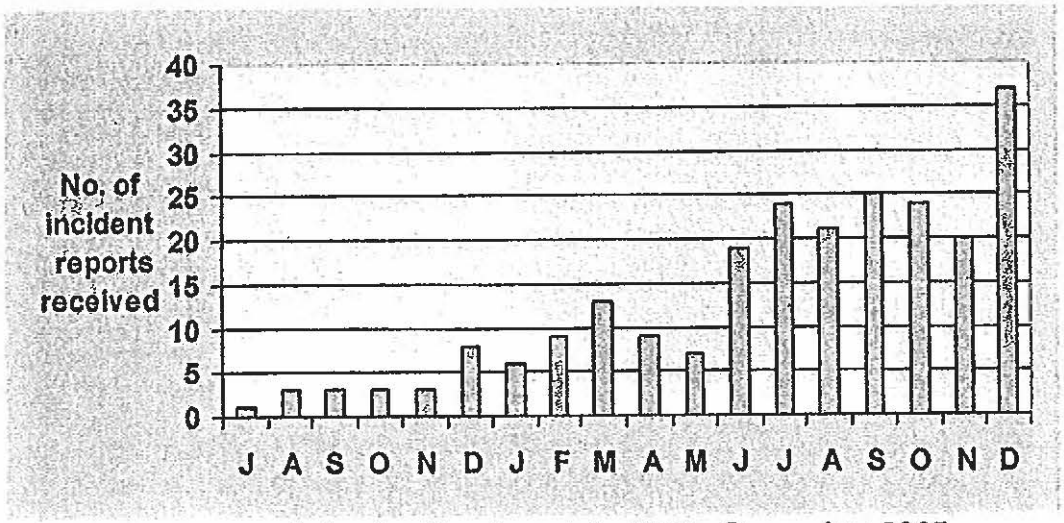
Between 1 July 2004 and 31 December 2005, there were a total of 235 incidents reported to the Department. Figure 1 shows a rise of incident reports to the Department, with the largest number being reported between July and December 2005 (151). This suggests an increasing willingness by HPSS organisations and family practitioner services to report SAIs which have occurred and share learning on a regional basis, where appropriate.

Figure 1: Serious Adverse Incidents (SAIs)
1st July 2004 to 31st December 2005



The growing participation and willingness to report SAIs is further illustrated when analysis is undertaken on monthly basis (Figure 2).

Figure 2: Frequency of Reporting By Month

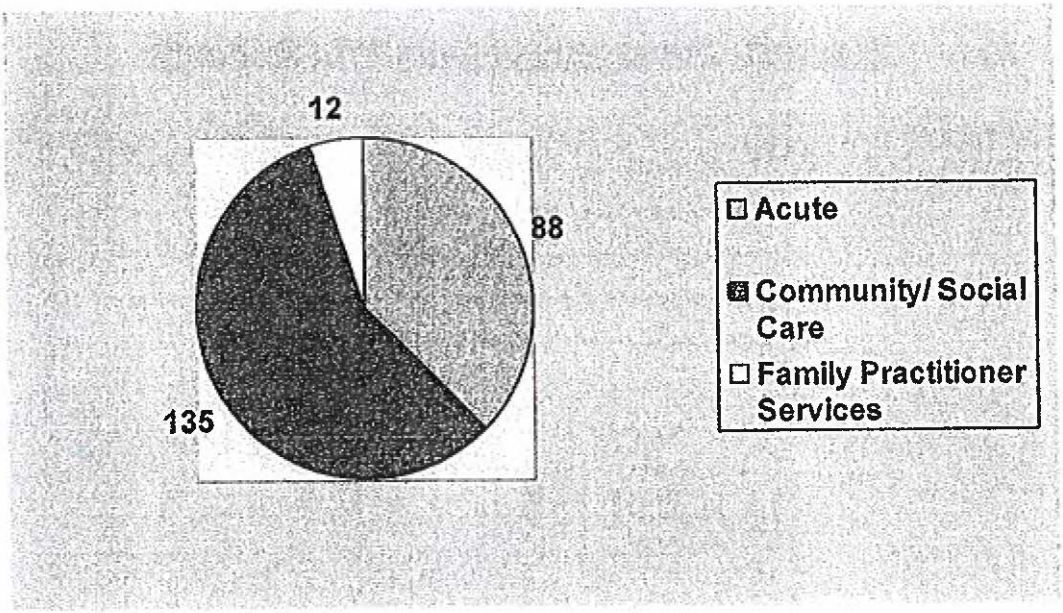


2.3 Reporting from HPSS Health and Social Care Settings

There is a significant variation in the type of reporting and the settings from which they arise. Serious adverse incidents reported include those arising from HPSS services either provided or commissioned. The incidents can be broken down into the following settings – acute, community/social care and family practitioner services.

The settings from which adverse incidents arise may be different to those recorded on other reporting systems; this is, in part, due to the integrated nature of health and social care service provision in Northern Ireland. This profile of service provision is different from the rest of the NHS. For example, the majority of NHS incidents reported to the National Patient Safety Agency[15] arose from acute healthcare settings.

Figure 3: Settings From Which Reported Adverse Incidents Arose (n = 235)



The majority of incidents come from community and social care settings, with relatively few arising from family practitioner services - i.e. GP, community pharmacy, dental and optometry services. In

[15] See the Patient Observatory Report *Building a memory: preventing harm, reducing risks and improving patient safety* (July 2005) http://www.npsa.nhs.uk/site/media/documents/1280_PSO_Report.pdf

addition, more from the acute hospital sector might have been expected.

For acute and/or community HSS Trusts, all trusts reported some adverse incidents, the range being 3 - 55 per Trust, within the specified time period. Figure 4 sets out the origin of the reporting organisations. No firm conclusion can be drawn regarding the quality of care provided by any one HSS Trust. This is because:

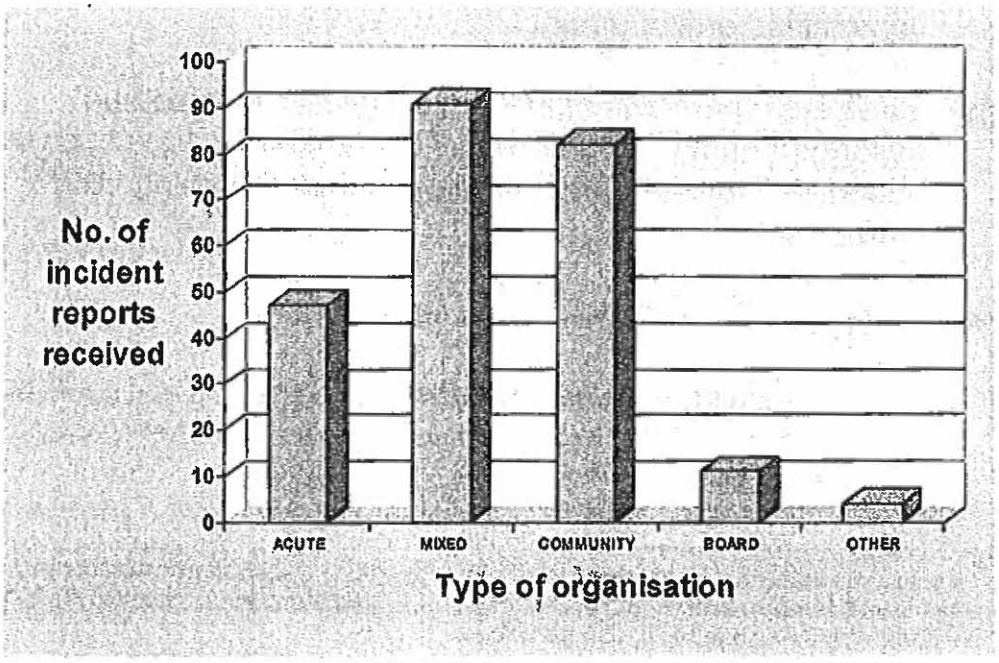
- Not all SAIs may have been captured at local level;
- Not all SAIs, within the remit of circular HSS (PPM) 06/04, may have been reported to the Department.

In addition, the following factors may have a bearing on the quality of care or reporting:

- The profile of care provided by HSS Trusts varies;
- The extent of population coverage varies; and
- There is likely to be underreporting by some Trusts, especially some acute trusts.

In light of this it would render comparisons inappropriate at this time.

Figure 4: Type of Organisation Reporting



SECTION 3: Summary of findings and high level learning

3.1 Summary of Issues Reported

Of the 235 reported incidents, the following represents an overview of the type of issue that was reported to the Department between July 2004 and end December 2005.

(i) Almost one-third of incidents reported involved the death of a person. It should be noted, however, that an SAI report, which documented a death, does not necessarily imply that the circumstances relating to the adverse incident contributed to the cause of the death.

(ii) Nearly two-thirds of these deaths were suspected suicides[16]. Almost all of these, involved people in recent contact with mental health services. There were also a small number of attempted suicides reported; the majority of these people were also in recent contact with mental health services.

(iii) Almost one-fifth of incidents reported involved people who are or had been in receipt of children's services. The majority of these reports related to children absent without leave from residential care or incidents where children in receipt of services either perpetuated a crime or had a crime committed against them.

(iv) Just over one-tenth of incidents reported involved an alleged[17] crime. These covered a range of issues such as homicide, assault, theft, arson and impersonating HPSS staff.

(v) Between 5% and 10% of incidents reported:

a. involved violence against HPSS staff. These events ranged from verbal aggression and threats to physical assault;

[16] 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.

[17] It is to be noted that criminal investigations will be ongoing on these incidents and allegations may not be proven in all cases

b. involved damage to HPSS/staff property;
c. concerned injuries to people. This covered a range of scenarios such as accidents, assaults, falls and medical equipment malfunction; and
d. contained allegations of professional misconduct, with almost half raising concerns about the competence of locums.

(vi) In 5% of incidents reported there were:

a. references to the possible malfunction of equipment, with just over half relating to decontamination issues; and
b. concerns about procedural errors in the acute sector. These include non-adherence to policies and procedures and delays in carrying out tests or transmitting results to appropriate personnel.

(vii) There were a range of issues which amounted to less than 5% of incidents reported. These include:

a. drawing attention to service pressures and the non-availability of appropriate specialist in-patient beds;
b. involvement of public health related issues e.g. communicable disease; and
c. medication management issues (from primary, social care and secondary care sectors).

SECTION 4: Action and Learning at Regional Level

4.1 Methodology used by the DHSSPS

The regional learning arising from these incidents reported to the Department is multifaceted and, as stated previously, is based on a relatively small amount of information received on each individual serious adverse incident (SAI).

Following receipt of an SAI report, the Department may seek further clarification of the incident from the HPSS organisation, and occasionally may advise the HPSS organisation on the appropriateness of an independent review. It remains the responsibility of the HPSS organisation to ensure that relevant procedures are in place to manage the incident, report it to statutory and/or local/national reporting systems and ensure steps are taken to prevent its reoccurrence at local level.

Under circulars HSS (PPM) 6/04 and 05/05, each case submitted to the Department is shared with relevant policy and professional directorates where comments are sought on the particular circumstances of the incident. These comments are then brought to an internal multidisciplinary review group, chaired by a senior professional officer. The Group considers the submitted proforma and any accompanying policy/professional comments. It then attempts to draw conclusions from the written evidence submitted. This might include whether further action is necessary, especially regional action, to prevent recurrence and to share learning.

The outcome of the discussion might be:

(i) further communication with the relevant HPSS organisation;

(ii) feedback on the particular incident(s) and learning through a workshop(s) organised with HPSS Trusts and Boards;

(iii) referral to a national body for urgent action- e.g. further assessment and investigation by the Northern Ireland Adverse Incident Centre[18](NIAIC) in respect of incidents associated with medical device safety which may be referred

[18] http://www.dhsspsni.gov.uk/niaic

to the Medicines and Healthcare products Regulatory Agency[19];

(iv) commissioning of local guidance e.g. from NI Medicines Governance Team or Clinical Resource Efficiency Support Team[20] (CREST);

(v) cascade of an urgent letter via the chief professional officers or relevant policy directorate and

(vi) increased collaboration with educational providers to enhance understanding of clinical and social care governance and promote the cascade of learning arising from specific incidents.

4.2 Emerging Learning

It is not the intention to drill down into each incident in order to cascade all elements of learning but rather to provide an overview of major areas of risk and learning identified through this process. Many of these categories are linked and often there is more than one contributory factor within a specific incident, thus contributing to the "swiss cheese"[21] effect leading to systems' failure.

In summary, the learning from the incidents reported may be grouped into five main categories. These are:

- Enhanced treatment and care;
- Enhanced professional performance;
- Improved communication procedures;
- Improved human resource policies and procedures; and
- Improved reporting and learning from serious adverse incidents.

4.2.1 Enhanced treatment and care

(i) The need for appropriate assessment and diagnosis of individual patients and service users;

[19] http://www.mhra.gov.uk/home/idcplg?IdcService=SS_GET_PAGE&nodeId=5
[20] http://www.crestni.org.uk/publications/pubsreply.asp
[21] A model of accident causation – Reason, J. *Managing the Risks of Organisational Accidents.* Ashgate. Aldershot 1997

(ii) Appropriate risk assessment of the environment, in which an individual patient/service user is placed, including community care settings, hospital wards or A/E departments;

(iii) Enhanced assessment, diagnosis, monitoring and post-discharge care of individuals who are known to be at risk of self harm or suicide;

(iv) The need for adherence to protocols and guidance e.g. the management of head injuries, blood transfusions;

(v) Enhanced use of clinical monitoring systems to aid detection and deterioration of seriously ill patients, especially in high pressure areas such as A&E departments or busy hospital wards;

(vi) The need for enhanced co-ordination of services for children and vulnerable adults; and

(vii) The need for full adherence to the Department's child protection guidance – *Co-operating to Safeguard Children*[22].

4.2.2 Enhanced professional performance

(i) Enhanced knowledge and care of common conditions (linked to above);

(ii) The recognition that failures of medical devices and medication errors, may often be due to the inherent design of the product or system, but can also be due to individual operator judgement/error; and

(iii) A need for early detection and intervention on professional performance issues arising from conduct, behaviour, lack of skills/ competencies or ill-health of the individual staff member.

4.2.3 Improved communication procedures

(i) The need for improved communication, for example;

[22] http://www.dhsspsni.gov.uk/safeguard_contents.pdf

a. *Written* - good and legible record keeping and notes, and the sharing of clinical notes between professional groups;

b. *Verbal* – good communication between professionals, particularly in aiding detection and deterioration of patients; and

c. *Organisational level* – good communication between organisations/committees e.g. on interhospital transfer or to Area Child Protection Committees/Department.

4.2.4 Improved human resource policies and procedures

(i) The need for tightening of recruitment procedures, checks and appraisal systems, especially in relation to locum doctors, agency staff, and other health and social care staff providing services to individuals in care settings;

(ii) The need for knowledge and implementation of relevant disciplinary procedures within the HPSS organisation or care setting, including suspension of staff where necessary, and use of the National Clinical Assessment Service[23], where the performance of a doctor or dentist gives rise to concern; and

(iii) The need for support services for staff who were subject to verbal or physical abuse.

4.2.5 Improved reporting and learning from serious adverse incidents

(i) The approach to local root cause analysis needs further development and standardisation in HPSS organisations; and

(ii) The system of reporting of SAIs to the Department and subsequent requests to HPSS organisations for more information needs further development. This is necessary to enhance learning from serious adverse incidents and improve communication.

[23] http://www.ncas.npsa.nhs.uk/

SECTION 5: Regional Examples of Learning and Action

Four examples are provided to demonstrate learning which has generated action at regional level. These examples have been selected to show the spectrum of care and environments where incidents arise, such as:

a. clinical care;
b. mental health services;
c. hospital service pressures; and
d. care settings especially for vulnerable adults and/or children.

5.1 Example 1: Clinical Care – Hyperkalaemia and Insulin Administration in Adults

Adverse Incident

It was intended to draw up 10 units of insulin to mix with 50 mls of 50% dextrose. 10 units of insulin was confused with 10 mls and a standard 10 ml syringe was used to draw up a full ampoule of 100 iu/ml into the syringe. The result of this was that the patient received a 1000 units of insulin.

Regional Action and Learning arising from Example 1

1. Insulin syringes must be used to draw up insulin. Appendix B is an example of a Trust poster which could be adapted for local use.
2. *Recommendations on the safe use of Insulin in Secondary Care in Northern Ireland* was developed by the Northern Ireland Medicines Governance Team and circulated by the Department on 22 December 2005.
3. Guidelines for the Treatment of Hyperkalaemia in Adults were developed by CREST in January 2006 and circulated to Trusts. These include the safe administration of insulin and glucose in the treatment of hyperkalaemia.
4. Guidelines on the Safe and Effective use of Insulin in Adults has been developed by CREST in May 2006.
5. CREST will shortly commence development of guidelines on the safe and effective use of Insulin in children, which will be published in early 2007.
6. The Department has convened a group to consider induction training of junior doctors. These will include the recognition that individuals must work within their skills and competencies and seek help, when working outside these limits. In addition, it will emphasise the need for generic induction procedures as well as ward based induction. This guidance will be published in June 2006
7. The Report on the induction programme for junior doctors will be relevant to the induction of other professional groups.

5.2 Example 2: Risk assessment of the environment and provision of emergency care

Adverse Incident

Fall from first floor window requiring on site emergency response.

Risk assessment of the environment, together with the need for care plans, was highlighted in several SAIs, particularly for those patients who were known to be at risk of suicide or self-harm or were confused, due to the nature of their underlying condition. Examples of environmental issues related to falls from windows, plastic pillow covers, anti-vandal smoke detector covers which presented a ligature risk and curtain rails which were all associated with reports covering suicide attempts.

Regional Action and Learning arising from Example 2

1. All HPSS bodies should undertake a regular risk assessment in respect of compliance with guidance and legislation for the built environment and put in place plans to address and/or manage risks. Further information is available on www.dhsspsni.gov.uk/niaic
2. All HPSS bodies should have implemented Professional Estates Letter PEL(03)04: Suicide Risk Associated with Non-Collapsible Curtain Rail Track and other Fixtures http://hea/files/documents/PEL(03)04.doc This PEL was issued as a result of further reports to NIAIC involving fatalities in HSS accommodation and followed on from the guidance contained in Safety Action Notice SAN(NI)98/53 in respect to addressing risks associated with ligature points such as curtain tracks and other fixtures.
3. All Trusts and care establishments should bring to the attention of staff the emergency procedures for the handling of emergencies which happen within their health estate to ensure timely emergency clinical care.
4. A comprehensive suicide prevention strategy called *Protect Life: A Shared Vision, The Northern Ireland Suicide Prevention Strategy and Action Plan* has been issued (March 2006).
5. The NI Clinical and Social Care Governance Support Team, as part of its education programme for 2006/7, will be focussing on improving mental health services.
6. The Department will set up a regional group which will assist the HPSS to take forward improvements in the risk assessment and management processes in mental health services

5.3 EXAMPLE 3: Hospital Service Pressures increasing the risk of an adverse incident

Adverse Incident

Due to pressure on beds in an A&E department, an elderly patient with a complex medical history, was nursed in a bed in the trauma corridor of an A&E department, out of sight of the nursing station. The patient suffered a fall sustaining a head injury.

This particular incident reflects the complexity of human, environmental and service pressures which have the potential to adversely impact on care. In difficult circumstances, staff continue to try and deliver high quality care, but such pressures add to the likelihood of adverse incidents occurring.

Regional Action and Learning arising from Example 3

1. A comprehensive regional reform programme to address hospital access issues is underway. As part of this programme waiting times in A&E will be addressed, supported by robust monitoring arrangements and reforms to existing systems and processes.
2. A public information campaign is currently underway to promote use of other clinical settings for speedy intervention such as at community pharmacies, and Out of Hours Centres, thus reducing pressures in A&E.
3. The placement of patients in non-designated beds spaces should be discontinued, except in exceptional circumstances. Where it occurs, it should be clearly documented in the notes, together with the risk assessment undertaken.
4. An assessment of risk of falling should be carried out on each patient; where bed rails are used these should be correctly engaged.
5. The staff need to ensure that the patient, in such circumstances, can communicate e.g. through a nurse call system or other method of communication.
6. The monitoring, recording of observations and use of a variety of documentation needs to be improved in A&E departments. All entries in clinical notes must be dated, timed, signed and printed.
7. The Department has asked CREST to review the use of early warning scoring systems to improve the early recognition of life threatening events. Such systems could be adapted for use in ward and A&E settings.
8. Head injury guidelines were produced by the Department in 2001; all Trusts should facilitate implementation of these guidelines.

5.4 EXAMPLE 4: Children Absconding from Residential Care

Adverse Incident

A number of SAI reports were received regarding children absconding from residential care. (In some instances the SAI reports received did not actually meet the criteria for reporting to the Department as set out in circulars HSS(PPM) 06/04 and 05/05).

However, the absconding issue reflects the complexity of the high level needs presented by some children in residential care settings.

Regional Action and Learning arising from Example 4

1. The Department recently submitted a proposal to the four HSS Boards to develop greater stability in relation to residential child care. This involves the introduction of Restorative Practices* in all Children's Homes after successful experience in the pilot at Glenmona Regional Centre. Recent research re-emphasises the importance of checking with a child on their return whether sexual abuse was a trigger in their absconding behaviour.

2. The HSS Boards' Fostering Strategy (draft August 2005) will increase the number of foster carers which will provide greater capacity in the looked after system and greater opportunity for more stable placement of children in need.

3. The increase in Intensive Residential Support Units being taken forward via *Children Matter Task Force* will expand the provision to handle those children with higher level needs.

4. The issue of the Department's revised circular HSS (PPM) 02/06 has provided greater clarity regarding notification to the Department when a child is missing from a children's home.

5. The Department has completed draft guidance on the Children's Homes Regulations (NI) 2005 which will further clarify the reporting of such incidents.

6. The issue of reporting incidents about children absconding and possible action will be discussed at the next Chief Inspector, Social Services Inspectorate's meeting with the Directors of the four HSS Boards in June 2006.

* Restorative practices seek to repair damaged relationships and specifically in the case of Looked after Children, prevent them becoming criminalised for acting out behaviours. This should occur preferably at a low level during daily one to one contacts, interpersonal contact, group contacts, but also in relation to serious incidents that cause harm.

Section 6: The Way Forward

Considerable numbers of serious adverse incidents have been reported to the Department through the SAI system. The Department commends those HPSS organisations and family practitioners services which are willing to promote adverse incident reporting and a culture of learning. Over the coming months, the Department will be working with the HPSS to further enhance incident reporting systems.

6.1 Sharing the Learning

A further workshop will be held in June 2006 to promote learning arising from these incidents, and to consider how best to move forward with the process of shared learning.

Subject to Ministerial approval, the Department aims to enter into a formal agreement with the National Patient Safety Agency (NPSA). This will include links to the NPSA's National Reporting and Learning System (NRLS). Once all organisations, including family practitioner services, are part of the NRLS, the Department will review the need for the local reporting of serious adverse incidents under existing arrangements. Meanwhile, in March 2006, the Department issued further guidance which takes account of the experiences of the first 18 months of reporting to the Department. The March 2006 guidance includes a revised proforma[24] which the Department considers will lead to an improvement in the information reported to it.

6.2 The role of RQIA

The Regulation and Quality Improvement Authority (RQIA) will have a pivotal role in reporting on the quality and safety of care both to the public and to the Department. This will focus, not just on HPSS systems, but will also look at health and social care outcomes. It will use the content of the Quality Standards as part of their overall assessment. This includes an emphasis on five themes:

- Corporate leadership and Accountability of Organisations
- Safe and Effective Care;
- Accessible, Flexible and Responsive Services;

[24] http://www.dhsspsni.gov.uk/gpi_unit_sai_reporting_template.doc

- Promoting, Protecting and Improving Health and Social Wellbeing; and
- Effective Communication and Information.

6.3 HPSS Re-organisation

In light of the Review of Public Administration, both the Department and the service are facing unprecedented change. However, it is vital that during the transition period, continued progress is made to improve service quality and learn from serious adverse incidents. In the future, new structures, legislation and ways of working offer the HPSS and the Department an opportunity to further promote and integrate quality and safety into everyday practice.

Acknowledgement

This Report has been made possible by the commitment of staff and senior management, within HPSS organisations and family practitioner services, to report and learn from serious adverse incidents. The Department also acknowledges the role played by the Planning and Performance Management Directorate, other policy directorates and professional advisers, in promoting, collating and learning from the serious adverse incidents.

APPENDIX A

Proforma for submission of serious adverse incidents (SAIs) to the Department from July 2004 (this pro-forma is revised with effect from March 2006)

SERIOUS ADVERSE INCIDENT REPORT
1. Organisation:
2. Brief summary (and date) of incident:
3. Why incident considered serious:
4. Action taken:
5. Is any regional action recommended? (if so, full details should be submitted) Y/N -
6. Is an Independent Review being considered? (if so, full details should be submitted) Y/N -
7. Other Organisations informed **PSNI** Y/N - **Coroner** Y/N - **NIHSE** Y/N - **HSS Board** Y/N - **Other** (please specify) Y/N -
8. Report submitted by (name and contact details of nominated senior manager or Chief Executive)

Completed proforma should be sent, by email, to:

adverse.incidents [redacted]

If e-mail cannot be used, fax to [redacted]

APPENDIX B

Insulin Safety Information

The dose of insulin must always be specified in units when writing prescriptions

Multi-dose vials of insulin are prescribed as third vials

Once opened, the multi-dose vials are stored at room temperature in the pharmaceutical fridge for up to 4 weeks. Contact Medicines Information for further details. Date each vial when opened and discard after the specified time

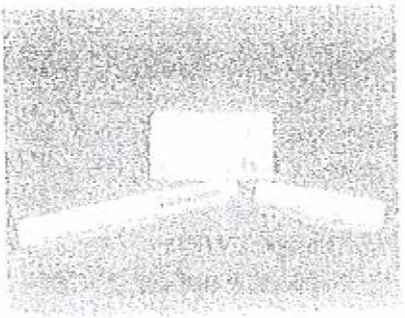
use an insulin syringe to draw up any dose of insulin from a vial.

Second check

A second check must be performed during both preparation and administration of subcutaneous, intramuscular and intravenous insulin must be involved, one of whom must be a registered nurse.

Pens and cartridges

- If a pen is in use for a named patient it should be stored at room temperature in a locked medicine trolley or FGD locker (as appropriate) with a name addressograph attached. Do not store in the pharmaceutical fridge
- The majority of pens can be stored at room temperature for up to 28 days. Contact Medicines Information for further details
- All unopened cartridges and pens should be stored in the pharmaceutical fridge



Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

SUPPORTING SAFER SERVICES

ANALYSIS OF SERIOUS ADVERSE INCIDENTS RECEIVED BETWEEN 1 JANUARY 2006 AND 31 MARCH 2007

(Circulars HSS(PPM) 06/04, 05/05 and 02/06)

DECEMBER 2007

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Foreword

All new HSC organisations have high aspirations for the future; to provide the highest quality of treatment and care and to improve the health and wellbeing of the local community.

The concept of safety first is an integral part of that high quality of care. To promote safety within an organisation requires the commitment of leaders, senior managers, teams and individuals.

This Report covers serious adverse incidents (SAIs) reported to the Department between January 2006 and March 2007. It is being presented to HSC organisations in the interests of promoting safety and learning, so that HSC leaders, educators, teams and individuals can share experiences, learn and use adverse incident reporting as a mechanism to improve organisational performance. This Report, therefore, is about using key adverse incident scenarios to drive improvement in health and social care. In doing so, it is recognised that in any organisation the principles should be "what has happened" and "how can we improve" rather than "who made the error".

A total of 309 SAIs were received in the reporting period. The main categories reported relate to:

Suspected suicides;
Children's services;
Service pressures;
Professional performance;
Medicines management;
Security management;
Public health; and
Violence against staff.

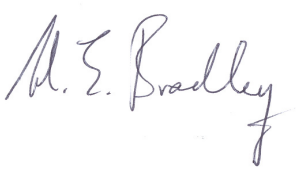
Since commencement of the SAI system in July 2004, the total number of SAIs reported is increasing. This does not mean that care has deteriorated but rather it suggests a willingness of individuals to report and a recognition that such systems-approaches are part of risk management and performance improvement.

The Report contains a number of topic specific sections including, record keeping & documentation; medicines management; communication; mental health issues; clinical treatment & care; recruitment & training; and children's services to highlight learning and to link it with recent guidance and policy documents on related topics. The appendix contains other sources of mainly local information which aims to act as an additional resource for HSC organisations, family practitioners and educators.

Regardless of changes that may occur due to the reorganisation of HSC bodies, the Department is committed to driving forward the agenda on safety and quality improvement. Key elements of this will be an emphasis on:

- performance improvement through effective commissioning and delivery of care;
- promoting leadership, with ownership of safety and quality throughout an organisation;
- development of key performance indicators and service frameworks to drive improvement;
- integration of reporting systems and implementation of specific safety solutions;
- promotion of collaborative approaches to learning through facilitation and support via the newly formed Safety Forum, and the reprioritisation of the Clinical & Social Care Governance Support Team work programme;
- incremental change through "improvement science" techniques, building on local, national and international interventions that are known to save lives;
- recognising the importance of professional engagement through leadership programmes; and
- understanding the pivotal place that patients, clients, families and carers can play in their own health and well-being.

The Department aims to promote this agenda throughout 2007/08 and beyond. Part of this will be re-organisation of the SAI system and the more timely cascade of regional learning arising from adverse incidents.



Martin Bradley
Chief Nursing Officer
Chair SAI Review Group

Maura Briscoe
Director, Safety, Quality and Standards

SECTION 1

OBJECTIVES OF THE DHSSPS SERIOUS ADVERSE INCIDENTS (SAIs) INTERIM REPORTING SYSTEM

1.1 Introduction

Health and Social Care is not risk free, so we must ensure that risks are identified and managed by changing the culture, and by enhancing systems and working practices to prevent or reduce the risk of injury or harm to patients, clients and staff.

That is why it is important to identify and learn from all adverse events and make improvements in practice, based on local and national experience and learning derived from the analysis of such events.

This is the second annual report on the learning arising from those serious adverse incidents (SAIs) notified to the Department of Health, Social Services and Public Safety (DHSSPS). The report covers the period January 2006 to March 2007 during which a total of 309 incidents were reported.

1.2 Criteria for reporting Serious Adverse Incidents to the DHSSPS

A serious adverse incident including a near miss is defined as those situations where the consequences are likely to:

- be serious enough to warrant regional action to improve safety or care within the broader Health and Social Care system;
- be of major public concern; and/or
- require an independent review.

The reporting criteria for the period 06/07 was outlined in circulars HSS(PPM) 06/04[1], 5/05[2] and 02/06[3]. This requires HSC organisations, and family practitioners services (via HSS Boards) to report serious adverse incidents to the Department.

[1] http://www.dhsspsni.gov.uk/hssppm6-04.doc
[2] http://www.dhsspsni.gov.uk/hssppm05-05.doc
[3] http://www.dhsspsni.gov.uk/qpi_adverse_incidents_circular.pdf

1.3 Management of SAIs within the Department

Each month the Department's Serious Adverse Incident Review Group meets under the Chairmanship of the Chief Nursing Officer. The Group's membership is drawn from social services, mental health, child care and secondary care, and since March 2007 – as a pilot exercise - has representation from each of the four HSS Boards.

Upon receipt in the Department each SAI is logged and views sought from the relevant professional leads and policy directorates, as required. This may result in further clarification being sought from the Trust. When all information has been obtained the case is considered by the SAI Review Group, regional learning, if any, is identified and in certain cases referral is made to the relevant policy or professional lead with a view to the issue of a professional letter, policy, guidance or NIAC alert to the service.

1.4 Identification of Regional Learning

The objectives of the SAI reporting system are to encourage an open and learning reporting culture, acknowledging that lessons need to be shared in order to improve service user and staff safety and apply best practice in assessing and managing risks. It also aims to provide feedback on high level analysis and themes arising from reported incidents and ensure that the service is alerted to emerging learning.

Out of the SAIs considered in this reporting period six main learning themes emerge and are reported on more fully in the body of the report. The themes are:

- Record keeping and documentation;
- Medicines management;
- Communication;
- Mental health issues;
- Clinical treatment and care; and
- Recruitment and training.

1.5 Levels of HSC Activity

While there were 309 reported SAIs, this needs to be set in the context of overall HSC activity. During 2005/2006, the HSC delivered levels of treatment and care in a variety of settings[4]. For example, these were:

- 700,000 accident and emergency (A&E) attendances;
- 29 million prescription items dispensed in the community;
- 1.5 million out-patient attendances;

[4] Source: DHSSPS

- 500,000 in-patient and day cases;
- 181,000 people in contact with Social Services;
- 2,400 looked after children;
- 19,000 children referred to Social Services; and
- 1,600 children on the Child Protection Register.

With complex activity taking place on this scale, it is inevitable that some serious adverse incidents occur.

1.6 Strategic Context

Since the statutory duty of quality was placed on HSS Boards and HSC Trusts in 2003, there have been significant national and local developments on quality and safety. During 2006/07, the Regulation & Quality Improvement Authority (RQIA) commenced its governance reviews based on two themes of the *Quality Standards in Health and Social Care*[5] - Corporate Leadership & Accountability and Safe & Effective Care. The annual compliance exercise against controls assurance standards is now in its fourth year. Work on the Safety First Action Plan[6] is substantially completed and it will be reviewed later in the year. Completed actions include the development of Safe & Effective key performance indicators which will assist HSC organisations in driving forward quality improvement.

A HSC Safety Forum has been established to keep pace with international and national developments on patient safety. Its work includes providing support to Trusts as they implement evidence-based patient safety interventions which demonstrate improved outcomes for patients and reduce harm. During this reporting period, HSS Boards have established SAI handling procedures in their respective areas. This helps inform Boards with regard to meeting the statutory duty of quality on the services they commission and also assists in strengthening accountability with Trusts on statutory and delegated functions. The Boards also have protocols in place with family practitioner services for the reporting of adverse events and for onward transmission to the Department by the area Board of those events which meet the SAI reporting criteria.

1.7 Conclusion

This report has been produced to support learning from serious adverse incidents. It is aimed at those who work in or manage health and social care and at those who have an interest in improving the safety and quality of care.

Safe and effective practice remains the top priority for health and social care in Northern Ireland. The public have a right to expect that every effort will be

[5] http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-standards/spsd-standards-quality-standards.htm
[6] http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-safety/sqsd_safety_safety_first.htm

made to ensure that their care and treatment will be in accordance with best practice and any risks minimised.

This report will be accompanied by a workshop to cascade learning and to discuss with HSC staff how the SAI reporting system might be improved.

SECTION 2

FREQUENCY OF REPORTING; VARIATION; HEALTH & SOCIAL CARE SETTINGS; AND SUMMARY OF ISSUES REPORTED

2.1 Setting the Scene

An adverse incident is "***any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation***".

This definition represents the current working definition for adverse incidents in HSC organisations, as outlined in the *Safety First: A Framework for Sustainable Improvement in the HPSS.* It recognises that not all errors result in harm to service users and/or staff, but some do. Where an incident is prevented, resulting in no harm this is called a "near miss". This report contains a subsection of all adverse incidents – ie. which are classified as serious adverse incidents and which meet the criteria contained in circulars (PPM) 06/04, 05/05 and 02/06.

It should be noted that:

- Adverse incidents arise in a variety of settings;
- Incident reporting systems are but one method that can be used to detect such events;
- When an incident reporting system is used, the success of it depends on individual/teams/organisations promoting its use in the interests of learning and sharing information;
- There are many local and national systems to which HSC organisations report; and
- The Department's interim SAI system is dependent on the voluntary reporting by HSC organisations; this "regional incident reporting" tool does not represent a complete picture of all adverse incidents occurring in organisations either in terms of the frequency or the severity of incidents.

In addition to the above, a number of other challenges emerge regarding the interpretation of the data provided by HSC organisations which a reader of this report needs to keep in mind:-

(i) the reporting system was solely designed to provide feedback on the three criteria (as defined within the departmental circulars); therefore, the data cannot be used for comparative purposes with other more comprehensive local, national or international systems;

(ii) from April 2006, the system requests the initial classification of the incident (ie. catastrophic, major, moderate, minor, insignificant) in order to assess the degree of harm caused to the individual service user or the level of severity of the reported incident – it remains the responsibility of the HSC organisation to investigate the incident fully;

(iii) the information supplied by HSC organisations is usually limited to a one page proforma; therefore, it is not possible to ascertain whether a service user outcome (e.g. a death) was caused by the safety incident – this is the responsibility of the HSC organisation to determine; and

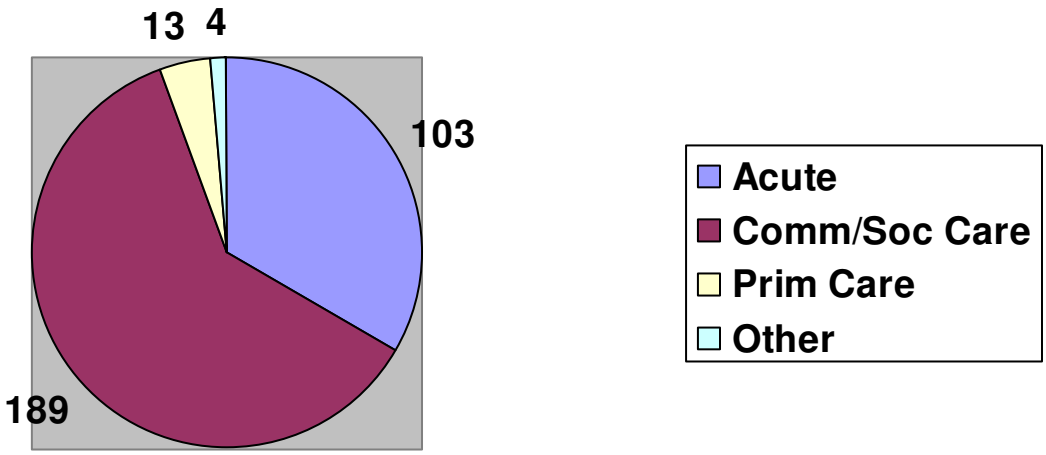
(iv) an organisation which reports many incidents, does not necessarily mean that this organisation is unsafe but rather the converse may be true i.e. the organisation may have achieved more in terms of supporting an open and learning culture, thus levels of reporting are higher than other similar organisations. Equally so, an organisation with low levels of reporting could be an unsafe organisation, as it may not support an open reporting and learning culture.

Within the identified constraints of the system, the following information on the frequency and variation of reporting an adverse incident is supplied to promote discussion at local level on whether each HSC organisation supports an open reporting and learning culture and whether individual organisations are assured that staff have knowledge of existing reporting pathways.

2.2 Reporting from Health and Social Care settings

309* incidents were reported to the Department between 1 January 2006 and 31 March 2007 (*3 incidents were reported twice by different organisations and are therefore only counted once). Due to the integrated nature of health and social care services in Northern Ireland, the settings from which the incidents are recorded are acute, community/social care and family practitioner services.

Figure 1 – Settings from which reported SAIs arose (N=309)

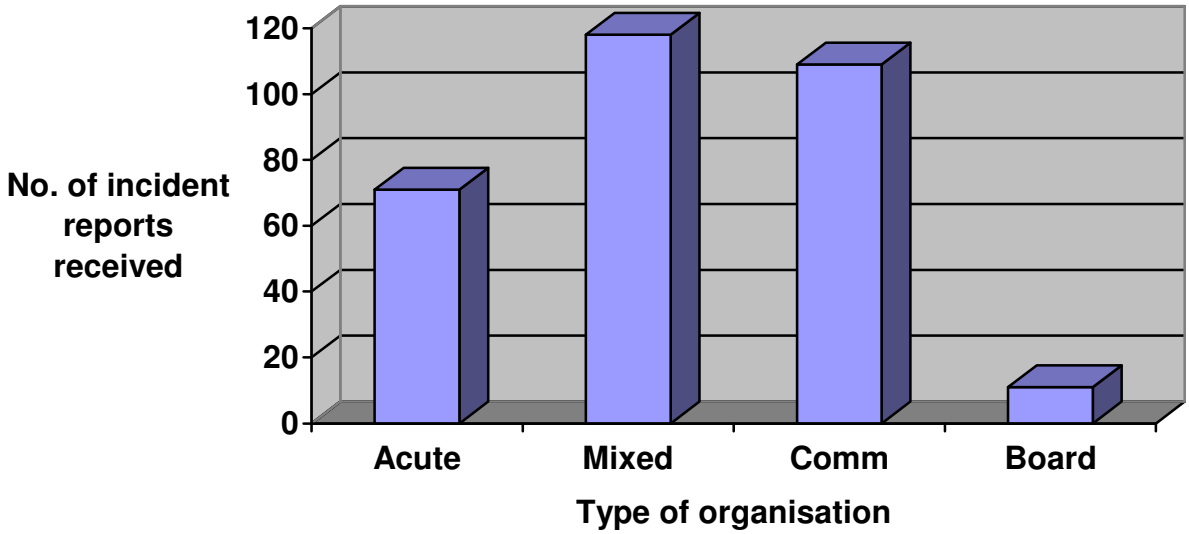


All HSS Boards and HSC Trusts reported at least one SAI. For acute and/or mixed/community Trusts, the range was 1 - 58 per Trust within the specified time period.

Figure 2 sets out the origin for the reporting organisation. Just over 20% of SAIs were reported from an acute trust (almost half of these were from acute mental health services). This would indicate that there continues to be underreporting by acute trusts. In its latest data summary, the National Reporting and Learning System continues to have around 70% of incidents reported from an acute/general hospital setting[7]. However, the 57% overall increase in local SAI reporting suggests an increasing commitment by HSC organisations to report SAIs. This includes an awareness in Family Practitioner Services of the value of reporting adverse incidents.

[7] Quarterly National Reporting and Learning System data summary, Issue 4: October to December 2006 (NPSA, 2007)

Figure 2 – Type of Organisation reporting (January 2006 – March 2007)



No firm conclusion can be drawn regarding the quality of care provided by any one HSC Trust. This is because:

- Not all SAIs may have been captured at local level;
- Not all SAIs, within the remit of circulars HSS (PPM) 06/04, 05/05 and 02/06 may have been reported to the Department.

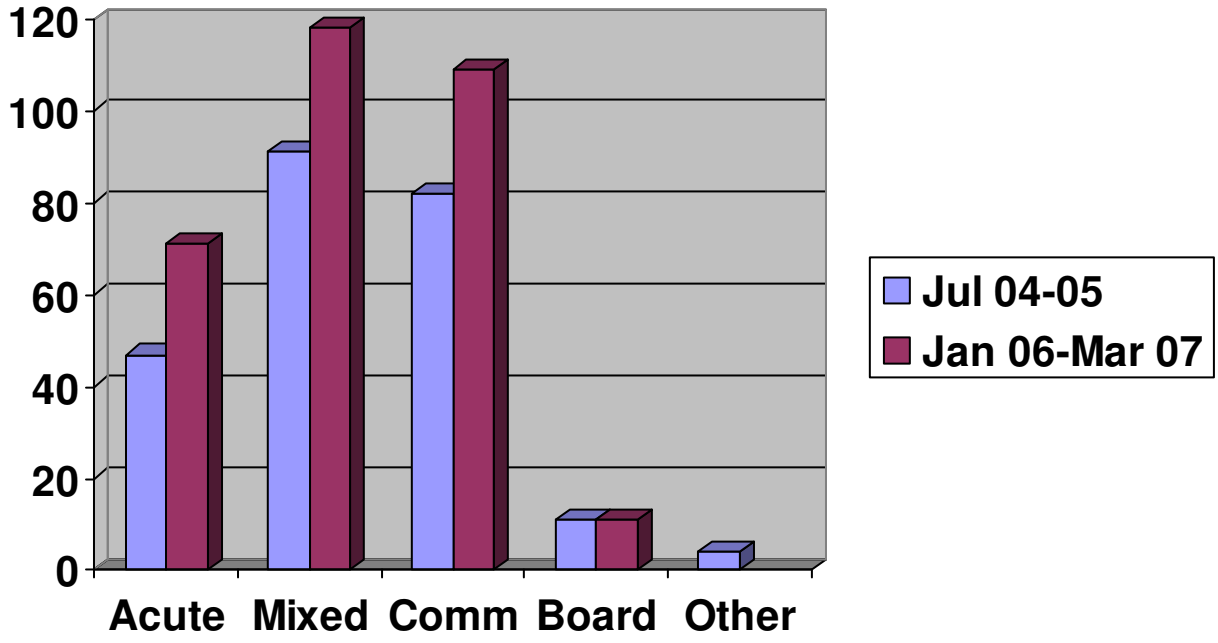
In addition, the following factors may have a bearing on the quality of care or reporting:

- The profile of care provided by HSC Trusts varies;
- The extent of population coverage varies; and
- There is likely to be underreporting by some Trusts, especially some acute trusts.

In light of this it would render comparisons inappropriate at this time.

Figure 3 demonstrates that the profile of origin of organisation reporting has not altered significantly during this period.

Figure 3 – Comparison of Types of Organisation reporting SAIs between July 2004-December 2005 and January 2006-March 2007



2.3 Summary of Issues Reported

Of the 309 reported incidents, the following represents an overview of the type of issue that was reported to the Department between January 2006 and March 2007.

- Almost one-third involved the death of a person. It should be noted, however, that an SAI report, which documented a death, does not necessarily imply that the circumstances relating to the adverse incident contributed to the cause of death.

- Just over two-thirds of these deaths were suspected suicides[8], involving people in recent contact with HSC services.

- Almost one-fifth involved people who are or had been in receipt of children's services. The majority relate to children absent without leave from residential care or incidents where children in receipt of services either perpetuated a crime or had a crime committed against them.

- Between 5% and 10% of incidents reported:

[8] In the absence of knowledge of an inquest verdict, these cases have been classified as "suspected suicides" regardless of the circumstances in which the individual was reported to have been found.

- involved service pressure issues, mainly around the non-availability of appropriate specialist child & adolescent mental health services; and
- addressed professional performance issues.

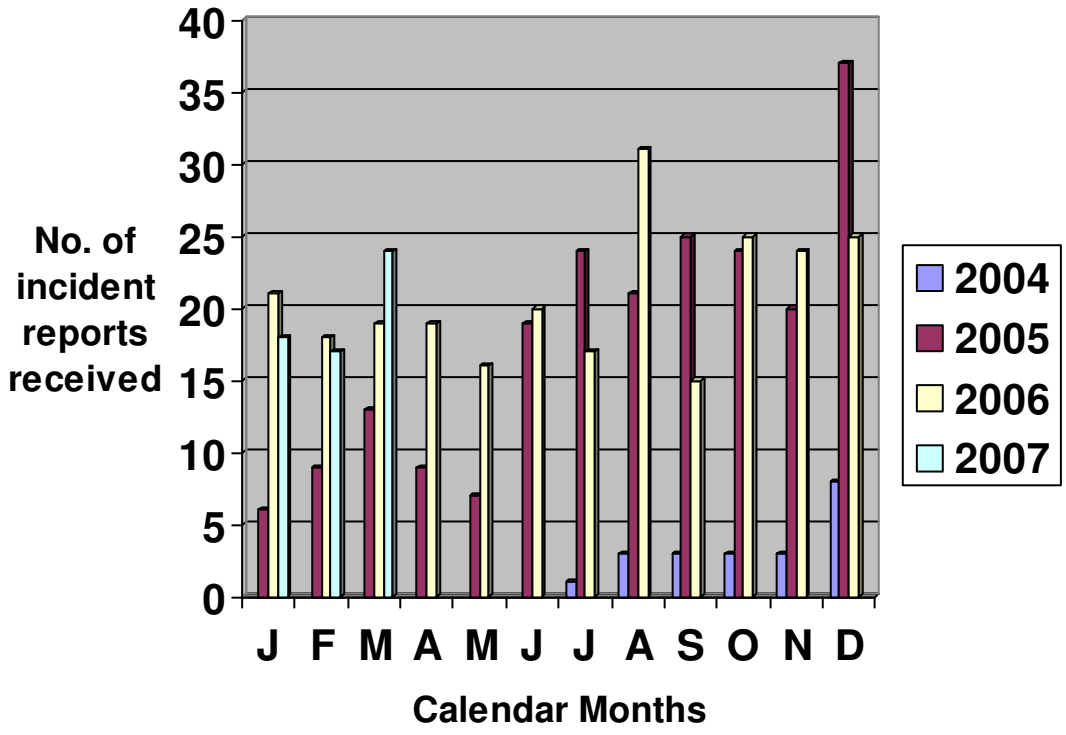
- There were a range of issues which amounted to less than 5% of incidents reported. These include:

  - Medication management issues (from primary, social care and secondary care);
  - Involvement of public health related issues eg. communicable disease;
  - Security management issues, including theft from, and threats against, HSC properties;
  - Violence against HSC staff, ranging from verbal aggression and threats to physical assault; and
  - Concerns about procedural errors in the acute sector, including non-adherence to policies and procedures.

2.4 Frequency of Reporting

Between 1 January 2006 and March 2007, there was a total of 309 incidents reported to the Department. Figure 5 shows that there has been a consistent volume of reports received during the 15 months period.

Figure 5 – Frequency of Reporting by Month (July 2004 – March 2007)



SECTION 3

RECORD KEEPING AND DOCUMENTATION

3.1 Record keeping and documentation is an integral part of good professional practice and helps to protect patients/clients from injury or harm by promoting:

- high standards of care;
- continuity of care;
- better communication and dissemination of information between members of the inter disciplinary teams;
- an accurate account of treatment and care planning and delivery;
- the ability to identify risks and detect problems such as changes in the patient/client condition.

Relevant related guidance is documented at paragraph 3.3 and in the Appendix.

Learning arising

3.2 Issues identified by HSC organisations for ***learning*** that have arisen in this SAI reporting period include:

Clinical records:

- All details in patient's/client's notes (including test results) must be dated, timed, signed and printed before filing.
- All records belonging to patients should have full demographic details
- Where patients are receiving treatment from several specialities it should remain clear and recorded in the notes who is responsible for which aspect of management.
- The format of patient's/client's and other notes should be uniform, consistent and, where possible, combined into one set of patient's/client's notes.
- All clinical contacts with the patient should be documented in the records (including those contacts by telephone).
- All appointments made/referrals should be dated and recorded in records.

Mental Health:

- When assessing a mental health patient, the first assessment should be documented fully and where criteria for detained admission are not met the reasons for this assessment should be written in full.
- A comprehensive social history should be contained in the case file.
- The need for formalised multi-disciplinary care plans to be a formal integral part of care planning, particularly in complex mental health cases. The management of these patients can require the input of a wide range of health and social care professionals and carers. The specific inputs and accountabilities should be clearly identified and documented in the care plan; including the individual professional who is taking the lead in the management of care.

Laboratory results:

- Systems should be in place to ensure a clear and permanent record is kept of results received; date and time received; who received them; to whom they have been communicated; and what action by a named individual has been taken on basis of results.

Early warning systems:

- Observation charts should be standardised across the organisation and incorporate an 'early warning system' score. All staff should be trained in the proper use and completion of observation and fluid balance charts.

Voluntary sector:

It is important to have appropriate communication and reporting systems in relation to supply of information between Trusts and voluntary sector organisations which provide services, with special emphasis on admissions and readmissions, in relation to respite clients. The Trust should ensure that case reviews have representation from the service users' respite provider, where applicable, and minutes issued to the provider.

Last Office Procedures

- Identity bracelets, even if soiled, should not be removed from bodies. If Last Office procedures include fixing identification bracelets these should be in addition to those already being worn by the patient during life.
- The details on the notification of death form should be checked against the identify bracelet both on admission to the mortuary and prior to release to an Undertaker.
- In a situation where more than one body is being dealt with, preparation of the body, including the administrative preparation at the patient's bedside, should be completed on one body before moving to the next body.

3.3 Related guidance:

- Inter-hospital transfer of patients and their records (CREST, August 2006).
- Use of physiological Early Warning Systems (CREST, May 2007)
- Good Management, Good Records (DHSSPS, December 2004)

Summary

3.4 There are a number of factors that contribute to effective record keeping. Patient/client records should:

- be factual, consistent and accurate, recorded in a way that the meaning is clear;
- be recorded as soon as possible after an event has occurred, providing current information on the care and condition of the patient/client;
- be recorded clearly and in such a manner that the text cannot be erased or deleted without a record of change;
- be recorded in such a manner that any justifiable alterations or additions are dated, timed and signed or clearly attributed to a named person in an identifiable role in such a way that the original entry can still be read clearly;

- be accurately dated, timed and signed, with the signature printed alongside the first entry where this is a written record, and attributed to a named person in an identifiable role for electronic records;

- not include abbreviations, jargon, meaningless phrases, irrelevant speculation, offensive or subjective statements;

- be readable when photocopied or scanned.

3.5 Members of the public expect that health and social care professionals will practice high standards of record keeping. Good record keeping is a mark of a skilled and safe practitioner.

3.6 Systems should be in place to ensure that the standard of record keeping and documentation is kept under continuous review.

SECTION 4

MEDICINES MANAGEMENT

4.1 The prescribing, supply and administration of medicines are important aspects of clinical practice.

4.2 Several errors in relation to the administration of medicines were reported as SAIs in 2006/07.

4.3 Good practice indicates that where there are medication-related adverse incidents a pharmacist should be included as part of the investigation team.

Relevant related guidance is documented at paragraph 4.5 and in the Appendix.

Learning arising

4.4 Issues identified by HSC organisations for ***learning*** that have arisen in this SAI reporting period include:

- There is a need for vigilance when dispensing "seldom used drugs". When these are entered onto computer systems they can sometimes move to default settings of more frequently used drugs. To avoid dispensing the incorrect medicine, items should be carefully read and checked against the prescription issued for signature and be aware of similarly named drugs.
- Pharmacists in community pharmacies should bring to the prescriber's attention any medication the identification of which they are not sure about or any dosage which appears inappropriate.
- GPs should be aware that computerised systems, whilst improving safety of prescribing, also introduce new risks such as 'picking' errors with similarly spelt and sounding medicines and should be vigilant against errors.
- All doctors working in Out of Hours services should be aware of the ready availability of pre-filled cardiac medicines to obviate the need for a doctor to prepare medication in an emergency situation.
- Where shortages exist in certain medicines (eg. diamorphine), to

consider having usage/warnings provided regarding alternative strengths of preparation and to have in place procedures for reading labels and dose calculation.

- To ensure that there is clear communication of the medicine dosage to the patient and that any risks associated with the medicine are understood by the patient.
- Registered homes should have a recent photograph of residents placed on each medication kardex to enable clear identification when staff are administering medication. Agency staff should be accompanied by regular staff for purposes of identification/verification of medication.
- Use of Insulin – the storage and labelling of insulin vials and syringes should be accompanied by appropriate signage. Induction training in the use of insulin should be available for junior clinicians. Two qualified members of staff should check all medication for parenteral administration.
- When using a syringe pump, it is important to have regular volume checks where patient controlled analgesia is being used and proper recording of these checks.
- To be aware of differing strength of opiod patches.
- To raise awareness among mental health professionals of the physical side-effects of psychotropic medication and in particular the cardiac side-effects
- To consider bespoke training for A&E staff on risk assessing and providing appropriate care for patients presenting with mental health needs
- The Clinical Pharmacy Standard for medication history taking should be adopted as a working model for charting what medication a patient is currently taking/used, either prescribed or bought .
- Patient referral letters should contain a clearly delineated ‘Medication’ section specifying,

- All current medication, and
- Any recommended medication changes.

4.5 Related guidance

- CPh2/03 - Guidance on the prescribing and supply of Warfarin Therapy (DHSSPS, April 2003)
- CPh1/04 – Use and controls of Medicines (DHSSPS, May 2004)
- HSS (MD) 46/04 – supply of diamorphine injection (DHSSPS, December 2004)
- HSS (MD) 06/05 – withdrawal of Co-Proxamol Products and Interim Updated Prescribing Information (DHSSPS, January 2005)
- Recommendations to improve the safe use of insulin in secondary care (DHSSPS, December 2005)
- Guidelines on Cyclosporin (Regional Group of Specialist Medicines, 2004, Rev 2006)
- Guidelines for the treatment of hyperkalaemia in adults (CREST, January 2006)
- CPh 2/06 - Regional Kardex Template (June, 2006)
- HSS (MD) 15/06 – Ensuring Safer Practice with High Dose Ampoules of Diamorphine and Morphine (DHSSPS, July 2006)
- Safe and Effective Use of Insulin in Secondary Care: recommendations for treating Hyperglycaemia in adults (CREST, August 2006).
- Newsletter - Medication Safety Today (NI Medicines Governance Team, February 2007)
- HSS(SQSD) 28/07 - NPSA Safe Medication Alerts (DHSSPS, June 2007)

Summary

4.6 When administering medication against a prescription written manually or electronically by a registered medical practitioner or another authorised prescriber, the prescription should:

- be based, whenever possible, on the patient's/client's informed consent and awareness of purpose of the treatment;
- be clearly written, typed or computer generated and be indelible;
- clearly identify the patient/client for whom the medication is intended;
- record the weight of the patient/client on the prescription sheet where the dosage of medication is related to weight;
- clearly specify the substance to be administered, using its generic or brand name, where appropriate, and its stated form, together with the strength, dosage, timing, frequency of administration, start and finish dates and route of administration;

- be signed and dated by the authorised prescriber;
- not be for a substance to which the patient is known to be allergic or otherwise unable to tolerate (all known allergies should be recorded on Kardex);
- in the case of controlled drugs, specify the dose to be taken, the dosage form, the strength of the preparation and either the total quantity (in both words and figures) of the preparation or the number (in both words and figures) of dosage units. If in an out-patient or community setting, the prescription may be hand-written or computer generated but must be signed by the prescriber, and it must be dated.

4.7 Staff in exercising their professional accountability in the best interests of their patient's/clients must:

- know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications;
- be certain of the identity of the patient/client to whom the medicine is to be administered;
- check that the prescription, or label on medicine dispensed by a pharmacist, is clearly printed and unambiguous;
- have considered the dosage, method of administration, route and timing of the administration in the context of the condition of the patient and co-existing therapies;
- check the expiry date of the medicine to be administered;
- check that the patient/client is not allergic to the medicine before administering it;
- contact the prescriber or another authorised prescriber without delay where contra-indications to the prescribed medicine are discovered, where the patient/client develops a reaction to the medicine, or where assessment of the patient/client indicates the medicine is no longer suitable;
- make a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient/client, ensuring that any written entries and the signature are clear and legible. It is also the individual's responsibility to ensure that a record is made when delegating the task of administering medicine;
- clearly countersign the signature of any student who is being supervised in the administration of medicines.

4.8 Some drug administrations can require complex calculations to ensure that the correct volume or quantity of medication is administered. In these situations it may be necessary for a second registrant to check the calculation in order to minimise the risk of error. The use of calculators to determine the volume or quantity of medication should not act as a substitute for arithmetical knowledge and skill.

SECTION 5

COMMUNICATION

5.1 Good and effective communication is one of the essentials for safe and effective practice. This requires the ability to share with patients and clients information that they want or need to know and to do this in a way that they can understand.

5.2 It is also important that relationships with clients are based on openness, trust and good communication which fosters partnership working with patients to address their needs.

Relevant related guidance is documented at paragraph 5.4 and in the Appendix.

Learning arising

5.3 Issues identified by HSC organisations for ***learning*** that have arisen in this SAI reporting period include:

- A patient's ability to communicate with staff should be addressed by easy access to a nurse call system/hand bell/or other communications system.
- To avoid confusing patients with similar names, Out of Hours services should consider identifying calls by a unique call number and secondly by name. It should be stressed to callers the importance of re-contacting the service if for some reason they do not receive a call back from a GP within a reasonable timeframe (usually no more than one hour).
- Health visitors should explain the programme of visits to parents and details of these should be recorded in the 'Red Book'. All Health and Social Care staff visiting homes should carry identification with them.
- Overseas travellers should be provided with written information on malaria medication, emphasising the need for prophylaxis to be region-specific and highlighting the need for co-ordination of medication according to written instructions.
- Protocols for management of clinical risky situations should be developed, easily accessible in clinical areas, available in suitable formats and included in induction (for example, the treatment of

hyperkalaemia and the use of insulin).

- When mental health patients are being considered for passes from hospital, responsibility lies with staff to ensure they get independent feedback from families and carers regarding any concerns or views prior to and after any period of leave.

Handover Arrangements

- Team members should be aware of challenges facing new team members and they should be encouraged to discuss anxieties or concerns with senior staff. Standard protocols for management of multi-disciplinary handovers should be developed.
- Handover arrangements should be formalised and working practices scrutinised to improve continuity of care by all grades of health and social care staff.

5.4 Related Guidance

- *Continuity of Clinical Care* (Royal College of Physicians, 2003).
- *Maintaining Good Clinical Practice* (Royal College of Physicians, 2004)
- Health Visiting Service in NI (DHSSPS News Release, July 2006)
- HSS(SQSD) 10/07 - Warning to travellers who change their travel plans (DHSSPS, February 2007)
- HSC(SQSD) 29/07 – Guidance on strengthening Personal & Public Involvement in Health and Social Care (DHSSPS, September 2007)

Summary

5.5 Staff need to be sensitive to the content of the communication and the situation, need to adopt approaches to the circumstances and be sensitive to language and cultural differences, using interpreters where appropriate.

5.6 To communicate effectively requires the ability to share with patients and clients the information that they want, in a way that they can understand and be in a position to respond to their questions and keep them informed of the progress of their care.

5.7 Health and Social Care records are also a tool of communication within the team and should contain an accurate account of treatment, care planning and delivery. These should be written wherever practicable with the involvement of the client and completed as soon as possible after the event has occurred.

The record should provide clear evidence of the care planned, the decisions made, the care delivered and the information shared.

SECTION 6

MENTAL HEALTH

6.1 The reporting of SAIs from the mental health field make up 43% of all incidents in the reporting period. Of those incidents involving suspected suicides[9], almost two thirds were male and just under half appear in the 15-34 age group. A further quarter appears in the 45-54 age group. Around one third were in receipt of addiction services for drug and alcohol misuse.

6.2 Figures from UK studies suggest that one in 5 adults have a mental disorder and one in 10 a personality disorder[10] and it is estimated that GPs spend one third of their time on mental health issues.

6.3 Suicide trends over the last 10 years show a 27% increase in Northern Ireland compared to a 9% decrease in the UK overall[11].

6.4 It is also known that mental health service users are vulnerable to a number of potential risks. Often these risks are related to their own behaviour or to the behaviour of other patients, (such as self harm, aggression and violence) and may be linked to their mental illness[12].

Analysis of Serious Adverse Incidents

6.5 Since the introduction of the SAI reporting system in July 2004 a significant number arise in mental health services and the learning from these incidents is categorised under the following headings:

- Assessment and Management of Risk;
- Trust Internal Reviews;
- Suicide and self harm.

6.5.1 Assessment and Management of Risk

An analysis of the SAIs coming from the mental health and learning disability services highlight the following areas in relation to the assessment and management of risk:

- Prompt and proactive follow up following discharge from inpatient care;
- Access to ligature points (showers, windows, etc) in inpatient facilities;
- Management of disengagement from services;

[9] 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
[10] Singleton et al 2001; Meltzer et al 1996
[11] http://www.nisra.gov.uk
[12] With Safety in Mind: patient safety in mental health services (NPSA, July 2006)

- Management of alcohol misuse, especially with dual diagnosis;
- Improving compliance with medication;
- Preventing absconding, especially detained patients;
- Access to services/assessments and waiting times;
- Mechanisms to decrease risk to staff from assault;
- Increased staff awareness/training to encourage identification of specific well known risk factors and their management. This should include that clients may be appropriately deemed low risk, with future adverse outcomes not reasonably predictable, and the need for staff support if things go wrong;
- Adequate provision for under 18 year olds.

6.5.2 Trust Internal Reviews

As part of the follow-up of Serious Adverse Incidents, Trusts on occasion, are asked for copies of their Internal Review Reports by the Department. These Internal Review Reports are considered in relation to:

(i) Method of Review

- Membership of Review Team – multi-disciplinary.
- Formal Multi-Disciplinary Review meeting(s).
- Use of independent Chair from outside Directorate/Programme.
- Service user, carer, or advocate involvement and participation.
- Specific reports requested and provided by clinicians.
- A structured information gathering process including one-to-one interviewing.

(ii) Content of Report

- Clear information about the incident addressing gaps or outstanding issues.
- Timeline including contact with professionals.
- Identification of critical issues and contributing factors.
- Analysis of issues and factors.
- Recommendations and action plan (includes cases were recommendation is that no action be taken).
- Review of implementation of actions.
- Staff support considered (not staff being commended or thanked).

The vast majority of Internal Review Reports had evidence of a multi-disciplinary approach with formal Multi-Disciplinary Review Meetings taking place, contained clear information about the incident including a timeline, identified critical issues/contributory factors, and contained an analysis and recommendations.

However in less than a third of the Reports was there evidence of an independent Chair, involvement of a service user, carer or advocate, provision

of reports by clinicians or use of individual one-to-one interviews, a review of implementation of actions or provision of staff support.

The Internal Trust Review Reports also raised the following themes:

- Provision for under 18 year olds admitted to adult wards.
- Services for people with substance misuse problems, in particular alcohol misuse and dual diagnosis.
- Improving assessment and management of risk, both to self and others, with particular focus on sometimes risk factors being identified but not managed prior to 'inevitable' incident.
- Improving communication including around assessment, follow-up and prescribing of psychiatric medication.
- Improving compliance with medication.
- Clients often viewed as low risk on last contact.
- Preventing disengagement from services.
- Potential of involving family and carers to promote compliance with medication or attendance at outpatient appointments, etc.
- Considering bereavement as significant risk factor.

6.5.3 Suicide and Self Harm

Not all suicides or incidents of self harm are preventable, however there is a danger in going from recognising risk in patients as a whole to accepting the inevitability of individual deaths. The National Confidential Inquiry into Suicide and Homicide (NCISH) by People with Mental Illness (England and Wales) 2006[13] suggests that virtually all in-patient suicides could be seen as preventable, unlike suicide in the community where supervision is less immediate.

In this reporting period, from those SAIs involving suspected suicides, over one third died from hanging (mostly in their own home), one tenth drowned and one tenth overdosed. Where information was available on the last contact with mental health services, just over 80% had been in contact with health and social care two months prior to their death and half of these within two weeks of their suicide.

A Regional Steering Group on the Assessment and Management of Risk in Mental Health Services has been established by the Department. Its aim is to improve risk assessment and management for generic adult mental health services by developing appropriate local standards and supporting their implementation by provision of training.

[13] http://www.medicine.manchester.ac.uk/suicideprevention/nci/Useful/avoidable_deaths.pdf

Relevant related guidance is documented at paragraph 6.7 and in the Appendix.

Learning arising

6.6 When considering the ***learning*** from incidents of suicide and self harm in this SAI reporting period the following has emerged:

- the need to listen to relatives' views and forming a partnership with families and carers in the planning and delivery of the patient/client's treatment;
- the need to establish consistency across HSC units on risk assessment and subsequent management (eg the use of special observation and the ratio of qualified to unqualified staff);
- to drive forward improvements in practice, including through the setting of standards (eg how to manage Do Not Attends. Documented assessment of community/family support structures);
- the need to adopt a standard approach to conducting an incident review so that the report reflects the learning which has taken place and that it has been conducted in line with Mental Health Commission guidance[14] and has the required independence and objectivity;
- the need to be mindful of treating the physical wellbeing of someone with mental health issues and the implications of medicating for a variety of conditions (see Section 4);
- the need to offer appropriate training to staff – to refresh skills and to change the culture (see Section 8);
- to effectively manage transitions (eg interface from acute to community; from young persons to adult services and between mental health and other service, such as childcare).

6.7 Related Guidance

- Discharge from Hospital of Mentally Disordered People, (DHSSPS, 1996, rev. 2004)
- SAN (NI) 98/53 – Curtain Tracks – Points of Ligature (Health Estates, September 1998)

[14] http://www.dhsspsni.gov.uk/mhc_guidance_on_monitoring_untoward_events.pdf

- HTM 55/98 – Building components: windows (Health Estates, 1998)
- HTM 58/05 – Internal doorsets (Health Estates, 2005)
- Guidance - Under 18 Year Olds in Adult Mental Health Facilities (DHSSPS, March 2006)
- HSC(SQSD) 08/2007 – National Confidential Inquiry: 5 year report into suicide and homicide by people with mental illness (NCISH, December 2006)
- MDEA(NI) 2007/61 – Cubical curtain track rails (anti ligature) (Health Estates, June 2007)
- HSC(SQSD) 33/07 – HSC Regional Template and Guidance for Incident Review Reports (DHSSPS, September 2007)

Summary

6.8 Not all deaths from suicide are preventable; however, much can be done to reduce risks. Mental health services should have suicide prevention strategies in place and monitor their implementation. Individual assessment of suicide risk needs to be undertaken for all patients entering the service, particularly those who have attempted suicide or who have self harmed in the past and are expressing suicidal feelings.

6.9 Patients at particular risk are those who are substance abusers and have a mental illness – dual diagnosis patients. Provision for dual diagnosis patients should be central to provision of mental health services and should include staff training in substance misuse management, joint working with drug and alcohol teams, local clinical leadership and enhanced supervision for those with a severe mental illness and a destabilising substance misuse problem.

6.10 Fundamentally staff must develop therapeutic relationships with service users, in which clients who feel suicidal or wish to self harm can talk openly about how they feel and develop strategies together with staff about how to manage self harm feelings and behaviours.

SECTION 7

CLINCIAL TREATMENT AND CARE

7.1 This theme covers a range of issues relating to the care and management of patients and clients. Practitioners must keep their knowledge and skills up to date throughout their working lives and should be familiar with relevant guidelines and developments that affect practice. Participation in educational activities that maintain and further develop competence and performance are essential.

Relevant related guidance is documented at paragraph 7.3 and in the Appendix.

Learning arising

7.2 Issues identified by HSC organisations for ***learning*** that have arisen in this SAI reporting period include:

- **Fluid Management** – Current guidelines on the administration of fluids should be available in all departments where children are cared for. Hypotonic sodium containing fluids should not be routinely stored in all areas. They should be kept locked away in designated areas such as Pharmacy and HDU. Paediatric Teams should work to standardise Fluid Management Records for both prescribing and administration.
- **Management of chest pain in A&E** – Trusts should have a protocol in place for the investigation and management of patients presenting in A&E with chest pain. Consideration should be given to a check list proforma completed to assist with diagnosis and appropriate referral.
- **Use of blood products** – Staff should be aware of the procedures relating to transfer of blood products from storage to theatre or wards and the importance of using cool boxes to ensure administration to the patient at the correct temperature.
- **Jaundice in new born babies** – There is a need to be able to identify and be increasingly vigilant about recognition and management of early, prolonged and late onset of jaundice and bleeding in the newborn.
- **Antenatal care of women** – HIV positive results should be forwarded in hard copy to the patient's Obstetric Consultant and the named Lead

Midwife for screening. There should be prompt filing of hard copy results into records. A full range of booking bloods should be taken on unbooked admissions and the labs should be informed that these samples be fast-tracked.

- **Postnatal care of women** – To be particularly vigilant in the management and recognition of sepsis; post-partum haemorrhage; pre-eclampsia/eclampsia; and pulmonary embolism or deep venous thrombosis.
- **Paediatrics patients presenting to A&E with severe headache** – (i) patients (especially those with severe symptoms and signs) require a written differential diagnosis covering the most likely and most severe possibilities, and a management plan; (ii) an inconsistency in presentation or expected clinical course should prompt further reassessment and investigation; (iii) all paediatric patients with high-risk headaches (unusual pattern, neurological signs, severe symptoms) should receive an urgent CT brain scan; (iv) all paediatric patients with a neurological illness admitted for observation should have regular neurological observations using an age-appropriate split GCS scale to detect subtle changes – not simply a single number. This scale is available from the paediatric neurosurgical ward at the Royal Belfast Hospital for Sick Children; (v) all paediatric patients with high-risk headaches (as at (iii) above) should be admitted to an inpatient unit and not discharged until symptoms resolve and the diagnosis is clear; and (vi) all medical and nursing staff caring for children should be familiar with the current best evidence for the treatment of paediatric migraine and its differential diagnosis.
- **Shoulder dystocia in newborns** – To be aware of studies and good practice in this area.
- **Laboratory processing of blood samples for STI screen and confirmation of results** - The importance of confirmatory testing, and proactive follow-up when a potential mismatch has occurred between the initial and confirmatory test on blood samples for HIV. Learning identified

includes:

- the potential for enhancement of record keeping, and a system to improve traceability, to identify the individuals who took the specific blood samples from the patient;
- proactive face to face communication and follow-up with the patient; and
- early use of "identity matching" technique on both the initial and confirmatory blood samples to give focus to where the investigation should concentrate its efforts when considering a recall of other patients or mapping laboratory processes.

- **Bedrails –** when in use, bed rails should be fully engaged and correctly re-engaged after every patient intervention.

7.3 Related guidance

- Focus Group Shoulder Dystocia. In: Confidential Enquiries into Stillbirths and Deaths in Infancy. *Fifth annual report.* London: Maternal and Child Research Consortium; 1998. P.73-9.
- Guidelines – Better use of Blood in NI (CREST, January 2001 – **currently under revision**).
- Wallchart – Any child receiving prescribed fluids is at risk of hyponatraemia (DHSSPS, April 2002)
- Webb S, Bonell, Lindsay K. the investigation of acute severe headache suggestive of probable subarachnoid haemorrhage; a hospital-based study. *Brit J Neurosurg* 2003: 17(6):580-584.
- Hinshaw K. Shoulder Dystocia. In: Johanson, Cox C, Grady K, Howell C, Editors. *Managing obstetric emergencies and trauma: the MOET course manual, London: RCOG press:* 2003. P.165-74.
- HSS(MD) 06/03 – Better Blood Transfusion; Appropriate Use of Blood (DHSSPS, March 2003)
- Finichel G. Headache. In: Fenichel G, editor. *Clinical paediatric neurology.* 5th ed. Philadelphia: Elsevier Saunders, 2005:77-90.
- Royal College of Obstetricians and Gnaecologists, *guideline No.42,* December 2005, Shoulder Dystocia.
- Serious Hazard of Transfusion Report (Annual Report, 2005) http://www.shotuk.org/SHOT%20report%202005.pdf
- Goadsby P. Recent advances in the diagnosis and management of migraine. *Brid Med J* 2006; 332:25-29.
- Prevention of Hyponatraemia in Children (DHSSPS, April 2006)

- MB97-06 – Antenatal infections screening programme: review of management of HIV results (DHSSPS, October 2006)
- HSS (MD) 43/2006 - NICE guidance: Routine Postnatal Care for Women and their Babies (DHSSPS, November 2006)
- HSS(MD) 24/2006 – NI Guidelines for the Antenatal, Intrapartum and Postnatal Care of HIV positive women and management of the HIV exposed infant (DHSSPS, July 2006)
- HSC (SQSD) 20/07 - NPSA Patient Safety Alert 22: Reducing the Risk of Hyponatraemia when Administering Intravenous Infusions to Children (DHSSPS, April 2007)
- HSC(SQSD) 21/2007 – National Patient Safety Agency: Slips, Trips and Falls in Hospital (PSO 3) (DHSSPS, May 2007)
- HSC(SQSD) 22/2007 – National Patient Safety Agency: Safer Practice Notice 17: Using Bedrails Safety and Effectively (DHSSPS, May 2007)
- HSC (SQSD) 30/07 - National Patient Safety Agency: Safer Practice Notice: "Right Patient, Right Blood" (DHSSPS, June 2007)
- Guidelines on blood transfusion - British Committee for Standards in Haematology (BCSH)
  http://www.bcshguidelines.com/publishedHO.asp?tf=Blood%20Transfusion&status=

Summary

7.4 HSC staff have a responsibility to deliver care based on current evidence, best practice and where applicable, validated research when it is available.

7.5 In a system as large as health and social care, accidents and incidents can be repeated over and over in different parts of the system unless information is shared and common lessons learnt.

7.6 Individuals and teams need to assess the quality of the care they provide, using a combination of clinical outcomes, data and measures of patient's or client's experiences. Reflect on this experience, including both successes and failures, and apply the lessons learnt.

SECTION 8

RECRUITMENT AND TRAINING

8.1 Employers have a duty to protect the public by ensuring that newly recruited staff are able to undertake the work they are employed to do. Where registration with a regulatory body is required the employer must check with that body the practitioner's current registration status and take up all appropriate references in relation to previous employment.

8.2 In addition the employer must ensure that all pre-employment checks have been satisfactorily carried out including Protection of Vulnerable Children and Adult (POCVA) checks and occupational health assessment.

8.3 New employees should have:

- a thorough induction into their area of work;
- training and supervision where necessary;
- mentoring;
- ongoing access to professional development;
- clinical supervision.

8.4 Getting the recruitment and initial employment process right is the first line of defence in protecting the public.

Relevant related guidance is documented at paragraph 8.6 and in the Appendix.

Learning arising

8.5 Issues identified by HSC organisations for ***learning*** that have arisen in this SAI reporting period include:

Recruitment

- Forms for pre-employment checks should ask for any previous addresses outside the UK or ROI.
- Trusts to be assured that employment agencies used in the provision of staff, carry out the requisite employment/registration checks.

Induction

- All newly appointed staff, whether substantive or locum should be given a formal induction programme.
- Dealing with emergencies should be included in induction training.

- All junior medical staff should receive a structured induction process regardless of the time of year employment commences.
- Systems should be in place to ensure locums are familiar with Trust protocols and guidelines.

Dealing with Emergencies

- There should be clear procedures on the management of emergencies occurring within HSC premises.
- In the event of an environmental incident, A&E Departments should follow appropriate procedures, which includes contact with the Public Health Department of the area HSS Board (so that it can involve other local agencies as necessary).
- In case of a medical emergency, dental practice staff should have up-to-date life support training and an emergency drug kit which should be regularly checked and replenished.

Primary Care

- All doctors working in Out of Hours service (including those from non-UK countries) should undertake pre-hospital life support training in accordance with UK guidelines.

Surgery

- When junior staff are being supervised it is important that the supervisor is satisfied that they are competent to undertake the task. Senior surgical staff need to be aware of their responsibilities for supervising junior staff.

Medical Equipment

- Staff should not use any surgical device or equipment unless they know how to do so.

Mentoring

- Staff should be encouraged to seek help and advice from senior suitably qualified colleagues in dealing with unfamiliar procedures.

General Training Issues

- No one should perform a procedure that they are not familiar with until they have received suitable instruction from a practitioner with experience.

8.6 Related Guidance

- Choosing to Protect (DHSSPS, April 2005) – Form POCVA(NI) 3: Service Check, as amended (current version February 2007)
- Report on Induction Processes for Medical Staff in the HPSS (DHSSPS, August 2006)
- HSS(TC8) 8/2006 - Interim Arrangements for the Appraisal of Locum Doctors in HPSS Trusts and Boards (DHSSPS, October 2006)
- Good Medical Procedure – General Medical Council, 2006
- CNO/01/2007 – Reminder of the importance to undertake comprehensive pre-employment checks on nurses and midwives (DHSSPS, August 2007)

8.7 All employees should receive regular performance appraisals (at least annually) during which their training needs should be identified. Employers have a responsibility to recognise and reinforce good performance, or to take steps to identify and deal with poor performance.

8.8 If an aspect of practice is beyond the level of competence of the practitioner or outside their area of professional practice, then they must obtain help and supervision from a competent practitioner until the individual and the employer consider that the practitioner has acquired the requisite knowledge and skill.

SECTION 9

CHILDREN'S SERVICES

9.1 The reporting of SAI incidents in relation to children's services make up one-fifth of the total SAIs received in the reporting period. SAI reports received during this period covered the following:

- children absconding from residential care,
- perpetration of criminal damage while in residential care,
- allegations of sexual activity between residents,
- deaths - including suspected suicides of children under 18 years, some of whom had previous involvement with social services, and
- non-compliance with child protection policies and procedures.

Key Themes

Child Protection

9.2 Of the SAI child protection reports received, a Case Management Review (CMR) to establish what learning, if any, can be identified and disseminated regionally was considered in four of the reports (in line with Chapter 10 of Co-operating to Safeguard Children). At this stage, the Department has been notified that the Area Child Protection Committees have agreed the commencement of at least one CMR; with internal reviews underway in the three other cases. Consequently regional learning from these CMR/reviews has not yet been identified but will be taken forward once available.

9.3 In view of the challenges presented by the increase in the number of potential CMRs the Department is currently reviewing the CMR process as currently operated. However, any new proposals will contain a focus on learning and in particular dissemination of regional learning.

Children Absconding from Residential Care and those with Challenging Behaviour

9.4 The majority of SAI reports received were related to the absconding of children from residential care and in particular a problem with persistent absconding regarding children in this category was identified within one Trust area.

9.5 The Department has corresponded with the relevant Trust seeking an urgent review of the cases involved and reassurance that all appropriate strategies and risk management practices have been brought to bear in the cases identified. The Department has sought the submission of a report which will contribute to the regional learning and development strategy for residential child care staff.

9.6 The Department launched a consultation document entitled Care Matters NI: Building a Bridge to a Better Future[15] in March 2007. This document looks at how best we can look at a range of preventative services designed to help children and their families stay together and to improve the experience and the outcomes of children who come into care, through improvements in health, education, career and recreational opportunities. The strategy acknowledges that meeting the needs of children in residential care is a complex process that places demands and pressures on residential staff and makes proposals for actions/outcomes required to achieve the vision for improvements in residential child care. Likewise, the Children Matter Task Force has commissioned a regional review of residential child care focusing on care planning and the strengthening of safeguarding arrangements through the development of a workforce strategy and a range of policies and procedures designed to improve the management of challenging behaviour in line with best practice, standards and guidance.

Interface with Juvenile Justice Centre

9.7 In order to address concerns about the number of young people being admitted to the Juvenile Justice Centre from care the Chief Social Services Officer issued a letter on 11th September 2006 asking that all such placements be reported as serious adverse incidents. From September 2006 to March 2007, a number of SAI reports continue to be received in relation to this issue. The Department will continue to monitor the submission of SAIs in this regard.

Process Issues

9.8 While more timely reporting of incidents when they occur and adherence to the Departmental SAI circular is acknowledged, the following issues have been identified as requiring further attention:

- there are issues regarding the lack of information provided on the initial SAI reporting form, for example in the case of a persistent absconder from

[15] http://www.dhsspsni.gov.uk/care-matters-ni-3.pdf

residential care, as this could reduce the amount of follow-up work needed; and

- the length of time it takes to obtain additional information on individual SAIs, as this can prevent case and regional learning being identified sooner.

9.9 The Department will be reviewing how these areas could be improved and will have further discussions within the Department and with key stakeholders on the management of SAIs and the responsibility for seeking additional information with a view to further streamlining the process.

SECTION 10

CONCLUSION – THE WAY FORWARD

The Department is encouraged by the willingness of HSC organisations and family practitioner services to promote adverse incident reporting and a culture of learning within their environments.

Working closely with HSC colleagues, a number of projects have been completed or are nearing completion. These developments will further enhance the safety and quality of services.

In relation to ***mental health and learning disability services***, there has been the establishment of the Mental Health & Learning Disability Board. This body will act as a champion for patients and clients and will be a driving force in delivering reforms through the Bamford recommendations. Complementary to this will be the outcome from the Regional Steering Group on the Assessment and Management of Risk to produce local standards for the improvement of risk assessment and management for generic adult mental health services. Such standards will also be developed for other mental health and learning disability services.

A model for an ***incident review template*** has been developed in order to standardise the format of reports and to place an emphasis on the learning arising from an adverse incident or near miss. Work on Phases 2 & 3 of the Patient/Client Safety project is concluding. This will produce ***a minimum dataset*** for incident reporting and will standardise ***coding and definitions*** of incidents.

Details on incidents/near misses involving ***medical devices and equipment*** continue to be reported to the NI Adverse Incident Centre for collation and further investigation, where appropriate. The learning from these is the subject of a separate annual report produced by Health Estates.

It is acknowledged that HSC organisations have to report incidents/near misses to a wide range of bodies, depending on the nature of the incident. This can often lead to confusion and duplication for the HSC as reporting systems can serve different purposes and may have different specialist audiences. An exercise has taken place to map these reporting lines; and ***algorithms*** will be developed in order to raise awareness and promote clarity of reporting within the HSC. It is hoped this work will facilitate a streamlined approach to incident/near miss reporting under new RPA structures.

During 2006/07, the first clinical and social care governance reviews were undertaken by the Regulation & Quality Improvement Authority (RQIA). In the first year the focus was on two themes from the Quality Standards for Health and Social Care – namely, Corporate Leadership & Accountability of Organisations and Safe & Effective Care. In the latter theme, organisations' procedures for the prevention, detection, communication and learning from adverse incidents/near misses were

considered. Any gaps identified by RQIA will have to be addressed by the individual organisation through an improvement plan which will be subject to independent monitoring.

The ***National Patient Safety Agency*** (NPSA) has undergone significant change in the last year with a remodelled National Reporting and Learning System (NRLS) and an extended programme of work. The National Institute for Health and Clinical Excellence (NICE) is also involved in the development of safety solutions. Further work will be done in 2007/08 to align Safety & Quality policy, systems and processes. A significant part of this will be through further development of the Safety Forum to support HSC organisations and promote shared learning in taking forward patient/client safety interventions. Linked to this will be the publication of key performance indicators for Safe & Effective Care to assist HSC bodies to improve the care provided for patients/clients within each organisation.

APPENDIX

LIST OF PUBLICATIONS RELATING TO QUALITY & SAFETY SINCE COMMENCEMENT OF INTERIM SAI REPORTING SYSTEM – 2004 to SEPTEMBER 2007 (MAINLY ISSUED BY DHSSPS)

(This list is not exhaustive.)

Document No	Description / Title	Issued By	Date of Issue
2004			
	Interim Report into Coronary Artery Bypass Graft	NCEPOD	2004/05
	Standards for the Inspection of Child Protection	SSI	2004
Guidance	Guidelines for Control of Infection in Dental Practice	Dental	2004
PEL(04)01	SARS Contingency Planning: Requirements for Segregation Rooms in all A&E Departments and Minor Injuries Units	Health Estates	23/01/04
	Guidance note- Implementing the Equality Good Practice Reviews on : Access to Information The Handling of Complaints Service User Involvement Promoting positive Staff Attitudes to Diversity	RS & PSD	02/02/04
HSS (PCD)1/2004	Prescribing Incentive Scheme Boards/Practice IPAs 2004/05	PCD	Draft-Feb 2004
HSS (MD) 06/04	Atypical Antipsychotic Drugs and Stroke	CMO's Office	09/03/04
HSS (MD) 07/04	HSS(MD)7/04 PAROXETINE (SEROXAT) Reminder to use the recommended dose	CMO's Office	11/03/04
HSS (GEN1) 1/2004	Campaign to stop violence against staff working in the HPSS - Recording and reporting incidents	HRD	16/03/04
HSS (MD) 08/04	Protecting the blood supply from variant CJD: deferral of donors who have received a blood transfusion	CMO's Office	19/03/04
PEL(04)04	Standards for Space Around the Acute Bed in Wards and Acute Single Rooms in Hospitals	Health Estates	April 2004
HSS (MD) 03/04	Guidance On Antenatal Care - Routine Care For Healthy Pregnant Women	CMO's Office	01/04/04
HSS (MD) 10/04	Good Practice In Consent – Regional Forms And Guides	CMO's Office	02/04/04
HSS (PPM) 4/2004 (Word 442 KB)	AS/NZS 4360: 2004 - Risk Management	PPMD	02/04/04
HSS (MD) 13/04	Anti-D Prophylaxis For Rhesus D Negative Women	CMO's Office	08/04/04
HSS (MD) 14/04	Hospital Services For The Acutely Ill Child In Northern Ireland Report Of A Working Group 1999	CMO's Office	14/04/04
HSS (MD) 15/04	Health For All Children (HALL 4)	CMO's Office	15/04/04

Document No	Description / Title	Issued By	Date of Issue
	Discharge from hospital and the continuing care in the community of people with a mental disorder who could represent a risk of serious physical harm to themselves or others	MH & DSD	May 2004
HSS (MD) 17/04	Reducing the risk of exposure of patients to the agent of CJD through brain biopsy procedures	CMO's Office	17/05/04
CPh1/04	Use and Controls of Medicines	CPO's Office	28/05/04
HSS (MD) 18/04	Incident Involving A Gastroscope At Lagan Valley Hospital	CMO's Office	01/06/04
HSS (PCD)7/2004	Performers List Regulations	PCD	02/06/04
HSS (MD) 19/04	Harley Street Wellman Clinic, 57 Harley Street, London W1G 8QS	CMO's Office	03/06/04
HSS (MD) 20/04	Decontamination Of Endoscopes	CMO's Office	15/06/04
HSS (MD) 21/04	Update On Decontamination Of Endoscopes	CMO's Office	21/06/04
PEL(04)13	Health Estates Decontamination Testing Service	Health Estate	22/06//04
HSS (PPM) 06/04	Reporting and follow-up on serious adverse incidents: interim guidance	PPMD	07/07/04
CPh2/04	Northern Ireland Guidelines On Substitution Treatment For Opiate Dependence	CPO's Office	22/06/04
HSS (PPM) 8/2004 (Word 442 KB)	Governance In The HPSS: Controls Assurance Standards – Update	PPMD	05/08/04
HSS (MD) 25/04	Improving Infusion Device Safety	CMO's Office	05/08/04
Guidance	Decontamination of re-usable medical devices	Dental	05/08/04
HSS (MD) 26/04	Protecting the breathing circuit in anaesthesia - Summary and Conclusions	CMO's Office	12/08/04
	Drug and Substance misuse in Mental Healthcare Settings – Guidance for Service Providers	MH & DSD	Sept 2004
HSS (MD) 29/04	Variant Creutzfeldt-Jakob Disease (vCJD) And Plasma Products	CMO's Office	21/09/04
HSS (MD) 30/04	Modified Pneumoccocal Immunisation Recommendations For Patients With Cochlear Implants	CMO's Office	21/09/04
HSS (MD) 35/04	REFECOXIB (Vioxx/VioxxAcute - Withdrawal Due To Increased Risk Of Thrombotic Events	CMO's Office	01/10/04
Guidance Document	Guidance on drug and substance misuse in mental health care settings and guidance on discharge from psychiatric or learning disability hospital and the continuing care in the community of people with a mental disorder who could represent a risk of serious physical harm to themselves or others	MH & DSD	19/10/04
PEL(04)09	Supplement 1 Crash Call Number	Health Estate	28/10/04
	Draft Standards: Approved Social Workers	SSI	Nov 2004
Guidance	Consent for School Dental Screenings	Dental	01/11/04
HSS (MD) 39/04	Updated Prescribing Advice On The Effect Of Depo-Provera Contraception On Bones	CMO's Office	18/11/04
	Good Management, Good Records (DHSSPS) http://www.dhsspsni.gov.uk/dhs-goodmanagement.pdf	P & CSD	Dec 2004
HSS (MD) 40/04	Safety Of Selective Serotonin Reuptake Inhibitor Antidepressants	CMO's Office	06/12/04
HSS (MD)	Isolation Rooms : Best Practice Standards for Capital	CMO's Office	30/12/04

Document No	Description / Title	Issued By	Date of Issue
41/04	Planning (includes report on Isolation Rooms)		
HSS (MD) 43/04	Advice On The Use Of Celecoxib And Other Selective COX-2 Inhibitors In Light Of Concerns About Cardiovascular Safety	CMO's Office	21/12/04
HSS (MD) 45/04	Withdrawal Of Pregestimil® By Mead Johnson Nutritionals	CMO's Office	22/12/04
Guidance	Guidance on Decontamination of reusable medical devices in General Dental Practice	Dental	22/12/04
HSS (MD) 46/04	Supply of Diamorphine Injection	CMO's Office	29/12/04
2005			
Report	Abdominal Aortic Aneurysm: A Service in Need of Surgery	NCEPOD	2005
Report	An Acute Problem	NCEPOD	2005
Guidance DB (NI) 2006/02	Adverse Incident Reports	HEALTH ESTATES	2005
Guidance	Choosing to Protect – A Guide to Using the Protection of Children, [POC (NI)] Service, DHSSPS		2005
Guidance	Choosing to Protect – A Guide to Using the Protection of Vulnerable Adults, Northern Ireland [POVA (NI)] Service, (DHSSPS)		2005
	Care Standards for Northern Ireland (draft), 2004-05, including draft standards for: • Child Minding • Children's Homes • Creches • Day Care Centres • Domiciliary Care Agencies • Fostering Agencies • Full Day Care • Independent Health Care • Nursing Agencies • Nursing Homes • Out of School Care • Pre-School Session Care • Regulation of Early Years by HPSS Trusts • Residential Family Centres • Residential Homes Draft standards available on www,dhsspsni.gov.uk/governance-careconsultation	PPMD	2005
HSS (PCD)11/2005	General Ophthalmic Services- Payments or continuing Education and Training (CET)	PCD	
HSS (MD) 03/05	Pathway of Care for Patients With Brucellosis	CMO's Office	06/01/05
HSS (MD) 05/05	Drug Alert/Medicines Recall - Bendrofluazde 2.5mg Tablets	CMO's Office	28/01/05
HSS (MD) 06/05	Withdrawal Of Co-Proxamol Products and Interim Updated Prescribing Information	CMO's Office	31/01/05
PEL(05)02	Estate Briefing Number 8 PEL(05)02 Enclosure	Health Estates	Feb 2005
HSS (MD)	Strattera (Atomoxetine) ? Risk of Hepatic Disorders	CMO's Office	03/02/05

Document No	Description / Title	Issued By	Date of Issue
07/05			
HSS (MD) 09/05	Updated Advice on the Safety of Selective COX-2 Inhibitors	CMO's Office	21/02/05
PEL(05)01	Publications CD-ROM Issue 2	Health Estates	Mar 2005
PEL(05)03	Audit Scotland: Hospital Cleaning & National Audit Office for Wales: The Management and Delivery of Hospital Cleaning Services in Wales	Health Estates	21/03/05
HSS (MD) 10/05	Influenza Pandemic Contingency Plan	CMO's Office	02/03/05
CCPD 1/05	Accessing Information from Inland Revenue to assist with enquires about a child's safety and welfare Supplement	CCPD	16/03/05
HSS (MD) 11/05	Guideline - Management of Minor Head Injury in Children	CMO's Office	23/03/05
DS60-05	Managed clinical networks: the way forward	SCD	14/04/05
PEL(05)06	Publications CD-ROM Issue 3	Health Estates	Apr 2005
HSS (MD) 14/05	Update on Appraisal and Revalidation	CMO's Office	18/04/05
HSS (ECCU) 2/2005	Intermediate Care	ECCD	26/04/05
HSS (MD) 16/05	Standards for Newborn Bloodspot Screening	CMO's Office	29/04/05
HSS (MD) 12/05	Acute Illness in Children - New Training DVD	CMO's Office	29/04/05
HSS (MD) 17/05	Publication of Revised Guidance on Transmissible Spongiform Encephalopathy Agents: Safe Working and the Prevention of Infection	CMO's Office	13/05/05
PEL(05)09	Firecode: Fire Practice Note11 Reducing Unwanted Fire Signals in Healthcare Premises	Health Estates	Jun 2005
HSS (MD) 19/05	Correct Site Surgery – Pre-operative Marking and Verification Checklists	CMO's Office	07/06/05
HSS (PPM) 05/05	Reporting of Serious Adverse incidents within the HPSS	PPMD	10/06/05
HSS (PCD) 7/2005	GOS (New arrangements for mobile optical services and direct referral of patients to hospital)	PCD	15/06/05
HSS (MD) 20/05	Good Practice in Consent - European Court of Human Rights Ruling	DCMO's Office	15/06/05
HSS (MD) 22/05	Safety Alert - Prescribing, Supply and Administration of Certain Medicines	CMO's Office	25/07/05
HSS(MD) 23/05	Evaluation Of Medical Appraisal Systems In HPSS Organisations Completion Instructions for Boards Completion Instructions for Trusts Board Question Trust Questions	CMO's Office	28/06/05
HSS (MD) 24/05	Exclusion of Femoral Heads From Living Donors - vCJD Precautions	CMO's Office	29/06/05

Document No	Description / Title	Issued By	Date of Issue
HSS (MD) 25/05	Changes to the BCG Vaccination Programme Follow up letter	CMO's Office	15/07/05
HSS (MD) 26/05	Cardiovascular Safety on NSAIDs - Review of Evidence	CMO's Office	03/08/05
PEL(05)07	The Use of Infra-Red Operated Water Taps	Health Estates	08/08/05
PEL(05)10	HFN 30: Infection Control in the Built Environment	Health Estates	08/08/05
HSS (MD) 27/05	Discontinuation of the Volumatic Spacer Device - Important New Information	CMO's Office	16/08/05
Regulations	The Health and Personal Social Services (Primary Medical Services) (Miscellaneous Amendments) Regulations (Northern Ireland) 2005	Nursing & Midwifery Advisory Group	25/08/05
HSS (MD) 29/05	Commencement Of The Newborn Hearing Screening Programme	CMO's Office	16/09/05
HSS (MD) 28/05	Good Practice in Consent - Student Health Professionals	CMO's Office	19/09/05
HSS (MD) 31/05	New Evidence On The Risk Of Suicidal Thoughts Or Behaviours With Strattera (Atomoxetine) Message from Professor G Duff re Strattera (atomoxetine) Questions and Answers	CMO's Office	30/09/05
PEL(05)13	Cleanliness Matters - A Regional Strategy for Improving the Standard of Environmental Cleanliness in HSS Trusts	Health Estates	12/10/05
HSS (MD) 32/05	Avian Influenza and Pandemic Influenza	CMO's Office	21/10/05
D56/05	Information for the Public and Health Professionals on Pandemic Influenza	CMO's Office	Oct 2005
Guidance	Maintaining High Professional Standards in the Modern HPSS – A Framework for the Handling on Concerns about Doctors and Dentist in the HPSS	HRD	Nov 05
HSS (MD) 34/05	National Patient Safety Agency -Patient Safety Observatory Report And Bulletin	CMO's Office	01/11/05
PEL(05)14	Re-Write of Safe Disposal of Clinical Waste - Consultation Draft 'Safe Management and Disposal of Healthcare Waste'	Health Estates	Nov 2005
HSS (MD) 33/05	Multiprofessional Integrated Care Pathway for Meningitis & Septicaemia in Children RBHSC – Multiprofessional Care Pathway	CMO's Office	18/11/05
HSS (MD) 35/05	Recall Women for Breast Cancer Assessment	CMO's Office	21/11/05
PEL(05)15	Hine Review of Endoscope Decontamination: Rinse Water Testing PEL(05)01 Publications CD-ROM Issue 2	Health Estates	28/11/05
HSS (TC8) 6/2005	Maintaining High Professional Standards in the Modern HPSS – A framework for the handling of concerns about Doctors and Dentists employed in the HPSS	HRD	30/11/05
HSS (MD)	Paroxetine (Seroxat) – Safety In Pregnancy	CMO's Office	07/12/05

Document No	Description / Title	Issued By	Date of Issue
36/05			
HSS (MD) 38/05	Falciparum Malaria in Travellers Returning From the Gambia	CMO's Office	12/12/05
HSS (MD) 37/05	Confidential Enquiry into Maternal and Child Health	CMO's Office	19/12/05
Guidance	Recommendations to improve the safe use of insulin in secondary care http://www.dhsspsni.gov.uk/insulin_recomendations.pdf	CPO's Office	22/12/05
2006			
Report	The Coroners Autospy – Do we Deserve Better	NCEPOD	2006
HSS (PCD)12/2006	Generic prescribing policy update	PCD	2006
CPh1/06	Amendments to the Misuse of Drugs Regulations (NI) 2002	CPO's Office	03/01/06
HSS(MD) 01/2006 - 4 January 2006 (PDF 104 KB)	Re-Introduction of Volumatic Spacer Devices - Important New Information	CMO's Office	04/01/06
HSS (F) 04/06	Corporate Governance in Central Departments	FD	23/01/06
Guidance	Establishing an Assurance Framework – A Practical Guide for Management Boards of HPSS Organisations http://www.dhsspsni.gov.uk/assurance_framework.pdf	Permanent Secretary	24/01/06
HSS(MD) 03/2006 - 10 February 2006 (PDF 91 KB)	NPSA Consultation on Hypotonic Fluids in Children	DCMO's Office	10/02/06
HSS(MD) 04/2006 - 17 February 2006 (PDF 40 KB)	Strattera (Atomoxetine) – Conclusions of Risk: Benefit Review	DCMO's Office	17/02/06
HSS (PPM) 02/06	Reporting and Follow-up on Serious Adverse Incidents Within the HPSS	PPMD	24/03/06
HSS (MD) 6/06	Memorandum of understanding. Investigating patient/client safety incidents (unexpected death or serious untoward harm): promoting liaison and effective communications between the HPSS, PSNI, HMC & HSENI.	DCMO's Office	20/02/06
HSS (MD) 07/06	NI Avian Influenza Diagnostic Algorithm	CMO's Office	29/02/06
Guidance	Under 18 Year Olds in Adult Mental Health Facilities	Andrew Hamilton	13/03/06
Standards	Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS	Permanent Secretary	14/03/06
Action Plan	Changing the Culture: An Action Plan for the Prevention and Control of Healthcare Associated Infections (HCAIs) in Northern Ireland 2006/2009	CMO's Office	21/03/06
HSS(MD) 09/2006 23 March 2006	Changing the Culture: An action plan for the prevention and control of Healthcare Associated Infections	CMO's Office	23/03/06

Document No	Description / Title	Issued By	Date of Issue
(PDF 58 KB)	(HCAI's) in Northern Ireland 2006/2009		
Consultation	Suicide Strategy and Action Plan Executive Summary Suicide Prevention Strategy Questionairre Suicide Prevention Strategy Consultation Questionairre Section 75 Analysis of suicide and self-harm in NI		29/03/06
HSS(MD) 10/2006 13 April 2006 (PDF 102 KB)	Control of Tuberculosis in Northern Ireland - Updated Guidance	CMO'S OFFICE	13/04/06
Letter	Prevention of Hyponatraemia in Children	CMO's Office	21/04/06
HSS(MD) 12/2006 24 April 2006 (PDF 64 KB)	Guidance document "How to classify Incidents and Risk"	CMO'S Office	24/04/06
Guidance	Choosing to Protect – A Guide to using the Protection of Vulnerable Adults Northern Ireland [POVA (NI)] Service	CCPD	Apr 05/ Rev Mar 06
Guidance	Re:Ozone (HealOzone) Therapy for Treatment of Dental Caries	CDO's office	25/04/06
Guidance	Choosing to Protect (Children) (PDF 356 KB) A Guide to Using the Protection of Children, Northern Ireland Service	CCPD	Apr 05/ Rev Mar 06
HSS (MD) 13/2006 May 2006	Paroxetine (Seroxat) ? Risk of Suicidal Behaviour in Adults	CMO's Office	08/05/06
HSS (MD) 16/2006 May 2006	Updated Prescribing Advice for Venlafaxine (Efexor/Efexor XL)	CMO's Office	31/05/06
HSS (MD) 17/2006 June 2006	Risk of Pneumococcal Meningitis in Cochlear Implants Patients - Update to Immunisation Recommendations	CMO's Office	06/06/06
CPh2/06	Regional Kardex Template (Circular) Kardex Training Presentation Kardex Template Booklet Kardex Template Card 1 Kardex Explanatory Notes	CPO's Office	20/06/06

Document No	Description / Title	Issued By	Date of Issue
HSS (MD) 18/2006	Transitional Arrangements for New Specialist Training Programmes – August 07 Appendix to HSS (MD) 18/06	CMO's Office	06/06/06
HSS (MD) 19/2006	Good Practice in Consent – 12 Key Points on Consent Consent desk aid – 12 key points	CMO's Office	09/06/06
Guidance	Safety First: A Framework for sustainable improvement in the HPSS	Permanent Secretary	12/06/06
HSS (MD) 20/2006	Good Practice in Consent: Working with Prisoners and Detainees	CMO's Office	14/06/06
HSS (MD) 23/2006	Update on GP Appraisal 2006/2007	CMO's Office	10/07/06
HSS (MD) 15/2006 July 2006	Re: Ensuring Safer Practice with High Dose Ampoules of Diamorphine and Morphine	CMO's Office	10/07/06
HSS (MD) 25/2006	Use of Imported Fresh Frozen Plasma (FFP)	CMO's Office	26/07/06
HSS (MD) 26/2006	Biological Agents: Managing the risks in Laboratories and Healthcare Premises	CMO's Office	27/07/06
HSS (MD) 24/2006	Northern Ireland Guidelines for the Antenatal, Intrapartum and Postnatal Care of HIV Positive Women and Management of the HIV Exposed Infant	CMO's Office	28/07/06
Report	Report on Induction Processes for Medical Staff in the HPSS Cover Letter	HR Directorate	03/08/06
HSS (MD) 2/2006	1. Human Tissue Authority Website 2. Publishing Codes Of Practice 3. Lifting of the Moratorium on the disposal of existing holdings of Post Mortem Material	CMO's Office	08/08/06
HSS (MD) 29/2006	Diabetic Retinopathy Screening Service in Northern Ireland and QOF Requirements	CMO's Office	09/08/06
PEL (06) 17	Strengthening Assurance of HSS Trust Compliance with NIAIC medical device/equipment alerts	Health Estates Agency	09/08/06
HSS (MD) 32/2006	Beclometasone Disproportionate Pressurised Metered Dose Inhaler	CMO's Office	14/08/06
HSS (MD) 33/2006	Guidance and Principles of Practice for Professional Staff: Health for all Children	CMO's Office	23/08/06
HSS (MD) 34/2006	Assessment to be carried out on patients, before certain surgery and endoscopy procedures, to identify patients with, a risk of, CJD	CMO's Office	21/08/06

Document No	Description / Title	Issued By	Date of Issue
HSS (MD) 36/2006	Endoscopic Decontamination	CMO's Office	21/08/06
HSS (MD) 39/2006	Development of an Integrated Plan for the Management of Blood (Red Cell Component) Shortages Integrated Plan	CMO's Office	04/09/06
Letter	Interface between Juvenile Justice Centre and Children in Residential Care	CSSO's Office	11/09/06
	NI Strategy for Surveillance, Prevention and Control of E.Coli O157. Cover Letter Press Release	CMO's Office	27/09/06
AMCC735	Report on the Review of Medical Appraisal in Northern Ireland	Permanent Secretary	02/10/06
MB 97-06	Antenatal Infections Screening Programme – Review of Management of HIV Results	M Mc Bride M Bradley	11/10/2006
AMCC793	RQIA Breast Screening Review	Permanent Secretary	12/10/06
HSS (MD) 41/2006	Safety of Selective and Non-selective NSAID's	CMO's Office	24/10/06
HSS (TC8) 8/2006	Interim Arrangements for the Appraisal of Locum Doctors in HPSS Trusts and Boards	HRD	27/10/06
HSS (MD) 43/2006	Routine Post Natal Care of Women and Their Babies – NICE Clinical Guidelines for Implementation	CMO's Office	23/11/06
	Lessons Learnt in Dentistry	Healthcare Policy Group	30/11/06
NCISH Report	Avoidable Deaths – Five year report into suicide and homicide by people with Mental Illness Report Summary Report	National Confidential Inquiry	Dec 2006
HSS (MD) 44/06	Interim Advice to Health Professionals Regarding the Radioactive Material "Polonium 210" Resulting from a radiological incident occurring in November 2006.	CMO's Office	01/12/06
HSS (MD) 45/06	Diabetic Screening Programme – Regional Information	CMO's Office	06/12/06
HSS (01/06)	Statutory Functions – Lewis Letter Guidance	Chief Social Services Officer	20/12/06
2007			
HSS (PPMD) (NICE) 01/07	National Institute for Health and Clinical Excellence (NICE) The Interventional Procedures Programme	PPMD	09/01/07
HSS (MD) 2/07	Hepatitis C – Information Pack for Professional, Patients and the Public Action Plan	CMO's Office	17/01/07
HSS (MD) 3/07	Contamination of herbal or 'skunk type' Cannabis with glass beads	CMO's Office	18/01/07

Document No	Description / Title	Issued By	Date of Issue
HSS (SQSD) (NICE) 01/07	NICE Technology Appraisal for Implementation in the HPSS – Psoriatic Arthritis – Etanercept & Infliximab	SQS Directorate	23/01/07
HSS (SQSD) (NICE) 02/07	NICE Technology Appraisal for Implementation in the HPSS – Breast Cancer (early) Trastuzumab (Herceptin)	SQS Directorate	23/01/07
HSS (SQSD) (NICE) 03/07	NICE Technology Appraisal for Implementation in the HPSS – Colorectal Cancer – Laparoscopic Surgery	SQS Directorate	23/01/07
HSS (SQSD) (NICE) 04/07	NICE Technology Appraisal for Implementation in the HPSS – Prostate Cancer (Hormone Refractory) - Docetaxel	SQS Directorate	23/01/07
HSS (SQSD) (NICE) 05/07	NICE Technology Appraisal for Implementation in the HPSS – Breast Cancer (early) - Docetaxel	SQS Directorate	23/01/07
HSS (SQSD) (NICE) 06/07	NICE Technology Appraisal for Implementation in the HPSS – Breast Cancer (early) - Paclitaxel	SQS Directorate	23/01/07
HSS (SQSD) (NICE) 07/07	NICE Technology Appraisal for Implementation in the HPSS – Cardiovascular Disease - Statins	SQS Directorate	23/01/07
HSS (SQSD) 08/07	National Confidential Inquiry: 5 year report into suicide and homicide by people with Mental Illness (NICISH)	SQS Directorate	15/01/07
HSS (SQSD) 09/07	Safety First: A Framework for Sustainable Improvement in the HPSS	SQS Directorate	29/01/07
DS 5-07	Priorities for Action 2007-08	Service Delivery Directorate	02/02/07
AMCC1021	Lessons Arising from the Death of Janine Murtagh	Permanent Secretary	1/02/07
HSS (MD) 5/2007	Gadolinium-Containing Mri Contrast Agents And Nephrogenic Systemic Fibrosis (NSF)	CMO CPO	08/02/07
HSS (SQSD) 10/07	Warning to Travellers who change their Travel Plans	SQS Directorate	20/02/07
HSS (SQSD) 18/07	Conducting Patient Service Reviews /Lookback Guidelines Guidance	Regional Governance Network/SQS Directorate	08/03/07
HSS (MD) 7/07	Healthcare Associated Infection Surveillance	CMO's Office	22/03/07
HSS (SQSD) 19/07	Reporting and follow-up on serious adverse incidents; and Reporting on breaches of patients waiting in excess of 12 hours in emergency care department	SQS Directorate/ Service Delivery Directorate	31/03/07
HSC (SQSD) (NICE) 11/07	NICE Technology Appraisal for Implementation in the HSC – Psoriasis – Efalizumab and Etanercept	OCMO	02/04/07
HSC (SQSD) (NICE) 12/07	NICE Technology Appraisal for Implementation in the HSC – Follicular Lymphoma – Rituximab	OCMO	02/04/07
HSC (SQSD) (NICE) 13/07	NICE Technology Appraisal for Implementation in the HSC – Inhaled Insulin for Treatment of Diabetes Mellitus Types 1 & 2	OCMO	02/04/07
HSC (SQSD) (NICE) 14/07	NICE Technology Appraisal for Implementation in the HSC – Drug Misuse – Methadone and Buprenorphine	OCMO	02/04/07

Document No	Description / Title	Issued By	Date of Issue
HSC (SQSD) (NICE) 15/07	NICE Technology Appraisal for Implementation in the HSC – Drug Misuse - Naltrexone	OCMO	02/04/07
HSC (SQSD) (NICE) 16/07	NICE Technology Appraisal for Implementation in the HSC – Colorectal Cancer – Bevacizumab & Cetuximab	OCMO	02/04/07
HSC (SQSD) (NICE) 17/07	NICE Technology Appraisal for Implementation in the HSC – The Management of Urinary Incontinence in Women	OCMO	02/04/07
HSS (MD) 9/07	Prevention of Infection Caused by Clostridium Difficile Good practice Guide	OCMO CNO	12/04/07
HSS (MD) 10/07	Recommendations of the Expert Working Group on the Prevention of Venous Thromboembolism (VTE) in Hospitalised Patients	OCMO	24/04/07
HSC (SQSD) 20/07	NPSA Patient Safety Alert 22: Reducing The Risk of Hyponatraemia When Administering Intravenous Infusions to Children	OCMO CPO CNO	27/04/07
HSC (SQSD) 21/07	National Patient Safety Agency: Slips, Trips and Falls in Hospital (PSO3)`	SQS Directorate	16/05/07
HSC (SQSD) 22/07	National Patient Safety Agency: Safer Practice Notice 17: Using Bedrails Safely and Effectively	SQS Directorate HEA	16/05/07
HSS (MD) 11/07	Update on seizures of cannabis contaminated with glass particles	OCMO	18/05/07
HSS (MD) 12/07	Decontamination of surgical instruments in light of National Institute for Health and Clinical Excellence (NICE) guidance – patient safety and reduction of risk of transmission of creutzfeldt-jakob disease (cjd) via interventional procedures	OCMO	18/05/07
Guidelines	CREST Guidelines on the Use of Physiological Early Warning Systems	CREST	May 2007
HSC (SQSD) (NICE) 23-07	NICE Clinical Guideline No CG 35 - Parkinson's Disease – Diagnosis and Management in Primary and Secondary Care	OCMO	06/06/07
HSC (SQSD) (NICE) 24-07	NICE Clinical Guideline No CG 38 – Bipolar Disorder - The management of bipolar disorder in adults, children and adolescents, in primary and secondary care	OCMO	06/06/07
HSC (SQSD) (NICE) 25-07	NICE Clinical Guideline No CG 39 – Anaemia Management in Chronic Kidney Disease	OCMO	06/06/07
HSC (SQSD) (NICE) 26-07	NICE Clinical Guideline No CG 44 – Heavy Menstrual Bleeding	OCMO	06/06/07
HSC (SQSD) (NICE) 27-07	NICE Technology Appraisal No TA106 – Peginterferon alfa and ribavirin for the treatment of mild chronic hepatitis C	OCMO	06/06/07

Document No	Description / Title	Issued By	Date of Issue
HSC (SQSD) 28/07	NPSA Safe Medication Alerts	CPO SQS Directorate	04/06/07
HSC (SQSD) 30/07	NPSA Safer Practice Notice: Right Patient, Right Blood	SQS Directorate	13/06/07
Guidance	Promotion of Safe, High Quality Health and Social Care in Undergraduate Curricula Letter Guidance	CMO CNO CSSO CPO CDO	13/06/07
HSC (SQSD) 31/07	Guidance on Complaints in Residential and Nursing Homes	SQS Directorate	22/06/07
HSS (MD) 18/07	Cyanide Poisoning	OCMO	11/07/07
HSC (SQSD) 32/07	NPSA: Safer Practice Notice 16: Early identification on failure to act on radiological imaging reports	SQS Directorate	16/07/07
HSS (MD) 19/07	Update to HIV Post-Exposure Prophylaxis (PEP) Guidance from the Expert Advisory Group on AIDS (EAGA) following the recent recall of Viracept (HSS (MD) 14/07)	OCMO	25/07/07
HSS (MD) 20/07	Risk of Depression and Suicidal Behavior with Acomplia (Rimonabant) Attachment	OCMO	25/07/07
CNO/01/2007	Reminder of the Importance to Undertake Comprehensive Pre-Employment Checks on Nurses and Midwives	CNO	10/08/07
HSS (MD) 24/07	Regional Guidelines for 0ff-licence use of Recombinant Factor VIIa (Eptacog-Alfa; Novoseven r) in aquired coagulopathy • Recombinant Factor VIIa Regional Guidelines	OCMO	17/08/07
HSC (SQSD) 29/07	Guidance on Strengthening Personal and Public Involvement in Health and Social Care	SQS Directorate	12/09/07
HSC (SQSD) 33/07	HSC Regional Template and Guidance for Incident Review Reports Letter Guidance	SQS Directorate	12/09/07

The NIAIC website contains the following information:

- **HEA and MHRA Device Bulletins can be assessed at http://www.dhsspsni.gov.uk/index/hea/niaic/niaic_device_bulletins.htm**

- **A full range of warning notices (MDEAS, hazard notices, advice notices, safety notices, pacemaker technical notes) can be assessed at: http://www.dhsspsni.gov.uk/niaic_warning_notices**

The CREST website contains the full range of guidance issued by the Team:

http://www.crestni.org.uk/publications/pubsreply.asp

Department of
Health, Social Services
and Public Safety
www.dhsspsni.gov.uk

SUPPORTING SAFER SERVICES

A SUMMARY OF KEY THEMES AND LEARNING ARISING FROM SERIOUS ADVERSE INCIDENTS REPORTED TO DHSSPS BETWEEN 1 APRIL 2007 AND 30 APRIL 2010

(Circulars HSS (PPM) 06/04, 05/05 and 02/06, HSC (SQSD) 19/07 and 22/09)

September 2011

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Foreword

Each year, in the period covered by this report, there were nearly 600,000 in-patient and day-case admissions to hospitals in Northern Ireland. Over 1.5 million patients were seen at consultant-led services within hospitals. That is to say nothing of all the care in the community and family practitioner services, such as GP consultations, available through health and social care. It is against a typical volume of some 15 million such patient events each year and variety of care that the 1,023 serious adverse incidents (SAIs), reported to the Department between 1 April 2007 and 30 April 2010 covered in this report should be viewed.

Advances in knowledge, technology, and treatment regimes, along with the rapid turnover of patients, continues to combine to create increasingly complex healthcare systems.

Similarly in the social care domain, the management of more and more complex cases in community care settings, and the decision to intervene in individual or family life to safeguard children or vulnerable adults, is difficult, pressurised work that requires an understanding of diverse needs.

This complexity brings with it risks, and we must ensure that those risks are identified and managed by the use of processes and working practices that prevent or reduce the possibility of harm.

That is why it is important to identify and learn from all adverse events; especially those graded as serious, and make improvements in practice, based on evidence, local and national experience and learning derived from the analysis of such events.

In this, the final Supporting Safer Services report, we acknowledge the commitment, contribution and determination of organisations and staff across all levels of the HSC in driving forward the patient/client safety agenda. By continuing to work together, we can all make HSC services in Northern Ireland safer and more effective.

This Report provides an overview of SAIs reported to the Department between April 2007 and April 2010. It does not deal with individual SAIs or the learning arising in individual cases. It is being made available to HSC organisations in the interests of promoting safety and learning, and to promote the concept of incident reporting as a tool to improve organisational performance.

The focus of the report is on general principles, i.e. "what has happened?" and "how can we improve?", rather than seeking to attribute individual blame, or "who made the error?"

The period covered by this report has seen a significant and fundamental restructuring of the HSC system in Northern Ireland. Changes have included a reduction in the number of Trusts from 19 to 6: the replacement of 4 existing HSS Boards with a single regional body, the HSC Board; the establishment of the Public Health Agency and Business Services Organisation; the creation of the Patient and

Client Council and the dissolution of the Mental Health Commission, with transfer of its functions to the Regulation and Quality Improvement Authority.

This new landscape has meant fundamental changes to accountability arrangements and governance structures. These new structures, together with the findings of a review carried out in 2008 of the existing serious adverse incident reporting system, led to the introduction in May 2010 of new interim arrangements for incident reporting, pending the implementation of a new model for incident reporting – the Regional Adverse Incident and Learning (RAIL) system.

Under these interim arrangements, all Serious Adverse Incidents, since1 May 2010, are reported to the HSC Board. The Board works in partnership with the Public Health Agency and RQIA to ensure that incidents are reported and investigated in an appropriate manner. They also have responsibility to ensure that trends, best practice and learning is identified, disseminated and implemented in a timely manner.

The Department is committed to protecting and improving quality within the HSC and will shortly be launching "*Quality 2020: a 10-year quality strategy for health and social care in Northern Ireland*". The strategy defines quality in three dimensions:

- safety;
- standards/effectiveness; and
- the patient/client experience.

An effective system to ensure that lessons are learned and repetition is avoided when things go wrong is an integral component of a high quality health and social care system. I commend this summary report to you as a valuable tool for disseminating such learning.

Dr Jim Livingstone
Director, Safety, Quality and Standards
DHSSPS

1. DHSSPS SERIOUS ADVERSE INCIDENTS (SAIs) INTERIM REPORTING SYSTEM

Introduction

1.1 By its nature, a Health and Social Care (HSC) system cannot be risk free. Advances in knowledge mean an ever greater range of treatments and interventions are now possible. While these improvements benefit us all and are undoubtedly to be welcomed, HSC practitioners and their patients/clients must weigh up the potential advantages of an individual programme of treatment or care against the risks involved.

1.2 Similarly, decisions about when and how to intervene in individual or family life to protect the vulnerable or to ensure their safety is complex and difficult work, which requires the highest levels of skill, integrity and dedication. The HSC system as a whole must therefore continually ensure that risks are identified and managed by changing the culture, and by enhancing systems and working practices to prevent or reduce the risk of injury or harm to patients, clients and staff while having regard to the safety of others.

1.3 For these reasons it is imperative that organisations identify and learn from all adverse events and make appropriate improvements in practice, based on local and national experience and on learning derived from the analysis of such events.

1.4 This is the third and final report on the learning arising from those serious adverse incidents (SAIs) notified to the Department of Health, Social Services and Public Safety (DHSSPS). The report covers the period April 2007 to April 2010, during which time a total of 1023 incidents were reported.

1.5 With effect from 1 May 2010 SAIs were no longer reported to DHSSPS. In line with the new roles and accountability arrangements established following the second stage of implementation of the Review of Public Administration in the HSC, responsibility for managing SAI reporting transferred to the HSC Board, working in partnership with the Public Health Agency (PHA) and the Regulation and Quality Improvement Authority (RQIA). These are interim arrangements, which will remain in place until the proposed new Regional Adverse Incident and Learning (RAIL) system is established, at which point they will be reviewed.

Context

1.6 Since the statutory duty of quality was placed on HSC (then HPSS) bodies in 2003, there have been significant national and local developments on quality and safety. During 2007/08, the RQIA completed a second governance review based on the *Quality Standards in Health and Social Care*[1]. It has also produced a series of thematic reviews under its review programme 2009 – 2012. The annual compliance exercise against controls assurance standards

[1] http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-standards/spsd-standards-quality-standards.htm

is continuing. The work on the 2006 Safety First Action Plan[2] has been substantially completed and the evaluation of this work has helped to inform the development of a new 10-Year Quality Strategy for the HSC.

1.7 A HSC Safety Forum supports Trusts and Family Practitioner Services as they implement evidence-based patient safety interventions that demonstrate improved outcomes for patients and reduce harm. During this reporting period, legacy HSS Boards continued to maintain protocols with family practitioner services for the reporting of adverse events, with each legacy Board in turn notifying the Department of those events which met the SAI reporting criteria. This function has now been taken over by the HSC Board.

1.8 In 2008 the Department, in partnership with the HSC, carried out a detailed review of adverse incident reporting and learning within the HSC. The review recommended the establishment of a new regional adverse incident and learning system for the HSC. The model was approved by the Minister in 2009 and is currently being developed under the leadership of the PHA.

Levels of HSC Activity

1.9 It is important that the 1023 SAIs reported during the period April 2007 to April 2010 are viewed in the context of overall HSC activity. During 2009/2010, for example, the HSC was responsible for delivery of treatment, care and services across a wide range of settings[3], including:

- 727,000 accident and emergency (A&E) attendances;
- 34 million prescription items dispensed in the community;
- 1.5 million out-patient attendances;
- 580,000 in-patient and day cases;
- 2,600 looked after children;
- 24,000 children referred to Social Services;
- 2,400 children on the Child Protection Register;
- 1,574 adult protection referrals and some 1,059 care and protection plans put in place;
- 1326 applications for assessment under the Mental Health Order made by Approved Social Workers; and 33 new applications for Guardianships, with 61 Guardianships in Trusts at the year's end;
- during a typical week[4], an estimated 235,559 contact hours of domiciliary care provided by HSC Trusts for adults in Northern Ireland; and
- around 9,500 older people supported by HSC Trusts in 490 registered residential care and nursing homes throughout Northern Ireland.

1.10 With complex activity taking place on this scale, it is inevitable that things will occasionally go wrong, and this may sometimes result in serious adverse incidents occurring.

[2] http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-safety/sqsd_safety_safety_first.htm
[3] Source: DHSSPS
[4] 20-26 September 2009

Reporting Arrangements

1.11 For reporting purposes, in the period covered by this report, DHSSPS defined a serious adverse incident as any incident (including a near miss), where the consequences were likely to:

- be serious enough to warrant regional action to improve safety or care within the broader Health and Social Care system;
- be of major public concern; and/or
- require an independent review.

1.12 The reporting criteria for the period covered by this report were set out in a series of Departmental circulars. These required HSC organisations, and family practitioners services (via the legacy HSS Boards), to report serious adverse incidents to the Department. A further circular (HSC (SQSD) 22/09) introduced some modifications to these reporting arrangements as part of the transition to the new Regional Adverse Incident and Learning System, and also to reflect the transfer of functions from the Mental Health Commission to RQIA in April 2009.

1.13 The Department's Serious Adverse Incident Review Group met monthly in the period covered by this report under the joint Chairmanship of the Chief Nursing Officer and the Director of Safety, Quality and Standards. The Group's membership included representation from social services, mental health, child care and secondary care from within the Department, as well as representatives from legacy HSS Boards, and from the new HSC Board following its establishment on 1 April 2009.

1.14 Once reported to the Department, each SAI was recorded and views sought from the relevant professional leads and policy directorates, as appropriate. Further clarification on the detail of incidents was sought from the reporting Trust, where required. When all relevant information had been obtained, the case was listed for consideration by the SAI Review Group, who identified any regional learning emerging. If necessary in particular cases, further referral was made to relevant policy or professional leads, with a view to disseminating any relevant learning to HSC organisations, for example through the issue of a professional letter, policy guidance or NIAIC alert to the service.

Objectives

1.15 The objectives of the DHSSPS SAI reporting system were to encourage an open reporting culture, which acknowledged that lessons need to be shared in order to improve service user and staff safety and to apply best practice in assessing and managing risks. It also aimed to provide feedback on analysis and themes from reported incidents, and to ensure that the service was made aware of emerging learning.

1.16 Out of the SAIs considered in this reporting period, the key learning identified for HSC organisations from specific incidents has been grouped under the following thematic headings, which emerged from an analysis of reported incidents:

- Record Keeping and Documentation, including security of patient/client information (Section 3);
- Communication (Section 4);
- Mental Health (Section 5);
- Clinical Treatment and Care (Section 6);
- Medicines Management (Section 7); and
- Children's Services (Section 8)

1.17 This report has been produced to support and promote the implementation of learning identified from serious adverse incidents. It is aimed at those who work in, or manage, health and social care services, and at those who have an interest in improving the quality of care and service provision.

1.18 Safe and effective practice remains a top priority for health and social care in Northern Ireland. Service users and the public have a right to expect that every effort will be made to minimise risk and to ensure that their care, treatment and services will be person-centred, rights-based and provided in line with best practice.

2. KEY DATA

Background

2.1 An adverse incident is defined as "any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation".

2.2 This remains the current working definition for adverse incidents in HSC organisations. It recognises that not all errors will result in harm to service users and/or staff, but some will. Where an incident is prevented, and no harm results, this is called a "near miss".

2.3 The learning identified in this report arises from a specified subset of all adverse incidents – those classified as serious adverse incidents, which were considered to meet the criteria set for reporting such incidents to DHSSPS as set out in Departmental circulars (PPM) 06/04, 05/05 and 02/06, HSC(SQSD) 19/07 and HSC(SQSD) 22/09.

2.4 It is important to acknowledge that:

- Adverse incidents may arise in a variety of settings;
- Incident reporting systems are only one method that can be used to detect such events;
- When an incident reporting system is used, its success depends on individuals/teams/organisations promoting its use in the interests of learning and sharing information;
- There are also a number of other local and national systems to which HSC organisations report certain categories of incident; and
- The Department's interim SAI system was dependent on voluntary reporting by HSC organisations, and the statistical information generated by this "regional incident reporting" tool should not therefore be interpreted or viewed as a complete picture of all adverse incidents occurring in HSC organisations, either in terms of the frequency or the severity of incidents.

2.5 In addition to the above points, a number of other factors also need to be borne in mind when considering the information provided by HSC organisations.

(i) The DHSSPS SAI reporting system was solely designed to provide feedback on those incidents which were considered to meet the three criteria defined within the departmental circulars in force at the time; the data it has generated should not therefore be used to draw comparisons with other more comprehensive local, national or international reporting systems.

(ii) With effect from April 2006, incidents were classified (catastrophic, major, moderate, minor, insignificant) according to either the assessed degree of harm caused to the individual service user or the level of

severity of the reported incident. Notwithstanding this classification, it remained the responsibility of the HSC organisation to investigate the incident appropriately and effectively.

(iii) The initial information supplied by HSC organisations when individual incidents were notified was usually limited to a one-page proforma, meaning that it was not always possible to determine with any degree of certainty whether a service user outcome (such as a death) was a direct outcome of the incident – this was the responsibility of the reporting HSC organisation to determine through its subsequent investigation.

(iv) A comparatively high reporting rate within one organisation should not be interpreted as an indication that that organisation's services are inherently unsafe - in fact the converse may be the case, as a high reporting rate often reflects an organisation that supports an open and learning culture, and is consequently safer than an equivalent organisation with lower levels of reporting. It is also important to bear in mind that reporting rates may vary according to the range and complexity of services offered by individual organisations.

Reporting from Health and Social Care settings

2.6 Since the introduction of the SAI reporting system in July 2004, the overall number of SAIs reported on an annual basis has shown a year-on-year increase. It is important to remember, however, that this increase does not mean that standards of care or treatment have deteriorated, but rather reflects a greater awareness and willingness on the part of individuals within organisations to report incidents, and also a growing organisational recognition that establishing effective reporting arrangements represents an important and integral part of managing risk and improving overall performance.

2.7 In total 1,023 SAIs were received by the DHSSPS in the reporting period April 2007 to April 2010. There were 264 incidents reported between April and December 2007; 397 in 2008; 287 in 2009; and 75 up to 30 April 2010. Figure 1 (page 12) sets out the annual reporting rates from 2005 until April 2010 (A factor contributing to the decrease in reported incidents in 2009 is the changes introduced by Circular HSC (SQSD) 22/09, which removed from SAI reporting certain categories of incident (suspected suicides and admissions of under-18s to adult mental health wards) from the DHSSPS SAI reporting system).

2.8 Reflecting the integrated nature of health and social care services in Northern Ireland, the main settings from which the incidents are recorded were acute/general hospital, acute mental health/learning disability, community/social care and family practitioner services (Figure 2 on page 13).

2.9 The community/social care category encompasses all incidents that happened in the community or in community-based settings, and includes reports of suspected suicides of people who had contact with mental health services in the two years preceding the suicide.

2.10 The majority of incidents reported were in relation to the following:

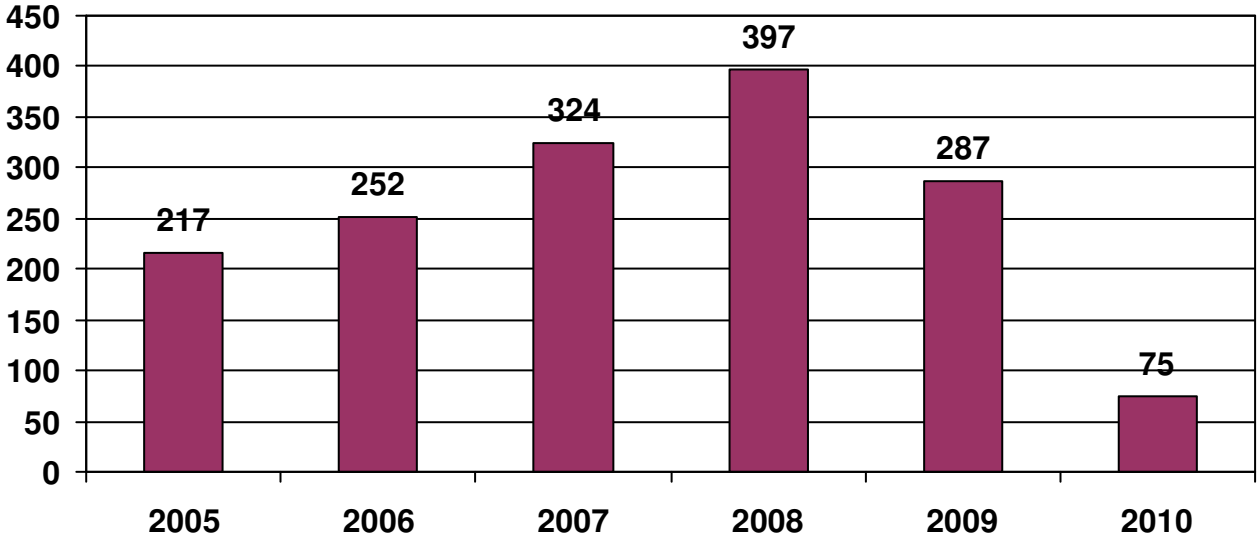
- Death of a person, including suspected suicides;[5]
- Children's services, in particular the interface with juvenile justice services, and children's absences without leave;
- Service pressures;
- Public health;
- Medicines management issues;
- Procedural errors in the acute/general hospital sector;
- Violence against staff;
- Security management issues related to HSC properties; and
- Information governance.

2.11 The key learning identified reflects the range of incidents reported to the Department in this period, and is set out thematically in the Report under the following headings;

- record keeping & documentation (Section 3);
- communication(Section 4);
- mental health (Section 5);
- clinical treatment and care (Section 6)
- medicines management (Section 7); and
- children's services (Section 8).

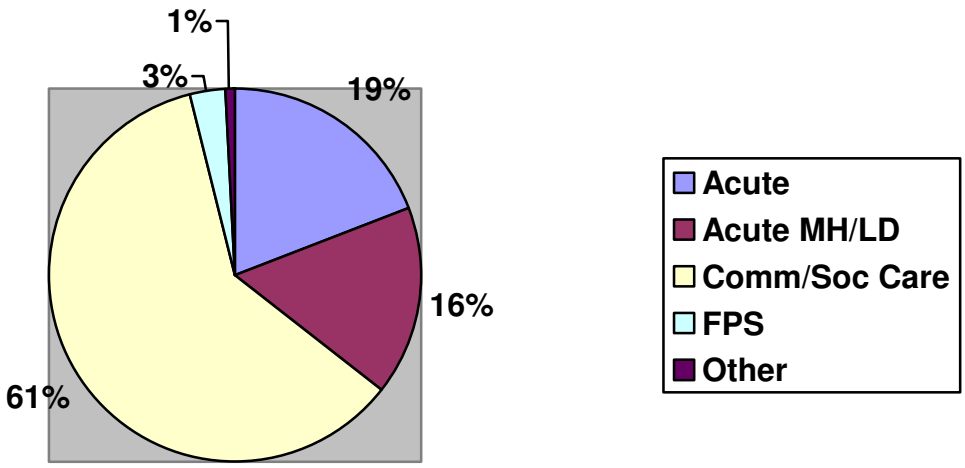
[5] In the absence of knowledge of an inquest verdict, these cases have been classified as "suspected suicides" regardless of the circumstances in which the individual was reported to have been found.

Figure 1 – Annual SAI Reporting Rates



2.13 The figure for 2007 includes the 60 SAIs reported during the period January to March 2007 covered by this current report. The figure for 2010 covers the period January 2010 to 30 April 2010, after which responsibility for managing SAI reporting was devolved to the HSC Board, working in partnership with the PHA and RQIA. A factor contributing to the decrease in volume of incidents reported in 2009 compared to 2008 reflects the removal of certain categories of incident from the DHSSPS SAI reporting system, effective from April 2009.

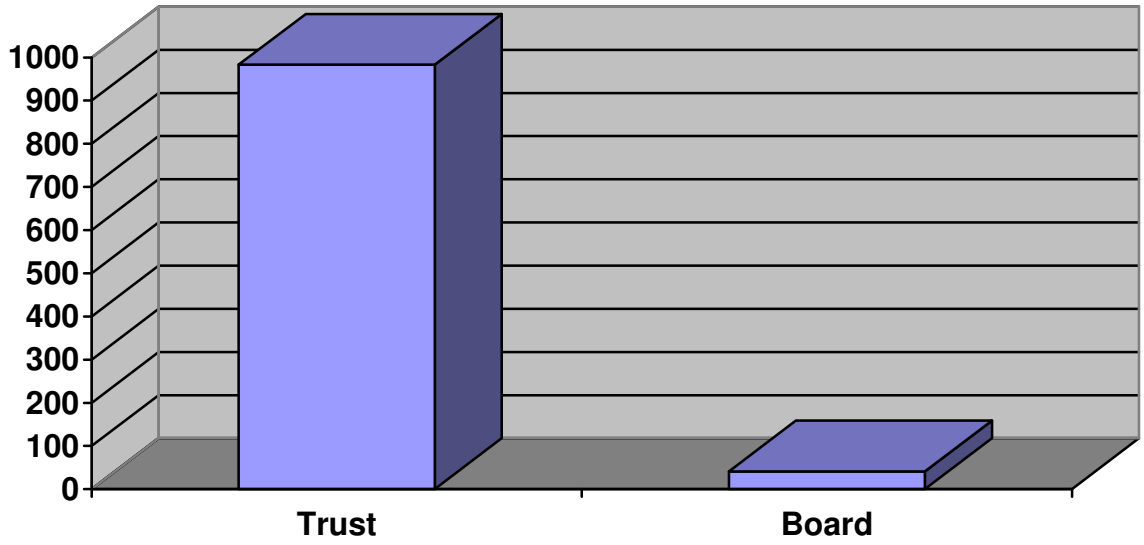
Figure 2 – Settings from which reported SAIs arose



2.14 The data summary available from the National Reporting and Learning System in 2009 showed almost three-quarters of incidents reported in England and Wales to be from an acute/general hospital setting.[6] Comparing this with the reporting pattern locally would imply that there continues to be under-reporting of incidents from this setting in Northern Ireland. Nevertheless, the year-on-year increase in local SAI reporting (taking account of the removal of certain categories of incident reporting with effect from 1 March 2009) suggests an increasing awareness of, and commitment to, SAI reporting on the part of HSC organisations.

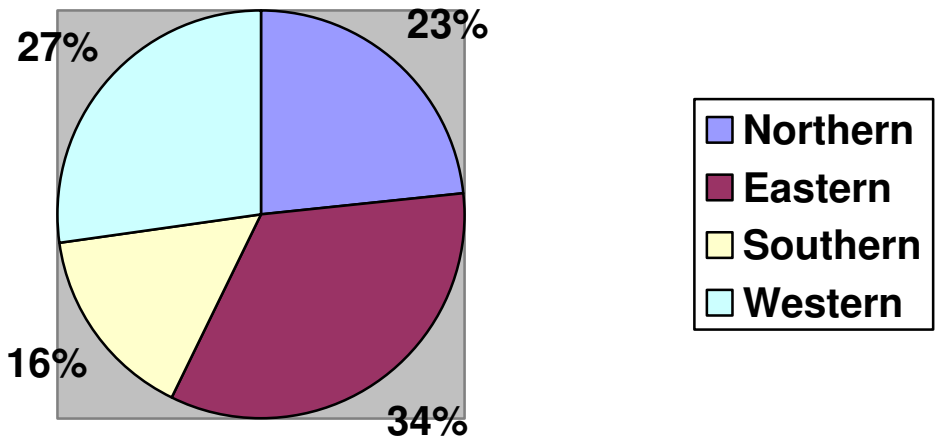
[6] Quarterly National Reporting and Learning System data summary, Issue 14: July 2009 to September 2009 (NPSA, November 2009)

Figure 3 – Type of Organisation reporting (April 2007 – April 2010)



2.15 All legacy HSS Boards and HSC Trusts reported at least one SAI in this period.

Figure 4 – Reporting by Legacy HSS Board area



2.16 Reports were received in the period from across all four legacy Board areas. For the purposes of this analysis, reports from the Northern Ireland Ambulance Service are included as part of the Eastern area.

2.17 It is important to exercise caution in attempting to draw any definitive conclusions from these figures in relation to the quality of care provided by individual HSC Trusts, as not all SAIs may have been captured at local level, or reported to DHSSPS. In addition, incidents involving suspected suicides and admissions of under-18s to adult mental health wards were no longer reported to the Department after 1 April 2009.

2.18 The numbers of incidents reported by individual HSC Trusts will also vary depending on the profile of treatment, care and services they provide. Reporting rates may also be influenced by variations in the size of population served across Trusts, particularly where regional services are provided, and overall reporting rates will be affected by any under-reporting in particular specialities, such as the acute/general hospital sector.

Summary of Main Issues Reported

2.19 Of the 1023 incidents reported to the Department between April 2007 and April 2010:

- Approximately one-third involved the death of a person. However it should be noted that an SAI report which documents a death does not necessarily mean that the circumstances of the incident contributed to the cause of that death.

- Around 45% of these deaths were suspected suicides[7], involving people who had had contact with HSC Mental Health services in the two years preceding the incident (suspected suicides were no longer reported to the Department with effect from 1 April 2009, as per Circular HSC (SQSD) 22/09).

- Just over 25% involved people who are, or who had been, in receipt of children's services. The majority relate to children's services interfacing with the juvenile or criminal justice system and to children absent without leave from residential care;

- Approximately 12% of incidents reported involved service pressure issues, which were mainly in relation to the non-availability of appropriate specialist child & adolescent mental health services (these were no longer reported to the Department with effect from 1 April 2009, as per Circular HSC (SQSD) 22/09);

[7] Pending an inquest verdict, these cases have been classified as "suspected suicides" regardless of the circumstances in which the individual was reported to have been found.

- The remaining 18% covered a range of other issues . These include:
    - Involvement of public health related issues e.g. communicable disease;
    - Medicines management issues, including prescribing errors, inadequate labelling and the security of controlled drugs;
    - Concerns about procedural errors in the acute sector, including non-adherence to policies and procedures;
    - Violence against HSC staff, ranging from verbal aggression and threats to physical assault;
    - Security management issues, including theft from, and threats against, HSC properties; and
    - Information governance issues, involving loss or theft of patient/client data.

3. RECORD KEEPING AND DOCUMENTATION

3.1 Record keeping and documentation is an integral part of good professional practice. Effective documentation can help to protect patients/clients from injury or harm by promoting:

- high standards of treatment, care and service provision;
- continuity of treatment, care and service provision;
- better communication and dissemination of information between members of inter-disciplinary teams;
- an accurate account of treatment and care planning, delivery and review; and
- the ability to identify risks and detect problems such as changes in the patient/client condition or life circumstances.

3.2 The sub-optimal assessment of patients for signs of clinical deterioration and the subsequent response has led to the development of early warning tools for tracking and responding to these situations. Such tools can provide support and guidance to decision making, but ultimately it is the clinical skill, and collaboration of other team members, along with the escalation of concerns to more senior staff that determine optimal care.

3.3 Records should contain an accurate account of treatment, care planning and delivery. These should be written as soon as possible after the event has occurred, and provide clear evidence of the decisions made, care delivered and information shared.

Security of Patient/Client Information

3.4 There has been an increase in the number of reported incidents involving the loss or theft of pen drives or lap-tops containing the personal details of patients. Extra diligence is required to ensure that all such information is secure, and pen drives/lap-tops and other portable storage devices are not left unattended, and are secured out of sight at the end of the working day and over weekends.

Learning arising

3.4.1 Issues identified by HSC organisations for learning in relation to record-keeping and documentation that have arisen in this SAI reporting period include:

Clinical records:

- Clinicians should ensure accurate recording of the diagnosis, treatment and care provided, as well as the date and time at which clinical intervention took place. Clinicians should also ensure accurate recording

of fluids administered, on the fluid balance charts provided.

- Where a clinical case review is required, immediate access to patient records should be secured and a photocopy of notes made before any handover to external agencies, such as the PSNI or the Coroner's Office. Record Keeping Protocols for the handing over of hospital clinical case notes should be put in place and all clinical staff made aware of these. Adherence to such protocols should be the subject of regular audit.
- Clear documentation to identify the lead professional for care is important in maternal notes, especially if obstetric care is required for a midwifery led patient. Guidelines regarding supervision of midwives performing scans should be reviewed to ensure they include countersigning of supervisee entries on patient records by the midwife supervising.
- All medical staff are reminded of the importance of recording all episodes of treatment and care in patient's medical notes, as well as decisions taken regarding a patient's plan of care.
- As far as possible, all successful and unsuccessful interventions should be recorded on a single form to ensure a complete record of the complexity of an individual patient's condition and thus better informed clinical decision making.
- When a patient is admitted to hospital or referred to a team for initial assessment, every effort should be made to determine previous contacts, if any, through the EPEX system. One set of case notes should follow the service user from first contact. If case notes are unavailable at this stage, the record which has commenced should be filed in the original notes.

Mental health records

- Trusts should develop appropriate mechanisms to ensure that inter-team referrals within mental health services are recorded by the referring team, and acknowledged by the receiving team. These should include dates of any recent or imminent assessments. If a patient has an imminent appointment, staff should ensure that any recent relevant assessments

are communicated to the appropriate mental health professional to ensure they have a full picture of the patient's recent history.

- When a patient engaging with mental health services indicates their desire to take their own discharge contrary to medical advice, the possibility of detention should always be considered and the outcome should be recorded in the patients' notes.
- Crisis plans for patients engaging with mental health services should include a section to record comments from the family/carer/patient and be signed accordingly. Assessment documentation should include a section for consideration of hospital admission to be clearly documented and signed by the person undertaking the assessment.
- The absentee notification form for absconding patients should incorporate a risk assessment section to better communicate the patient's level of risk to himself and others.
- A summary sheet should be placed at the front of patient's case notes documenting risk, self-harm attempts and warnings to support risk assessment and management of risk.

Transfer of records

- Sealed boxes should be used to transport medical records. Protocols should be agreed for the transfer of records between sites.
- Documentation should be reviewed on transfer of patients between care environments, with particular attention paid to the frequency of intervals of physiological interventions.

Early warning systems

- Staff should be trained in the proper use of Physiological Early Warning Scores including adding scores at each set of observations, acting on the score and documenting actions taken.
- Trusts should review all observation charts to ensure that there is no duplication of charts that could increase the risk to patient safety.
- The importance of completing Modified Early Warning System (MEWS) documentation on a consistent basis is emphasised.

Out of hours

- Organisations should ensure that there is a system in place for easy access to patients' notes and documentation during a bank holiday period.
- All clients using the on-call service on an ongoing basis should have a multi-disciplinary review care and treatment plan. All teams should have a system in place to record the reasons for cancelling appointments.

Community care

- New HSC organisations should ensure appropriate steps have been taken across legacy teams to standardise protocols and processes for documentation, record keeping and storage.

Contact with family members

- The names and contact details of the client/patient and key family members should be recorded accurately and reviewed throughout contact with services to ensure they are kept up to date.

Staff

- Staff should be trained in the importance of documenting their own involvement, in the form of a written report, as soon as they hear of an adverse outcome.
- Staff should be reminded of their professional responsibility to adhere to current NMC and GMC Guidelines on Records and Record Keeping. Trusts should ensure that all recommendations from the Regional NIPEC Record Keeping Audit are effectively implemented.

Security of Patient/Client Information

- Staff should be aware of their responsibilities in relation to safekeeping of patient records when travelling to outlying facilities. Staff must also recognise the importance of reporting in a timely fashion any loss of sensitive personal patient information.

- Trusts should ensure that all staff receive up-to-date training on information governance issues. Clear guidance should be provided for staff on organisational arrangements for encryption of IT equipment. Any data relating to patients or clients that is maintained electronically, for example on pen drives or memory sticks, should be treated as patient/client records, and consequently must be handled and stored securely in accordance with organisational records management and IT security guidance.

4. COMMUNICATION

4.1 Clear and effective communication remains a recurring theme in reported incidents within this period, both with patients/clients and their carers/family, and between staff. It is one of the essentials for safe and effective practice, and is a positive indicator of the culture of an organisation and the teams within it.

4.2 It requires relationships based on openness and trust, and communications that foster partnership working in the interests of patients/clients and carers/family. Poor working relationships within the clinical environment or service setting can pose a risk to patient/client safety, and potentially to carer/family well-being.

Learning arising

4.3 Issues identified by HSC organisations for learning in respect of effective communication that have arisen in this SAI reporting period include:

- Staff working in mental health services should be reminded of the importance of an appropriate and supportive response to the family of a patient following a suicide.
- When a death has been notified, administrative staff should be informed to ensure no further letters or appointments are sent that might cause further distress to family members. All letters and appointments should be dated.
- In circumstances where patients fail to engage with follow-up services following repeated presentations for emergency assessments and/or in-patient admissions, a multi-disciplinary case review should be convened to explore alternative interventions aimed at maintaining contact.
- Relatives/carers of patients attending psychiatric in-patient services should be informed of any leave arrangements/plans for the patient. A contact number for the ward should be included on relatives/carers visiting cards.
- Ill patients require multidisciplinary input and good liaison between different specialities. A system should be in place to ensure that requests for opinions on seriously unwell patients are responded to promptly by all specialities.

- Families of seriously ill patients should have a single designated point of contact with medical staff to ensure clear, consistent and up-to-date information is given. Information given to relatives should be recorded.
- Trusts should consider arrangements for alerting GP practices, A&E departments and out-of-hours primary care services regarding the leave status of patients from mental health hospitals, particularly where there is a history of abuse of prescribed medication.

Handover arrangements

- Acute and community mental health teams should ensure that they have effective protocols in place to manage referrals from other health and social care professionals.
- Trusts should ensure that formal discharge plans are communicated between acute and community services.
- Clinical staff should take appropriate account of handover information when considering appropriate investigations.
- Ward day and night staff should carry out a joint morning and evening check to ensure patients' well-being at shift handover time.
- Patients who are significantly unwell should have care led by a single consultant. Any change in lead consultant, either within a unit or on transfer between units, should include clear handover and discussion of the patient's management plan at the senior level of consultant to consultant.

Communication after an incident has occurred

- Debriefing of all staff involved in serious clinical incidents should happen as soon as possible after the incident and should be a routine part of the governance process. This will enable staff to talk about what happened, share their anxieties and receive mutual support from colleagues who were involved.

- The findings of Trust investigations into incidents should be shared with family members and also the staff involved in the care of patients.
- Staff must be supported and given feedback on the outcome of serious adverse incidents.
- Patients and their family require timely, sensitive communication during and after any incident. This should be co-ordinated through one member of staff.

5. MENTAL HEALTH

5.1 Suicide continues to make up the single largest category of reported incidents. As highlighted in previous Supporting Safer Services reports, not all suicides or incidents of self harm are preventable. However caution should be taken to ensure that acknowledging this does not translate into an acceptance of any individual death as inevitable. The National Confidential Inquiry into Suicide and Homicide (NCISH) by People with Mental Illness (England and Wales) 2006 suggests that virtually all in-patient suicides could be seen as preventable, unlike suicides which occur in the community, where supervision is less immediate.

5.2 This reporting period has also seen several cases of suicide in women with post-natal depression. Professionals caring for pregnant women need to take full and accurate medical histories and be alert to the risks for women with a previous history of mental illness and, in particular, bi-polar disorder. A training programme to raise awareness on these issues is being developed.

5.3 This period also saw the publication of a combined Independent Inquiry/Case Management Review Report on the death of a mother and her child, which, among other things, lead to DHSSPS commissioning and publishing Filicide: A Literature Review, a review of the content and uptake of child protection training and commencement of work on a joint protocol designed to manage the interface between mental health and child care services. These recommendations are currently being taken forward.

5.4 To address recurrent issues in relation to mental health services identified from previously reported SAIs, the Department has developed "Promoting Quality Care', guidance on risk assessment and management in Mental Health and Learning Disability services, and is also piloting the "Think child, think parent, think family" concept, which is designed to improve the interface between mental health and children's services.

5.5 In relation to vulnerable individuals being seen in A&E departments, the" card before you leave" scheme was launched in 2010.

Learning arising

5.6 When considering the learning from incidents of suicide and self harm in this SAI reporting period the following recommendations have emerged, which are currently at various stages of implementation:

- Staff should recognise the importance of consultation with patients' families during an in-patient stay, in particular at admission, discharge and where the patient has a dependent child or children.

- The need for a joint protocol designed to manage the interface between mental health and child care services.
- Protocols for discharging patients from a service should be clear and should include the principle of informing the referral agent, the patient's GP and other professional colleagues involved in the care of the patient.
- Parental mental health is integrated into all stages of the new Northern Ireland Assessment Framework for Children (Understanding the Needs of Children in Northern Ireland).
- Development of guidance that would lead to the implementation of consolidated assessments in mental health to underpin improvements in risk assessment, key working/case co-ordination, multidisciplinary working, care planning and discharge planning.
- Development and implementation of bed management policies.
- Development and implementation of a policy in relation to identifying and recording 'next of kin' information.
- Provision of support to families bereaved by suicide.
- Inter-hospital transfer of patients and their records and subsequent discharge arrangements.
- Arrangements to secure all relevant documents and files in relation to sudden and unexplained deaths.

Inpatient services

- Mental Health Inpatient Unit staff must seek and record information from professionals involved in the admission, transfer or return of patients to the Unit following a period of leave.

- Search policies and procedures when voluntary in-patients in Psychiatric Units go missing should be reviewed to ensure roles and responsibilities are clear. A policy on the use of mobile phones by in-patients should be developed. A review of in-patient access to potential ligatures and removal of property that could be used in this way from patients on their admission, and on discontinuation of special observation arrangements, should be undertaken.

- Trusts should recognise the potential contribution families/carers can make to the care planning process for clients by identifying key supportive relatives and liaising with them as appropriate and with the consent of the client.

General medical ward environment

- Staff should be aware of the need for appropriate risk assessment of the ward environment to minimise any potential environmental risks when dealing with patients with self-harm or suicidal tendencies, with a particular emphasis on areas where the patient may be unobserved, even for a short time, such as clinical cubical spaces. Any such assessment should take account of the potential for harm which may arise from the presence of otherwise unremarkable clinical equipment, e.g. bandages.
- All staff should be trained on assessment skills for patients who self-harm, including appropriate questioning techniques.
- Trusts should consider the development of guidance for hospital services, addiction services and mental health services, to deliver a joined-up approach to the management of people who are opiate dependent and who require admission or treatment in general hospitals.

Security on Ward

- The use of plastic covers or bags for pillow cases or duvets should be prohibited on wards. Patients who are at risk of self-injury or suicide and are subject to higher level of observation should have restricted access to plastic bags. This may mean removal of these bags from their proximity.
- Decisions taken as a result of risk assessments should be reviewed on a regular basis, and should also take account of any learning identified from adverse incidents.
- When a child attends an Accident and Emergency department having self-harmed, a referral should be made to the hospital Social Work Team and notification sent to the Health Visitor.

- Accident and Emergency staff should be aware of the need to enquire, and record responses, regarding domestic violence where there is a history of relationship difficulties.
- Mental Health assessment following self-harm should take place prior to discharge from Accident and Emergency.
- Consideration should be given to whether Family and Childcare Social Work Team should be notified by CAMHS when a child presents with self-harm.

Maternity services and self harm

(It should be noted that regional perinatal mental health services are currently being reviewed by a group led by the Public Health Agency)

- All maternity units receiving an urgent referral giving a history of self-harm should convene a multi-disciplinary meeting to plan the care needed. As a minimum, this should include the hospital and community midwives, hospital social worker, health visitor and GP. Special consideration should be given to inviting those whose postnatal care falls beyond the Trust providing antenatal and intrapartum care.
- At first knowledge that a pregnant woman has a history of self-harm, consideration should be given to whether a referral should be made to Family and Childcare Social Services in the hospital setting. This should be done in conjunction with the hospital social worker. The decision and rationale should be recorded in the patient/client notes. Referrals must be made in accordance with Safeguarding Procedures.
- In addition to written information, where there are specific concerns regarding a mother, a verbal handover should be given by the community midwife to the health visitor. This should be recorded in the notes.
- Antenatal notifications should be sent immediately following booking to the relevant community midwives and health visitors, and include specific information such as a history of self-harm.
- The provision of Safety First assessments for all service users presenting with self harm within 7 days of discharge from hospital is sound

professional practice arising from the National Confidential Inquiry into Suicide and Mental Health Safer Services report and should be extended as standard practice across Trusts. Additional and refresher training should be offered to all mental health professionals engaged in the Safety First follow-up assessments or in emergency duty assessments to try to capture the initiative when the crisis occurs.

Referral Arrangements

- Staff should be reminded that it is the responsibility of a professional, when making a referral to another service, to ensure that the referral is recorded and followed up.
- Trusts should have systems in place to ensure that information regarding out-of-hours work is disseminated in a timely manner to other professionals involved.

6. CLINCIAL TREATMENT AND CARE

6.1 This theme covers a range of issues relating to the care and management of patients and clients. Practitioners must keep their knowledge and skills up to date throughout their working lives and should be familiar with relevant guidelines and developments that affect practice. Participation in educational activities that maintain and further develop competence and performance are essential.

Learning arising

6.2 Learning identified by HSC organisations in relation to clinical treatment and care in this SAI reporting period includes the following:

- The roles of the Accident and Emergency consultant and surgical and medical teams in care of a patient in the emergency setting should be clearly defined, as should the role of the Accident and Emergency consultant in coordination of patient care in the accident and emergency setting.
- Where differences of opinion exist between surgical and medical staff, the relevant consultants must be involved to ensure correct clinical diagnosis, effective communication between all clinicians and clear coordination of care, particularly of the acutely ill patients in the accident and emergency setting.
- Trusts should review their pain relief policies and procedures to ensure effective analgesia is maintained, especially during transfer of an acutely ill patient to another unit.
- Where oncology patients present at A&E, advice should be sought from the Cancer Centre on the management of the patient before any treatment other than stabilisation is given.
- Triage in Accident and Emergency setting should not be performed by administrative staff.
- Any specific requests recorded in post operative instructions should give definitive guidance on the nature and duration of follow-up care.

- Trusts should take account of any potential implications for service delivery in cases where they are providing services to patients who are also healthcare professionals or, where appropriate, their families.
- Existing policies on labelling of fluid lines, infection control in relation to disconnection of lines, and on reconnecting fluids must be followed. Basic checks – right patient, right drug and right time – must also be adhered to when administering medications.
- Wards should have in place a protocol to guide decision making on the appropriate placement of patients transferring from ICU, which takes appropriate account of the condition of the transferring patient and the conditions of other patients already on the ward.
- Trusts should develop a policy on the frequency of observations of patients with femoral lines, setting recommended intervals of observation and the location of documented records of these.
- Trusts should ensure that staff are clear about the process in relation to equipment isolation where it has been involved in a serious incident, and their responsibilities in relation to investigations of patient safety incidents, as set out in the Memorandum of Understanding on Investigation of Patient Safety Incidents.
- Staff should be aware that snoring can be indicative of partial airway obstruction caused by opiates, anaesthetic or sedative drugs or alcohol.
- Trusts should ensure consistent use of PCA infusors including producing guidelines and training staff in their use.
- Trusts must ensure that guidelines in the Memorandum of Understanding on the Investigation of Patient Safety Incidents are implemented, especially those on the need to retain clinical equipment that was attached to a patient in the event of his/her death.
- Trusts should ensure that they have implemented National Patient Safety guidance on correct site surgery, including use of the World Health Organisation surgical checklist.

Maternity Services

- Trusts should produce a clear Trust-wide multiprofessional shared vision and maternity services strategy, including leadership structure and style.
- Trusts should develop an overall patient pathway or design for maternity services that makes best use of existing resources to deliver efficient, safe care. This should include appropriate use of the skills of midwives and obstetricians.
- Trusts should establish multiprofessional Labour Ward forums in which obstetricians, midwives, neonatologists, anaesthetists, nurse, managers and others can come together to continuously review and improve the maternity service e.g. through review of near misses, adverse incidents, samples of electronic fetal monitoring tracings.
- The leadership and management structure of maternity services should have clear accountability at Directorate, Ward, Labour Ward and Clinic levels. The structure and leadership style need to create open constructive challenge and an evidence-based environment in which safety, efficiency and best practice will flourish.
- Trusts should develop effective Maternity Services Liaison Committees that include staff, service users, commissioners and other stakeholders to design, review and develop maternity services.
- Maternity services should have clear links to Trust governance arrangements and robust monitoring of safety and risk management. services should be able to demonstrate improvements arising from issues reported by any member of staff.
- Maternity services should have one designated person to co-ordinate, record and audit multiprofessional training. Senior managerial support is required to develop training in multiprofessional teams and strengthen working relationships.
- All policies and procedures should be developed and reviewed annually by a multi-professional working group.

- Statutory supervision of midwives is a unique part of ensuring safe practice and protection. The recommended ratio of one supervisor to fifteen midwives must be achieved in order to comply with the annual supervision arrangements.
- Regular review of staff and skill mix should be undertaken to ensure that there are adequate staffing levels to address and meet the needs of the service.
- Midwives should be trained to insert IV cannulae and administer IV antibiotics.
- Midwifery staff should rotate regularly to maintain their skills and knowledge. This applies particularly to permanent night staff.
- Trusts should consider developing a high dependency area in the labour ward for ill or potentially ill women who do not need intensive care. Midwives should be trained to support these women.
- Trusts should develop and implement protocols for the emergency in-utero transfer of high risk women, to include potential transfer outside Northern Ireland via air ambulance. The protocol should also cover arrangements for the transfer of mother and baby back from units outside Northern Ireland.

7. MEDICINES MANAGEMENT

7.1 Medicines are the ubiquitous treatment within the HSC with some 35m prescription items dispensed annually in primary care and a total cost of the drugs bill (primary and secondary care) of £500-550m per year. The extensive use of medicines increases the possibility for errors associated with their use to occur, and the potency of some agents markedly increases the risk of serious adverse incidents if they are used in error.

7.2 Medicines Management describes the processes whereby medicines are procured, selected, prescribed, dispensed, administered and monitored ultimately for the benefit of the patient. Errors may occur at any point in this medicines management chain.

7.3 Errors in prescribing may involve the wrong choice of therapy, incorrect duration of treatment, mistakes in dosage calculations, wrong route of administration or errors in correct patient identification.

7.4 Dispensing of medicines and their administration constitutes further potential opportunities for risk and errors can be precipitated by poor standard operating procedures, inadequate or incorrect labelling, use of common liveries for different products and drug names that look and sound alike

7.5 Patients may also use prescribed medication incorrectly, thus contributing to the occurrence of adverse events.

7.6 The types of error indicated above are often associated with poor communication such as unclear or inadequate documentation or the transmission of information by telephone. .

7.7 Also the risk of such adverse events occurring may be higher in contexts where the potential for human error is increased, for example where there is inadequate staffing, time pressures to complete the task, environmental distractions and lack of training and support for additional checking.

7.8 Good medicines management practices are essential and practitioners who are trained and authorised to administer medication must know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, interactions, toxicity profile and precautions and contra-indications.

7.9 The practitioner must be certain of the identity of the patient to whom the medicine is to be administered, be clear about the dosage, and the time of administration. A clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, must be made, ensuring that any written entries and the signature of the practitioner are clear and legible.

7.10 Some drug administrations require complex calculations to ensure that the correct volume or quantity of medication is given. In these situations it may be necessary for a second practitioner to check the calculation in order to minimise the risk of error.

7.11 In respect of controlled drugs, a signed record should be made of all quantities of drug that have been disposed of.

Learning arising

7.12 The following learning points arising from incidents involving medicines management in this period have been identified by HSC organisations.

Opioid Patches

- Risks associated with the inappropriate use, storage or disposal of opioid patches should be considered before prescribing opioids via the transdermal route.
- Patients on opioid patches should be advised about safe storage and disposal as part of counselling on their discharge medicines, as detailed in the patient information leaflet.
- A patient information leaflet should be dispensed with all prescriptions.
- Staff are reminded of their responsibilities in relation to controlled drug usage.
- Consideration should be given to implementing a system of recording when a bolus dose of drugs is administered.
- Medical staff should ensure that buprenorphine patches are discontinued prior to prescribing a morphine infusion.
- Medical staff should ensure care is taken to ensure the correct concentration of drugs is recorded on the medicine kardex, to prevent potential errors in administration.
- Drugs that are prescribed should be administered. Any reason for not giving a prescribed drug must be recorded.

Storage of Medicines

- Trusts are reminded that appropriate processes and safeguards must be in place to provide assurance on the security of medicines in HSC wards and departments.
- Trust Pharmacy departments should agree and implement procedures for dealing with telephone calls from suppliers regarding delivery of problematic orders, and for discrepancies in receipting.
- There should be direct communication between prescriber and pharmacist when a change occurs to the medication regimen of a patient receiving medicines by instalment dispensing.

8. CHILDREN'S SERVICES

8.1 The reporting of SAI incidents in relation to children's services make up around one-quarter of the total SAIs received in the reporting period. SAI reports received during this period covered the following issues:

- non-compliance with child protection policies and procedures;
- children absconding from residential care;
- perpetration of criminal damage/assault while in residential care;
- deaths of children - including suspected suicides of children and young people, some of whom had previous involvement with social services; and
- interfaces with the Juvenile Justice Centre.

Child Protection

8.2 Case Management Reviews (CMRs)[8] are undertaken to determine the learning, if any, that can be identified and disseminated regionally. CMRs were progressed in relation to eight of the SAI reports received. In the same period an Independent Review was undertaken and a report submitted to the Department.

8.3 In view of the challenges presented by the increase in the number of potential CMRs and the emergence of some recurring themes, a review was undertaken and this identified a number of areas for improvement. This is an ongoing process and the Regional Child Protection Committee (RCPC) is working to improve the consistency and quality of CMRs, including training for those involved in the process. This drive toward continuous review and improvement of process will be further enhanced by the establishment of a statutory regional Safeguarding Board for Northern Ireland, which will replace the current RCPC administrative arrangements. Responsibility for CMRs will transfer to the SBNI once it becomes operational in 2012 and the circumstances for CMRs will be set out in Regulations along with a requirement to disseminate learning from such cases.

8.4 DHSSPS issued Standards for Child Protection Services in July 2008.[9] The standards are an important part of the overall framework to deliver continuous improvement in, and strengthening of, child protection services in Northern Ireland and their associated accountability arrangements. They should also help families and members of the public understand how services work to protect children and the important contribution they themselves can make to the safeguarding of children and young people. Among other matters, the Standards address the Interfaces and Joint Working Arrangements for

[8] The circumstances under which a CMR should be conducted or considered, its purpose and the framework for its completion are set out in Chapter 10 of *Co-operating to Safeguard Children* (May 2003). *Co-operating to Safeguard Children* can be accessed through: http://www.dhsspsni.gov.uk/show_publications?txtid=14022

[9] The Standards and reports related to the Inspection of Child Protection Services can be accessed through: http://www.dhsspsni.gov.uk/index/ssi/oss-child-protection.htm

Children in Need of Residential Care, across Fieldwork, Child and Adolescent Mental Health Services (CAMHS), Adult Mental Health and other Agencies. The RQIA has, subsequently, published a number of reports from the first phase of its Child Protection Review.[10]

8.5 The Reform Implementation Team (RIT) was established in 2007 to drive forward the comprehensive change agenda for child protection services in Northern Ireland, based on a Care Pathway approach. Subsequently, through the work of the RIT a number of developments have taken place to assist with regard to safeguarding all children generally, and, specifically, in addressing the needs of children in Residential Care.

8.6 Through the use of Understanding the Needs of Children in Northern Ireland (UNOCINI) assessment and planning documentation there is a system to ensure improved and consistent methods of referral and initial assessment of children who may be at some level of risk. This was then developed as more in-depth assessment using specific Pathways of Family Support, Child Protection and Looked after Children. These Pathways will also become available as Web Based tools.

8.7 To further enhance this work and ensure it is facilitated on a multi-agency basis, a protocol on Multi-agency Information Sharing is to be issued. The RIT Implementation Group and the Children's Services Programme Improvement Board, in conjunction with the Trust Change Co-ordinators and the Workstreams, are all mechanisms to ensure good practice with regard to children is discussed fully and agreed by all Trusts and with partner Agencies.

Children Absconding from Residential Care and those with Challenging Behaviour

8.8 The majority of SAI reports received related to the absconding of children from residential care. DHSSPS wrote to all Boards and Trusts seeking an urgent review of the cases involved and reassurance that all appropriate strategies and risk management practices have been brought to bear in the cases identified.

8.9 From 1 April 2009, a joint protocol between HSC Trusts and the PSNI came into operation entitled *Regional Guidance – Police Involvement in Residential Units – Safeguarding of Children Missing from Home and Foster Care*. It provides guidance to carers, social workers and police officers in dealing with situations where children go missing and where police officers attend residential units. A number of other policies have been developed to ensure good/safe practice in relation to a range of issues related to preparing for and caring for children in a residential setting. These include guidance on:

[10] Reports from the RQIA Child Protection Review can be accessed through: http://www.rqia.org.uk/publications/rqia_review_reports.cfm

- Use of Children's Resource Panels (to ensure a safe and appropriate allocation of Residential Care/Foster Care to children);
- Admission Policy & Procedure, Record Keeping, Review and Monitoring arrangements;
- Child Protection Policies for Children's Homes;
- Misuse of Substances Policy for Children's Homes;
- Anti-bullying Policy for Children's Homes; and
- Protocol on the use of Physical Restraint.

8.10 DHSSPS has also funded the development of a range of therapeutic approaches within a number of children's homes across Northern Ireland. It is anticipated that this initiative will have consequential benefits for the management of challenging behaviours.

8.11 DHSSPS, in conjunction with other Government Departments and other voluntary sector partners, sought to develop a comprehensive strategy to better enable care-experienced young people to achieve their potential and deliver improvements in their health, educational, social and economic outcomes. The Department launched a consultation document entitled *Care Matters in Northern Ireland – a Bridge to a Better Future* in March 2007; *Care Matters in Northern Ireland* outlines a strategic vision for wide-ranging improvements in services to children and young people in, and on the edge of, care. *Care Matters in Northern Ireland* was fully endorsed by the Northern Ireland Executive in September 2009.[11] The *Care Matters in Northern Ireland* strategy acknowledges that meeting the needs of children in residential care is a complex process that places demands and pressures on residential staff and makes proposals for actions/outcomes required to achieve the vision for improvements in residential child care.

Interface with the Juvenile Justice Centre

8.12 In order to address concerns about the number of young people being admitted to the Juvenile Justice Centre from care, the Chief Social Services Officer issued a letter on 11 September 2006 asking that all such placements be reported as serious adverse incidents. Work is being progressed in this arena, with guidance being developed to include

- Children in Residential Care who are in conflict with the law;
- Protocol between PSNI and Residential Child Care in relation to police involvement in Residential Child Care incidents;
- Protocol between PSNI and Residential Child care with regard to admissions to care and custody;
- Supporting Young people through Court processes; and
- Care Planning for Children admitted to the Juvenile Justice Centre.

[11] http://www.dhsspsni.gov.uk/index/hss/child_care/child_care-carematters.htm

Process Issues

8.13 While more timely reporting of incidents when they occur and adherence to the Departmental SAI circular is acknowledged, the following issues have been identified as requiring further attention:

- there are issues regarding the lack of information provided on the initial reporting form, which could reduce the amount of follow-up work needed; and
- the length of time it takes to obtain additional information on individual SAIs, as this can prevent case and regional learning being identified sooner.

8.14 The establishment of a single HSC Board offers an opportunity to achieve greater consistency in the recording and analysis of child-related events, including those which, under the new RAIL system, require to be reported to DHSSPS.

Learning arising

8.15 Learning with regional application for Children's Services provided by HSC organisations that has arisen in this SAI reporting period from SAIs, CMRs and Independent Review include:

- Training in the use of assessment frameworks, including risk assessment, interface with other models and the timely completion of assessments;
- Ensuring that awareness training on the arrangements established for the risk management of sexual and violent offenders (PPANI)[12] is an integral part of child protection training;
- Interventions that are structured, therapeutically sound and outcome focused, and informed by the skill, expertise and experience of all relevant professionals;
- Need for routine enquiry, priority referral, and follow-up of suspected domestic violence cases where there are children in the family;

[12] Public Protection Arrangements Northern Ireland (PPANI) – http://www.publicprotectionni.com - refers to the arrangements introduced in October 2008 for the risk management of sexual and violent offenders, and certain potentially dangerous persons whose assessed risks require multi agency input to the delivery of individual risk management plans. PPANI replaced and extended the previous Multi Agency Sex offender Risk Assessment and Management (MASRAM) arrangements.

- Improving communication, information sharing, analysis, decision-making and planning in safeguarding children across disciplines, between agencies, with primary care and other processes such as Multi Agency Risk Assessment Conferences and PPANI;
- Effective and timely record keeping;
- Clear guidance on data protection matters, consent with regard to information sharing and competent decision making with regard to young people;
- Ensuring continuity of service provision to vulnerable children and notifications of failure to keep planned appointments;
- Safe escort arrangements for young people who are at risk;
- Ensuring consistent application of thresholds for referral and intervention;
- Conflation of guidance and ensuring access for staff to up-to-date information on policy, practice and procedures;
- Effective interfaces between Adult Mental Health Services, Child and Adolescent Mental Health Services and Children's Services;
- Effective interfaces between General Practice and Children's Services;
- Responding to anonymous referrals;
- Effective systems to address unallocated cases and waiting lists;
- The recruitment and retention of skilled staff in child protection and adherence to NISCC Codes of Practice;
- Review of out-of-hours provision;
- Strengthened supervision and management; and
- Monitoring and audit by senior management of the implementation by staff of Regional Child Protection Committee and DHSSPS policies and standards for child protection.

9. CONCLUSION – THE WAY FORWARD

9.1 Safety, defined as "avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them", must continue to be a cornerstone of health and social care in Northern Ireland.

9.2 The Department will continue to promote safety as a key element of protecting and improving the quality of services. "*Quality 2020: A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland"* will be launched in the autumn of 2011 with a view to implementation beginning in 2012. It will set strategic goals for:

- Transforming the Culture;
- Strengthening the Workforce;
- Measuring the Improvement;
- Raising the Standards; and
- Integrating the Care.

9.3 The Public Health Agency is leading a project to devise a new Regional Adverse Incident and Learning System. It is hoped that phased implementation will begin later in 2012.

9.4 The HSC Board will continue to receive reports of serious adverse incidents and disseminate key learning widely.

9.5 The Regulation and Quality Improvement Authority is working on a new Review Programme to cover the period 2012 to 2015, which will help to inform and improve health and social care.

9.6 In these and other ways the HSC will continue to take appropriate action when things go wrong and provide appropriate assurance that learning has been taken account of and improvements made, where appropriate.

Department of Health, Social Services and Public Safety
An Roinn Sálinte, Serbhísí Sóisialta augus Sábháilteacht Phioblí

Subject:

Reporting and follow-up on serious adverse incidents and Reporting on breaches of patients waiting in excess of 12 hours in Emergency Care Department

Circular Reference: HSC (SQSD) 19/2007

Date of Issue: 30 March 2007

For action by:

- Chief Executives of HSC Trusts
- Chief Executives of HSS Boards
- Chief Executives of Special Agencies
- Chief Executive of Central Services Agency
- General Medical, Community Pharmacy
- General Dental & Ophthalmic Practices

For Information to:

- Chief Executive designate, HSC Authority
- Chief Officers, HSC Councils
- Directors of Public Health in HSS Boards
- Directors of Social Services in HSS Boards and HSC Trusts
- Directors of Dentistry in HSS Boards
- Directors of Pharmacy in HSS Boards
- Directors of Nursing in HSC Boards and HSC Trusts
- Directors of Primary Care in HSS Boards
- Medical Directors in HSC Trusts
- Regional Director, Commissioning
- Area Directors, Commissioning
- Chairs, Local Commissioning Groups
- Chairs, Area Child Protection Committees
- Chief Executive, Regulation & Quality Improvement Authority
- Chief Executive, Mental Health Commission
- CSCG/Risk management leads
- Unscheduled care improvement managers

Related documents

HSS (PPM) 06/2004
HSS (PPM) 05/2005
HSS (PPM) 02/2006
DS 154/06 – Emergency Care Reform – Definition & Guidance Framework
Priorities for Action 2007-08

Superseded documents

Annex to Circular HSS (PPM) 02/06

Summary of Contents:

The purpose of this Circular is to notify a number of changes to the reporting and management of Serious Adverse Incidents (SAIs) and to introduce the reporting on breaches of patients waiting in excess of 12 hours

Status of Contents:

Action

Enquiries:

Any enquiries about the content of this Circular should be addressed to:

Safety & Quality Unit
DHSSPS
Room D2.4
Castle Buildings
Stormont
BELFAST
BT4 3SQ

Tel: [redacted]

Implementation:

From 01 April 2007

(To be reviewed by 31 March 2008)

Additional copies:
Available to download from
http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-guidance.htm

Safety, Quality & Standards Directorate

For action:

Chief Executives of HSC Trusts
Chief Executives of HSS Boards
Chief Executives of Special Agencies
Chief Executive of Central Services Agency
General Medical, Community Pharmacy
General Dental & Ophthalmic Practices

For information:

Chief Executive designate, HSC Authority
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Directors of Social Services in HSS Boards and HSC Trusts
Directors of Dentistry in HSS Boards and HSC Trusts
Directors of Pharmacy in HSS Boards and HSC Trusts
Directors of Nursing in HSC Boards and HSC Trusts
Directors of Primary Care in HSS Boards
Medical Directors in HSC Trusts
Regional Director, Commissioning
Area Directors, Commissioning
Chairs, Local Commissioning Groups
Chairs, Area Child Protection Committees
Chief Executive, Regulation & Quality Improvement Authority
Chief Executive, Mental Health Commission
CSCG/Risk management leads
Unscheduled care improvement managers

Castle Buildings
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Circular HSC (SQS) 19/2007

30 March 2007

Dear Colleague

REPORTING AND FOLLOW-UP ON SERIOUS ADVERSE INCIDENTS; AND

REPORTING ON BREACHES OF PATIENTS WAITING IN EXCESS OF 12 HOURS IN EMERGENCY CARE DEPARTMENT

Introduction

The purpose of this circular is to:

a) advise you of refinements to the Department's Serious Adverse Incidents (SAI) system and of changes which will be put in place, from April 2007, to promote learning from

SAIs and reduce unnecessary duplication of paperwork for Trusts, Boards and Agencies, **Section 1;** and

b) clarify arrangements for the reporting on breaches of patients waiting in excess of 12 hours in emergency care departments, **Section 2.**

You are asked to ensure that this circular is widely communicated to staff.

Yours sincerely

MAURA BRISCOE
Director Safety, Quality and Standards Directorate

DEAN SULLIVAN
Director of Service Delivery

SECTION 1: Refinements to Serious Adverse Incident (SAI) System

1. This section outlines refinements to the Department's SAI system by:

   a) promoting increased reporting of SAIs;
   b) clarification of how SAIs, relating to family practitioner services, should be reported;
   c) amendments to existing reporting form (Annex A);
   d) learning from SAIs through development of a new proforma (Annex B); and
   e) integration of follow-up action on SAIs.

Promoting increased Reporting of SAIs

2. Since the introduction, in July 2004, of interim reporting procedures for SAIs and near misses for HSS Boards, HSC Trusts, Agencies and Family Practitioner Services, the Department has been monitoring the effectiveness of the system. HSS (PPM) 06/2004 outlined the steps to be taken by the designated senior manager, within a HPSS organisation/Agency, when alerted to an SAI. The manager has to consider whether the incident should be reported to the Department where it is likely to:

   (i) be serious enough to warrant regional action to improve safety or care;
   (ii) be of public concern (such as serious media interest); or
   (iii) require an independent review.

3. To date, the majority of SAIs reported to the Department arise from the community sector with relatively small numbers being reported from the acute sector or the family practitioner services. This circular re-emphasises the need to report SAIs, which meet the above criteria. This needs to be promoted in order to develop a more complete picture of the breadth of SAIs and their associated learning.

Reporting of SAIs from the Family Practitioner Services

4. In the interests of learning, the Department welcomes the increasing number of family practitioners who are reporting adverse incidents to their HSS Board. When a HSS Board receives an adverse incident, which falls within the above criteria, it is the HSS Board's responsibility to complete the SAI proforma (Annex A) and refer it to the Department. The HSS Board may seek to clarify the nature of the adverse incident in order to assess whether it meets the above criteria and whether there is any local or regional learning.

Amendments to existing reporting proforma (Annex A)

5. In order to ensure appropriate information is returned to the Department, and to avoid unnecessary follow-up communication, the SAI Report proforma (formerly attached as the Annex to Circular HSS (PPM) 02/06) has been revised as follows.

6. Trusts should continue to ensure that all SAIs are reported to their commissioning HSS Board as a matter of course. This is even more important given the role the HSS Boards will be undertaking regarding follow-up action in the implementation of their individual SAI handling procedures.

Box 2
Service pressure incidents

7. When reporting incidents relating to pressures in the Child & Adolescent Mental Health Services, Box 2 should contain details of the action taken by the reporting organisation to minimise risks in accordance with the Department's letter of 13 March 2006 on *Under 18 Year Olds in Adult Mental Health Facilities* (http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-guidance/sqsd_guidance_dhssps_guidance.htm). Reporting organisations should also be aware that where under 18 year olds are placed in adult learning disability facilities, these should also be reported to the Department.

Box 4
Classification of incidents

8. Officers are reminded to complete the classification assessment. (Circular HSS(MD) 12/2006 *How to Classify Incidents and Risks* refers)

Box 7
Actions on employment-related issues arising from incidents

9. This new Box has been added to include any initial action taken by the reporting organisation on employment-related issues as a result of the SAI (where this is known within 72 hours). This would include suspension; referral under the Protection of Children and Vulnerable Adults (POCVA) procedures; or referral to a regulatory body, the National Clinical Assessment Service (NCAS) or Police Service (PSNI).

10. Specifically in relation to POCVA procedures, child care organisations must refer an individual who is or has been employed in a regulated position to the Disqualification from Working with Children (NI) List where there have been allegations that the individual has on the grounds of misconduct harmed or placed a child at risk of harm and the individual has resigned or been suspended or transferred to a non-regulated position. Non-child care organisations may also refer in such circumstances (Article 4(1) of POCVA refers). The Department strongly recommends that referrals in the latter circumstances, while not compulsory, are good practice and will assist organisations in making informed decisions about individuals under investigation, who may seek work in a regulated position in either voluntary or paid employment.

11. Providers of care to vulnerable adults in residential homes, nursing homes or in a vulnerable adult's own home must also refer care workers to the Disqualification from Working with Vulnerable Adults (NI) List, if a care worker on the grounds of misconduct has harmed or placed at risk of harm, a vulnerable adult (Article 36 of POCVA refers).

12. Referrals under the POCVA procedures must be forwarded without delay in all cases where the criteria for a referral are met, including cases where internal investigations are ongoing and the organisation has not yet decided to dismiss the individual or confirm the transfer to a non-regulated or caring position.

Learning from SAIs through the development of a new proforma (Annex B)

13. From April 2007, a new proforma will be introduced to enable learning arising from adverse incidents to be captured and shared. When the Department's SAI group seeks the learning from a particular incident, the follow-up proforma at Annex B will be issued to the reporting organisation usually within 12 weeks of the date of the incident (or receipt of the SAI report where the date is not known). It is hoped that the information gathered from this source will be easier to analyse and disseminate effectively and faster at local level and that it will reduce the need for the Department to request copies of Investigation Reports or Root Cause Analysis. The learning proforma should also be copied to the relevant area Board; however, Boards will continue to operate their individual SAI handling procedures and may request further information as part of their follow-up action. The 12 weeks deadline has been selected in order to align with the reporting requirements of other organisations such as the Mental Health Commission.

Integration of follow up action

14. The Department's SAI group is currently piloting participation of each of the four HSS Boards in the Department's SAI process. It has been decided to extend membership in order to:

- minimise duplication between the Department's and Boards' handling procedures;
- promote fast and effective dissemination of learning across the HPSS; and
- achieve consistency of approach.

The membership of the Department's SAI group will continue to be reviewed throughout 2007/08.

Conclusion

15. The SAI system is designed to inform the Department of serious adverse incidents which meet the three criteria outlined in paragraph 2. This remains an interim procedure pending clarification of the future direction of the National Patient Safety Agency and local changes arising from the Review of Public Administration.

16. Summary learning arising from SAIs received between July 2004 and December 2005 was documented in the Department's publication *Supporting Safer Services (June 2006).* A further report, of the learning arising from reported SAIs between January 2006 and March 2007 will be issued later this year.

ANNEX A

SERIOUS ADVERSE INCIDENT REPORT

1. Organisation:

Incident Identifier No.

2. Date and brief summary of incident:

3. Why incident considered serious:	**Briefly, explain why this SAI meets the criteria:**
a. warrants regional action to improve safety or care within the broader HPSS; b. is of public concern; or c. requires an independent review.	

4. Immediate action taken:

Classification of incident as initially assessed by organisation: **Catastrophic / Major / Moderate / Minor / Insignificant**

5. Is any regional action recommended? Y/N (if 'Yes', full details should be submitted):

Are there any aspects of this incident which could contribute to learning on a regional basis?

6. Is an Independent Review being considered? Y/N (if 'Yes', full details should be submitted):

7. Has any employment-related action been taken as a result of this incident, such as:
a. suspension from duties? Y/N
b. a referral been made to POCVA? Y/N
c. a referral to the relevant Professional Regulatory Body, NCAS or PSNI? Y/N (if 'Yes', specify which organisation)

8. Other Organisations informed:		**Date informed**	Other (please specify) Y/N
HSS Board	Y/N		
HM Coroner	Y/N		
Mental Health Commission	Y/N		
NIHSE	Y/N		
PSNI	Y/N		**Date informed:**
RQIA	Y/N		

9. I confirm that the designated senior manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Department. (*delete as appropriate*)
Report submitted by:
(name and contact details of reporting officer)

Date:

Completed proforma should be sent, by email, to:
adverse.incidents@dhsspsni.gov.uk
If e-mail cannot be used, fax to (028) 9052 3206

MAHI - STM - 089 - 5734

ANNEX B

LEARNING FROM SERIOUS ADVERSE INCIDENT

The Department will complete Parts 1, 2, 3a) and 4 from original reporting template before issuing to reporting organisation

1. Organisation:

Incident Identifier No.

2. Date and brief summary of incident: (As provided in reporting template)

3. a) Classification of incident as initially assessed by organisation:

3. b) Has Classification changed since initial assessment? Catastrophic / Major / Moderate / Minor / Insignificant

4. Regional action recommended in reporting template

5. (Where applicable) Date of organisation's internal review: __/__/__

(Where applicable) Date independent review concluded: __/__/__

6. A summary of the key learning points emerging from local investigation of SAI: *

For reporting organisation:

(i)
(ii)
(iii)

For region:

(i)
(ii)
(iii)

(additional page(s) can be used if necessary)

7. Since the initial report, has any further employment-related action been taken as a result of this incident, such as:

a. suspension from duties? Y/N
b. a referral been made to POCVA? Y/N
c. a referral to the relevant Professional Regulatory Body, NCAS or PSNI? Y/N (if 'Yes', specify which organisation)

8. *Should any further points of learning emerge from other external sources: (eg. Coroner's inquest report, RQIA report/improvement review, MHC visit, HSE(NI) investigation, PSNI investigation, etc), the reporting organisation may submit this additional information at a later date

(i)
(ii)
(iii)

9. I confirm that the designated senior manager and/or Chief Executive are aware of the follow-up action taken and that the learning has been disseminated and implemented throughout the organisation as a result of this SAI. (*delete as appropriate*)

Report submitted by:
(name and contact details of reporting officer)

Date:

Completed proforma should be sent, by email, to:
adverse.incidents@dhsspsni.gov.uk
If e-mail cannot be used, fax to (028) 9052 3206

SECTION 2: Breaches of Patients waiting in excess of 12 hours in Emergency Care Departments

1. Section 2 is designed:

   a) to clarify arrangements for the reporting and learning from breaches of the 12 hour Accident & Emergency (A&E) standard; and

   b) to introduce a new reporting form (Annex 1) for breaches of this standard; such reports should be sent to the Department to ensure that appropriate follow-up action occurs and that any learning arising from these breaches is captured centrally.

Emergency Care Reform Targets

2. On 13 November 2006, the Department's Service Delivery Directorate issued a Definitions and Guidance Framework for Emergency Care Reform (Letter DS 154-06 and related guidance refers). The Framework advised the HPSS that from 1 April 2007 the SAI reporting system would be used to alert the Department of breaches of the 12 hour A&E standard. The Department believes that a single reporting portal on these issues is a practical approach during the current RPA changes.

3. When a report is submitted to the Department, these reports will **not** be handled in the same way within the Department as other SAIs. They will not be considered by the Department's SAI Review Group (unless, of course, the excess waiting has resulted in a serious adverse incident which has caused harm to patients or staff as defined in Section 1, paragraph 2). Instead they will be referred onwards to the Service Delivery Directorate for appropriate follow-up action and cascade of learning. Breaches of the 12 hour A&E standard should be reported separately using the proforma at Annex 1.

Completing the new reporting proforma (Annex 1) for breaches in 12 hour waiting times

4. Annex 1 contains the new reporting form for documentation of breaches of the 12 hour standard and reporting such breaches to the Department.

Box 2

5. When reporting a breach, Box 2 should contain the following details:

   (i) Where a breach of the 12 hour standard has occurred, but the patient has now been placed in a ward:

   - indicate the total length of time the patient was in A&E (from time of arrival to time of departure);
   - confirm whether the patient was placed in a ward clinically appropriate for their condition;
   - if not, indicate what type of ward the patient was placed in; and
   - confirm whether the Trust policy for managing escalating pressures was implemented (Section 5 of the Definition and Guidance Framework); or

(ii) Where a breach of the 12 hour standard has occurred and the patient has not yet been placed in a ward:

- describe the current situation.

Box 9

6. All breaches of the 12 hour standard should be reported to the designated senior manager within the Trust to ensure that there is corporate knowledge of the breach.

Conclusion

7. The Department has adopted a pragmatic approach to the reporting of breaches of the 12 hour standard to the Department using the same reporting portal as SAIs. Learning arising from these breaches will be collated centrally by the Service Delivery Unit (SDU) and will be fed back to Trusts through routine SDU monitoring meetings.

8. Such arrangements will be reviewed in 2008, in light of changes arising from the Review of Public Administration and may be subject to change.

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ANNEX 1

REPORT ON BREACH OF PATIENT WAITING IN EXCESS OF 12 HOURS

1. Organisation:

Incident Identifier/A&E No.

2. Date and brief summary of incident:

(i) Where a breach of the 12 hour standard has occurred, but the patient has now been placed in a ward:

- indicate the total length of time the patient was in A&E: _____ hours
- was patient placed in a ward clinically appropriate for their condition? (Y/N)
- if 'No', indicate what type of ward the patient was placed in: _____
- was Trust policy for managing escalating pressures implemented? (Y/N)

(ii) Where a breach of the 12 hour standard has occurred and the patient has not yet been placed in a ward:

- describe the current situation

9. I confirm that the designated senior manager and/or Chief Executive has/have been advised of this breach and is/are content that it should be reported to the Department. (*delete as appropriate*)
Report submitted by:
(name and contact details of reporting officer)

Date:

Completed proforma should be sent, by email, to:
adverse.incidents@dhsspsni.gov.uk
If e-mail cannot be used, fax to (028) 9052 3206

Safety, Quality and Standards Directorate
Office of the Chief Medical Officer

Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

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Belfast
BT4 3SQ
[redacted]
Email:
[redacted]

Your Ref:
Our Ref: HSS(SQSD) 34/2007
Date: 12 September 2007

Chief Executives of Boards and Trusts for cascade to
- Governance/CSCG leads
- Risk managers

Mr David Sissling – Chief Ex. Designate, HSCA
Dr Anne-Marie Telford, Regional Director of Public Health & Care Standards Designate, HSCA
Medical Directors of HSC Trusts
Directors of Nursing -Boards and Trusts
Pharmacy Directors -Boards and Trusts
Directors of Public Health- HSS Boards
Directors of Primary Care -HSS Boards
Directors of Social Services -Boards and Trusts
Chair and Chief Executive RQIA (for cascade to independent hospitals, hospices, clinics and establishments)
Office of the Ombudsman
Chief Executive NISCC
Chief Executive NIPEC
Director, NI CSCG Support Team
Chief Executive, Mental Health Commission

Dear Colleague

HSC REGIONAL TEMPLATE AND GUIDANCE FOR INCIDENT REVIEW REPORTS

This HSC Regional Template and Guidance for Incident Review Reports has been developed on behalf of the Department's Safety in Health and Social Care Steering Group. This work represents part of an on-going process to develop clarity and consistency when conducting reviews as outlined in *Safety First: A Framework for Sustainable Improvement in the HPSS* (March 2006).

This template and guidance notes should be used, in as far as possible, for the drafting of all HSC incident review reports whether internal or external to the organisation. However, it is not intended that the template be used without adaptation as it is recognised that certain incident review reports may require a greater level of

detail appropriate to the specialist nature of the incident. In such circumstances, the template may be tailored to suit the specific requirements of each HSC organisation.

The attached guidance makes reference to the importance of independence in investigations/ reviews particularly in relation to incidents involving suicide and of the need to have corporate systems in place to ensure learning and effective closure of the incident within a HSC organisation.

Further recommended reading is provided within the bibliography and in particular I would draw your attention to the principles outlined in the NPSA policy document *Being Open: Communicating Patient Safety Incidents with Patients and their Carers* http://www.npsa.nhs.uk/site/media/documents/1456_Beingopenpolicy1_11.pdf and to the guidance contained in *A Practical Guide to Conducting Patient Service Reviews or Look Back Exercises* *http://www.dhsspsni.gov.uk/microsoft_word_-_hss_sqsd_18-07_patient_service_review_guidelines_-_final_feb07.pdf*

The Department will evaluate the impact of this guidance over the coming year through the incident reports received via the SAI Review Group. It is hoped that the standardisation of Incident Review Reports will facilitate the future collation and dissemination of regional learning.

I would like to take this opportunity to thank Mrs Heather O'Neill, Regional Governance & Risk Management Advisor and her Project Team for their contribution.

Yours sincerely

DR MAURA BRISCOE
Safety, Quality and Standards Directorate
Office of the Chief Medical Officer

cc: Departmental Board Members & Directors
Safety in Health & Social Care Group

Department of
Health, Social Services and Public Safety

An Roinn
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www.dhsspsni.gov.uk

Health and Social Care Regional Template and Guidance for Incident Investigation/Review Reports

September 2007

Introduction

This work has been commissioned by the DHSSPS Safety in Health and Social Care Steering Group as part of the action plan contained within "*Safety First: A Framework for Sustainable Improvement in the HPSS*" (under 5.1.2 Agreeing Common systems for Data Collection, Analysis and Management of Adverse Events). The following work forms part of an on-going process to develop clarity and consistency in conducting investigations and reviews. This is an important aspect of the safety agenda.

This template and guidance notes should be used, in as far as possible, for drafting all HSC incident investigation/review reports. It is intended as a guide in order to standardise all such reports across the HSC including both internal and external reports. It should assist in ensuring the completeness and readability of such reports. The headings and report content should follow as far as possible the order that they appear within the template. Composition of reports to a standardised format will facilitate the collation and dissemination of any regional learning.

All investigations/reviews within the HSC should follow the principles contained within the National Patient Safety Agency (NPSA) Policy documents on "*Being Open – Communicating Patient Safety Incidents with Patients and their Carers*".
http://www.npsa.nhs.uk/site/media/documents/1456_Beingopenpolicy1_11.pdf

It is also suggested that users of this template read the guidance document "*A Practical Guide to Conducting Patient Service Reviews or Look Back Exercises*" – Regional Governance Network – February 2007.
http://www.dhsspsni.gov.uk/microsoft_word_-_hss__sqsd__18-07_patient_service_review_guidelines_-_final_feb07.pdf

This template was designed primarily for incident investigation/review however it may also be used to examine complaints and claims.

The suggested template can be found in the following pages.

Template Title Page

Date of Incident/Event

Organisation's Unique Case Identifier (for tracking purposes)

Introduction

The introduction should outline the purpose of the report and include details of the commissioning Executive or Trust Committee.

Team Membership

List names and designation of the members of the Investigation team. Investigation teams should be multidisciplinary and should have an independent Chair. The degree of independence of the membership of the team needs careful consideration and depends on the severity / sensitivity of the incident. However, best practice would indicate that investigation / review teams should incorporate at least one informed professional from another area of practice, best practice would also indicate that the chair of the team should be appointed from outside the area of practice. In the case of more high impact incidents (i.e. categorised as catastrophic or major) inclusion of lay / patient / service user or carer representation should be considered. There may be specific guidance for certain categories of adverse incidents, such as, the Mental Health Commission guidance
http://www.dhsspsni.gov.uk/mhc_guidance_on_monitoring_untoward_events.pdf

Terms of Reference of Investigation/Review Team

The following is a sample list of statements of purpose that should be included in the terms of reference:

- To undertake an initial investigation/review of the incident
- To consider any other relevant factors raised by the incident
- To agree the remit of the investigation/review
- To review the outcome of the investigation/review, agreeing recommendations, actions and lessons learned.
- To ensure sensitivity to the needs of the patient/ service user/ carer/ family member, where appropriate

Methodology to be used should be agreed at the outset and kept under regular review throughout the course of the investigation.

Clear documentation should be made of the time-line for completion of the work.

This list is not exhaustive

Summary of Incident/Case

Write a summary of the incident including consequences. The following can provide a useful focus but please note this section is not solely a chronology of events

- Brief factual description of the adverse incident
- People, equipment and circumstances involved
- Any intervention / immediate action taken to reduce consequences
- Chronology of events
- Relevant past history
- Outcome / consequences / action taken

This list is not exhaustive

Methodology for Investigation

This section should provide an outline of the methods used to gather information within the investigation process. The NPSA's "Seven Steps to Patient Safety" is a useful guide for deciding on methodology.

- Review of patient/ service user records (if relevant)
- Review of staff/witness statements (if available)
- Interviews with relevant staff concerned e.g.
  - Organisation-wide
  - Directorate Team
  - Ward/Team Managers and front line staff
  - Other staff involved
  - Other professionals (including Primary Care)
- Specific reports requested from and provided by staff
- Engagement with patients/service users / carers / family members
- Review of Trust and local departmental policies and procedures
- Review of documentation e.g. consent form(s), risk assessments, care plan(s), training records, service/maintenance records, including specific reports requested from and provided by staff etc.

This list is not exhaustive

Analysis

This section should clearly outline how the information has been analysed so that it is clear how conclusions have been arrived at from the raw data, events and treatment/care provided.

Analysis can include the use of root cause and other analysis techniques such as fault tree analysis, etc. The section below is a useful guide particularly when root cause techniques are used. It is based on the NPSA's "Seven Steps to Patient Safety" and "Root Cause Analysis Toolkit".

(i) Care Delivery Problems (CDP) and/or Service Delivery Problems (SDP) Identified

CDP is a problem related to the direct provision of care, usually actions or omissions by staff (active failures) or absence of guidance to enable action to take place (latent failure) e.g. failure to monitor, observe or act; incorrect (with hindsight) decision, NOT seeking help when necessary.

SDP are acts and omissions identified during the analysis of incident not associated with direct care provision. They are generally associated with decisions, procedures and systems that are part of the whole process of service delivery e.g. failure to undertake risk assessment, equipment failure.

(ii) Contributory Factors

Record the influencing factors that have been identified as root causes or fundamental issues.

- Individual Factors
- Team and Social Factors
- Communication Factors
- Task Factors
- Education and Training Factors
- Equipment and Resource Factors
- Working Condition Factors
- Organisational and Management Factors
- Patient / Client Factors

This list is not exhaustive

As a framework for organising the contributory factors investigated and recorded the table in the NPSA's "Seven Steps to Patient Safety" document (and associated Root Cause Analysis Toolkit) is useful.
www.npsa.nhs.uk/health/resources/7steps

Where appropriate and where possible careful consideration should be made to facilitate the involvement of patients/service users / carers / family members within this process.

Conclusions

Following analysis identified above, list issues that need to be addressed. Include discussion of good practice identified as well as actions to be taken. Where appropriate include details of any ongoing engagement / contact with family members or carers.

Involvement with Patients/Service Users/ Carers and Family Members

Where possible and appropriate careful consideration should be made to facilitate the involvement of patients/service users / carers / family members.

Recommendations

List the improvement strategies or recommendations for addressing the issues above. Recommendations should be grouped into the following headings and cross-referenced to the relevant conclusions. Recommendations should be graded to take account of the strengths and weaknesses of the proposed improvement strategies/actions.

- Local recommendations
- Regional recommendations
- National recommendations

Learning

In this final section it is important that any learning is clearly identified. Reports should indicate to whom learning should be communicated and copied to the Committee with responsibility for governance.

Further Reading

A Protocol for the Investigation and Analysis of Clinical Incidents. Clinical Risk Unit, University College London and ALARM (September 1999).

A Practical Guide to Conducting Patient Service Reviews or Look Back Exercises – Regional Governance Network – February 2007 http://www.dhsspsni.gov.uk/microsoft_word_-_hss__sqsd__18-07_patient_service_review_guidelines_-_final_feb07.pdf

Being Open. Communicating Patient Safety Incidents with Patients and their Carers. The National Patient Safety Agency, 2005. http://www.npsa.nhs.uk/site/media/documents/1456_Beingopenpolicy1_11.pdf

Circular HSS (PPM) 06/2004 -Reporting and Follow-up on Serious Adverse Incidents: Interim Guidance

Circular HSS (PPM) 05/2005 – Reporting of Serious Adverse Incidents

Circular HSS (PPM) 2/2006 – Reporting and Follow-up on Serious Adverse Incidents.

Circular HSS (MD) 12/2006 – Guidance Document – How to classify Incidents and Risk

SAI Reporting Template from 1st April 2007 (PDF 20 KB) - Reporting and Follow-up on Serious Adverse Incidents http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-circulars.htm

Confidentiality: Protecting and Providing Information. General Medical Council 2004

Decision making tool to reduce unnecessary suspensions and support a safety culture – The National Patient Safety Agency www.npsa.NHS.uk/idt

Dineen, M 2002, Six Steps to Root Cause Analysis, *Consequence UK Ltd.* Oxford.

Doing Less Harm; Improving the Safety and Quality of Care through Reporting, Analysing and Learning from Adverse Incidents, Department of Health and The National Patient Safety Agency, 2001

Mental Health Commission for Northern Ireland: Monitoring of Untoward Events by the Mental Health Commission (Revised Guidance) S6/2006 April 2006.

Managing risk and minimising mistakes in services to children and families, (SCIE: Children and Families' Services Report 6) 2005, http://www.scie.org.uk/publications/children.asp

Memorandum of Understanding Investigating patient or client safety incidents (Unexpected death or serious untoward harm) DHSSPS, PSNI, Coroners Service and HSENI, February 2006

Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults DHSSPS & PSNI 2003

Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – NI September 2004

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