To be used for the submission of issues to Chief Executive/SMT

FROM: Corporate Services

DATE: 19 October 2021

TO: HSCB SMT

ISSUE:	12th Annual Complaints Report 2020/21
TIMING:	Routine
PRESENTATIONAL ISSUES	N/A
FOI IMPLICATIONS	N/A
FINANCIAL IMPLICATIONS	None
LEGISLATION/POLICY IMPLICATIONS	Legislative/Policy requirement for quarterly report to SMT
EQUALITY/HUMAN RIGHTS/RURAL NEEDS IMPLICATIONS	None
RECOMMENDATION:	To note the attached 12th Annual Complaints Report 2020/21 and to be considered by GAC at next meeting.

Submission may include the following areas as a guide.

Introduction/Background

The 12th Annual Complaints Report of the HSC Board provides a review of events during the year 2020/21, and an overview of complaints activity throughout this period.

Issue 12th Annual Complaints Report 2020/21

Considerations N/A

Options N/A

Risks N/A

Recommendation (Should be a direct lift from first page)

To note the attached 12th Annual Complaints Report 2020/21 and to be considered by GAC at the next meeting.

Name of Director – Lisa McWilliams, Strategic Director of Performance and Corporate Services

Ext no. 363265

Copied to: N/A

**(Any additional material referenced should be included as Appendices eg letters
Draft responses, papers)**

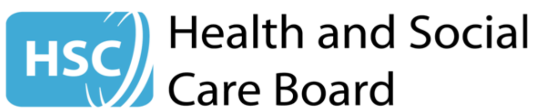
Special 'Complaints' Edition Learning Matters

Thematic Review Analysis– DNAR/CPR

Mealtimes Matter – Poster

Reminder of Best Practice Guidance – SQ-SAI-2020-060

Letter to SHSCT - SQ-SAI-2020-060



THE 12th ANNUAL COMPLAINTS REPORT

OF THE

HEALTH AND SOCIAL CARE BOARD

April 2020 – March 2021

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1.0 Summary Position

This is the 12th Annual Complaints Report of the HSC Board and provides an overview of complaints activity during 2020/2021.

COVID-19 remains a dominant feature in everyday life and continues to cause significant impact on the delivery of Health and Social Care services, which remain under considerable pressure. The number of complaints returns received by the HSC Board concerning FPS Practices has continued to reduce, consistent with the position in recent years. The number of occasions that the HSC Board has acted in the role of 'honest broker' is on a parallel with the previous year. However, there has been a significant decrease in the number of complaints regarding Health and Social Care Trusts in the period.

Position at a glance

- This year has shown a significant decrease in the number of issues of complaint received by the Health and Social Care Trusts (HSC Trusts) with 5,005 issues being received compared with 6,105 in the previous year (2019/20).

- Nonetheless, the top three categories of complaint remain quality of treatment and care, communication/information and staff attitude/behaviour.

- In response to the continued pattern/trend of complaints regarding staff attitude/behaviour and communication a number of HSC Trusts have initiated and concentrated complaints training on specific programmes of care or areas of work where there are high level of complaints received of this nature.

- In relation to Family Practitioner Services (FPS) there continues to be a downward trend in the number of complaints and responses being received by the HSC Board from FPS Practices. In 2020/21 105 local resolution returns were received by the HSC Board. This compares with 140 the previous year.

- In terms of complaints where the HSC Board acted as an 'honest broker' there has been a consistent level with 69 complaints being received in 2020/21 compared with 70 in 2019/20. There has also

been an improvement in the number of such complaints being responded to within the 20 working day timescale.

- Throughout the course of 2020/21 HSC Board complaints staff both directly and through daily contacts with colleagues in FPS Practices have noticed an increase in dissatisfaction from patients experiencing difficulty in getting through the telephony systems, accessing the triage mechanisms, and booking appointments in GP Practices. There has also been an increase in difficulties with service users gaining registration with NHS dental practices. These expressions of dissatisfaction may not always progress to formal complaints being made, but electronic or telephone replies are being given.

- There was a significant reduction in the number of complaints received by the HSC Board in 2020/21 (16) compared with 29 in 2019/20 and 18 in 2018/19. Unfortunately, only four of these complaints were responded to within 20 working days due to a number of reasons ranging from the involvement of other HSC organisations and the scheduling of meetings regarding the complaints.

- The HSC Board carried over 4 complaints from the previous year (2018/19); received a total of 85 complaints during 2019/20 (both HSC Board and honest broker complaints); responded to 52 of these complaints within 20 working days and has carried over 18 ongoing complaints into 2020/2021.

- During 2020/21 HSC Trusts received 14,683 compliments - a compliment is described as ‘an expression of praise, commendation or admiration’. Of note, the three top categories of compliments remain consistent with the three top categories of complaint.

- A special ‘complaints’ edition of the HSC Board/Public Health Agency ‘Learning Matters’ newsletter was published outlining examples where regional learning had been identified.

- The HSC Board Regional Complaints sub-Group (RCsG) undertook a review of complaints regarding discharge arrangements across the HSC Trusts over a 12 month period and shared this with the Regional Discharge Group.

- The outstanding recommendations from the Audit of Complaints Management undertaken in 2019 have been followed up and only one recommendation remains incomplete.

- During the period the HSC Board/HSC Trust Monitoring Group met on 2 occasions. Discussions included the impact of COVID on HSC Trusts' ability to respond to complaints within timescale, and the pattern and nature of COVID related complaints which began to emerge as the year progressed.

2.0 HSCB Monitoring Process for HSC Complaints

The RCsG is a sub-group of Quality Safety and Experience Group (QSE). It reviews complaints information received from HSC Trusts and FPS Practices and also any complaints received by the HSC Board and the Public Health Agency (PHA). Membership comprises representatives from the HSC Board, the PHA and the Patient and Client Council (PCC). The HSC Board's complaints staff share specific categories of complaint to designated professionals in the HSC Board and PHA for review and consideration at RCsG meetings. These include complaints concerning Emergency Departments, maternity and gynaecology, social services, Out of Hours services, allied health professions, and issues associated with patient and client experience. Complaints relating to FPS are reviewed by the HSC Board's respective professional advisers and a summary of all FPS complaints are circulated on a quarterly basis to this Directorate.

A standing item on the QSE agenda requires the RCsG to provide regular updates on complaints issues and/or developments. A quarterly report advising of any key issues or trends arising from complaints and any learning identified from individual complaints is also submitted. During the year the meetings of the QSE have been significantly impacted by pressures associated with COVID and the governance arrangements around safety and quality are currently under review. Areas of concern or patterns from the RCsG may be reported through to the weekly 'Safety brief' jointly led by the Director of Strategic Performance, HSC Board and the Director of Nursing and Allied Health Professionals, PHA.

2.1 HSC Trusts -

In keeping with the requirements of the HSC Complaints Procedure, the HSC Board receives information from all of the HSC Trusts for monitoring purposes. This information is categorised into specific areas of complaint and shared with designated professionals within the HSC Board and PHA, who sit as members of the RCsG. This monitoring process ensures that complaints information is routinely linked into existing work streams/professional groups, for example: -

- Food and Nutrition (Mealtime work)
- Falls
- Development of Pathways for Bereavement from Stillbirths, Miscarriages and Neonatal Deaths
- Development of Pathways for End of Life Care/Palliative Care
- Maternity Commissioning Group
- Patient Experience Working Group (10,000 more voices)
- Regional Discharge Group

The monitoring also highlights specific complaints concerning sepsis and stroke (typical and atypical presentation).

Quarterly reports from the RCsG are shared with the HSC Board's SMT, and with the HSC Board's Governance Committee on a twice yearly basis.

2.2 Family Practitioner Services (FPS) -

There are in excess of 1500 FPS Practices across Northern Ireland. Under the HSC Complaints Procedure all of these are required to forward to the HSC Board anonymised copies of any letters or statements of complaint together with the respective responses, within three working days of the response having been issued.

From day to day contact with FPS Practices, it is apparent that the process of resolving complaints *'on the spot'* is continuing to flourish across FPS, with Practice staff successfully addressing issues/queries and concerns from patients and families without the need for formal submission of a complaint. This is to be welcomed and the HSC Board would encourage Practices to seek to resolve complaints in this way and effectively de-escalate the situation and reach resolution, provided the complainant is content with this approach. This is in line with the ethos of local resolution within the HSC Complaints

Procedure in seeking to resolve complaints as close to their source as possible.

However, the HSC Board also strives to remind FPS Practices of their obligations in terms of the HSC Complaints Procedure, in relation to the requirement to share complaints and responses with the HSC Board. The e-learning package had been updated and re-launched on a new platform last year and all FPS Practices reminded of these requirements.

While many Practices are content to deal with complaints directly, there is an increasing number of Practices contacting the HSC Board complaints staff for 'support and advice' in relation to resolving complaints at local level.

As in previous years, during 2020/21 treatment and care again accounted for the majority of all complaints handled under local resolution. In line with other years, complaints concerning staff attitude/behaviour and communication were the next highest categories.

3.0 Complaints Activity

3.1 The Year in Detail

3.2 Review of Complaints regarding HSC Trusts

During the period 5,005 issues of complaint were received by the six HSC Trusts. This represents a significant decrease from 6,105 issues received in 2019/20 and similar numbers received in recent years: 6,049 issues received in 2018/19; 6,189 received in 2016/17; and 6,181 received in 2015/16.

While the figures should be viewed in the context of the considerable volume of interactions between service users and health and social care professionals on a daily basis, the pandemic has obviously impacted on the volume of complaints being received. This may have resulted from 'lockdowns' and general reluctance to enter hospitals particularly when levels of COVID-19 were high, and possibly understanding, and to some extent sympathy, for the pressure Health and Social Care staff were working under.

Number of complaints issues received per HSC Trusts in 2019/20 and 2020/21 and percentage responded to within 20 working days

Trust	2019/20	% in 20 working days	2020/21	% in 20 working days
Belfast	1,646	49.7%	1,610	53.0%
Northern	672	77.5%	614	70.2%
South Eastern	769	43.2%	1,228	29.0%
Southern	701	50.4%	857	49.0%
Western	489	26.2%	545	46.0%
NI Ambulance	93	6.5%	151	23.2%
Total	**6,105**	**49.4%**	**5, 005**	**49.4%**

In terms of programme of care, the top six were: -

2019/20		2020/21	
1. Acute Services	(58.6%)	**1.** Acute Services	(53.8%)
2. Mental Health	(7.8%)	**2.** Family & Child Care	(10.5%)
3. Family & Child Care	(7.5%)	**3.** Elderly Services	(8.3%)
4. Elderly Services	(7.0%)	**4.** Maternity/Child Health	(7.9%)
5. Maternity/Child Health	(6.0%)	**5.** Mental Health	(7.4%)
6. Primary Health & Adult Community	(1.9%)	**6.** Learning Disability	(1.6%)

Composite HSC Trusts complaints by Programme of Care during 2019/20 and 2020/21 were:

Programme of Care	2019/20	2020/2021
Acute	3,576	2,695
Maternal & Child Health	367	394
Family & Child Care	458	524
Elderly Services	426	413
Mental Health	474	368

Learning Disability	113	82
Sensory Impairment & Physical Disability	40	28
Health Promotion & Disease Prevention	24	12
Primary Health & Adult Community	113	51
None (No POC assigned)	474	376
Prison Healthcare*	40	62
Total Complaint Issues	**6,105**	**5,005**

***South Eastern HSC Trust only**

HSC Trusts complaints by Subject during 2020/21

Subject	Belfast	Northern	South Eastern	Southern	Western	NIAS	Total
Access to Premises	9	4	13	4	2	1	**33**
Aids/Appliances/Adaptations	16	5	3	6	6	0	**34**
Clinical Diagnosis	59	36	69	34	35	1	**234**
Communication/Information	370	74	294	217	78	1	**1034**
Complaints Handling	1	0	6	0	1	0	**8**
Confidentiality	20	7	16	8	13	0	**64**
Consent to Treatment/Care	2	0	2	2	1	0	**7**
Children Order complaints	0	0	0	0	5	0	**5**
Contracted Regulated Domiciliary Services	0	5	5	0	0	0	**10**
Contracted Regulated Residential Nursing	0	16	3	0	0	0	**19**
Contracted Independent Hospital Services	0	0	0	0	0	0	**0**
Other Contracted Services	1	2	0	0	0	0	**3**
Delay/Cancellation for Inpatients	1	1	2	10	2	0	**16**
Delayed Admission from A&E	1	0	3	4	5	0	**13**
Discharge/Transfer Arrangements	48	15	26	18	16	0	**123**
Discrimination	3	2	6	5	1	0	**17**
Environmental	18	6	7	10	1	0	**42**
Hotel/Support/Security Services	6	9	6	10	3	0	**34**
Infection Control	22	5	10	10	1	3	**51**
Mortuary and Post Mortem	0	0	1	0	0	0	**1**
Policy/Commercial Decisions	16	19	16	11	7	0	**69**
Privacy/Dignity	3	3	25	3	6	1	**40**
Professional Assessment of Need	13	17	11	82	7	0	**130**
Property/Expenses/Finance	50	11	12	14	12	1	**100**
Records/Record Keeping	20	7	42	7	3	0	**79**
Staff Attitude/Behaviour	208	102	199	161	95	45	**810**

Transport, Late of Non-arrival/Journey Time	1	0	1	1	1	56	**60**
Transport, Suitability of Vehicle/Equipment	0	0	0		0	0	**0**
Quality of Treatment & Care	292	217	359	157	164	35	**1224**
Quantity of Treatment & Care	107	9	17	34	26	0	**193**
Waiting List, Delay/Cancellation Community Based Appts	10	7	22	3	12	0	**54**
Waiting List, Delay/Cancellation Outpatient Appts	164	22	18	12	3	0	**219**
Waiting List, Delay/Cancellation Planned Admission to Hospital	107	5	9	9	14	0	**144**
Waiting Times, A&E Departments	7	2	8	2	2	0	**21**
Waiting Times, Community Services	10	1	4	6	2	0	**23**
Waiting Times, Outpatient Departments	14	5	9	8	2	0	**38**
Other	11	0	4	9	21	8	**53**
Total	**1,610**	**614**	**1,228**	**857**	**545**	**151**	**5,005**

The three most common ‘subject of complaint’ issues continue to be quality of treatment and care (1,224); communication/information (1,034); and staff attitude/behaviour (810).

3.3 Review of Family Practitioner Services (FPS) Complaints

3.3.1 Complaints handled under Local Resolution

Subject	**GP**	**Dental**	**Pharmacy**	**Ophthalmic**	**Total**
Treatment & Care	**35**	**5**	**0**	**0**	**40**
Appointments	**11**	**0**	**0**	**0**	**11**
Prescriptions	**9**	**0**	**0**	**0**	**9**
Communication/Information	**16**	**0**	**0**	**0**	**16**
Staff Attitude	**13**	**0**	**0**	**0**	**13**
Confidentiality	**1**	**0**	**0**	**0**	**1**
Personal Records	**1**	**0**	**0**	**0**	**1**
Warnings	**2**	**0**	**0**	**0**	**2**

Medication	4	0	0	0	4
Removals	0	0	0	0	0
Registration	1	0	0	0	1
Failure to Follow procedures	0	0	0	0	0
Other	6	0	1	0	7
Total	**99**	**5**	**1**	**0**	**105**

The downward trend in the number of complaints and responses being received by the HSC Board from FPS Practices has continued in recent years. Previously the HSC Board would have received between 170 – 200 returns from FPS Practices. During 2019/20, 140 returns were received and this has decreased again to 105 during 2020/21. A reminder was recently issued to all FPS Practices of their obligation to forward complaints/responses to the HSC Board.

3.3.2 'Honest broker' complaints

Subject	**GP**	**Dental**	**Pharmacy**	**Ophthalmic**	**Total**
Treatment & Care	**23**	**8**	**0**	**0**	**31**
Appointments	**0**	**0**	**0**	**0**	**0**
Prescriptions	**2**	**0**	**0**	**0**	**2**
Communication/Information	**5**	**2**	**0**	**0**	**7**
Staff Attitude	**6**	**0**	**0**	**0**	**6**
Confidentiality	**0**	**0**	**0**	**0**	**0**
Failure to follow Procedures	**1**	**0**	**0**	**0**	**1**
Registration	**7**	**0**	**0**	**0**	**8**
Medication	**0**	**0**	**1**	**0**	**1**
Removals	**4**	**0**	**0**	**0**	**4**
Warnings	**2**	**0**	**0**	**0**	**2**
Personal Records	**2**	**0**	**0**	**0**	**2**
Other	**4**	**2**	**0**	**0**	**6**
Total	**56**	**12**	**1**	**0**	**69**

On occasions where complainants do not wish to approach the FPS Practice directly, the HSC Board's complaints staff can act as an 'honest broker' between both parties. This intermediary role may arise due to a patient's or relative's concern about the impartiality of the FPS Practice to investigate the complaint, or because of a breakdown

in the relationship between the patient and the practitioner. However, for the HSC Board's complaints staff to act in this role, with the aim of assisting local resolution and/or in helping restore relationships (where possible), or reaching a position of understanding, both parties must be in agreement to this occurring.

Not all complaints can be resolved by an exchange of written communication and on occasions this can involve meetings with the complainant to discuss the issues involved, the response subsequently received and what further action can/should be taken; as well as meeting separately with the Practice being complained about, or facilitating joint meetings of both parties.

While the HSC Board may become involved as an 'honest broker' the responsibility for investigation of the complaint lies with the Practice. In this regard, there is an option for the Practice to respond directly to the complainant, or via the HSC Board.

In the period 2020/21 the HSC Board acted as an 'honest broker' in 69 complaints concerning FPS Practices compared to 70 in 2019/20, which is very much in line with numbers received in previous years.

Of the 69 'honest broker' complaints received, 45 were responded to within 20 working days. This is substantial improvement as in previous years only about 50% of the complaints were responded to within the timescale: - 29 out of the 70 in 2019/20, 67 out of the 115 in 2018/19 and 17 out of 43 in 2016/17. The role of 'honest broker' demands continued contact and liaison between the relevant parties and this ensures that timely and accurate updates are provided.

FPS Practices themselves can request the services of the HSC Board to act in this role and while the complainant must also be in agreement, these instances may often involve complex complaints.

3.3.3 Complaints concerning the HSC Board

The HSC Board received 16 complaints in 2020/21 a significant decrease from that received in 2019/20 (29) and 2018/19 (25). This number of complaints would be more in line with those received in previous years, 9 in 2017/18, 12 in 2016/17 and 8 in 2015/16.

In relation to the 16 complaints received in 2020/21 the vast majority of these (6) related to decisions taken by the HSC Board in respect of

Extra-Contractual Referrals and also reimbursement in respect of Cross Border treatment. Other concerns raised related to the HSC Board's complaints handling, the governance review of Muckamore Abbey Hospital, pharmacy opening hours and suspension of the Minor Ailment Scheme.

In terms of response times for HSC Board complaints – 4 of the 16 complaints were responded to within 20 working days. It is disappointing that only a quarter of the complaints were responded to within timescale. In regard to those not meeting the timescale reasons for delays were due to the involvement of another organisation (BSO); the scheduling of mutually agreeable date for a meeting with the complainant; delays in HSC Board staff reviewing a draft response; and reviewing the HSC Board's decision not to appoint an independent expert on a dental complaint.

3.4 Independent Lay Persons

The involvement of an independent Lay Person is one of the potential options available within the HSC Complaints Procedure to resolve complaints at local resolution. This year neither the HSC Board nor any of the HSC Trusts involved an Independent Lay Person in any of their complaints.

3.5 Independent Experts

Similarly, obtaining an independent medical opinion/professional is a further option available under the HSC Complaints Procedure as a means of seeking to resolve complaints under local resolution.

During the period 2020/21 the HSC Board did not seek independent expert opinions in any complaints.

In 2020/21 the HSC Trusts involved independent experts' opinions as follows: -

HSC Trust	**Number of Opinions**
Belfast	4
Northern	1
South Eastern	0
Southern	0
Western	0
NI Ambulance Service	0
Total	**5**

4. Other Issues

4.1 Learning Matters Newsletter
During the year a special 'Complaints' edition of Learning Matters was published outlining complaints where regional learning had been identified (Annex 4). Feedback from the HSC Trusts at the HSC Board Monitoring meeting indicated that this special 'Complaints' edition had been very well received by staff in the HSC Trusts. (see attached)

4.2 Advance Care Planning Policy Engagement
Palliative Care complaints are reviewed by professionals and Do Not Attempt Resuscitation Cardio-Pulmonary Resuscitation (DNAR CPR) is a long standing theme within complaints. The Regional Advance Care Planning Lead continues to update RCsG in respect of any developments in this regard (see attached).

4.3 Complaints concerning Discharge
As professionals continued to note the volume and nature of complaints relating to safe discharge arrangements - discharge and transfer of patients are within the top ten issues of complaints received by HSC Trusts, the RCsG agreed that a review of complaints regarding discharge arrangements across the HSC Trusts over a 12 month period should be undertaken. The purpose being to share the findings in the first instance with the Regional Discharge Group, chaired by the Director of Social Care and the Director of Nursing and highlighting potential to inform Policy and a Standard Framework around safe discharge. This review was undertaken and a paper was subsequently discussed at a Safety Brief meeting in June 2021.

It was agreed that in order to provide a complete picture, data should also be reviewed concerning SAIs, AIs and Patient Experience. In the interim the paper will be shared with the Regional Discharge Group in the knowledge that further information will follow. This will ensure there is no delay in sharing the rich information from complaints.

4.4 Revalidation - is a legal requirement for all doctors who are registered with the General Medical Council (GMC). Failure to revalidate results in placing a doctor's licence to practice at risk

and therefore they are unable to work. The Assistant Director of Integrated Care/Head of General Medical Services is the Responsible Officer for making the revalidation recommendation for all GPs in Northern Ireland. This process involves establishing if there are any complaints or concerns regarding each GP both at Practice and OOH level etc. The Complaints Team provides information to colleagues in the Directorates of Integrated Care Services to inform this process throughout the year.

4.5 COVID-19 Complaints - Discussion at the HSC Board Monitoring meeting with HSC Trusts confirmed that HSC Trusts continued with existing processes to grade and escalate complaints of concern during the COVID-19 pandemic. It was noted that specific themes of complaint were beginning to emerge, specifically relating to the impact of COVID-19, ie complaints regarding palliative care/care of the dying/access to loved ones when dying; visiting arrangements; and waiting times associated with delayed treatment/care. As time has progressed this has also included the impact on vulnerable people who are unable to give a history when unaccompanied to HSC facilities. During the period October to December 2020 (Q3 20/21) 86 COVID-19 related complaints were received and 105 during the period January to March (Q4 20/21). This represented a 22% increase in complaints concerning these particular issues. The largest number of complaints related to the impact on waiting times, reduction or suspension of services and visiting restrictions.

4.6 **'**Mealtimes Matter' - This is an 'Always Event' and a key priority for HSC Trusts, led by the Northern HSC Trust (Attached). At the request of the Patient Safety, Quality and Experience Lead, a review of complaints was undertaken for the period October 2019 - March 2021 to identify key themes to inform this improvement work on Mealtimes.

5.0 NI Public Services Ombudsman

The NI Public Services Ombudsman 2020/21 Annual Report has yet to be published.

Further information on the NI Public Services Ombudsman can be found on the website: - nipso@nipso.org.uk

Annex (1)

Examples of Complaints with Learning/Change to Policy or Procedure

Example 1 - FPS Complaint

A complaint reviewed related to an error in patient's medication when they received their medibox. The patient's consultant had increased the dosage from 25 mgs to 50 mgs. Having become unwell, the patient contacted their GP and checked the medication, and it was established that while the label was correct the medication was not.

Practice Response: - The Pharmacy explained how the error had occurred and apologised for the distress caused. It advised that it was cooperating with Pharmaceutical Society of NI and HSC Board Integrated Care professionals in relation to this adverse incident and confirmed that an incident report was submitted to the Directorate of integrated Care.

This confirmed that the incident was due to human error and the pharmacy advised that there had been learning arising from the complaint. The pharmacy identified the contributory factors and implemented a number of changes to improve patient safety and prevent reoccurrence.

The following contributory factors were identified:

- Additional pressures caused by Coronavirus. The workload in the pharmacy has increased substantially due to the pandemic.

- The blister pack concerned had significant polypharmacy with 11 tablets in the morning which made the error less apparent.

- Non-adherence to Standard Operating Procedures (SOP) was not a contributory factor. However, additional information has been added to the SOP to prevent this reoccurring again.

Additional actions have been taken to reduce the risk of re-occurrence of the incident:

- A new step added to the standard operating procedures as an extra safety measure. A coloured note is attached to the front of a patient's file to highlight any changes to medication (including dose changes).

- Learning to be careful when dealing with half tablets and recent dose changes with blister packs with considerable polypharmacy.

- The proprietor has increased the size of the dispensary and improved the lighting and the dispensary space. This improved working area should reduce the risk of dispensing errors.

The Integrated Care Team confirmed that it will not be taking any further action. It had shared a copy of Learning from Adverse Incidents: Adherence to Requests for Dispensing in Instalments & Communication of Instalment Dispensing Medication Changes and a copy of a newsletter on clinical checks with the Pharmacy; an electronic link was also shared Medicines Safety Matters Community Pharmacy Vol 3 Issue 1. The Team confirmed that the incident has been recorded for sharing learning with other pharmacies.

Example 2 - HSC Trust Complaint:

A lady raised concerns that her husband should have been with her when she was told their daughter would be born sleeping (he was not allowed in due to covid-19 restrictions). She also believes that the belt to monitor her daughter's heart rate should have been put on when she first went into labour. She and her husband were not informed that the hospital could have provided a coffin for their daughter; this information was relayed to her husband by the undertaker when he called to make funeral arrangements. The lady also raised concerns in respect of the information provided to parents in relation to post mortem arrangements.

HSC Trust Response:- The Trust offered its sincere and deepest condolences and apologised unreservedly for how this devastating news was relayed to the mother. It acknowledged that the restrictions in place as a result of Covid-19 meant she was alone when she was told her baby had passed away. The Trust explained that medical staff have a duty of care to be open and transparent and to withhold the news could have caused more anxiety whilst waiting on her husband to come in. The Doctor apologised that they did not communicate clearly enough

and for the distress this had caused.

In respect of monitoring her daughter's heart rate, the Trust explained that NICE guidelines do not indicate a cardiotocography for low risk women. It confirmed that staff had auscultated her baby's heartbeat and no heart rate abnormalities where detected.

The Trust apologised for the confusion in relation to information provided by staff regarding funeral arrangements; staff were not aware that coffins were available at the hospital, they have met with the Trust mortician and are now familiar with processes. The Trust apologised for any further distress this may have caused.

Additional RCSG Action:- A redacted copy of the correspondence relating to this complaint was requested and shared with relevant professionals. On review professionals have sought clarification from a Public Health Specialist, to identify any regional learning in relation to the pathology service with Alder Hey, Liverpool, and communication with families. They have confirmed that they have a planned for the review of the PM pathway in May and this feedback will be taken on board.

Example 3 – HSC Trust Complaint:

A family raised concerns that their relative had fallen from a sling which was not properly attached to a hoist; the family provided CCTV footage to the Trust which was distressing to watch as it involved a very vulnerable elderly person who is a dementia patient; is immobile and relies on full professional support and care from the Trust's care workers. The operation of the Hoist caused concern to the relatives as there appeared to be no support to the patient while the equipment was being operated. The relatives were also unhappy with the behaviour of the staff - the care plan book was 'propped' against their relative's legs and set on their stomach. The family were informed that there was no fault with the sling or hoist rather the issue had been human error.

HSC Trust Response: The Trust apologised and noted that the carers had also apologised in person to the complainant on the day of the incident. It advised that the incident was escalated to the locality manager, who arranged for a supervisor to visit the service user's home the following morning to check on them, examine the hoist and make sure there was no obvious fault with the equipment; they reported that

the hoist was working correctly. This was also confirmed by Trust Estates staff.

The Trust acknowledged it had reviewed the CCTV footage which also confirmed the hoist was working correctly. The Trust acknowledged that the CCTV footage from the incident was distressing to watch and the performance of the staff concerned was not as the Trust would have expected. The sling had not been correctly connected to the hoist. The Trust indicated that its investigation had found that this unfortunate incident was as a result of human error. The Trust was disappointed to hear that the care plan had been set on the elderly patient's stomach and rested against their legs which is not acceptable practice and apologised for this. The Trust advised that all Domiciliary Care workers (DCWs) have been reminded of the policy in relation to recording and safe storage of records during visits.

Assurances were given that the DCWs were managed appropriately and in accordance with the Trust Policies and Procedures.

RCSG Action: Additional correspondence relating to the complaint was requested and shared with relevant professionals. On review, professionals agreed that a letter should be issued to the Trust for the attention of the Interim Director of Older People and Primary Care enclosing a reminder of best practice guidance letter (attached) and a request that the Trust undertake the following actions to prevent and mitigate the risks of this incident occurring again:

1. Share the Reminder of Best Practice letter with all relevant staff and discuss it at safety briefings/team meetings to highlight/raise awareness of the risk of death / serious harm if a person falls from a hoist.

2. Ensure current guidance as detailed in the letter is being followed.

3. Ensure all Domiciliary Care Worker staff are aware of the importance of not using manual handling equipment unless trained to do so.

Example 4 – HSC Trust Complaint:

A patient raised concerns that their baby's heart defect was not detected at their scan.

HSC Trust response: The Trust apologised and explained that detection rates for cardiac abnormalities nationally are approximately 50%. The images were reviewed again and there was no indication of a cardiac abnormality. The private scan was done nine days later, which can make a difference to the size of structures within the heart, equipment may differ and the foetal position may become optimal for scanning within this period. The Trust stated that the cardiac imaging was not carried out using the pre-set cardiac settings on the scanner and that this had been discussed with the Sonographer and learning shared. The consultant reviewed the patient with the foetal anomaly scan that had been performed at the Trust and their private scan. Noting the presence of mild bilateral renal pelvic dilatation, they discussed the implications of this finding, including a risk of underlying chromosomal problem of 1-2% and a referral was made to paediatric cardiology.

RCSG Action: Professionals requested additional correspondence in relation to this complaint and noted the Trust had explained learning had been identified. It advised that the diagnostic quality of the saved cardiac imaging was not good. The pre-set cardiac setting had not been used. It is imperative, especially when scanning the heart that the image quality is optimised with appropriate manipulation of all scanner settings. Professionals noted this learning had been shared with the Anomaly Scan Improvement Group/all Obstetric Sonographers in all of the five HSC Trusts and were content the learning had been shared appropriately.

Annex (2)

COVID related Complaints October – December 2020 (Q3 2021) and January – March 2021 (Q4 20/21)

October – December 2020

Subject	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total
Waiting times associated with delayed treatment/care	24	1	6	0	0	31
Reduced/ Stopped Service	2	6	2	5	9	24
Visiting Restrictions inc palliative care patients	3	4	1	4	7	19
Communication with families	3	3	2	1	2	11
Treatment and Care	0	1	0	0	0	1
Total	32	14	11	10	18	86

January – March 2021

Subject	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total
Waiting times associated with delayed treatment/care	21	1	5	2	9	38
Reduced/ Stopped Service	14	3	2	1	4	24
Visiting Restrictions inc palliative care patients	6	3	2	3	2	16
Communication with families	0	4	1	2	7	14
Treatment and Care	1	4	0	1	4	10
Adherence to Guidance	0	2	0	1	0	3
Total	42	17	10	10	26	105

Complaints Contact Points:

HSC Board
Tel: 028 95 363893
Email: complaints.hscb@hscni.net

Belfast Health and Social Care Trust
Tel**:** 028 95 048000
Email: complaints@belfasttrust@hscni.net

Northern Health and Social Care Trust
Tel**:** 028 94 424655
Email: userfeedback@northerntrust.hscni.net

South Eastern Health and Social Care Trust
Tel: 028 90 561427
Email: complaints@setrust.hscni.net

Southern Health and Social Care Trust
Tel: 028 38 614150
Email: complaints@southerntrust.hscni.net

Western Health and Social Care Trust
Tel: 028 71 611226
Email: complaints@westerntrust.hscni.net

Northern Ireland Ambulance Service Trust
Tel**:** 028 90 400 999
Email: complaints@nias.hscni.net

Patient and Client Council
Freephone: 0800 917 0222
Complaints.PCC@hscni.net

NI Public Services Ombudsman
Freephone: 0800 34 34 24
nipso@nipso.org.uk

Welcome to
Learning Matters
Special 'Complaints' Edition 16
March 2021

Introduction

Welcome to this special 'complaints' edition of Learning Matters. All cases presented in this edition have been dealt with through the various Trusts complaints departments. Following resolution of all complaints within Trusts they are forwarded to the Health and Social Care Board (HSCB) complaints department to be reviewed by HSCB and Public Health Agency (PHA) professionals, who ascertain if there is any regional learning from cases or if there are recurring themes, patterns or trends in relation to complaints; that are important to highlight and learn from, so that improvements can be made in relation to patient safety, quality of care and the patient experience.

IN THIS EDITION

Safe Discharge: Remember to check the peripheral intravenous (IV) cannula has been removed 01

Importance of considering flexor sheath infection in any patient presenting with signs of soft tissue infection in the fingers/hand 03

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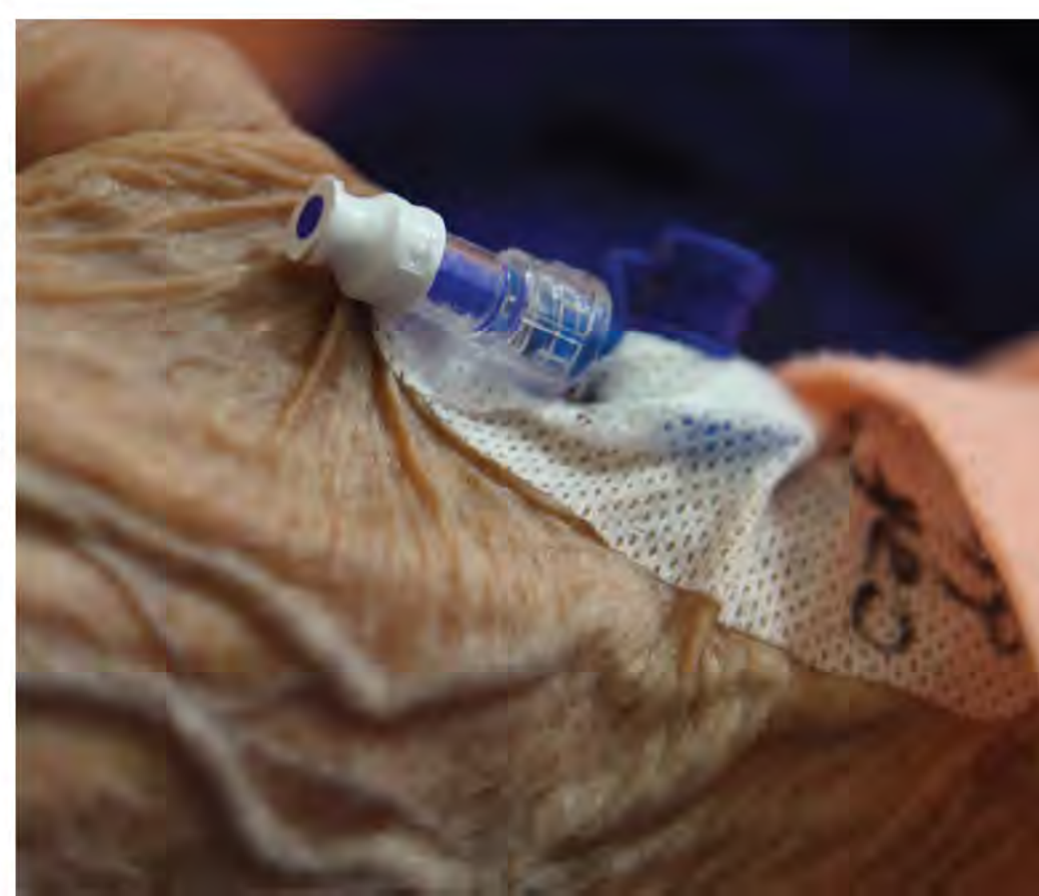
'Focus on' Professionalism 07

Safe Discharge: Remember to check the peripheral intravenous (IV) cannula has been removed

Across the HSC there have been an increasing number of complaints generated, i.e. at least 7 in the past 18 months, in relation to patients being discharged from the hospital setting with a peripheral intravenous cannula still in place because the healthcare professional has omitted to check it has been safely removed prior to discharge. Although none of these complaints resulted in any patient coming to harm, it is however a patient safety issue and should not happen if robust, safe person-centred discharge is undertaken.

A common finding following analysis of these complaints is that this type of incident occurs most frequently following discharge from the Emergency Department (ED).



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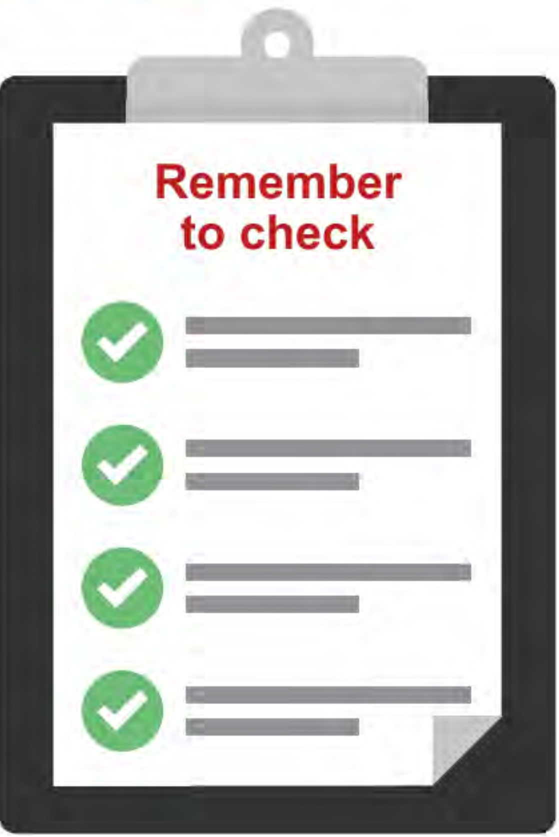

KEY LEARNING

HSC Trusts should have robust processes in place for safe patient discharge, including documentation that details the IV cannula check has been undertaken to ensure it is removed if one is in place.

There are several strategies to avoid accidental discharge with IV cannula in situ including:

- A **clear and simple discharge checklist** that includes a check for cannulas.
- Regular reminders at team meetings/safety briefings for staff to always check for IV cannula in situ and complete the necessary documentation, when the patient is being discharged.
- As part of the insertion procedure healthcare staff should always **inform the patient** (and family members) that it ***must*** be removed on discharge and advise them to flag with a staff member if this has not occurred.
- Regardless of setting, a peripheral IV cannula observation chart must **always** be completed on insertion, as this will also be another prompt for removal on discharge.
- In the ED or primary care setting, beware of the patient that enthusiastically re-dresses themselves prior to discharge, as it is very easy for long sleeved shirts etc. to obscure that visual cue of the cannula still in situ.

The date, time and reason for removal of cannula should always be documented in the patient's nursing and/or medical notes.

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Importance of considering flexor sheath infection in any patient presenting with signs of soft tissue infection in the fingers/hand

A patient presented to the Emergency Department with a red, swollen, tender finger and feeling unwell. The patient had a history of a thorn foreign body in the left middle finger, which they had attempted to remove. On presentation the patient looked pale and was complaining of feeling shivery and nauseated.

The patient was triaged appropriately and bloods were taken which did not indicate any significant systemic infection. The assessing doctor did consider the possibility of flexor sheath involvement but felt there was no evidence of this at the time of assessment. The doctor administered a single dose of intravenous antibiotics and discharged the patient with a course of oral antibiotics and safety net advice to seek further medical review should their symptoms worsen.

The patient's pain did not improve and the swelling in the hand worsened, so they had to urgently re-attend hospital for emergency surgery, due to an **infection of the flexor tendon sheath** of the finger.

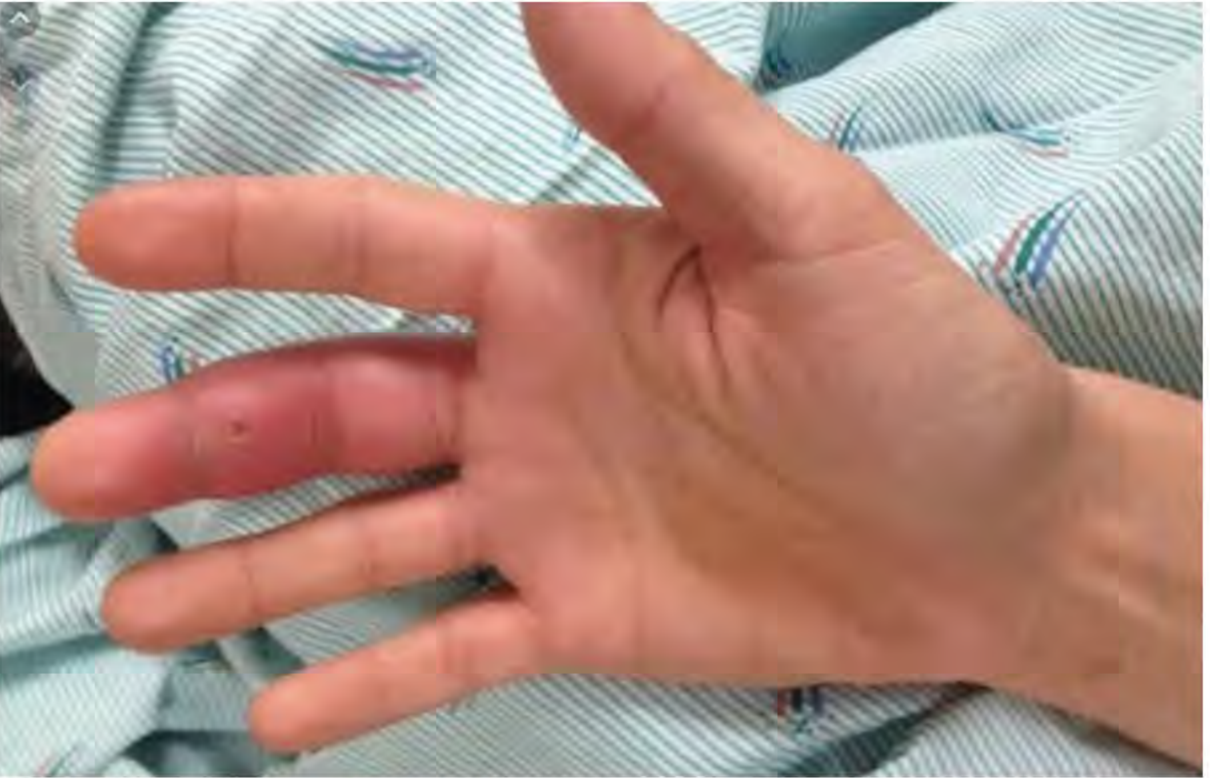

Figure 1. Flexor sheath infection of the right middle finger from a patient with a drill puncture wound.
From: Chan E, Robertson BF, Johnson SM. Kanavel signs of flexor sheath infection: a cautionary tale. Br J Gen Pract 2019; https://bjgp.org/content/69/683/315

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KEY LEARNING

Flexor tendon sheath infection or pyogenic flexor tenosynovitis is an aggressive, closed-space bacterial infection that can lead to significant morbidity if not effectively managed. The purpose of presenting this case is to raise awareness amongst all staff of the importance of thorough history taking, examination and documentation in relation to this important diagnosis.

- Pyogenic flexor tenosynovitis accounts for 2.5-9 % of all hand infections.
- Treatment typically consists of intravenous (IV) antibiotics and surgical drainage of the sheath with open or closed irrigation.
- Despite advances in antibiotic therapy, pyogenic flexor tenosynovitis remains a clinical challenge that requires prompt diagnosis and management.
- Patients present with one or more positive Kanavel's cardinal signs:

  1. Exquisite pain on passive extension of finger
  2. Exquisite tenderness along course of tendon sheath
  3. Fusiform swelling of entire digit
  4. Digit with semi-flexed posture

- Treatment is usually IV antibiotics if the injury is less than 48 hours old. If this is unsuccessful within 12-24 hours then surgical intervention is recommended.
- If the patient presents after 48 hours, then surgical intervention is recommended.
- Healthcare professionals should be aware of the importance of considering the diagnosis of a flexor tendon sheath infection when patients present with a history of injury to the finger, a deep cut, or penetrating trauma, ensuring that they are referred to Plastics at the earliest opportunity.

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Headache: Assessment in the Emergency Department (ED)

A patient attended their GP with a history of increasing headaches, vertigo and tiredness, causing disturbed sleep particularly due to nocturnal headaches with vomiting. Following eye assessment by the GP, the patient was advised to attend the ED immediately with a GP letter of referral suggesting a CT brain scan was required.

At the ED the patient was assessed by medical staff. All clinical observations were within normal limits. The doctor noted that the patient had a moderately severe unilateral throbbing headache with nausea and vomiting; that there was a known history of migraine headaches and that this episode had woken the patient from their sleep. Clinical examination revealed the patient was alert, orientated and coherent, with a Glasgow Coma Score (GCS) of 15/15. There were no cranial nerve deficits, no motor or sensory deficits and pupils were equal and reactive to light. There is **no documentation** that a fundoscopy examination was undertaken.

The doctor did consider a "space occupying lesion" such as a Meningioma in their assessment, but did not consider that it was likely enough to require an emergency brain CT scan on the night of attendance, nor did they ask the patient to return the next day for this investigation. The patient was subsequently diagnosed with migraine headache and on discharge from the ED was provided information regarding adequate hydration, analgesics, and safety net advice to return if symptoms worsened.

One week later, following review by the optician and complaining of worsening vision, the patient was urgently referred to the regional centre with raised intracranial pressure. A CT brain scan showed grade 1 parasagittal meningioma attached to superior sagittal sinus which required urgent surgery.

KEY LEARNING

Headache is a common presentation to the ED and assessment can be complicated. Headaches waking patients from sleep, as in this case, is suggestive of a more serious cause.

The purpose of presenting this case is to raise awareness amongst all staff of the importance of being alert to features suggestive of a serious cause of headache and the importance of seeking advice from **senior colleagues** at the earliest opportunity. Senior advice was **not** sought in this case.

As per NICE guidance - assessment for a person attending with headache should include:

A detailed history, being alert for features suggestive of a serious cause of headache including: progressive or persistent headache, headache with vomiting

Check: Vital signs including fundoscopy

NICE guidelines available here

Also applicable to the learning from this case is The Royal College of Emergency Medicine Consultant Sign-Off (June 2016) which states: *'there are many other presentations that carry important risk (e.g. headache), and individual departments may wish to add these and other conditions locally when staffing allows.'* Full detail of the Consultant Sign-Off is available here to read for context and completeness in relation to how it may relate to this complaint.

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Recognising Ovarian Torsion

A young girl presented to the Emergency Department (ED) with sudden onset abdominal pain and associated vomiting. A history of recurrent abdominal pain was noted. Examination was normal and she was discharged with a diagnosis of non-specific abdominal pain and advised to return if any further concern.

The patient re-presented to the ED the next day with worsening symptoms of abdominal pain. The pain was now associated with anorexia and radiation to the right thigh. Examination revealed a soft abdomen with mild right iliac fossa tenderness and bowels were moving normally.

Vital signs and blood results were normal. Urinalysis was positive for leucocytes, but there were no features of urinary tract infection (UTI). The patient was diagnosed with constipation and discharged. The patient's mother was asked to attend the GP to consider referral to Paediatrics if the issue continued.

The patient re-presented to the ED later the same day with worsening of abdominal pain, making this the third ED attendance in 48 hours. The patient was examined by the ED Consultant. Abdominal examination was unremarkable, however she was admitted to hospital, as this was the third attendance with the same presenting complaint.

The following morning she was reviewed by surgeons who considered taking her to theatre to rule out atypical presentation of appendicitis, however an ultrasound scan of abdomen and pelvis, ordered by ED the evening before was performed, which confirmed the diagnosis of **ovarian torsion.**

KEY LEARNING

Ovarian torsion is rare in children but accounts for 3% of all cases, in the child who presents with acute abdominal pain. Importantly it requires immediate surgical intervention. The presence of vomiting, short duration of abdominal pain, and elevated CRP level has a predictive value for the diagnosis of ovarian torsion in children (Bolli et al., 2017).

Re-attendance to the ED with an ongoing issue should prompt review by a senior ED doctor. The Royal College of Emergency Medicine (RCEM) recommend consultant sign-off for patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. RCEM standard is available here.

Important to note:

Blood markers should **not** be solely relied upon as an indicator of significant pathology or as criterion for admission. Normal inflammatory markers can be falsely reassuring.

Ultrasound abdomen is the first line imaging modality for suspected appendicitis in paediatric patients, but as demonstrated in this case is useful for detecting other pathology.

References

Bolli, P., Schädelin, S., Holland-Cunz, S. and Zimmermann, P. (2017). Ovarian torsion in children. *Medicine,* 96(43), p.e8299.

www.rcem.ac.uk. (n.d.). *RCEM Standards - Consultant Sign-off.* [online] Available at: https://www.rcem.ac.uk/RCEM/Quality-Policy/Clinical_Standards_Guidance/RCEM_Standards.aspx?WebsiteKey=b3d6bb2a-abba-44ed-b758-467776a958cd&hkey=0c1979a4-cd10-4592-babd-9a76d8000d2f&RCEM_Clinical_Standards=2 [Accessed 26 Feb. 2021].

Welcome to Learning Matters Special 'Complaints' Edition 16 March 2021

DURING 2019/20:
- HSCTs received 6105 complaints.

The top three categories of complaints were in relation to:
1. **Treatment and care (1399 complaints)**
2. **Staff attitude and behaviour (1021 complaints)**
3. **Communication (948 complaints)**

'Focus on' Professionalism

A family member of a child attending a chemotherapy appointment raised a complaint with the respective Trust, after witnessing staff 'laughing and joking' inappropriately and 'being on mobile phones'. A further complaint was made by the family member in relation to a staff member they had encountered who was 'rude'.

We should be aware of our surroundings at all times, while working in health and social care, particularly when interacting with work colleagues or patients and be sensitive to others who may witness or overhear our conversations. It is important to consider how interactions or behaviours which may hold no ill-intention, such as joking with colleagues or looking at your phone, is perceived from the point of view of a service user or their family members.

Complaints relating to poor patient experience concerning staff professionalism; namely attitudes and behaviour are not uncommon within the NI health service. This is clearly evident from the complaints information below, where **1021** complaints were received by HSC Trusts in 19/20, that related to **staff attitude and behaviour.** It is therefore **essential** this pattern and trend is highlighted and most importantly improved for those who use our services, often at a very vulnerable and uncertain time in their life.

KEY LEARNING

Professionalism is integral to delivering high quality, safe and effective person centred care across the HSC system in N. Ireland. Being an inspiring role model and working in the best interests of people in our care, regardless of what position we hold and where we deliver care, is what really brings practice and behaviour together in harmony.

In N. Ireland the four Health and Social Care Values provide clarity for all HSC staff, including prospective staff, on the values we should live every day, and the behaviours expected of us, regardless of the HSC organisation we work for. These values and behaviours will send a clear message to patients, service users, families, and carers about the care and support they should expect, and how this should be delivered.

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For all **nursing staff** the following key information is applicable to learning from this complaint and others of similar nature: Enabling professionalism in nursing and midwifery practice is available at the link below:
Enabling professionalism in nursing and midwifery practice.

NMC Code available at the link below:
Nursing and Midwifery Council (2018).

For all **medical staff** the following key information is applicable to learning from this complaint and others of similar nature: The General Medical Council (GMC) **'Good medical practice'** guidance which is available at the link below:
Good medical practice - GMC (gmc-uk.org)

For all **AHP staff** the following key information is applicable to learning from this complaint and others of similar nature: The Health and Care Professions Council (HCPC) **Standards of conduct, performance and ethics** available at the link below:
HCPC Standards.

All pharmacists are expected to abide by the Pharmaceutical Society NI Code
https://www.psni.org.uk/psni/about/code-of-ethics-and-standards/

Another useful resource for all Health and Social Care staff in relation to learning from complaints on attitudes and behaviour is the link below to the Cleveland Clinic video on Empathy:
Cleveland Clinic Empathy - Cleveland Clinic Annual Report 2012

In summary, health and social care staff should be aware of the large volume of complaints generated across the HSC in relation to professionalism concerning staff attitudes and behaviours. HSC staff must act at all times in a polite and courteous manner and with the highest of professional standards and behaviours as set out in guidance by their professional regulatory body.

Contact Us
If you have any comments/feedback or questions on the articles in the newsletter please get in contact by email at learningmatters@hscni.net

Learning Matters is available on:
https://www.publichealth.hscni.net/publications/learning-matters-newsletters

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Mealtime Matters

Antrim Hospital - Our pledge - putting patients first at mealtimes

The mealtime co-ordinator will ensure that all patients receive timely assistance with their meal when required

1. Menu order

Nursing staff must:

- Take menu order using electronic tablet.
- Assist patients / carers with choice and consider patient meal preferences / allergens.
- Ensure right meals are ordered for the right patients; consider need for texture, speech and language needs and special diets including food allergeries.
- Consider the need for snacks for patients with reduced appetite.
- Ensure menus are uploaded to Catering office by 10am each morning.

2. Before mealtime

Nursing staff must ensure:

- A Registered Nurse leads and co-ordinates the mealtime service for patients in their bay or the entire ward.
- Food texture and dietary recommendations are clearly identified.
- Plate method is displayed above bed to identify patients' needs.
- Patients are in a comfortable upright position. Bed tables are cleared and positioned correctly.
- Patients are offered/assisted to visit bathroom.
- Patients hands are washed.
- Provision of adapted plates or cutlery and protective napkin where required.
- That patients requiring mealtime assistance are identified at handover and safety briefings.
- Encourage carers of patients with dementia to visit and assist their relative at mealtimes.

The registered nurse in charge of a bay/ward liaises with and guides Mealtime Companions in relation to specific mealtime care of patients

Staff with catering responsibilities:

- Remove and store snacks until required.
- Ensure food trolley is immediately plugged in once delivered from the kitchen at lunch and dinner times.
- To alert nursing staff / mealtime co-ordinator that meals will be served in five minutes.
- Ensure the food temperatures are checked and recorded in line with Food Safety requirements.

The staff member responsible for the service of beverages:
Must in advance liaise with the registered nurse in charge of a bay / ward to ensure support is provided to patients who require their drinks to be thickened. Check signage for patients not eating or drinking.

3. During mealtime

Staff with catering responsibilities:

- Proceed to the ward service area and take direction from the mealtime co-ordinator.
- Serve food in correct portion size as ordered.
- Present food attractively as per the standard plate model.
- Ensure that seasoning and accompanying sauces are served.

Nursing staff must ensure:

- Patients are not interrupted during mealtime unless it is clinically necessary.
- All available nursing staff and auxiliary staff will assist with mealtimes.
- Staff hands are washed prior to service delivery.
- Staff focus on assisting one patient at a time with feeding.
- The right meal is served to the right patient and corresponds with speech and language/dietetic recommendations.
- Alternatives are offered to patients who refuse their meal.

4. After mealtime

Staff with catering responsibilities:

- Before clearing away, check with the meal co-ordinator if anyone would like more to eat.
- Check meal service has gone well with the meal co-ordinator.
- Report any problems to the Supervisor/Manager.

Nursing staff must ensure:

- Mealtime co-ordinator must scan the ward to ensure all patients have eaten and received assistance.
- Ensure patients are satisfied with their meal and communicate any issues to the Manager/Supervisors.
- Record patient intake of food/fluid where appropriate.
- In the event of a patient missing their meal or being admitted after mealtimes the out of hours catering service can be utilised.

Northern Health and Social Care Trust

August 2018

Department of Health Advance Care Planning Policy for Northern Ireland (for adults)

DNACPR

Thematic Review of DNACPR Issues

February 2021

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1.0 Executive Summary

1.1 Introduction

Advance Care Planning is one of the key priority areas for the Palliative Care in Partnership Programme since 2016. During COVID – 19 the issues relating to Advance Care Planning and in particular Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) have gained a greater emphasis, urgency, and priority.

In response, the Department of Health has tasked a small project team to develop a Regional Advance Care Planning Policy (Adults) for NI. They are also tasked with drafting a comprehensive suite of supporting documentation and with implementing a comprehensive training and education plan.

The high level plan has been approved by the Minister of Health. The Regional Clinical Ethics Forum and the Palliative Care in Partnership members have provided commentary on the scheme of work, inclusive of methodology for the various stages of the development of this Policy.

To ensure rigour from the outset, a thematic analysis was undertaken on a number of key data sources which related to either advance care planning broadly, or DNACPR specifically. These sources included the following six recently published reports;

- Age NI, 'Lived Experience: Voices of older people on the COVID-19 Pandemic 2020',
- Amnesty International, 'As if expendable. The UK Governments failure to protect older people in Care Homes during the Covid-19 pandemic'.
- The CQC interim report from its review into the application of do not attempt cardiopulmonary resuscitation (DNACPR) decisions during the COVID-19 pandemic,
- The National Audit of Care at the End of Life (NACEL), Second round of the audit report Northern Ireland (2019/20),
- The Patient Client Council: Exploring the experiences and perspectives of clinically extremely vulnerable people during COVID 19 shielding December 2020.
- NI Assembly Committee for Health, Inquiry Report on the Impact of COVID-19 in Care Homes (February 2021)

The thematic analysis also included Health and Social Care data; "Regional Complaints" received from across all the Health and Social care Trusts in Northern Ireland between April 2018 and June 2020

which related to ACP or DNACPR. A search of "Serious Adverse Incidents" reported similarly, will be completed when the data is made available to the Project Team.

This paper presents the findings from this initial thematic analysis and is intended as a live document that will be developed further as the work progresses, to include new relevant information as it emerges.

1.2 Thematic analysis overarching themes

Following this initial analysis, a number of overarching themes are evident.

- There should be No blanket approach to DNACPR (Human Rights issue)
  (In both Amnesty UK and CQC interim Report)
- Public misunderstanding of DNACPR
- HSC professionals misunderstanding/poor knowledge of DNACPR process (including no review of status)
- No/Poor/insensitive Communication re DNACPR
- CQC finds that a combination of increasing pressures and rapidly developing guidance may have contributed to inappropriate advance care decisions

2.0 Evidence

What follows is a synopsis of key findings from the six abovementioned reports.

2.1 Age NI – "Lived Experience: Voices of older people on the COVID-19 Pandemic 2020"

Using feedback from older people who accessed their support services during COVID-19 or through hearing older people views during the weekly consultative forum, Age NI compiled this publication, which reflects key concerns and experiences through four key themes:

1. Support, health and care

2. Communication and connection

3. Loneliness and isolation

4. Grief and loss.

Figure I – Extracts from the Age NI report

"Older people around the world bear the brunt of the impact of the COVID-19 pandemic. In Northern Ireland, as elsewhere, statistics paint a stark picture:

• People aged over 65 make up 90% of all the deaths attributed to COVID-19

• People who were living in care homes account for over 50% of related deaths"

Our thematic analysis focused on issues pertaining to DNACPR

- *These are without doubt challenging times, but it is crucial that we continue to protect people's fundamental human rights. The role and timing of advanced (sic) care planning has taken on particular significance.*
- *Advanced (sic) care planning Families were distressed and concerned when advanced (sic) care planning and DNA CPR (Do not attempt cardiopulmonary resuscitation) forms were raised during the early stages of the pandemic.*
- *Action point: Start the conversation and follow best practice in advanced (sic) care planning.*

Key messages / Recommendations

- Older people must not be discriminated against particularly, on the basis of age or condition when it comes to treatment options and choices.
- Older people need to be kept at the heart of compassionate, best practice, care.

Other than that outlined in figure I, there was no further detail provided in the report regarding DNACPR, however Age NI will participate in the Stakeholder engagements.

2.2 Amnesty International: As if expendable. The UK Governments failure to protect older people in Care Homes during the Covid-19 pandemic

This report focuses on the number of COVID-19 related deaths of people over the age of 65 in England, between March and June 2020 (40% of the total of all those who died). Of these, 76% lived in care homes. The report makes the case that the UK government, national agencies, and local-level bodies have taken decisions and adopted policies during the COVID-19 pandemic that have directly violated the human rights of older residents of care homes in England—notably their right to life, their right to health, and their right to non-discrimination.

Figure II - Extracts from Amnesty International Report

"Throughout the pandemic, concerns about the inappropriate use of Do Not Attempt Resuscitation (DNAR) forms have been repeatedly raised."

"Concerns about blanket imposition of DNAR were reported across the country, pointing to flaws with how decisions were taken and policies communicated to those who are supposed to implement them—CCGs, GPs, and care homes. Care home managers reported to Amnesty International and to media cases of local GP surgeries or Clinical Commissioning Groups (CCGs) requesting them to insert DNAR forms into the files of residents as a blanket approach."

The guidance also included instructions related to hospital admission, asking GPs to ensure "patients who do not already have a 'do not convey to hospital' decision are prioritised and have one in place".

"Discussions on advanced (sic) care planning should be warm and natural conversations. This is not how they should be done. One care home with 26 residents had 16 residents sign DNARs in a 24-hour period. It was distressing for staff and residents ... Care homes felt like they were being turned into hospices, and being asked to prepare to manage deaths instead of managing life."

"Following investigations by a senior local figure and news coverage of the story, the CCG responded that while "agreeing advance care plans is a routine and important part of how GPs and care homes support their patients and residents, we recognise there may have been undue alarm caused by the interpretation of this particular guidance." (129 A local official told Amnesty International that the CCG sent a follow-up letter apologising and clarifying guidance shortly after the news coverage).

"indicate that pressure was being exerted from the acute sector to free up hospital beds with little concern for the consequences on the health and lives of those in other settings, including care homes, or for equal treatment in access to care. Discussing how the CCG guidance came to be issued, a senior local figure told Amnesty International that it was clear from conversations he had with senior figures in the local health system that they were under "an enormous amount of pressure from upwards" and

that they were given instructions orally which were not sent in writing or would be worded differently when sent in writing. This would explain why so many CCGs and GPs asked care homes to put DNAR instructions on their residents in a blanket approach even though there is no written record of any such government policy".

"The concern about blanket DNAR instructions was widespread and serious enough, right from the outset of the pandemic, to prompt warnings by the UK's main medical and social care bodies at the beginning of April 2020. In a joint statement issued on 1 April, the British Medical Association (BMA), the Royal College of General Practice (RCGP), the Care Quality Commission (CQC), and the Care Provider Alliance (CPA) warned that: "It is unacceptable for advance care plans, with or without DNAR form completion to be applied to groups of people of any description. These decisions must continue to be made on an individual basis according to need."

"blanket DNACPR" decisions, or decisions taken about resuscitation status by others (GPs, hospital staff or clinical commissioning groups) without discussion with residents, families or care home staff, or that they disagreed with some of the decisions on legal, professional or ethical grounds".

Human Rights violations

"The UK is a state party to international and regional human rights treaties which require it to protect and guarantee fundamental human rights relevant to the concerns addressed in this report, including, notably, the right to life, the right to highest attainable standard of physical and mental health, the right to non-discrimination—including on the grounds of age, disability or health status—the right not to be subjected to inhuman or degrading treatment, and the right to private and family life.206 The UK's obligations under international human rights law requires that it respect, protect and fulfil the human rights of individuals within its jurisdiction. Most of these rights have been enshrined in UK law by the Human Rights Act, which incorporates into domestic law the rights set out in the European Convention on Human Rights (ECHR)"

"Decisions by some CCGs and GPs to direct care homes to put blanket DNAR on all residents and the government's failure to ensure compliance by CCGs, GPs and care homes with standard DNAR procedures violated the right to life, the right to health and the right to non-discrimination of care home residents, who were subjected to such practices as members of a specific category—older persons with and without disabilities living in assisted facilities".

The Report also noted with regard to issues of *"PPE, testing, etc the suspension of inspections by the CQC meant that there was little meaningful protection against such practices"* i.e. the application of blanket DNACPR decisions or decisions taken about resuscitation status that did not involve the person or those closest to them.

Key messages / Recommendations including an Enquiry re DNACPR:

- The extent to which there was inappropriate use of DNARs by health and care professionals, including the incorrect interpretation of them to mean that a person should not be sent to hospital.
- Call for an urgent and thorough review of all DNACPR forms that have been added to care home residents' file since the beginning of the pandemic to ensure they have been completed with the full knowledge, consideration and consent of the resident and/or their family or legal guardian where they do not have mental capacity according to the terms set out in the Mental Capacity Act.
- Call to ensure all staff working in the home understand when and how DNARs/DNACPRs apply and that they do not in themselves indicate that a patient does not want to be taken to hospital or does not want to receive (non-CPR) medical treatment.

2.3 The Care Quality Commission (CQC) interim report from its review into the application of do not attempt cardiopulmonary resuscitation (DNACPR) decisions during the COVID-19 pandemic. (Dec 3rd 2020)

The CQC is the independent regulator of all health and social care services in England. Prompted by concerns about the blanket application of DNACPR decisions during the early stages of the COVID -19 pandemic, it conducted a special review. The review looked at all key sectors, including care homes, primary care and hospitals, and explored the implementation of best practice DNACPR guidance.

Figure III Extracts from the CQC report

"Early findings are that at the beginning of the pandemic, a combination of unprecedented pressure on care providers and other issues may have led to decisions concerning DNACPR being incorrectly conflated with other clinical assessments around critical care".

Recommendations/Outcome

"DNACPR decisions and advance care plans should only ever take place with clear involvement of the individual, or an appropriate representative, and a clear understanding of what they would like to happen".

CQC is now undertaking a more in-depth review in fieldwork, to establish current practice and identify "what local systems need to do so they can protect against possible future errors."

2.4 National Audit of Care at the End of Life (NACEL) Second Round of the Audit (2019/20) Report Northern Ireland.

NACEL is an annual audit managed by the NHS Benchmarking Network, supported by the Co-Clinical Leads, the NACEL Steering Group.

The overarching aim of NACEL is to improve the quality of care of people at the end of life in acute, mental health and community hospitals. The audit monitors progress against the *"Five priorities for care"* set out in *"One Chance To Get It Right"* and *"NICE Quality Standards 13 and 144"*.

The *Five priorities for care* reflect the Northern Ireland Department of Health circular "HSS (MD) 21/2014 *Advice To Health And Social Care Professionals For The Care Of The Dying Person In The Final Days And Hours Of Life – Phasing Out Of The Liverpool Care Pathway In Northern Ireland By 31 October 2014". The circular sets* out five principles that should underpin high quality care in the final days and hours of life. These principles reflected the good practice outlined in the Department's *"Living Matters; Dying Matters (LMDM), Palliative and End of Life Care Strategy for adults"*, published in 2010.

The NI audit, undertaken during 2019/20, comprised:

- An **Organisational Level Audit** covering hospital/submission level questions;
- A **Case Note Review** which reviewed consecutive deaths in the first two weeks of April 2019 and the first two weeks of May 2019 (acute providers) or deaths in April and May 2019 community providers.

Key messages / Recommendations

NACEL shines a spotlight on the last admission to hospital prior to death and highlights whether hospital staff in Northern Ireland are delivering against the quality standards and statements which are universally accepted as good practice.

Figure IV Extracts from the NACEL report

"Advance care planning is an important part of individualised care planning. Analysis from round two indicates that in Northern Ireland, there is limited advance care planning occurring."

"An important element of individualised care planning is understanding the wishes and preferences of dying people, and those important to them. Advanced care planning is one element of this. Given that on average, the dying person was in hospital up to three and a half days before dying in Northern Ireland, it is documented in 5% of cases only that the dying person had participated in end of life care planning during the final admission. It was documented that 3% of dying people had participated in advance care planning prior to their last admission. This is in relation to all deaths."

"Further, analysis indicated that participation in advance care planning was limited, even though Northern Ireland have guidance available, across all care settings, to facilitate this process. Given that the median time from recognition of death to dying was almost three and a half days in Northern Ireland, there may well have been missed opportunities for patients to participate in advance care planning."

Similarly, the audit found limited evidence of discussions regarding DNACPR with the person or with their family/caregivers. The report goes on to make the following recommendation;

"Ensure that every opportunity is taken to give dying people the option to participate in advance care planning, to reflect their choices and wishes at the end of their life. This should include documenting in the patient's care records, the preferred place to die (if known), and facilitating this wherever possible."

2.5 PCC: Exploring the experiences and perspectives of clinically extremely vulnerable people during COVID 19 shielding December 2020

Shielding advice was issued to an estimated 80,000 people in Northern Ireland, significantly changing their lives and those living with them. In May 2020, the Patient and Client Council (PCC) sought to engage with these groups, in partnership with the Department of Health (DoH). The rationale was to ensure that the voices of those impacted by shielding informed decision making and messaging around changes to the restrictions introduced in March 2020.

Respondents who indicated that they were using palliative care support were asked a series of follow-on questions:

Q11. Have you (the person shielding) discussed your future wishes/preferences for care (known as Advance Care Planning) with your GP or another health or social care professional?

Q12. If 'yes', did you have this discussion before you began shielding?

Q13. If 'no', would you like the opportunity to discuss your future wishes/preferences for care?

Q14. What would be the best, most appropriate way to have this discussion in your circumstances?

Key Findings:

despite their serious health conditions, only 24% of the 209 respondents who reported receiving palliative care support indicated that they had discussed Advance Care Planning (ACP) with a health professional. A large majority of respondents (72%) indicated that they had not discussed ACP with a health professional.

Of those who had discussed ACP with a health or social care professional, the majority (68%) had done so prior to the start of shielding.

Of those who had *not* discussed ACP with a health or social care professional, 41% reported that they would like the opportunity to discuss these issues.

However, several respondents reported that being asked about ACP by a health or social care professional during a pandemic would make them feel as though their lives were less valued than those of other ill or well persons.

Among those open to having a conversation about ACP, shielding appeared to influence how they would like to be approached. Around half of these respondents reported that they would prefer to have such discussions over the phone or by email, with some specifically attributing this to their need to shield. It is of interest that a small number of respondents, while open to discussing ACP, felt it was too early for them to be having such discussions.

DNACPR did not feature in this report

2.6 DNACPR Related Complaints to HSCTs April 2018 - June 2020

A trawl of all complaints to HSC Trusts across the Region pertaining to DNACPR related issues, between April 2018 and June 2020 was undertaken and two clear themes were identified; Issues in relation to communication and public and professional lack of understanding regarding DNACPR decision making. The issue of no review of DNACPR was also raised. What follows are the recorded complaints cited under each respective themes;

Communication:

“DNR placed on the patient's file but not discussed with the patient or his family; family not kept informed of the patient's condition”;

“Family felt pressured into agreeing with DNR; no solution given to help with diagnosis; family provided with conflicting information; incorrect information provided to family; incorrect information on patient's records; staff did not tell the family the patient was in his final hours of life”;

“Patient was discharged from hospital with a DNR which family were not told or consulted about”.

“A gentleman raised concerns regarding lack of communication following a meeting regarding a DNR placed on his mother's records”

“Family only spoken to directly by Dr/Consultant once by telephone to discuss DNAR. Daughter lives in England and was not given enough information over telephone”.

Complaint regarding the confusion over a DNR order being placed on a patient with a rare syndrome while in Acute hospital. Also feel that DNR was not discussed in an appropriate manner.
"Service user with late stage dementia was admitted to the Emergency Department. On transfer to the ward it was noticed that a DNAR was on his records. His NOK was informed that staff in the Emergency Department had made this decision. NOK feels this should have been discussed with him".
"Doctor in A&E issued a DNR form in the patients file without consulting family in respect to it. Wants an immediate explanation of this and why it was done".
"No Review of DNACPR"

Public and professional lack of understanding regarding DNACPR decision making

"Family state as she was extremely unwell, decisions were made at A&E to put a DNAR in place. Family disagree with this decision which was later removed. Family want to know how and on what basis this decision was made".
To be reinforced with both medical and nursing staff the importance of patients and their next of kin being fully involved in discussions and decisions taken in relation to DNR
"Patient was upset by comments made by a doctor about resuscitation. Comments from consultant which stated that it was clinically correct for the doctor to discuss resuscitation with the patient, even though it caused him distress".
Complaint letter regarding a deceased gentleman's consultant. This consult is accused of authorising a DNR. The family were not consulted regarding this.
*query regarding DNAR practice; attitude of doctor. (*No detail available in data)

2.7 NI Assembly Committee for Health, Inquiry Report on the Impact of COVID-19 in Care Homes

The Health Committee decided in July 2020, based on evidence it had taken in the spring in relation to the particular impact of COVID-19 on care homes, to conduct a short inquiry, in order to produce recommendations to help mitigate and manage the impact of a potential second surge of the virus in care homes. The report on the Inquiry was published in February 2021 and makes specific recommendations pertaining to ACP.

Figure V: Extract from the NI Assembly Report NIA 59/17-22

Advance Care Planning is another issue that was brought to the Committee's attention in recent months and the Committee acknowledges the sensitivity of such conversations and the importance of this matter being dealt with on an individual basis, supported by the appropriate professional and taking account of the unique needs, preferences and changing circumstances of the individual, ideally well in advance of a crisis.

The Committee also notes that ACP goes well beyond circumstances where resuscitation is appropriate and covers a wide range of care and treatment preferences, in a variety of circumstances.
The Committee notes the pressure felt by some care home staff to lead these important conversations for which they felt further training and medical input was required.

Recommendation 34: Advance Care Planning should be discussed with each care home resident, on an individual basis, ideally ahead of any crisis; it should be led by the clinician who knows the individual best, with the input of other relevant professionals; and reviewed as necessary.

Recommendation 35: The Department of Health should clearly outline and communicate the rights of older people and families regarding end-of-life planning and this should reference the approach to treatment and care planning recommended under NICE guideline NG163.

Recommendation 36: Steps should be taken to ensure that relevant professionals have access to appropriate training in advance care planning.

3.0 Conclusion

The findings from this thematic analysis identifies five key themes; There should be No blanket approach to DNACPR (Human Rights issue); Public misunderstanding of DNACPR; HSC professionals misunderstanding/poor knowledge of DNACPR (including no review of status) and No/Poor/insensitive Communication re DNACPR. Taking cognisance of these issues during the development of a regional ACP Policy for adults in Northern Ireland, is vital and provides a degree of rigour to the work. Some of the findings from this thematic analysis also provide a useful steer for the focus of any public messaging from the Department of Health, Public Health Agency and the Project team regarding advance care planning and DNACPR.

4.0 References

Age NI, (2020) Lived Experience: Voices of Older People on the COVID-19 Pandemic 2020

https://www.ageuk.org.uk/globalassets/age-ni/documents/policy/lived-experiences-brochure-final.pdf

Amnesty International, (2020) As If Expendable: The UK Governments failure to protect older people in Care Homes during the COVID-19 Pandemic

https://www.amnesty.org.uk/files/2020-10/Care%20Homes%20Report.pdf?kd5Z8eWzj8Q6ryzHkcaUnxfCtqe5Ddg6

The Care Quality Commission (CQC), (Dec 3rd 2020), Interim report from the review into the application of do not attempt cardiopulmonary resuscitation (DNACPR) decisions during the COVID-19 Pandemic

https://www.cqc.org.uk/sites/default/files/20201204%20DNACPR%20Interim%20Report%20-%20FINAL.pdf

National Audit of Care at the End of Life (NACEL) Second round of the Audit report Northern Ireland (2019/20)

https://s3.eu-west-2.amazonaws.com/nhsbn-static/NACEL/2020/NACEL_Northern_Ireland_Round_2_Summary_Report_FINAL.pdf

NI Assembly Committee for Health, (February 2021) Inquiry Report on the Impact of COVID-19 in Care Homes Report: NIA 59/17-22

http://www.niassembly.gov.uk/globalassets/documents/committees/2017-2022/health/reports/covid-19-and-its-impact-on-care-homes/report-and-images/health-committee-inquiry-report-on-impact-of-covid-19-in-care-homes.pdf

The Patient Client Council (2020), Exploring the Experiences and Perspectives of Clinically Extremely Vulnerable People during COVID-19, Shielding December 2020

https://patientclientcouncil.hscni.net/download/19/reports/2722/pcc-covid-19-shielding-survey-report-final-dec-20-2.pdf

Health and Social Care Board

Public Health Agency

SAFETY AND QUALITY
REMINDER OF BEST PRACTICE GUIDANCE

Subject	**RISK OF DEATH OR SERIOUS HARM BY FALLING FROM A HOIST**
HSCB reference number	SQR-SL-2020-060 (All PoCs)
Programme of care	All programmes of care

LEARNING SOURCE			
SAI/Early Alert/Adverse incident		Complaint	
Audit or other review		Coroner's inquest	
Other (Please specify) Risk identified following observation of a member of staff on a ward using hoisting equipment incorrectly.			

SUMMARY OF EVENT
A member of staff reported observing another member of ward staff attach a loop sling to a hoist with a clip hanger bar. Such practice could lead to serious harm or death of a service user.

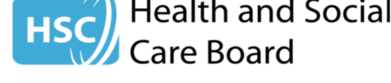
REQUIREMENTS UNDER CURRENT GUIDANCE

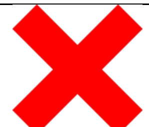
PLEASE ENSURE THAT ALL STAFF INVOLVED IN THE ASSESSMENT AND HOISTING OF PATIENTS / CLIENTS ARE MADE AWARE OF THE FOLLOWING:

If you are using a hoist and sling from 2 different manufacturers then a hoist / sling compatibility risk assessment should be completed to ensure that it is safe to use the two items together.

If you are using a sling with loop attachments, the loop attachments should never be attached to a clip hanger bar.

If you are using a sling with clip attachments, the clip attachment should never be attached to a loop hanger bar.

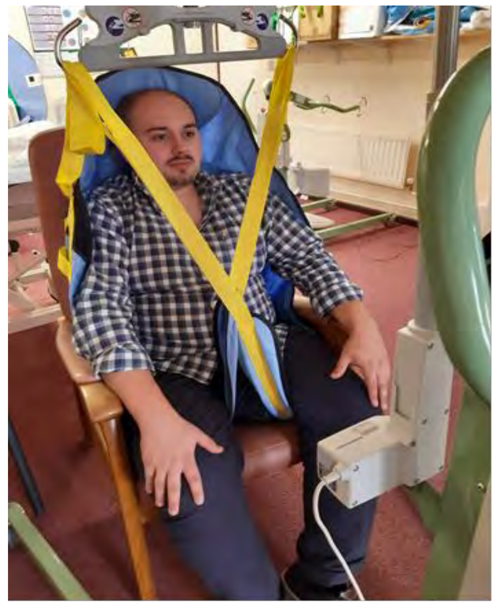




Attaching the sling to the incorrect hanger bar e.g. Attaching a sling with loop attachments to a clip hanger bar will result in a fall from a hoist and possible <u>fatal</u> outcome for a patient / client.

A loop sling has been designed to be used with a loop hanger bar

A clip sling has been designed to be used with a clip hanger bar



Lifting equipment, used in the context of work, is subject to the requirements of the **Lifting Operations and Lifting Equipment Regulations (Northern Ireland) 1999 or LOLER** as the regulations are commonly known. See link below.

http://www.legislation.gov.uk/nisr/1999/304/contents/made

Lifting equipment must be fit for purpose, appropriate for the task, suitably marked and, in many cases, subject to statutory periodic 'thorough examination' by a competent person.

Periodic thorough examinations during the life of the equipment are required for lifting equipment exposed to conditions which cause deterioration likely to result in dangerous situations. Typically equipment used for lifting people must be examined every 6 months. Other lifting equipment should be examined every 12 months.

It should be noted that the provision of some handling aids may bring about other risks such as those caused by unsuitable equipment or untrained staff.

Before using work equipment check the maximum user weight and safe working load. You will need to have an idea of the patient / client weight and ensure that they don't exceed the weight bearing capacity of the equipment.

Do not use equipment unless trained to do so. Visually inspect the equipment to ensure that it is in good working order and suitable for the task. Follow the manufacturer's instructions for use.

Recommended checklist before using a hoist:

- You have been trained and feel confident to use the equipment.
- The person's care plan should detail that a hoist is to be used. The size and type of sling should be recorded and the leg / shoulder loop configuration stated if a loop system is used.
- If you are using a hoist and sling from 2 different manufacturers then a hoist / sling compatibility risk assessment should be completed to ensure that it is safe to use the two items together.
- The hoist should be in good working order – it should go up and down. For a mobile hoist, the legs open and close, and it moves back and forward (wheels are free running).
- You should know how to operate the emergency lowering system.
- The sling should be clean and undamaged and the label readable.
- The sling is the right size and type for the person and task.
- The safe working load (SWL) of the hoist and sling are suitable for the patient's weight and needs.
- You have explained to the person what you are going to do and have consent and cooperation to proceed.
- You know how to seek further advice and the person's needs are reviewed.

References / Evidence Base:

Health & Safety Executive Guidance on the:

The Lifting Operations and Lifting Equipment Regulations (Northern Ireland) 1999
http://www.legislation.gov.uk/nisr/1999/304/contents/made

The Provision and Use of Work Equipment Regulations (Northern Ireland) 1999
http://www.legislation.gov.uk/nisr/1999/305/part/II/made

The Guide to the Handling of People 6th Edition. Backcare in collaboration with National Back Exchange 2011.

ACTION REQUIRED

HSC Trusts should:

1. Share this Reminder of Best Practice letter with all relevant staff.
2. Ensure current guidance as detailed above is being followed.
3. Ensure staff are aware of the importance of not using manual handling equipment unless trained to do so.
4. Confirm by 20 May 2020 to Alerts.HSCB@hscni.net that actions 1, 2 and 3 have been completed.

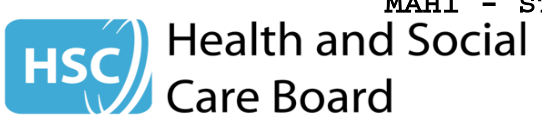
RQIA should:

1. Should share this Reminder of Best Practice letter with all relevant staff in care homes, domiciliary services and the independent sector.

Date issued	19 February 2020		
Signed:	[signature]	[signature]	[signature]
Issued by	Marie Roulston Director of Social Care & Childrens Directorate	***PP*** Dr A Mairs Acting Director of Public Health	Mr Rodney Morton Director of Nursing, Midwifery and Allied Health Professionals

RE: **SQR-SL-2020-060 (All PoCs) - Risk of death or serious harm by falling from a hoist – Distribution list**

	To – for Action	Copy		To – for Action	Copy
HSC Trusts			**PHA**		
CEXs	✓		CEX		✓
First point of contact		✓	Acting Director of Public Health		✓
			Director of Nursing, Midwifery and AHPs		✓
NIAS			Director of HSCQI		✓
CEX	✓		AD Service Development, Safety and Quality		✓
First point of contact		✓	PHA Duty Room		
			AD Health Protection		
RQIA			AD Screening and Professional Standards		
CEX	✓		AD Health Improvement		
Director of Quality Improvement		✓	ADs Nursing		✓
Director of Quality Assurance		✓	AD Allied Health Professionals		✓
			Clinical Director Safety Forum		✓
NIMDTA					
CEX / PG Dean			**HSCB**		
QUB			CEX		
Dean of Medical School		✓	Director of Integrated Care		✓
Head of Nursing School		✓	Director of Social Services		✓
Head of Social Work School		✓	Director of Commissioning		
Head of Pharmacy School			Alerts Office		✓
Head of Dentistry School			Interim Director of PMSI		
UU					
Head of Nursing School		✓	**Primary Care (through Integrated Care)**		
Head of Social Work School		✓	GPs		✓
Head of Pharmacy School			Community Pharmacists		
Head of School of Health Sciences (AHP Lead)		✓	Dentists		
Open University					
Head of Nursing Branch		✓	**BSO**		
			Chief Executive		
Clinical Education Centre		✓			
NIPEC		✓	**DoH**		
NICPLD			CMO office		✓
NI Medicines Governance Team Leader for Secondary Care			CNO office		✓
NI Social Care Council			CPO office		
Safeguarding Board NI			CSSO office		
NICE Implementation Facilitator			CDO office		
Coroners Service for Northern Ireland			Safety, Quality and Standards Office		✓



HSC Public Health Agency

Sent by email only

12-22 Linenhall Street
BELFAST BT2 8BS
Tel : 0300 555 0115
Web Site : www.hscboard.hscni.net

To: Brian Beattie,
Director of Older People &
Primary Care Services

Our Ref: SQR-SAI-2020-060 (All PoCs)

19 July 2021

Dear Brian,

Risk of Death or Serious Harm by Falling from a Hoist – SQR-SL-2020-060 (All PoCs)

You will be aware of the above safety and quality reminder of best practice letter that the HSCB/PHA issued in February 2020, entitled '*Risk of Death or Serious Harm by Falling from a Hoist'*. This regional learning was issued following a staff member observing another member of staff attaching a loop sling to a hoist with a clip hanger bar. This practice had the potential to cause serious harm or death of a service user.

Despite the detailed assurance from the Southern Trust stating the required actions had been completed, I am writing to you as a complaint relating to the Trust has recently came to the attention of the HSCB/PHA (12988).

The complaint relates to an incident which occurred in a client's own home on 23rd September 2020, where they fell from a sling which was not correctly attached to the hoist. I trust you appreciate this is extremely concerning in light of the assurance the Trust provided in response to the above letter.

I am now reissuing the attached reminder of best practice guidance letter and request that the Trust undertake the following actions to prevent and mitigate the risks of this incident occurring again:

1. Share this Reminder of Best Practice letter with all relevant staff and discuss it at safety briefings/team meetings to highlight/raise awareness of the risk of death / serious harm if a person falls from a hoist.
2. Ensure current guidance as detailed in the letter is being followed.
3. Ensure all domiciliary staff are aware of the importance of not using manual handling equipment unless trained to do so.

Health and Social Care Board
Public Health Agency

I am happy to discuss if you feel this would be helpful.

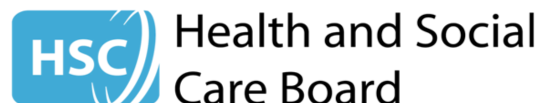
Yours sincerely

Signed:	Anne-Marie Phillips
Issued by	Anne-Marie Phillips Patient Safety, Quality & Experience Nurse Lead, PHA

Enc.

Copy to:

Nicole O'Neill, Complaints Manager, SHSCT
Governance Lead for SQAs, SHSCT
David Petticrew, Programme Manager, Social Care, HSCB
Mrs Liz Fitzpatrick, Complaints Manager, HSCB



Protocol for the Role of a HSCB/PHA Designated Review Officer (DRO) allocated to a Serious Adverse Incident (SAI)

Revised: March 2017

Version 1.0

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1.0 Background

The requirement on HSC organisations to routinely report Serious Adverse Incidents (SAIs) to the Department of Health (DoH) ceased on 1 May 2010. From this date, the revised arrangements for the reporting and follow up of SAIs, transferred to the Health and Social Care Board (HSCB) working both jointly with the Public Health Agency (PHA) and collaboratively with the Regulation and Quality Improvement Authority (RQIA). During 2012/13 the HSCB, working with the PHA, undertook a review of the Procedure, issued in 2010, and issued revised guidance in September 2013.

A further review was undertaken in November 2016 and issued to all Arm's Length Bodies (ALBs) for full implementation on 1 January 2017. The procedure provides guidance to all Arms Length Bodies in relation to the reporting and follow-up of SAIs arising during the course of business of a HSC organisation/Special Agency or commissioned service.

2.0 Role of the HSCB/PHA in the SAI Process

- Responsible for the effective implementation of the procedure for the reporting and follow up of SAIs across the region;

- Ensuring there are mechanisms in place for SAIs to be reviewed by relevant professionals/senior officers;

- Ensuring there are adequate safety and quality structures within the HSCB/PHA so that trends, best practice and learning is identified, disseminated and implemented in a timely manner in order to prevent recurrence;

- Identify any immediate/medium/long term strategic issues which contributed to the incident and that need to be addressed, and communicate these to the relevant commissioning service;

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

3.0 What are the HSCB/PHA Safety and Quality Structures relating to SAIs?

It is important that when a SAI occurs, that there is a systematic process for reviewing the incident and identify potential learning. The key aim being to improve patient safety and reduce the risk of recurrence, not only within the reporting organisation, but across health and social care as a whole.

The HSCB and PHA therefore have developed a safety and quality structure that provides an effective mechanism for identifying and disseminating regional learning across the province.

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

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

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

- **Regional Serious Adverse Incident Review Sub-Group (RSAIRSG)**

The RSAIRSG is chaired by the HSCB Governance Manager and the PHA Senior Manager for Safety, Quality and Patient Experience. Membership comprises of professional representatives from the HSCB and PHA; RQIA are also in attendance.

The RSAIRSG has responsibility to ensure that trends, examples of best practice and learning in relation to SAIs are identified and disseminated in a timely manner.

- **SAI Professional Groups**

A number of professional groups from individual programmes of care have recently been established which allow DROs who share the same area of expertise to meet and discuss SAI reviews and where relevant identify regional learning prior to closure of the SAI. These professional groups also provide support to DROs when they may require advice in relation to specific SAIs.

The groups benefit from:

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

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

SQAT, which is closely aligned to the work of QSE, is responsible for performance managing the implementation and assurance of Regional Safety and Quality Alerts / Learning Letters / Guidance issued by HSCB/PHA in respect of SAIs.

SQAT is a multidisciplinary group with representatives from the HSCB and PHA and is chaired by the PHA Medical Director/ Director of Public Health. The Group meet fortnightly to co-ordinate the implementation of regional safety and quality alerts, letters and guidance issued by the DoH, HSCB, PHA and other organisations. This provides a mechanism for gaining regional assurance that alerts and guidance have been implemented or that there is an existing robust system in place to ensure implementation.

An overview of the Safety and Quality Structures is outlined in Appendix 1.

- **HSCB Governance Team**

The HSCB Governance Team provides the co-ordination, administrative support to all of the above groups and to individual DROs in relation to the management of SAIs from notification to closure of a SAI.

4.0 What is a DRO?

A DRO is a senior professional/officer within the HSCB / PHA who has a degree of expertise in relation to the programme of care / service area where a SAI has occurred.

5.0 What is the role of a DRO?

The DRO has a key role in the implementation of the SAI process namely:

- liaising with reporting organisations:
  - on any immediate action to be taken following notification of a SAI;
  - where a DRO believes the SAI review is not being undertaken at the appropriate level.

- Agreeing the Terms of Reference for Level 2 and 3 RCA reviews;

- Reviewing completed SEA Learning Summary Reports for Level 1 SEA Reviews and full RCA reports for Level 2 and 3 RCA Reviews, including service user/family/carer engagement and liaising with other professionals (where relevant);

- Liaising with reporting organisations via the Governance Team, where:

  - More information is required in relation to a Level 1 summary report. (Whilst the HSCB will not routinely receive the full Level 1 SEA report, these can be requested.)

  - There may be concerns regarding the robustness of the Level 2 and 3 RCA reviews and providing assurance that an associated action plan has been developed and implemented.

- Identification of regional learning, where relevant;

- Surveillance of SAIs to identify patterns/clusters/trends.

- Escalate concerns/issues as necessary to the Director and onwards to the respective Chief Executive as required.

6.0 Process

The following details the systematic approach in relation to the nomination of a DRO to a SAI and the process that follows until such time as the SAI can be closed. (A flowchart reflecting each step of the SAI process is detailed in Appendix 2.)

Step 1 - Notification of SAI

- SAI notified to Governance Team by Reporting Organisation;

- Governance Team.
  - Records SAI on the Datix Risk Management System;
  - Forward SAI Notification to DRO as per Regional DRO Listing or Allocation Flowchart and copy to relevant Directors/Senior Managers (current listing and flowcharts available via the following Link http://insight.hscb.hscni.net/resources/safety/);
  - Where the DRO is not automatically allocated from a Flowchart the Regional Lead/s will assign a DRO (this may be a Regional Lead or another member of staff from within their programme of care / area of specialism). Governance Team will forward SAI Notification to the assigned DRO;

- Acknowledge receipt of SAI Notification to reporting organisation and advise on date for submission of learning summary/review report.

Step 2 - Immediate Actions

- DRO will consider SAI and if they decide it to be of major concern they will liaise immediately with their Director with a view to bringing it to the attention of the Chief Executive;
- If required, the DRO will liaise with the Reporting Organisation regarding any immediate actions required. This will be carried out in conjunction with the Governance Team;
- Governance Team will update DATIX accordingly.

Step 3 - Submission of Learning Summary/Review Report/Additional Information

- Governance Team will liaise with Reporting Organisation with regard to review report deadlines i.e. reminders, DRO queries etc;
- Reporting Organisation submit learning summary/review report to serious.incidents@hscni.net (Governance Team);
- Governance Team forward learning summary/review report to DRO;
- DRO will liaise with other professional leads, including RQIA (where relevant) on receipt of learning summary/review report. For those SAIs that are medication related, the DRO may wish to liaise with the Secondary Care Medicines Governance Team (refer to appendix 2)
- If DRO and professional leads (where relevant) are not satisfied with learning summary/review report, DRO will request additional information from the Reporting Organisation until adequate assurance is provided.
- When a DRO has received all the information it is expected the reporting organisation will be informed within a period of 12 weeks that the SAI has been closed.

Step 4 - Closure of SAI

- When a DRO is satisfied with learning summary/review report, and where relevant any additional information that has been requested, he/she informs the HSCB Governance Team they are content to close the SAI in line with HSCB/PHA 'Criteria for Closing SAIs' (Appendix 3);

- The HSCB Governance Team refers the SAI to the relevant SAI Professional Group;

  - Acute;
  - Maternal and Child Health (Including Acute Paediatrics);
  - Elderly Services and Physical Disability and Sensory Impairment;
  - Mental Health and Learning Disability Services;
  - Prison Health;
  - Integrated Care;
  - Corporate Services;
  - Childrens Services – Social Care;
  - Adult Services – Social Care.

- SAI discussed at SAI Professional Group meeting and the following agreed:
  - SAI closed with regional learning and referred to RSAIRG and/or QSE Group either for noting or discussion;
  - SAI closed without regional learning.

- Governance Team closes SAI on DATIX and informs the Reporting Organisation (and RQIA where applicable) that SAI has been closed.

Step 5 – Regional Learning Identified

- Once regional learning has been identified by the Professional Group a DRO may be required to:
  - Refer learning to Network or Group that has already been established;
  - Draft an article for inclusion within a newsletter or draft a reminder or best practice or learning letter;
  - Attend a meeting of the RSAIRG or QSE group to discuss proposed learning;
  - Be involved in a Thematic Review or Task and Finish Group.

A flowchart outlining the approval process and dissemination of regional learning can be accessed via the following link.

http://insight.hscb.hscni.net/resources/safety/

7.0 Supporting the DRO Process

7.1 Datix

In order to ensure Statutory Information Governance requirements are adhered to, all communication for each stage in the process should be communicated by the DRO to the HSCB Governance Team. This ensures the Corporate Record for each SAI is fully documented on the Datix Risk Management System.

7.2 DROs Supporting Information

Appendix 4 provides DROs with some supporting information which they may wish to consider on receipt of SAI notifications and learning summary/review reports.

7.3 Escalation Process for DRO Requests

Throughout the process there may be occasions where the reporting organisation does not agree with a DRO request. Examples include:

- escalate a SAI to a higher level review;
- amend a review report;
- issues around family engagement;
- requests for additional information are withheld;
- request for a SAI following notification of an Early Alert;
- where a DRO/Professional has been made aware of an incident that they feel should be reported as a SAI.

On these occasions, DROs should follow the escalation process as detailed below:

Stage 1 – Reporting organisation notifies the DRO that they do not agree with their request

- DRO discusses the SAI at the next relevant SAI Professional Group and if agreed the reporting organisation is notified via the Chair of the Professional Group.

Stage 2 - If the reporting organisation does still not agree:

- The DRO informs the relevant HSCB/PHA Director;
- Relevant HSCB/PHA Director discusses this with the relevant Director within the Reporting Organisation.

Stage 3 – If the Reporting Organisation is still not in agreement:

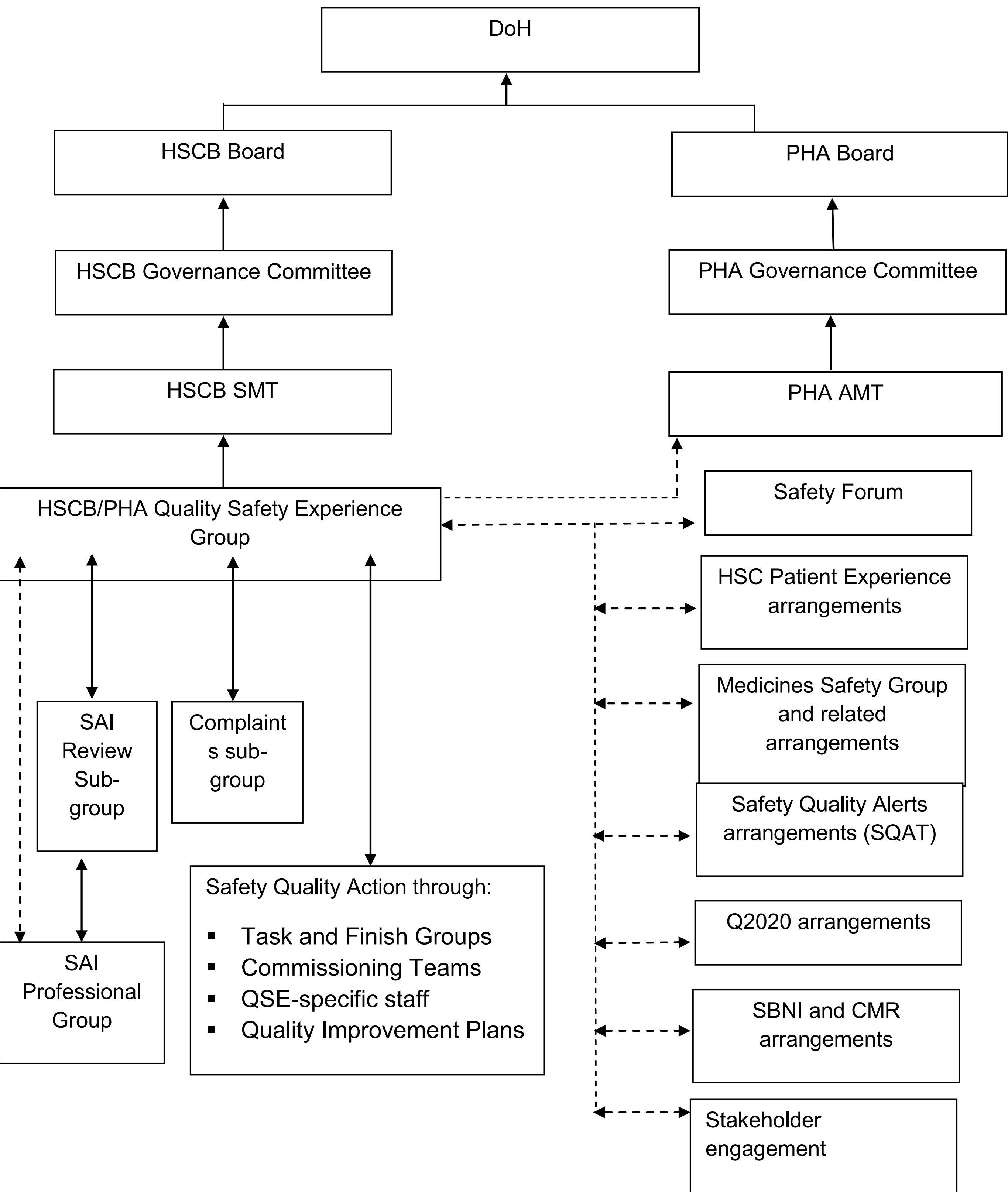
- This should be listed for consideration at QSE.

7.4 Interface Incidents Process

The HSCB/PHA process for the management of interface incidents notified to the HSCB can be accessed via the following link:
(TO BE INSERTED)

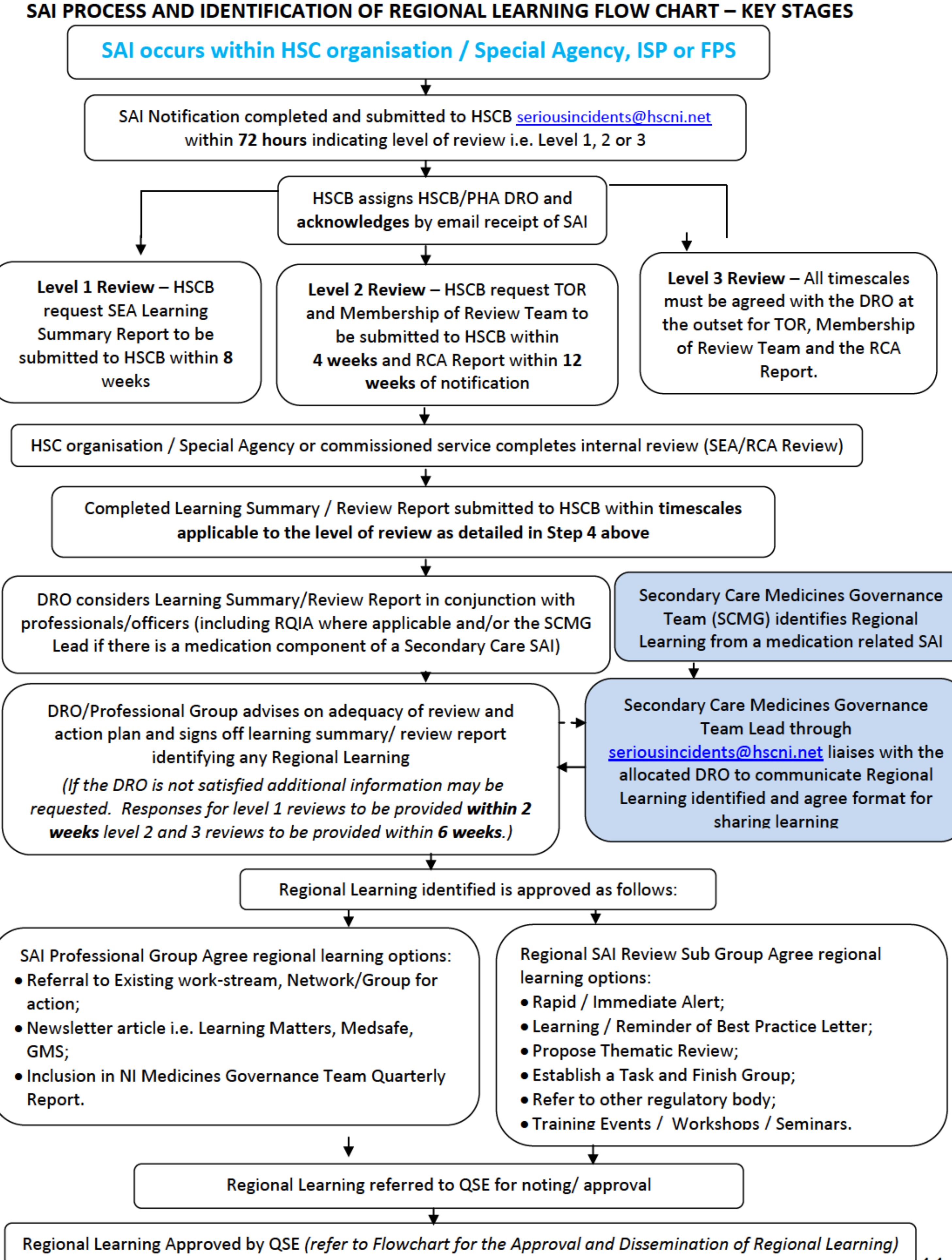
BW-256
Appendix 1

HSCB/PHA SAFETY AND QUALITY STRUCTURES



Appendix 2

SAI PROCESS AND IDENTIFICATION OF REGIONAL LEARNING FLOW CHART – KEY STAGES



CRITERIA FOR CLOSURE OF SAIs

A DRO can close an SAI when it meets one of the following three criteria:

1. An independent evaluation of the learning summary/review report received from the reporting organisation has been undertaken by a nominated HSCB/PHA Designated Review Officer (DRO) in conjunction with other officers/professionals (including RQIA) where relevant.

   Prior to closure the DRO must be satisfied that:

   - Format and content of the learning summary/review report is in line with regional templates for Level 1 and level 2/3 Reviews;
   - Review has been carried out appropriately by the reporting organisation (this is only applicable for level 2/3 reviews as the quality assurance of Level 1 reviews is the responsibility of the reporting organisation);
   - All reasonable steps have been taken to prevent recurrence;
   - Recommendations and actions are appropriate and where required there are performance mechanisms in place via the HSCB Governance Team to monitor these;
   - Any queries arising from the learning summary/review report have been resolved including confirmation of how local learning has been disseminated and regional learning identified;

     Other specifics of independent evaluation/review DRO may wish to consider are the Reporting Organisation:

     - has confirmed that it has discharged all statutory requirements;
     - has confirmed that all necessary safeguarding requirements associated with the incident are in place;
     - confirms details of any disciplinary action arising from the incident.

2. DRO has been informed the SAI has transferred to another relevant investigatory process i.e.

    - Case Management Review;
    - Public Inquiry;
    - Independent Expert Inquiry.

3. Following initial notification DRO is advised by reporting organisation that following preliminary reviews, incident is no longer considered a SAI. DRO will consider in conjunction with other officers/professionals, requesting additional information from reporting organisation if necessary; prior to de-escalating SAI and closure.

Supporting Information for Designated Review Officers

1) At the time the SAI is notified

Immediate Actions

- Is the DRO satisfied that the Trust have taken reasonable actions to reduce the risk of recurrence pending the full review report. HSCB/PHA recognise that this cannot prejudge the outcome of the full review and that what appear to be the circumstances at the time of reporting, may not be substantiated through review;
  - The DRO should also consider if the HSCB/PHA have previously issued regional learning in relation to a similar type incident. In those circumstances, it may be appropriate to ask the Trust whether or not they have:
- Brought the incident to the attention of individual(s) staff involved to ensure that all are aware and to do an immediate review of the circumstances that led to the incident;
- Provided training/refresher training on relevant policies/procedures for the staff involved
- Informed other staff in the unit of the incident.

Level of Review

Do you agree with the level of review the Trust has proposed to undertake?

The nature, severity and complexity of serious incidents vary on a case-by-case basis and therefore the level of response should be dependent on and proportionate to the circumstances of each specific incident. The appropriate level of investigation will be proposed by the provider and agreed by the DRO upon notification, however the level of review may change as new information or evidence emerges as part of the review process.

- **Level 1 Review – Significant Event Audit (SEA)**

  Concise, internal review which is suited to less complex incidents which can be managed by individuals involved in the incident at local level.

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- **Level 2 Review - Root Cause Analysis (RCA)**

  A comprehensive internal review which includes an independent element and is suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist advisors.

- **Level 3 Review - Root Cause Analysis (RCA)**

  This level of review is suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist advisors. It is required where the integrity of the review is likely to be challenged or where it will be difficult for an organisation to conduct an objective review internally.

  The HSC Regional Risk Matrix (Appendix 5) assist organisation to determine the level of seriousness and subsequently the level of review to be undertaken. DROs can similarly use this matrix to determine if they agree with the level of review being undertaken.

2) At the time the SAI Review Report is received

In your best professional judgment and from the information available to you:

- Has the family been involved appropriately?
- Where appropriate, has the Coroner been notified?
- Was membership of the Review Team appropriate for the level of review undertaken?
- From the information in the report, does it appear that the Review Team identified and reviewed the factors that led to the incident correctly and thoroughly?
- Do the conclusions reflect the facts of the incident?
- Do the recommendations address the underlying contributing factors?
- Is the Action Plan a reasonable set of actions to address the issues/recommendations identified by the review?
- Is there regional learning and if yes, what is that and how should it be handled
  - Learning Matters newsletter article
  - Learning Letter
  - Bespoke piece of work
  - Other?

- To the best of your knowledge, are you aware of other SAIs where the factors have been similar to this SAI?

- Can the SAI be closed – yes/no?

HSC Regional Impact Table – with effect from April 2013 (updated June 2016)

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment • Any patient safety incident that required extra observation or minor treatment e g first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks)	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year) • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days) • Any patient safety incident that resulted in a moderate increase in treatment e g surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma) • Increase in length of hospital stay/care provision by >14 days	• Permanent harm/disability (physical/ emotional trauma) to more than one person • Incident leading to death
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues	• Single failure to meet internal professional standard or follow protocol • Audit/Inspection – recommendations can be addressed by low level management action	• Repeated failure to meet internal professional standards or follow protocols • Audit / Inspection – challenging recommendations that can be addressed by action plan	• Repeated failure to meet regional/ national standards • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities • Audit / Inspection – Critical Report	• Gross failure to meet external/national standards • Gross failure to meet professional standards or statutory functions/ responsibilities • Audit / Inspection – Severely Critical Report
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern • Local press < 1day coverage • Informal contact / Potential intervention by Enforcing Authority (e g HSENI/NIFRS)	• Local public/political concern • Extended local press < 7 day coverage with minor effect on public confidence • Advisory letter from enforcing authority/increased inspection by regulatory authority	• Regional public/political concern • Regional/National press < 3 days coverage Significant effect on public confidence • Improvement notice/failure to comply notice	• MLA concern (Questions in Assembly) • Regional / National Media interest >3 days < 7days Public confidence in the organisation undermined • Criminal Prosecution • Prohibition Notice • Executive Officer dismissed • External Investigation or Independent Review (eg, Ombudsman) • Major Public Enquiry	• Full Public Enquiry/Critical PAC Hearing • Regional and National adverse media publicity > 7 days • Criminal prosecution – Corporate Manslaughter Act • Executive Officer fined or imprisoned • Judicial Review/Public Enquiry
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m • Loss of assets due to damage to premises/property • Loss – £1K to £10K • Minor loss of non-personal information	• Commissioning costs (£) 1m – 2m • Loss of assets due to minor damage to premises/ property • Loss – £10K to £100K • Loss of information • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m • Loss of assets due to moderate damage to premises/ property • Loss – £100K to £250K • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m • Loss of assets due to major damage to premises/property • Loss – £250K to £2m • Loss of or corruption of sensitive / business critical information • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m • Loss of assets due to severe organisation wide damage to property/premises • Loss – > £2m • Permanent loss of or corruption of sensitive/business critical information • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care • Insignificant unmet need • Minimal disruption to routine activities of staff and organisation	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care • Minor unmet need • Minor impact on staff, service delivery and organisation, rapidly absorbed	• Loss/ interrup ion 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care • Moderate unmet need • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resul ing in major damage or loss/impact on service. • Major impact on public health and social care • Major unmet need • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care • Catastrophic unmet need • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release	• On site release contained by organisation	• Moderate on site release contained by organisation • Moderate off site release contained by organisation	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc)	• Toxic release affecting off-site with detrimental effect requiring outside assistance

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HSC REGIONAL RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016)

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency (How often might it/does it happen?)**	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	Medium	Medium	High	Extreme	Extreme
Likely (4)	Low	Medium	Medium	High	Extreme
Possible (3)	Low	Low	Medium	High	Extreme
Unlikely (2)	Low	Low	Medium	High	High
Rare (1)	Low	Low	Medium	High	High

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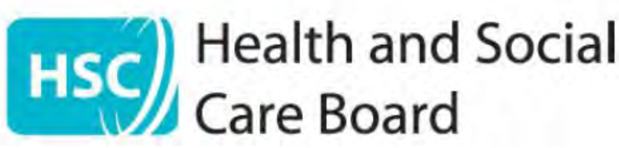
BW-256

DRO Workshop - 9 December 2013

Reporting and Follow up of SAIs

Overview of Revised Procedure

Mrs Anne Kane, Governance Manager, HSCB



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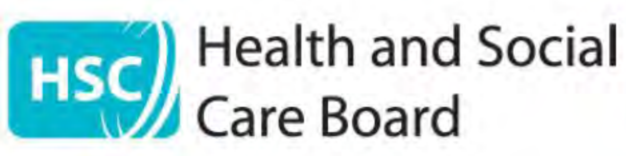
Implementation

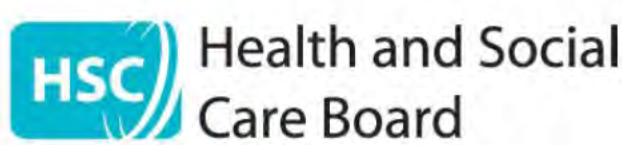
- Procedure implemented on 1 October 2013
  - Following extensive consultation with HSC Trusts and other relevant organisations
  - DROs
    - Some issues raised by DROs not addressed in procedure but will be within internal DRO protocol
- Training – Dec 2013, Jan & Feb 2014
- Full operational implementation 1 April 2014



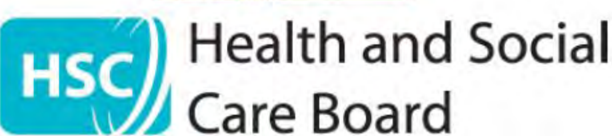
How is this working for you?

Are you clear on all aspects of the procedure?

Are you clear on your role as a DRO?

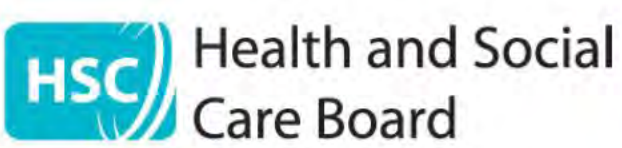


Or.....do you feel you are.... drowning in process?

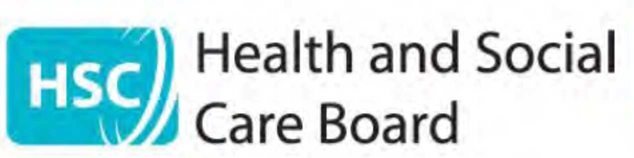


Overview of Revised Procedure

- What aspects of the process have changed
- Highlight DRO role within the process
- Acknowledge current and potential difficulties DROs experience
- Look for solutions



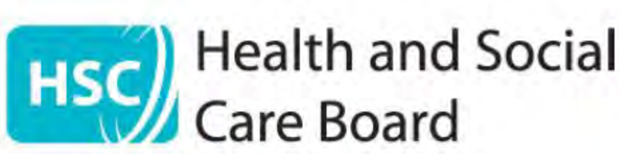
What are the key Changes?



Application of Procedure

Procedure is now clearer on who procedure is applicable to and specifically who we receive SAIs from:

- **All HSC Organisations & Special Agencies**
- **Family Practitioner Services**
  - Reported as adverse incident to HSCB Integrated Care
  - Integrated Care report as SAI
- **Voluntary and Community Sector**
  - Organisation who referred the service (including ECR's)
  - The organisation who holds the contract
- **Interface incidents**
  - Reporting form when one SAI has occurred in one organisation but identified in another

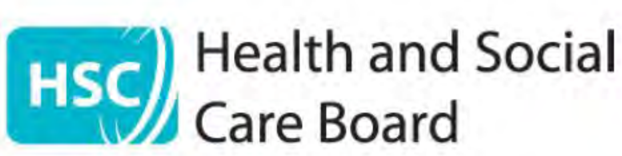


Criteria

Key Changes

- New Child Death Notification

- Known to Mental Health, Related Services and/or Learning Disability services
  - Time limit aligned to England – reduced from 2 years to 1 year



SAI Notification

Process

- Notified 72 hours following the organisation being made aware the SAI has occurred.
- Trusts also notify RQIA:
  - All mental health and learning disability SAIs reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986.
  - Any SAI that occurs within the regulated sector (whether statutory or independent) for a service that has been commissioned/funded by a HSC organisation
- Notification form advises on level of investigation
- DRO nominated by lead officer
- Flowchart for direct nomination

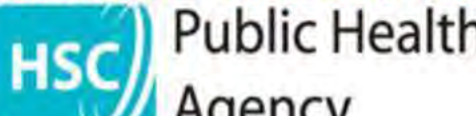
DRO Responsibilities

If required:

- Ask for additional information
- Follow up on immediate action
- Challenge investigation level

All communication via Governance Team

HSC Health and Social Care Board

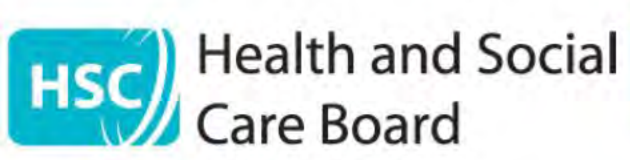


Public Health Agency

SAI Investigation

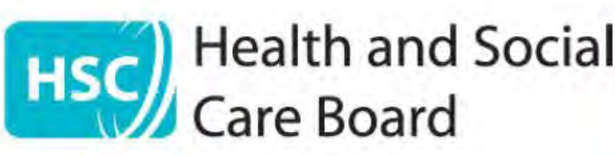
3 levels of investigation – previously all SAIs same level of investigation

- Level 1 – Significant Event Audit
- Level 2 – Root Cause Analysis
- Level 3 - Independent Review



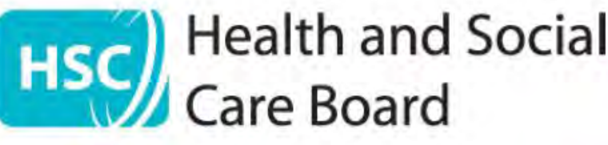
Level 1 – Significant Event Audit (SEA)

- Following SAI notification the reporting organisation will immediately undertake an SEA
  - Assess why and what has happened
  - Agree follow up actions
  - Identify learning
- SEA report completed using relevant template within 4 weeks (6 by exception)
- If SEA determines SAI more complex – investigation will move to level 2 or 3 investigation
- SEA will still be forwarded and will also contain TOR and membership of level 2/3 investigation team



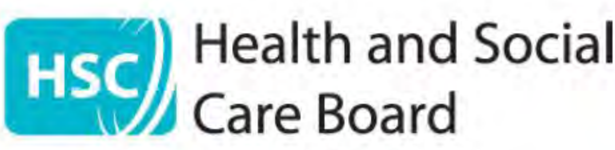
SEA – DRO Responsibilities

- On notification form – is SEA the correct level of investigation?
- There are no extensions granted for a SEA investigation – 4 weeks (6 by exception)
- On receipt of report
  - Consider adequacy of investigation
  - Liaise with relevant professionals (including RQIA where relevant)
  - If not satisfied, liaise with reporting org. until satisfactory response received and
  - satisfied to close or move to a level 2 or 3 investigation
  - Identification of regional learning



Level 2 – Root Cause Analysis (RCA)

- May be carried out following SEA as stated previously
- Reporting organisation may commence RCA immediately following notification
- Where two or more organisations involved, there must be a lead organisation however all orgs. should be involved in the review
- TOR and membership will be forwarded to DRO 4 weeks following notification
- Full investigation report using relevant template to be submitted within 12 weeks



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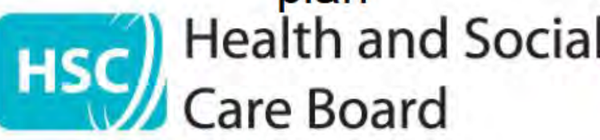
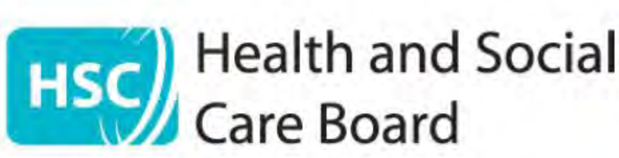
RCA – DRO Responsibilities

- Is level 2 correct level of investigation
- Agree TOR & Membership
  - Independence of review team & chair and adequate family involvement
  - Extension Request should be raised at this point
- On receipt of report
  - Consider adequacy of investigation & action plan (min standards for action plans (appendix 8)
  - Liaise with relevant professionals (including RQIA where relevant)
  - If not satisfied, liaise with reporting org. until satisfactory response and action plan is received and you are satisfied to close
  - Identification of regional learning
  - Identification of any additional assurance mechanisms re: action plan



Level 3 – Independent Review

- Particularly complex requiring specialist expertise / multi organisational / very high profile
- Require a full independent RCA
- Timescales for reporting, Chair & membership to be agreed by DRO from outset
- Use same template as level 2 RCA
- Alleged homicide by service user known to mental health & related services – additional guidance as per appendix to procedure



Level 3 – DRO Responsibilities

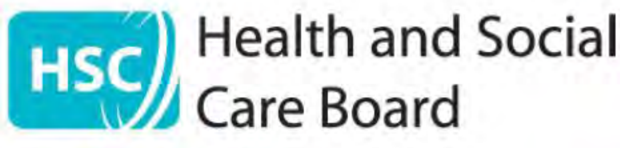
- DRO involved immediately following notification
- Timescales for reporting, TOR and membership to be agreed by DRO
- On receipt of report
  - Consider adequacy of investigation and action plan (min standards for action plans (appendix 8)
  - Liaise with relevant professionals (including RQIA where relevant)
  - If not satisfied, liaise with reporting org. until satisfactory response and action plan is received and satisfied to close
  - Identification of regional learning
  - Identification of any additional assurance mechanisms re: action plan

TOR/ Membership and Action plans will be considered during workshop

Independence of Investigation Review Teams – Additional Support

Development of panel of ‘lay people’ with professional areas of expertise:

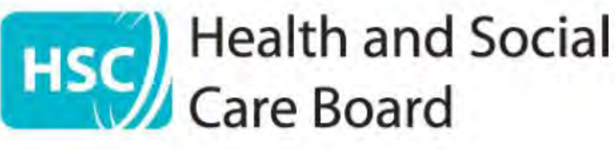
- Chair of independent review teams
- Member of RCA (level 2/3) review team



Timescales

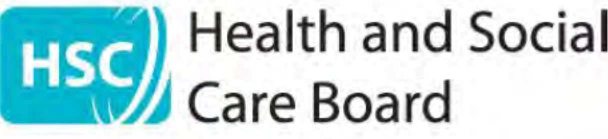
- Notification – 72 hours
- Level 1 Investigation – 4 weeks (6 by exception) – **no extension**
- Level 2 – 12 weeks – extension can be agreed by DRO
- Level 3 – timescales agreed by DRO from outset – there should be no extension
- Requests for additional information
- DRO timescales following receipt of reports

This will be covered in workshop



Managing Extensions

- Notification delays – managed through Governance Team – QSE and where relevant bi monthly performance meetings
- Level 1 SEA – no extensions
  - Governance Team issue reminder after 4 weeks or 6 (if org advised of exception) advising the org. in breach of procedure and one week to return SEA report
  - If not received escalated to Director of Nursing and Director of Performance & Corporate Services
  - Organisational performance discussed at monthly SAI Review Group
  - QSE
  - Escalated to bi-monthly Trust performance meetings



Managing Extensions con/t

Level 2 & 3

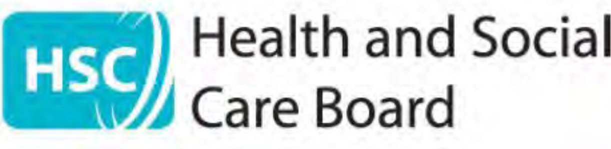
- Should not be extension for level 3 as timescale already agreed by DRO
- For level 2, organisation should advise 4 weeks after initial notification's
    - On submission of SEA when moving to RCA
    - Completion of RCA template section 2 & 3
- When extension requested:
    - If DRO content - agree realistic extension in liaison with org. this will avoid multiple extensions
- If DRO not content to agree extension, or report is outstanding without request for an extension:
    - Governance Team will issue reminder, advising org. in breach of procedure and one week to return RCA report
    - If not received escalated to Director of Nursing and Director of Performance & Corporate Services
    - Organisational performance discussed at monthly SAI Review Group
    - QSE
    - Where necessary to bi-monthly Trust performance meetings

De-escalating a SAI

Following notification and on initial investigation, a reporting organisation may determine an incident no longer meets criteria of a SAI and requests the SAI is de-escalated

DRO Responsibilities

- DRO reviews request and will inform Governance Team if content or not to de-escalate
- Governance team will inform reporting org on DRO's decision and RQIA (if decision is to de-escalate)

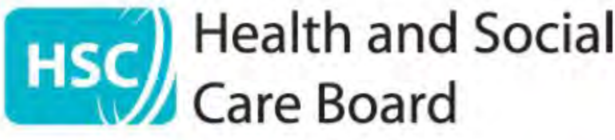


Transferring SAIs to other Investigative processes

- Following notification and initial investigation of a SAI, more information may emerge that determines the need for a specialist investigation.
- This type of investigation includes:
  - Case Management Reviews
  - Serious Case Reviews
  - Independent / Public Inquiry.

- Once a DRO has been informed a SAI has transferred to one of the above investigation s/he will close the SAI

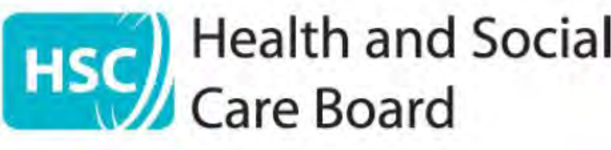
- The Governance team will inform all relevant organisations.



Closing a SAI

- DRO (*in conjunction with relevant professionals/officers*) is satisfied (based on the information provided) that the investigation has been robust and recommendations are appropriate, he/she will complete an internal DRO Form validating their reason for closure.

- On receipt of the internal DRO Form, the Governance Team will submit an email to the reporting organisation to advise the SAI has been closed, copied to RQIA (where relevant).

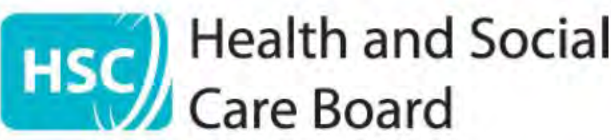


Closing a SAI con/t

- This will indicate that based on the investigation report received and any other information provided that the DRO is satisfied to close the SAI. It will acknowledge that any recommendations and further actions required will be monitored through the reporting organisation's internal governance arrangements

- On some occasions and in particular when dealing with particularly complex SAIs, a DRO may close a SAI but request the reporting organisation provides an additional assurance mechanism by advising within a stipulated period of time, that action following a SAI has been implemented. In these instances, monitoring will be followed up via the Governance team.

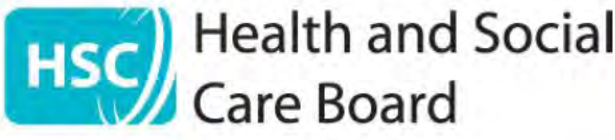
Action plan to be discussed at workshop



DRO not content to close

- Investigation not robust
- Not satisfied with response following request for additional information

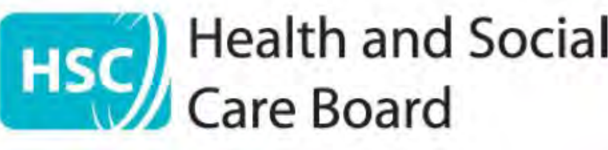
1. Liaise with other professionals
2. Liaise with reporting organisation/s
3. Escalate to SAI Review Subgroup
4. Escalate to Professional Director or QSE Group



Re-opening a SAI

New process with Coroners office:

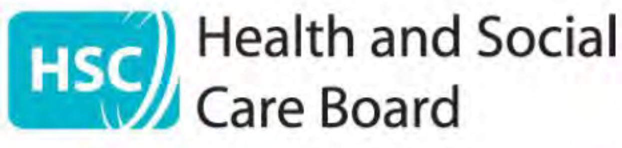
- HSC learning is identified by the Coroner it will be forwarded to HSCB
- If Coroner's report relates to a SAI – report will be forwarded to DRO
- If DRO identifies learning from Coroners report which was not already identified in the SAI investigation
- SAI will be re-opened and action taken forward either with relevant organisation/s / regionally or both



Coroners Reports Con/t

SAI investigations should not be 'suspended' pending a coroners report

- Not be within SAI timescales
- Prevent timely dissemination of learning



Suspending SAIs

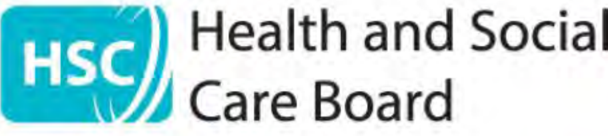
General rule: SAIs should not be suspended as this could potentially delay regional learning

However:

- PSNI investigations – e.g. alleged fraud, assault
- HSE investigations

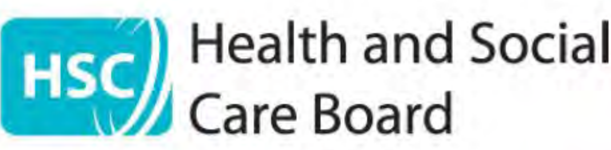
DRO Responsibility

- Liaise with reporting organisation to determine if there is a legitimate reason to suspend
- Memorandum of Understanding between HSC, HSE & PSNI
  - to avoid long term suspensions
  - invoked if required



Service Users/Relatives/Carers Involvement in Investigations

- It is important that teams involved in investigations in any of the above three levels ensure sensitivity to the needs of the service user/relatives/carers involved in the incident and agree appropriate communication arrangements, where appropriate.
- The Investigation Team should provide an opportunity for the service user / relatives / carers to contribute to the investigation, as is felt necessary.
- Involvement should not delay an investigation being reported to the HSCB

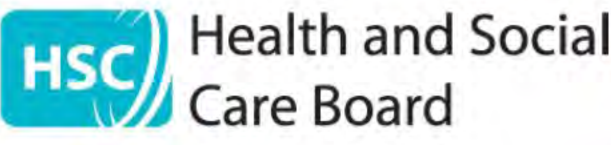


How do DROs determine adequate family involvement

The level of involvement clearly depends on the nature of the incident and the service users/relatives/carers wishes to be involved

- SEA Investigations
  - Difficult in light of tight timescale – can this be conducted following submission of a SEA?
  - If substantive family involvement required level 2 may be required
- Level 2 or 3
  - Should be highlighted in TOR received by DRO after 4 weeks – at this point DRO can challenge level of involvement
  - Adequate family involvement will now be incorporated in DRO form when SAI is being closed

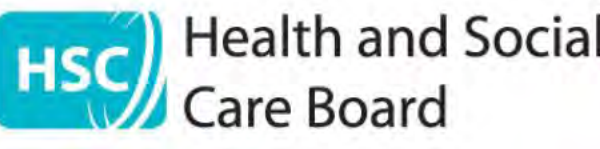
To be discussed during workshop



Regional Learning from SAIs

Process:

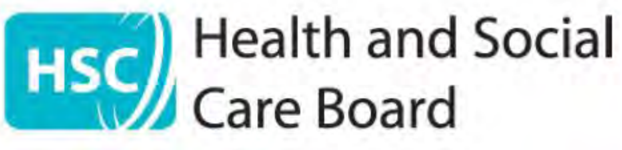
- DRO identifies regional learning on DRO form
- Brought to monthly SAI Review Group
  - Learning newsletter
- Onward referral to Quality Safety Experience Group (QSE)
  - learning letters
  - thematic reviews
- Safety and Quality Alerts team (SQAT) provide an assurance mechanism that learning from SAIs has been disseminated and appropriate action taken by all relevant organisations;



DRO's involvement in learning

- Draft article for learning newsletter
- Draft learning letter for director's approval
- Advise SQAT on action taken by Trusts in relation to learning letter is adequate

This will be covered in workshop

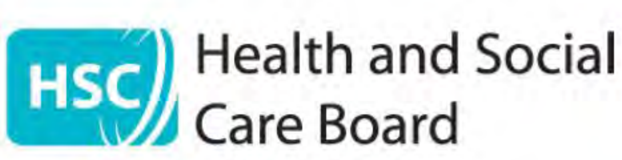


Individual DRO Support

- Liaise with professional colleagues within HSCB/PHA or where relevant HSC
- Special circumstances – outside of HSC

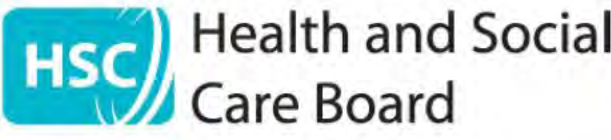
e.g. pseudomonas – Health Protection Agency

This will be covered in workshop



Training / Support

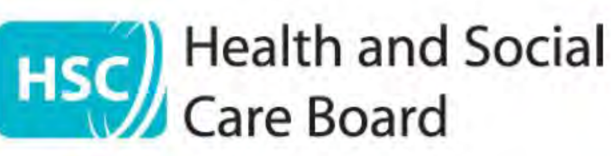
- SEA Training – w/c 2 December 2013 (HSC)
- DRO Workshop – 9 December 2013 (HSCB/PHA)
- RCA Training – Jan/Feb 2014 (HSC)
- DRO Protocol – Feb/March 2014 (HSCB/PHA)
- DATIX – early 2014 (HSCB/PHA)
  - DRO read only access



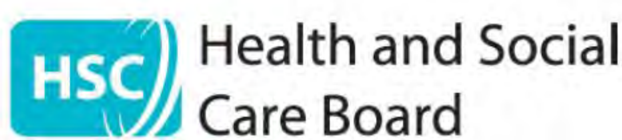
Governance Team

- Anne Kane – Governance Manager
- Jacqui Burns – Assistant Governance Manager
- Elaine Hamilton – Assistant Governance Manager
- Margaret McNally – Assistant Governance Manager
- Mareth Campbell – Office Manager
- Elaine Hyde – Governance Support Officer (SHSCT, NIAS, Integrated Care, BSO, HSCB, NIBTS, PHA & Independent / Voluntary sector)
- Shauneen Loughran – (NHSCT)
- Roisin Hughes – (SEHSCT & BHSCT)
- Nicola Brennan – (WHSCT)

All SAI communication reported via the Governance Team and recorded on Datix

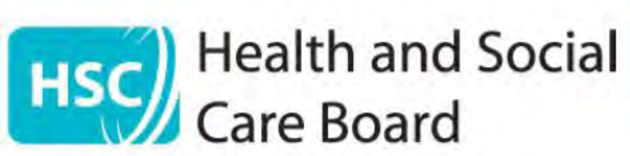


Thank you



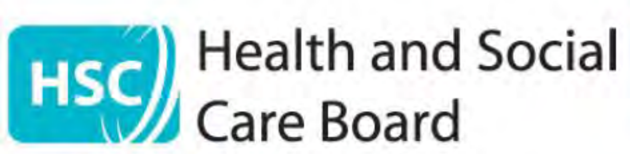
Issues relevant to SAIs and DROs in relation to Hyponatraemia Inquiry

Mr Michael Bloomfield
Director of Performance and Corporate Services



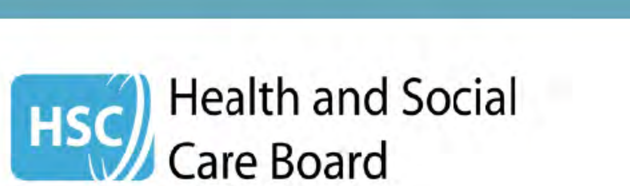
Panel Discussion

Questions & Answers



DRO SAI Information Session

October 2015



- Welcome & Introductions
- Setting the context

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Confused?

Datix Information Request Form

HSCB/PHA Flowchart for the Approval & Dissemination of Learning

OPTIONS FOR DISSEMINATING / IMPLEMENTING LEARNING

Process for Closure of SAIs for DROs

Flow chart for identification of DRO for SAIs and SEAs notified to HSCB relating to Maternal and Child Health Service (including Acute Paediatrics)

HSCB/PHA INTERFACE INCIDENTS PROCESS FLOW CHART – KEY STAGES

. Cause Analysis report review of a Serious Adv Incident including Service User/Family/Ca Engagement Checklis

Organisation's Unique Case Identifier:

Date of Incident/Event:

HSCB Unique Case Identifier:

Service User Details: (complete where relevant)
D.O.B: Gender: (M/F) Age: (yrs)

Responsible Lead Officer:

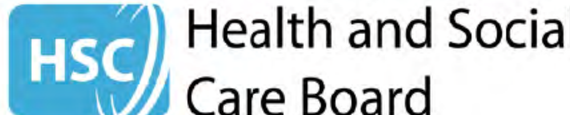
Designation:

Report Author:

Date report signed off:

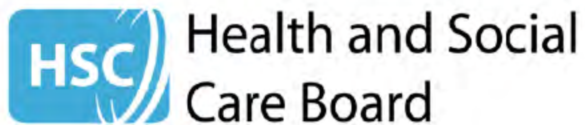
Date submitted to HSCB

Checklist for Engagement / Communication with Service User/ Family/ Carer following a Serious Adverse Incident



Aims for Today

- **Provide an outline of the key stages :**
  - ✓ SAI process
  - ✓ Service User/Family Engagement process
  - ✓ Learning process
  - ✓ Early Alert Process
- **Overview of key documentation**



SAI Procedure

- From 1 May 2010 responsibility for the management of SAIs transferred from DHSSPS to HSCB (*working jointly with PHA and collaboratively with RQIA*)
- Current procedure operational from October 2013

Health and Social Care Board

Procedure for the Reporting and Follow up of Serious Adverse Incidents

October 2013

Engagement

In January 2015:

- Guidance for HSC organisations when involving service users/families throughout the SAI process

A Guide for

Health and Social Care Staff

Engagement/Communication with the Service User/Family/Carers following a Serious Adverse Incident

January 2015

Overview of the Management of SAIs

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

- **Regional reporting system**
- **Nominated DROs by POC**
- **Professional Groups**
- **SAI Review Sub Group**
- **Overarching HSCB-PHA QSE Group**
- **SQA Team**

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

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SAI Process – Key Stages

SAI occurs within HSC organisation/ Special Agency, FPS or Commissioned Service

↓

SAI Notification Form completed by relevant ALB and submitted to HSCB seriousincidents@hscni.net within **72 hours** indicating level of Review i.e. Level 1, 2 or 3

↓

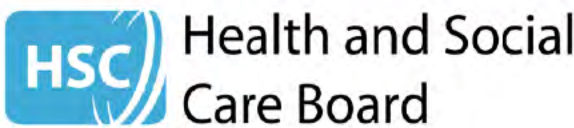
HSCB **acknowledges**, by email, receipt of SAI to Reporting Organisation, and assigns HSCB/PHA DRO

↓

Level 1 Review – HSCB request SEA Report to be submitted to HSCB within **4** weeks

Level 2 Review – HSCB request TOR and Membership of Review Team to be submitted to HSCB within **4 weeks** and RCA Report within **12 weeks** of notification

Level 3 Review– All timescales must be agreed with the DRO at the outset for TOR, Membership of Review Team and the RCA Report.



SEA / RCA Report and Engagement Checklist Received

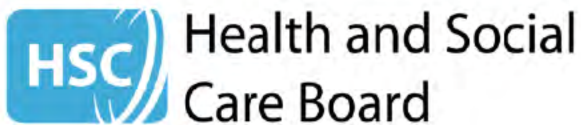
DRO Satisfied

(in conjunction with other officers or RQIA)

that the review is robust and is content with checklist

- **Professional Group** – will close and if learning identified DRO completes Learning Submission Form;
- **Non-Professional Group** – DRO will close and complete DRO Form and Learning Submission Form;

SAI closed on DATIX and reporting organisation informed.



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NEW DRO Form

- Sections 2 and 3 have been revised

HSCB / PHA DESIGNATED REVIEW OFFICER FORM

UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE		[illegible] REFERENCE NUMBER
«INC_NAME»		«INC_OURREF»
DATE SAI NOTIFIED	CURRENT LEVEL OF INVESTIGATION	ORGANISATIONS NOTIFIED (EXTERNAL
«INC_DREPORTED»	«INC_onstitype»	«INC_NOTIFY»
DATE SAI OCCURRED	DRO:	SEA/RCA REPORT DUE:
«INC_DINCIDENT»	«INC_MGR_F»	«EXTRA3_VALUE»
CORONERS REPORT:	DRO SUPPORT OFFICER/S	PROGRAMME OF CARE
«EXTRA12_VALUE»	«INC_INVESTIGATOR_F»	«INC_CLINGROUP_F»

DESCRIPTION OF INCIDENT
«INC_NOTES»

IMMEDIATE ACTION TAKEN BY REPORTING ORGANISATION:
«INC_ACTIONTAKEN»

IMMEDIATE ACTION TAKEN BY HSCB/PHA:
«EXTRA2_VALUE»

TOR DUE:	TOR RECEIVED:	SEA RECEIVED:	RCA RECEIVED
«EXTRA8_VALUE»	«EXTRA7_VALUE»	«EXTRA4_VALUE»	«EXTRA10_VALUE»

DATE DRO CLOSED	SAIRSG DATE	NFA NOTIFIED	LEARNING LTR REF
[illegible]	«EXTRA14_VALUE»	[illegible]	[illegible]

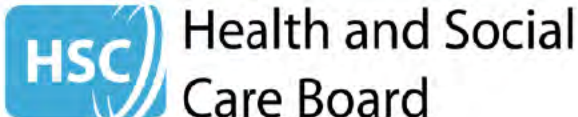
SECTION 1:	HSCB-PHA CLOSURE OF SAI:		
BASED ON INFORMATION PROVIDED IS DRO CONTENT TO CLOSE? *(confirm in conjunction with other professionals and RO/A where relevant):*		YES	NO
DRO'S COMMENTS INCLUDING HOW IDENTIFIED RECOMMENDAITONS/ACTIONS SHOULD BE MONITORE *(in conjunction with other professionals and RO/A where relevant):*			

SECTION 2:	SERVICE USER / FAMILY ENGAGEMENT:		
SU/FAM INFORMED	DATE CLIST RECEIVED	SEA/RCA SHARED SU/FAM	
[illegible]	[illegible]	[illegible]	
BASED ON INFORMATION PROVIDED HAS THERE BEEN ADEQUATE ENGAGEMENT:		YES	NO
DRO'S COMMENTS ON RATIONALE PROVIDED FOR NOT INFORMING SERVICE USER or NOT SHARING SEA/RCA REPORT *(complete where applicable):*			

SECTION 3:	REGIONAL LEARNING IDENTIFED: *(learning identified in this section will be submitted to HSCB/PHA SAI Review Sub Group)*

Please select and include narrative

- Rapid / Immediate Alert
- Learning Letter / Alert
- Professional Letter
- Learning Matters / GMS / Med Safe Newsletter Article
- Existing Work stream or Network
- Propose Thematic Review
- Establish a task and finish group
- Refer to other regulatory body
- Training Events
- Workshops / Seminars
- Other



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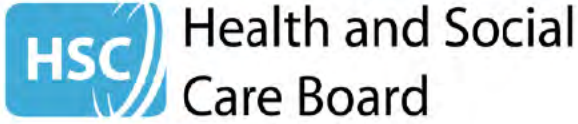
SEA / RCA Report and Engagement Checklist Received

DRO Not Satisfied

- DRO requests more information from reporting organisation within associated timescales;
- Seek other professional advice within PHA/HSCB
- This will continue until DRO is satisfied with SEA / RCA review and engagement checklist.

Please note all requests for additional information are via Serious Incidents Mailbox



Agreed EXTERNAL Timescales

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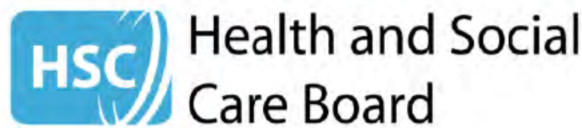
BW-258

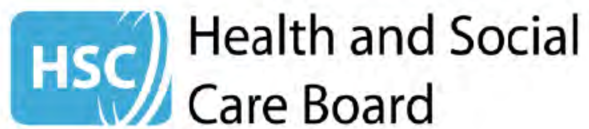
Submission of	Timeframe
Immediate Actions	For immediate return (or within 1 week)
Terms of Reference	within 4 weeks following date of notification.
SEA / RCA Review Reports	Level 1 – 4 weeks Level 2 – 12 weeks Level 3 – To be agreed by DRO at outset
RQIA Comments (*where relevant*)	3 weeks
DRO Queries	Level 1 – within 1 week Level 2 and 3 – within 4 weeks
Engagement Checklists	All SEA / RCA reports are to be submitted with an engagement checklist.

Note:
Timescales for response by reporting organisation may change from the above if the DRO has approved a specific timescale



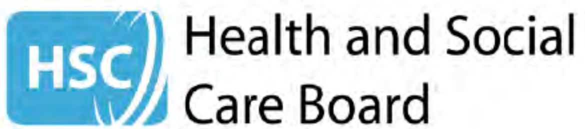
Recent Stats on Learning Timescales

Stage in Process	Average weeks
Weeks from receipt of SAI to completion of SEA/RCA Review Report	39 weeks
Weeks from completion of review to issue of S&Q Learning / Reminder Letter	63 weeks



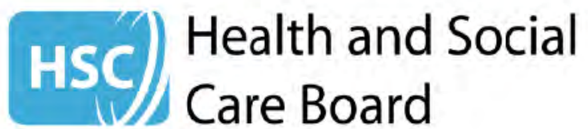
Suggested INTERNAL Timescales

Action	Timeframe
Identification of immediate actions	Immediately
Completion of review of SEA / RCA Report	4 weeks
Review of responses to DRO SEA / RCA queries	2 weeks



Early Alert Process

- DHSSPS policy
- HSCB copied into all EA Notifications
- Main role for DRO is to determine if EA should be reported as a SAI
- Timescales are in line with SAI process



Interface Incidents

- Is part of SAI Process
- What is an interface incident ?
- Role of DRO
  - to determine whether the incident should be reported as a SAI based on the information provided
  - DRO may request more information from the organisation where the incident occurred before making a decision
- Timescales are in line with SAI Process

Engagement

- Revised SAI Notification Form (March 2014);
- Revised SEA/RCA Review Report including engagement Checklists

In January 2015:

- Guidance for HSC organisations when involving service users/families throughout the SAI process

A Guide for

Health and Social Care Staff

Engagement/Communication with the Service User/Family/Carers following a Serious Adverse Incident

January 2015

MAHI - STM - 184 - 939

BW-258

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

(This checklist should be completed in full and submitted to the HSCB along with the completed SAI Report for all levels of SAI reviews)

Reporting Organisation SAI Ref Number:		HSCB Ref Number:	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, a number of service users or if the SAI relates **only** to a HSC Child Death notification *(SAI criterion 4.2.2)* **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		**HSC Child Death Notification only**	
	Comment: **If multiple service users involved please indicate the number involved*					
2) Was the Service User[1] / Family / Carer informed the incident was being investigated as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**			
	If YES, insert **date informed**:					
	If NO, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being investigated as a SAI					
	a) No contact or Next of Kin details or Unable to contact					
	b) Not applicable as this SAI is not 'patient/service user' related					
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user					
	d) Case involved suspected or actual abuse by family					
	e) Case identified as a result of review exercise					
	f) Case is environmental or infrastructure related with no harm to patient/service user					
	g) Other rationale					
	If you selected c), d), e), f) or g) above please provide further details:					
For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓))						
Content with rationale?	**YES**		**NO**			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER
(complete this section where the Service User / Family / Carer has been informed the incident was being investigated as a SAI)

3) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If YES, insert date informed:			
	If NO, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			
	c) Report not shared but contents discussed *(if you select this option please also complete 'l' below)*			
Continued overleaf	d) No contact or Next of Kin or Unable to contact			
	e) No response to correspondence			
	f) Withdrew fully from the SAI process			
	g) Participated in SAI process but declined review report			
	(If you select any of the options below please also complete 'l' below)			
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer			
	i) case involved suspected or actual abuse by family			
	j) identified as a result of review exercise			
	k) other rationale			
	l) If you have selected **c), h), i), j), or k)** above please provide further details:			
For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓))				
Content with rationale?	**YES**		**NO**	

[1] Servi... This ... 2013 and the ... a SAI

SECTION 2

INFORMING THE CORONER'S OFFICE
(under section 7 of the Coroners Act (Northern Ireland) 1959)
(complete this section for all death related SAIs)

1) Was there a Statutory Duty to notify the Coroner at the time of death? **Please select as appropriate (✓)**	**YES**		**NO**	
	If YES, insert **date informed**:			
	If NO, please provide details:			
2) Following or during the review of the SAI was there a Statutory Duty to notify the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If YES, insert **date informed**:			
	If NO, please provide details:			
3) If you have selected 'YES' to any of the above '1' or '2' has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If YES, insert **date report shared**:			
	If NO, please provide details:			

DATE CHECKLIST COMPLETED	

This checklist should be completed in line with the HSCB Procedure for the reporting and follow up of SAIs October 2013 and the HSC Guidance for staff on engagement/communication with Service Users[1] / Families/Carers following a SAI

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

1. ORGANISATION:	2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE
3. HOSPITAL / FACILTY / COMMUNITY LOCATION *(where incident occurred)*	4. DATE OF INCIDENT: DD / MMM / YYYY
5. DEPARTMENT / WARD / LOCATION EXACT *(where incident occurred)*	
6. CONTACT PERSON:	7. PROGRAMME OF CARE: *(refer to Guidance Notes)*

8. DESCRIPTION OF INCIDENT:

DOB: DD / MMM / YYYY *(complete where relevant)* GENDER: M / F AGE: years

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING

STAGE OF CARE: *(refer to Guidance Notes)*	DETAIL: *(refer to Guidance Notes)*	ADVERSE EVENT: *(refer to Guidance Notes)*

9. IMMEDIATE ACTION TAKEN TO PREVENT RECURRANCE:

10. CURRENT CONDITION OF SERVICE USER: *(complete where relevant)*

11. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*	YES	NO	N/A
12. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? *(please specify where relevant)*	YES	NO	N/A

13. WHY INCIDENT CONSIDERED SERIOUS: *(please select relevant criteria below)*

- serious injury to, or the unexpected/unexplained death of:
  - a service user
  - a staff member in the course of their work
  - a member of the public whilst visiting a HSC facility.
- any death of a child in receipt of HSC services (up to eighteenth birthday). This includes hospital and community services, a Looked After Child or a child whose name is on the Child Protection Register
- unexpected serious risk to a service user and/or staff member and/or member of the public
- unexpected or significant threat to provide service and/or maintain business continuity
- serious self-harm or serious assault *(including attempted suicide,homicide and sexual assaults)* by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service
- serious self-harm or serious assault *(including homicide and sexual assaults)*
  - on other service users,
  - on staff or
  - on members of the public

  by a service user in the community who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services)* and/or learning disability services, in the 12 months prior to the incident
- suspected suicide of a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services)* and/or learning disability services, in the 12 months prior to the incident
- serious incidents of public interest or concern relating to:
  - any of the criteria above
  - theft, fraud, information breaches or data losses
  - a member of HSC staff or independent practitioner

14. IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED: *(please select)*	YES	NO

if 'YES' *(full details should be submitted)*:

15. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING INVESTIGATED AS A SAI	YES *Date Informed:*	If NO – *specify reason*
16. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant*	YES	NO

if 'YES' *(full details should be submitted including the date notified)*:

17. OTHER ORGANISATION/PERSONS INFORMED: *(please select)*	DATE INFORMED:	OTHERS: *(please specify where relevant, including date notified)*
DHSS&PS EARLY ALERT		
HM CORONER		
INFORMATION COMMISSIONER OFFICE (ICO)		
NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC)		
NORTHERN IRELAND HEALTH AND SAFETY EXECUTIVE (NIHSE)		
POLICE SERVICE FOR NORTHERN IRELAND (PSNI)		
REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA)		
SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI)		
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)		

18. LEVEL OF INVESTIGATION REQUIRED: *(please select)*	LEVEL 1	LEVEL 2*	LEVEL 3*

* FOR ALL LEVEL 2 OR LEVEL 3 INVESTIGATIONS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6

19. 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 Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. *(delete as appropriate)*

Report submitted by: ______________ Designation: ______________

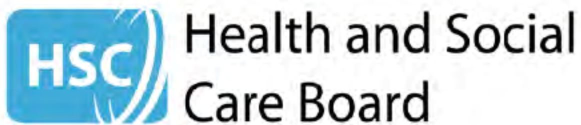
Email: Telephone: Date: DD / MMM / YYYY

20. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION: *(refer to Guidance Notes)*

Additional information submitted by: ______________ Designation: ______________

Email: Telephone: Date: DD / MMM / YYYY

Completed proforma should be sent to: seriousincidents@hscni.net
and (*where relevant*) seriousincidents@rqia.org.uk



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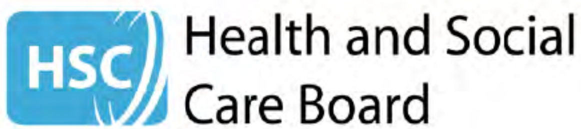
BW-258

DEPARTMENTAL REQUIREMENT

Analysis of checklists received for period 1/4/14 – 31/3/15 (excluding Child Health Deaths)

Table 1 a- Analysis of Engagement with patient /family/carer (excludes HSC Child Deaths)	BHSCT		NHSCT		SEHSCT		SHSCT		WHSCT		TOTAL	
Checklists received	67	100%	190	100%	86	100%	95	100%	89	100%	527	100%
Patient / Service User / Family Notified not informed incident was being investigated as an SAI	9	13.4%	9	5%	9	10.5%	5	5.3%	16	18.0%	48	9.1%
Patient / Service User / Family informed incident was being investigated as an SAI	58	86.6%	181	95%	77	89.5%	90	94.7%	73	82.0%	479	90.9%

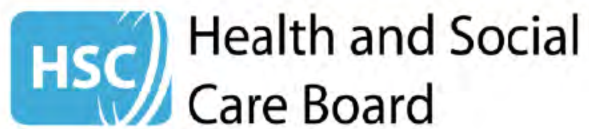
Table 1b - Analysis of Rationale for patient /family/carer not informed that incident was being investigated as an SAI (excludes HSC Child Deaths)	BHSCT		NHSCT		SEHSCT		SHSCT		WHSCT		TOTAL	
Not informed	9	100%	9	100%	9	100%	5	100%	16	100%	48	100%
No Contact details or NOK	2	22.2%	3	33.3%	4	44.4%	1	20.0%	2	12.5%	12	25.0%
Not applicable	3	33.3%	1	11.1%	1	11.1%	0	0.0%	2	12.5%	7	14.6%
Other rationale provided	3	33.3%	4	44.4%	4	44.4%	4	80.0%	12	75.0%	27	56.3%
Declined involvement	1	11.1%	1	11.1%	0	0.0%	0	0.0%	0	0.0%	2	4.2%



DEPARTMENTAL REQUIREMENT

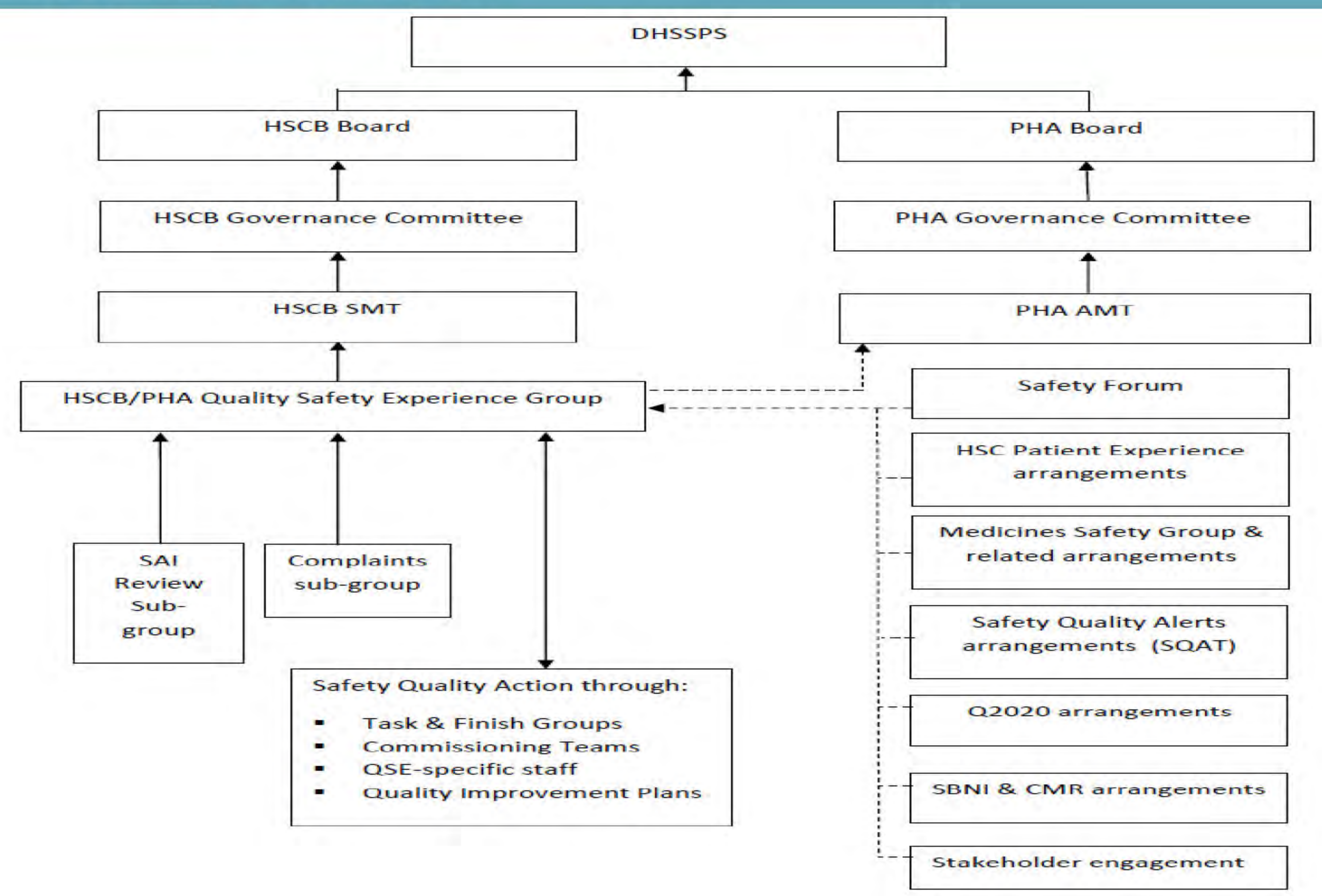
Table 2a - Analysis of Investigation Reports shared/not shared (excludes HSC Child Deaths)	BHSCT		NHSCT		SEHSCT		SHSCT		WHSCT		Total	
Checklists received	67	100%	190	100%	86	100%	95	100%	89	100%	527	100%
Investigation Report shared	35	52.2%	135	71.1%	36	41.9%	77	81.1%	38	42.7%	321	60.9%
Report not shared	32	47.8%	55	28.9%	50	58.1%	18	18.9%	51	57.3%	206	39.1%

Table 2b - Analysis of Investigation Reports not shared (excludes HSC Child Deaths)	BHSCT		NHSCT		SEHSCT		SHSCT		WHSCT		Total	
Report not shared	32	100%	55	100%	50	100%	18	100%	51	100%	206	100%
Plan to share report	5	16%	10	18%	13	26%	2	11.1%	11	22%	41	20%
Withdrew from process prior to finalisation of report	6	19%	10	18%	4	8%	0	0.0%	4	8%	24	12%
Declined report	5	16%	3	5%	14	28%	0	0.0%	3	6%	25	12%
No response to correspondence	3	9%	16	29%	7	14%	9	50.0%	14	27%	49	24%
Other rationale provided	9	28%	12	22%	4	8%	6	33.3%	14	27%	45	22%
No contact details or NOK	2	6%	3	5%	6	12%	1	5.6%	2	4%	14	7%
Not applicable	1	3%	1	2%	1	2%	0	0.0%	2	4%	5	2%
Report not shared but contents discussed	1	3%	0	0%	1	2%	0	0.0%	1	2%	3	1%



SAI Learning

HSCB-PHA S&Q Structures

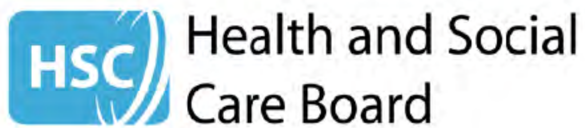


SAI Learning Actions

Possible **Regional Learning actions** following the review of SEA / RCA Review reports:

- **Disseminate**

✓ Issue a urgent Learning Letter*
✓ Issue a Learning Letter / Alert*
✓ Include an article in the Learning Matters Newsletter or Medicines Safety Matters Newsletter or GMS Newsletter



SAI Learning Actions Cont'd

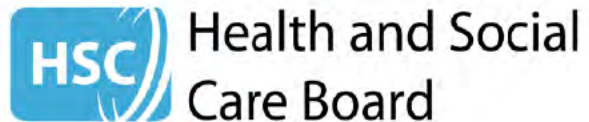
- **Implement**

✓ Through an existing work stream or established group
✓ Through a Thematic Review*
✓ Establish a task and finish group

- **Inform others**

✓ Refer to other regulatory body
✓ Commission or organise training event/workshop

*An update on progress of the regional learning will also be included within the HSCB/PHA Learning Report.

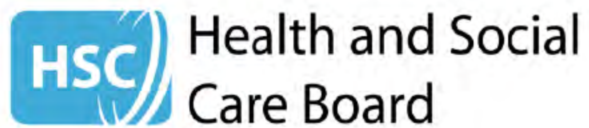


Identification of Learning from SAIs

Step 1 - Learning identified by a DRO or a Professional Group;

Step 2 – Learning Submission Form completed by DRO and considered by SAI Review Sub-Group

- SAI Review Subgroup may approve articles / recommendations to existing work streams / networks



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Learning Submission Form

REGIONAL SAI LEARNING SUBMISSION FORM

UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:		[illegible] NUMBER
DATE SAI NOTIFIED:	CURRENT LEVEL OF INVESTIGATION:	ORGANISATIONS NOTIFIED (EXTERNAL)
DATE SAI OCCURRED:	DRO:	PROGRAMME OF CARE

DESCRIPTION OF INCIDENT

IMMEDIATE ACTION TAKEN BY REPORTING ORGANISATION:

IMMEDIATE ACTION TAKEN BY HSCB/PHA:

TOR DUE:	TOR RECEIVED:	SEA RECEIVED:	RCA RECEIVED
		10-Feb-2015	

REGIONAL LEARNING IDENTIFIED:

DRO TO COMPLETE

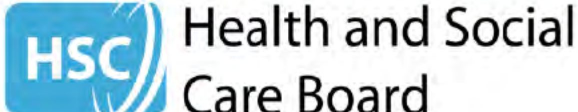
PLEASE INDICATE WHAT ACTION IS REQUIRED:

DRO TO COMPLETE

Please select **and include narrative**

- Rapid / Immediate Alert
- Learning Letter / Alert
- Professional Letter
- Newsletter Article
- Existing Work stream or Network
- Propose Thematic Review
- Establish a task and finish group
- Refer to other regulatory body
- *Training Events?*
- *Workshops / Seminars?*
- ***Other***

Example: Professional Letter from DPHM to HSC Trusts for the attention of ED staff



Identification of Learning Cont'd

Step 3 - Referred to Quality, Safety and Experience (QSE) Group – for approval / noting

Step 4 – There will be different actions required depending on the type of learning identified.

- **Disseminate**
- **Implement**
- **Inform**

NOTE: Where urgent/immediate learning has been identified the DRO should take forward in conjunction with the relevant professional Director and the Governance Team.

Learning Examples

Learning Matters

QUALITY 2020

June 2015

Special maternity edition

Introduction

Welcome to a special maternity edition of the Learning Matters Newsletter.

Investigation reports into maternity serious adverse incidents (SAIs) frequently identify regional learning. This is usually disseminated through:

- Safety & Quality learning letters and reminder of best practice letters (available to HSC staff at http://intranet.hscb.hscni.net/documents/Safety_and_Quality_Learning_Letters.html)
- Occasional articles in the Learning Matters Newsletter (also available at the above website)
- The Maternity Quality Improvement Collaborative

This special edition of the Learning Matters Newsletter presents six articles on topics which have been recognised to be recurring themes in a number of maternity SAIs.

Contents / Page

Care of women who have had a previous caesarean section ... 2

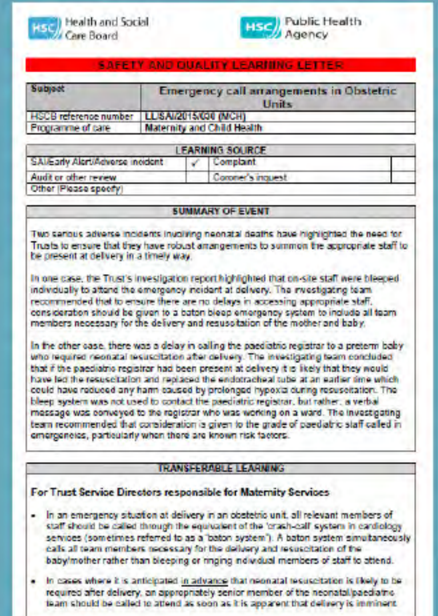
Antenatal Fetal Growth Monitoring ... 4

Obstetric Early Warning Scores ... 6

Operative vaginal delivery ... 8

Human Factors and Situational Awareness ... 10

Inadequate arrangements for caesarean section ... 12



Health and Social Care Board | Public Health Agency

SAFETY AND QUALITY LEARNING LETTER

Subject	Emergency call arrangements in Obstetric Units
HSCB reference number	LL/SAI/2015/030 (MCH)
Programme of care	Maternity and Child Health

LEARNING SOURCE

SAI/Early Alert/Adverse incident	✓	Complaint	
Audit or other review		Coroner's inquest	
Other (Please specify)			

SUMMARY OF EVENT

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

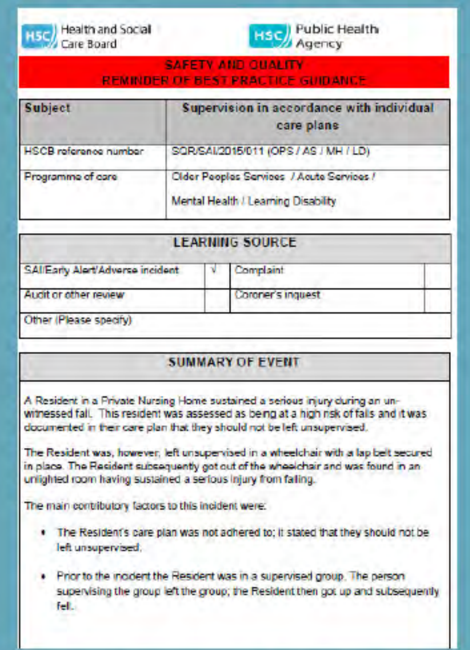
In one case, the Trust's investigation report highlighted that on-site staff were bleeped individually to attend the emergency incident at delivery. The investigating team recommended that to ensure there are no delays in accessing appropriate staff, consideration should be given to a baton bleep emergency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

In the other case, there was a delay in calling the paediatric registrar to a preterm baby who required neonatal resuscitation after delivery. The investigating team concluded that if the paediatric registrar had been present at delivery it is likely that they would have led the resuscitation and replaced the endotracheal tube at an earlier time which could have reduced any harm caused by prolonged hypoxia during resuscitation. The bleep system was not used to contact the paediatric registrar, but rather, a verbal message was conveyed to the registrar who was working on a ward. The investigating team recommended that consideration is given to the grade of paediatric staff called in emergencies, particularly when there are known risk factors.

TRANSFERABLE LEARNING

For Trust Service Directors responsible for Maternity Services

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



Health and Social Care Board | Public Health Agency

SAFETY AND QUALITY
REMINDER OF BEST PRACTICE GUIDANCE

Subject	Supervision in accordance with individual care plans
HSCB reference number	SQR/SAI/2015/011 (OPS / AS / MH / LD)
Programme of care	Older Peoples Services / Acute Services / Mental Health / Learning Disability

LEARNING SOURCE

SAI/Early Alert/Adverse incident	√	Complaint	
Audit or other review		Coroner's inquest	
Other (Please specify)			

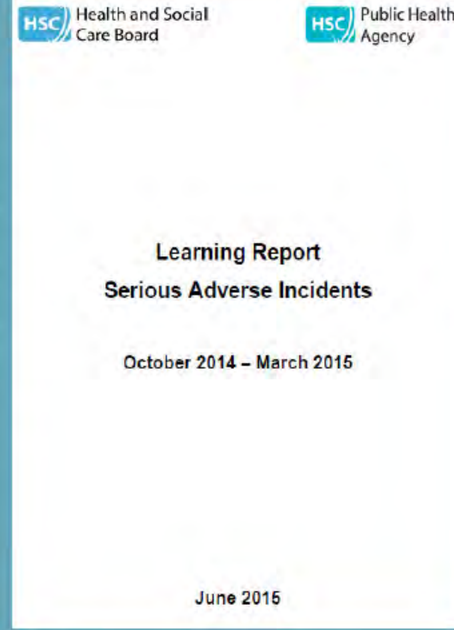
SUMMARY OF EVENT

A Resident in a Private Nursing Home sustained a serious injury during an un-witnessed fall. This resident was assessed as being at a high risk of falls and it was documented in their care plan that they should not be left unsupervised.

The Resident was, however, left unsupervised in a wheelchair with a lap belt secured in place. The Resident subsequently got out of the wheelchair and was found in an unlighted room having sustained a serious injury from falling.

The main contributory factors to this incident were:

- The Resident's care plan was not adhered to; it stated that they should not be left unsupervised.
- Prior to the incident the Resident was in a supervised group. The person supervising the group left the group; the Resident then got up and subsequently fell.



Health and Social Care Board | Public Health Agency

Learning Report

Serious Adverse Incidents

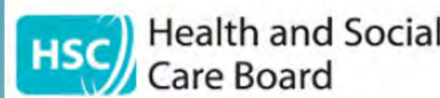
October 2014 – March 2015

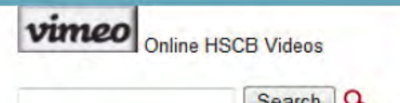
June 2015

Note: Safety and Quality alerts including all learning and reminder letters can be accessed on the HSCB intranet via the following link

http://intranet.hscb.hscni.net/documents/Safety_and_Quality_Learning_Letters.html

INTRANET HUB FOR DROs

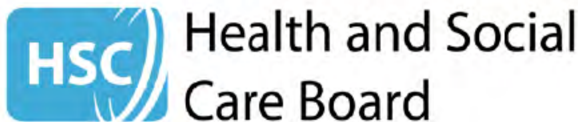




Home | Documents | Directorates | Links | Contacts

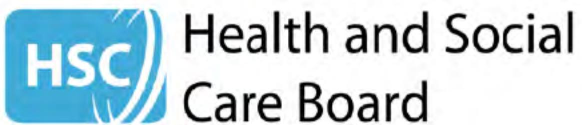
Information for DROs

- 001 Access to Safety and Quality Alerts considered by SQAT
- 002 HSCB-PHA Protocol for Safety Alerts
- 003 Options for Disseminating or Implementing Learning
- 004 HSCB-PHA Flowchart fo the approval and dissemination of learning
- 005 Letter to ALBs-Special Agencies - Service User Family Involvement
- 005 Letter to Trust CXs re SAIs - Service User Family Involvement
- 005 SAI Notification Form - Word version
- 005 Service User - Family Involvement
- 006 Outstanding Investigation Reports



Review of SAI Procedure

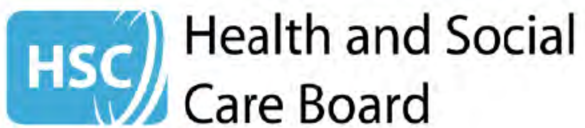
- **Scheduled for 2015/16**
  - Donaldson Review
    - SAI Criteria/removal of Child Death Criterion (1 Dec 2015)
    - Mental Health SAIs
  - Other process issues identified since the implementation in 2013
  - DRO Protocol revised following SAI Procedure Review



Points of Contact for areas:

Email: seriousincidents@hscni.net

Area	Governance Support Officer	Contact Details
Belfast Trust	Roisin Hughes	028 9536 2064
Northern Trust	Sarah Glass	028 9536 2016
Southern Trust	Elaine Hyde	028 9536 2050
South Eastern Trust & Other ALBs	Geraldine McArdle	028 9536 2785
Western Trust & Integrated Care	Nicola Brennan	028 9536 2102
Governance Support Manager	Mareth Campbell	028 9536 3207



MAHI - STM - 184 - 953

For further information or enquires contact:

Anne Kane – Governance Manager

Email: anne.kane@hscni.net

Telephone: **028 9536 2148**

or any of the Assistant Governance Managers as follows:

Email: jacqui.burns@hscni.net

Telephone: **028 9536 2803**

Email: elaine.hamilton@hscni.net

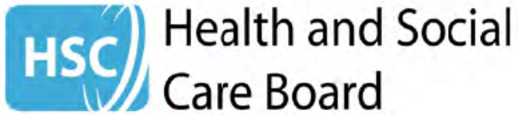
Telephone: **028 9536 2152**

Email: margaret.mcnally@hscni.net

Telephone: **028 9536 2036**

DRO SAI Information Session

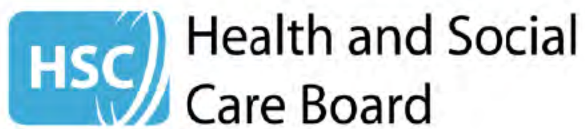
February 2017



- Welcome & Introductions
- Setting the context

Aims for Today

- **Provide an outline of the :**
  - ✓ Revisions to the SAI process
  - ✓ Revisions to the DRO Protocol
  - ✓ Revisions to the Early Alert Process



SAI Procedure

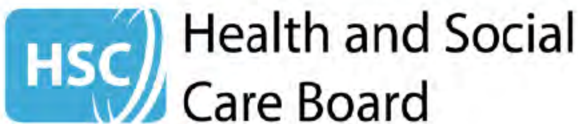
In November 2016:

- Revised procedure for the reporting and follow up of SAIs issued to all ALBs

Health and Social Care Board

Procedure for the Reporting and Follow up of Serious Adverse Incidents

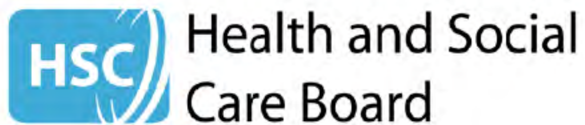
November 2016
Version 1.1



Key changes to SAI Process

Quality Assurance of Level 1 SEA Review Reports

- ✓ Learning Summary replaces Level 1 SEA
  - ✓ Reporting organisations to QA robustness of level 1 SEA Reviews;
- ✓ Level 2 and 3 SAI Reviews unchanged;
- ✓ Guidance on the use of an 'incident debrief' developed;
- ✓ The role of HSCB/PHA DROs has been updated to reflect the above amendments in both SAI Procedure and DRO Protocol.



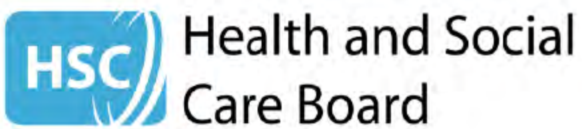
Key changes cont'd

Introduction of Never Events

- ✓ October 2016 DoH circular issued regarding the DoH intention to introduce a Never Events process which would be captured as part of the SAI process;
- ✓ SAI notification form has been revised;
- ✓ Updates made to HSCB DATIX reporting system to enable monitoring of Never Events.

Neve Events List

CATEGORY	Never Event
SURGICAL	1. Wrong Site Surgery
SURGICAL	2. Wrong Implant / Prosthesis
SURGICAL	3. Retained foreign object post-procedure
MEDICATION	4. Mis-selection of a strong potassium containing solution
MEDICATION	5. Wrong route administration of medication
MEDICATION	6. Overdose of insulin due to abbreviations or incorrect device
MEDICATION	7. Overdose of methotrexate for non-cancer treatment
MEDICATION	8. Mis-selection of high strength midazolam during conscious sedation
MENTAL HEALTH	9. Failure to install functional collapsible shower or curtain rails
GENERAL	10. Falls from poorly restricted windows
GENERAL	11. Chest or neck entrapment in bedrails
GENERAL	12. Transfusion or transplantation of ABO-incompatible blood components or ograns
GENERAL	13. Misplaced naso - or oro - gastric tubes
GENERAL	14. Scalding of patients



Key changes cont'd

Engagement/Communication

- ✓ Service User/Family/Carer Engagement Checklist updated to reflect where relevant, the service user/family carer has been advised:
  - ✓ the SAI is a never event;
  - ✓ if a case has been referred to the Coroner, where the reporting organisation had a statutory duty to do so.

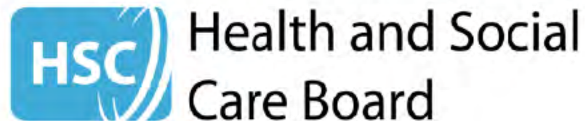
BW-259

Key changes cont’d

Engagement/Communication cont’d

A Guide for HSC Staff – Engagement / Communication with the Service User/Family/Carers Following a SAI revised to reflect: Addendum 1

- ✓ The term ‘SAI Review’ replaces ‘investigation’;
- ✓ A service user/family/carer’s right to contact the Northern Ireland Public Services Ombudsman (NIPSO);
- ✓ The engagement leaflet updated to reflect Never Events.



Key changes cont'd

Reporting of Falls:

- ✓ Report on Falls Resulting in Moderate to Severe Harm issued in March 2016.
- ✓ Falls no-longer routinely reported as SAIs;
- ✓ A new process has been developed with phased implementation
- ✓ Trusts undertake a timely local post falls review, and report the learning from these incidents to the Regional Falls Group, rather than being reported routinely as SAIs.

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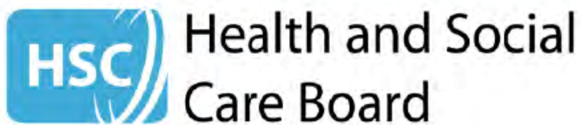
Agreed EXTERNAL Timescales

BW-259

Submission of	Timeframe
Terms of Reference	within 4 weeks following date of notification.
SEA / RCA Review Reports	Level 1 Learning Summary – 8 weeks Level 2 RCA Report – 12 weeks Level 3 RCA Report – To be agreed by DRO at outset
Escalation of SEA to RCA	If outcome of SEA Level 1 determines a RCA Level 2/3 Review is required. Timescale to be agreed by DRO.
RQIA Comments (*where relevant*)	3 weeks
DRO Queries	Level 1 Learning Summary – within 2 weeks Level 2 and 3 RCA Report– within 6 weeks
Engagement Checklists	An engagement checklist should accompany all summary/review reports.

Note: **Timescales for response by reporting organisation may change from the above if the DRO has approved a specific timescale**



INTERNAL Timescales

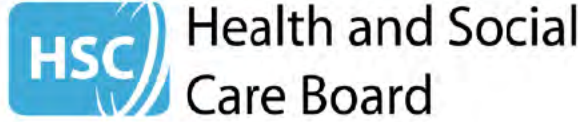
Action	Timeframe
Identification of immediate actions	Immediately
Review of responses to DRO queries	2 weeks
Closure of SAI and identification of regional learning	As soon as all information has been submitted by reporting organisation – SAI should be listed for next SAI professional Group Exceptional circumstances – maximum of 12 weeks for reporting org to be notified SAI is closed

Recap of how SAIs are managed in HSCB/PHA

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

- ✓ **Regional reporting system**
- ✓ **Nominated DROs by POC**
- ✓ **SAI Professional Groups**
- ✓ **SAI Review Sub Group**
- ✓ **Overarching HSCB-PHA QSE Group**
- ✓ **SQA Team**

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



Identification of Learning from SAIs

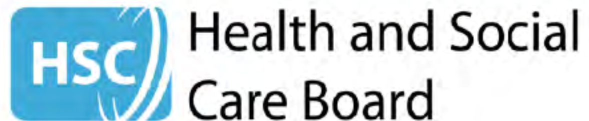
Step 1 – Regional Learning identified by DRO/Professional Group;

Step 2 – Regional Learning discussed at SAI Professional Group and:

- Learning Actions agreed. For example, article in newsletter, referred onto another group/network;

Or

- Learning referred to SAI Review Subgroup for consideration of approval. For example, Learning Letter, Reminder of Good Practice Letter, Thematic Review to be undertaken.



Identification of Learning Cont'd

Step 3 - Referred to Quality, Safety and Experience (QSE) Group – for approval / noting

Step 4 – There will be different actions required depending on the type of learning identified.

- **Disseminate**
- **Implement**
- **Inform**

NOTE: Where urgent/immediate learning has been identified, this should be taken forward by the DRO in conjunction with the relevant professional Director and the Governance Team.

Learning Examples

Learning Matters

QUALITY 2020

June 2015

Special maternity edition

Introduction

Welcome to a special 'maternity' edition of the Learning Matters Newsletter.

Investigation reports into maternity serious adverse incidents (SAIs) frequently identify regional learning. This is usually disseminated through:

- Safety & Quality learning letters and reminder of best practice letters (available to HSC staff at http://intranet.hscb.hscni.net/documents/Safety_and_Quality_Learning_Letters.html)
- Occasional articles in the Learning Matters Newsletter (also available at the above website)
- The Maternity Quality Improvement Collaborative.

This special edition of the Learning Matters Newsletter presents six articles on topics which have been recognised to be recurring themes in a number of maternity SAIs.

Contents | Page

Care of women who have had a previous caesarean section ____ 2

Antenatal Fetal Growth Monitoring ____ 4

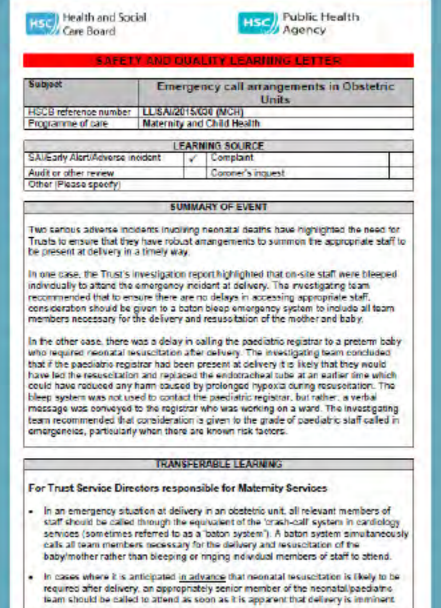
Obstetric Early Warning Scores ____ 6

Operative vaginal delivery ____ 8

Human Factors and Situational Awareness ... 10

Inadequate arrangements for caesarean section ... 12

1



HSC Health and Social Care Board | HSC Public Health Agency

SAFETY AND QUALITY LEARNING LETTER

Subject	Emergency call arrangements in Obstetric Units
HSCB reference number	LL/SAI/2015/030 (MCH)
Programme of care	Maternity and Child Health

LEARNING SOURCE			
SAI/Early Alert/Adverse incident	✓	Complaint	
Audit or other review		Coroner's inquest	
Other (Please specify)			

SUMMARY OF EVENT

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

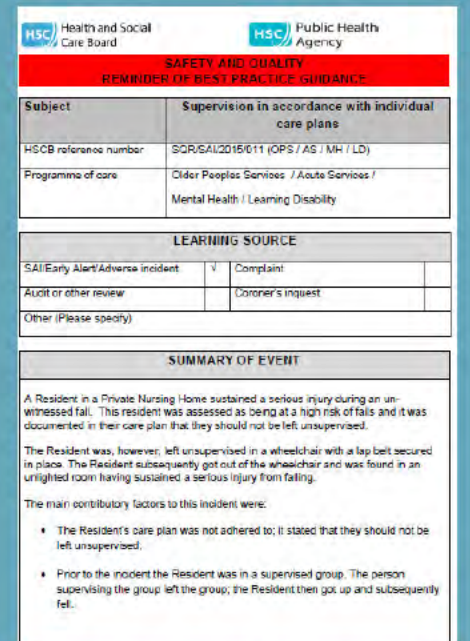
In one case, the Trust's investigation report highlighted that on-site staff were bleeped individually to attend the emergency incident at delivery. The investigating team recommended that to ensure there are no delays in accessing appropriate staff, consideration should be given to a baton bleep emergency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

In the other case, there was a delay in calling the paediatric registrar to a preterm baby who required neonatal resuscitation after delivery. The investigating team concluded that if the paediatric registrar had been present at delivery it is likely that they would have led the resuscitation and replaced the endotracheal tube at an earlier time which could have reduced any harm caused by prolonged hypoxia during resuscitation. The bleep system was not used to contact the paediatric registrar, but rather, a verbal message was conveyed to the registrar who was working on a ward. The investigating team recommended that consideration is given to the grade of paediatric staff called in emergencies, particularly when there are known risk factors.

TRANSFERABLE LEARNING

For Trust Service Directors responsible for Maternity Services

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



HSC Health and Social Care Board | HSC Public Health Agency

SAFETY AND QUALITY
REMINDER OF BEST PRACTICE GUIDANCE

Subject	Supervision in accordance with individual care plans
HSCB reference number	SQR/SAI/2015/011 (OPS / AS / MH / LD)
Programme of care	Older Peoples Services / Acute Services / Mental Health / Learning Disability

LEARNING SOURCE			
SAI/Early Alert/Adverse incident	√	Complaint	
Audit or other review		Coroner's inquest	
Other (Please specify)			

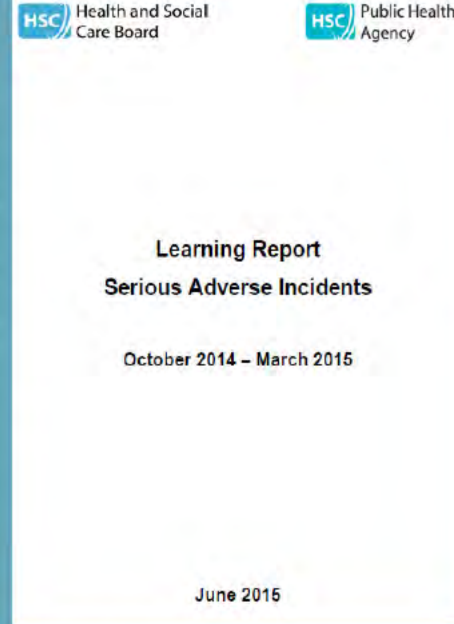
SUMMARY OF EVENT

A Resident in a Private Nursing Home sustained a serious injury during an un-witnessed fall. This resident was assessed as being at a high risk of falls and it was documented in their care plan that they should not be left unsupervised.

The Resident was, however, left unsupervised in a wheelchair with a lap belt secured in place. The Resident subsequently got out of the wheelchair and was found in an unlighted room having sustained a serious injury from falling.

The main contributory factors to this incident were:

- The Resident's care plan was not adhered to; it stated that they should not be left unsupervised.
- Prior to the incident the Resident was in a supervised group. The person supervising the group left the group; the Resident then got up and subsequently fell.



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Learning Report

Serious Adverse Incidents

October 2014 – March 2015

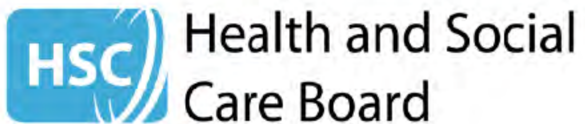
June 2015

Note: Safety and Quality alerts including all learning and reminder letters can be accessed on the HSCB intranet via the following link

http://intranet.hscb.hscni.net/documents/Safety_and_Quality_Learning_Letters.html

DRO Protocol

- ✓ What is a DRO?;
- ✓ Role of a DRO;
- ✓ Process;
- ✓ Supporting the DRO process.



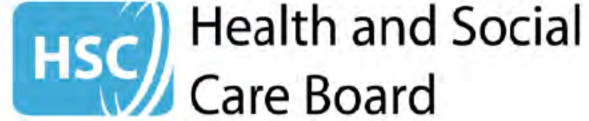
Early Alert Procedure

- In June 2010, the process for Early Alerts was introduced by DoH;
- Circular HSC (SQSD) 64/16 issued 28 November 2016;
- DoH responsible for the Early Alert Process;
- HSCB receive all Early Alerts notified to DoH.

HSCB/PHA Role in Early Alert System – 2 Functions

Function 1

- ✓ **Reporting an Early Alert**
  - ➢ Report to DoH 48 hrs after event
  - ➢ Verbally and in writing using proforma



Function 2

Process when Early Alerts copied to HSCB/PHA

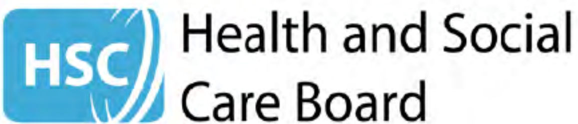
- **Two approaches**

✓ Outside of the SAI process - when a SAI for the same incident has not been received

- If further/immediate action is required;
- If, in your professional opinion, a SAI should be submitted;
- If no further action is required by HSCB/PHA and the Early Alert can be closed on Datix.

✓ When a SAI for the same incident has been received

- Early alert is closed and managed as a SAI.



INTRANET HUB FOR DROs

Health and Social Care Board **INTRANET**

vimeo Online HSCB Videos

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Information for DROs

- 001 Access to Safety and Quality Alerts considered by SQAT
- 002 HSCB-PHA Protocol for Safety Alerts
- 003 Options for Disseminating or Implementing Learning
- 004 HSCB-PHA Flowchart fo the approval and dissemination of learning
- 005 Letter to ALBs-Special Agencies - Service User Family Involvement
- 005 Letter to Trust CXs re SAIs - Service User Family Involvement
- 005 SAI Notification Form - Word version
- 005 Service User - Family Involvement
- 006 Outstanding Investigation Reports

For further information or enquires contact:

Anne Kane – Governance Manager

Email: anne.kane@hscni.net
Telephone: **028 9536 2148**

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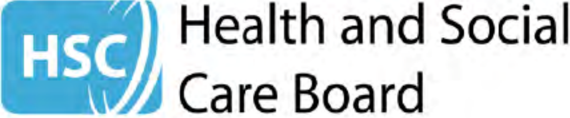
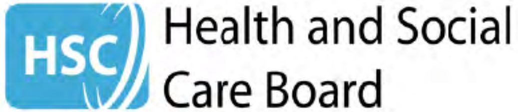


Role of a DRO DOIC Pharmacy

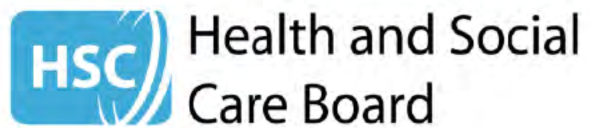
January 2019



- Welcome & Introductions
- Setting the context

Aims for Today

- **Provide an outline of the :**
  - ✓ Your role as a DRO
  - ✓ Your input into the DOIC SAI Professional Group



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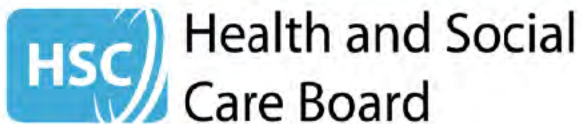

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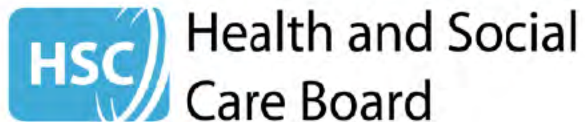
Key changes to SAI Process

Quality Assurance of Level 1 SEA Review Reports

- ✓ Learning Summary replaces Level 1 SEA
  - ✓ Reporting organisations to QA robustness of level 1 SEA Reviews;
  - ✓ DOIC (review team to QA robustness)
- ✓ Level 2 and 3 SAI Reviews unchanged;
- ✓ The role of HSCB/PHA DROs has been updated to reflect the above amendments in both SAI Procedure and DRO Protocol.



Key changes cont'd

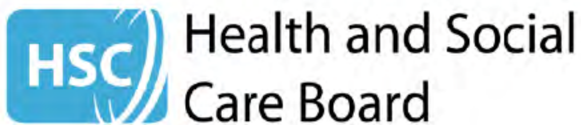
Introduction of Never Events

- ✓ October 2016 DoH circular issued regarding the DoH intention to introduce a Never Events process which would be captured as part of the SAI process;
- ✓ SAI notification form has been revised;
- ✓ Updates made to HSCB DATIX reporting system to enable monitoring of Never Events.

Key changes cont'd

Engagement/Communication

- ✓ **Service User/Family/Carer Engagement**
  - ✓ Guidance is now appendix to procedure
  - ✓ Checklist
    - ✓ updated to reflect where relevant, the service user/family carer has been advised:the SAI is a never event;
    - ✓ if a case has been referred to the Coroner, where the reporting organisation had a statutory duty to do so.



Key changes cont'd

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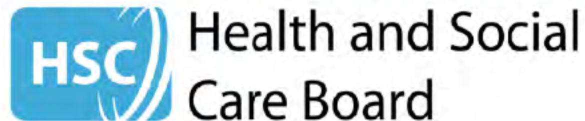

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Agreed EXTERNAL Timescales

Submission of	Timeframe
Terms of Reference	within 4 weeks following date of notification.
SEA / RCA Review Reports	Level 1 Learning Summary – 8 weeks Level 2 RCA Report – 12 weeks Level 3 RCA Report – To be agreed by DRO at outset
Escalation of SEA to RCA	If outcome of SEA Level 1 determines a RCA Level 2/3 Review is required. Timescale to be agreed by DRO.
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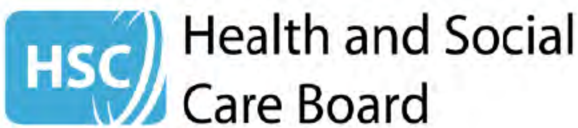
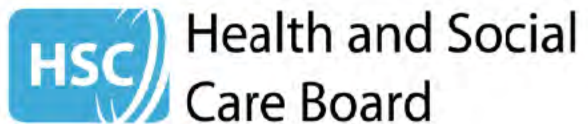


MAHI - STM - 184 - 985

INTERNAL Timescales for DRO/Professional Group

Action	Timeframe
Identification of immediate actions	Immediately
Review of responses to DRO queries	2 weeks
Closure of SAI and identification of regional learning	As soon as all information has been submitted by reporting organisation – SAI should be listed for next SAI professional Group Exceptional circumstances – maximum of 12 weeks for reporting org to be notified SAI is closed



Recap of how SAIs are managed in HSCB/PHA

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

- ✓ **Regional reporting system**
- ✓ **Nominated DROs by POC**
- ✓ **SAI Professional Groups**
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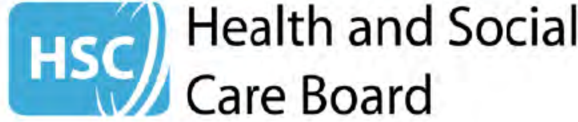
- ✓ **SQA Team**

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



Identification of Learning from SAIs

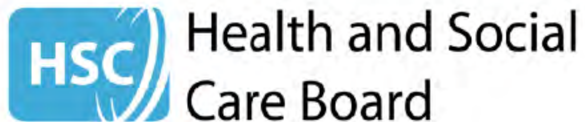
Step 1 – Regional Learning identified by DRO/Professional Group;

Step 2 – Regional Learning discussed at SAI Professional Group and:

- Learning Actions agreed. For example, article in newsletter, referred onto another group/network – referred to QSE 'for noting'

Or

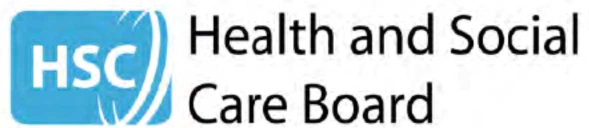
- Learning referred to QSE for consideration of approval. For example, Learning Letter, Reminder of Good Practice Letter, Thematic Review to be undertaken.



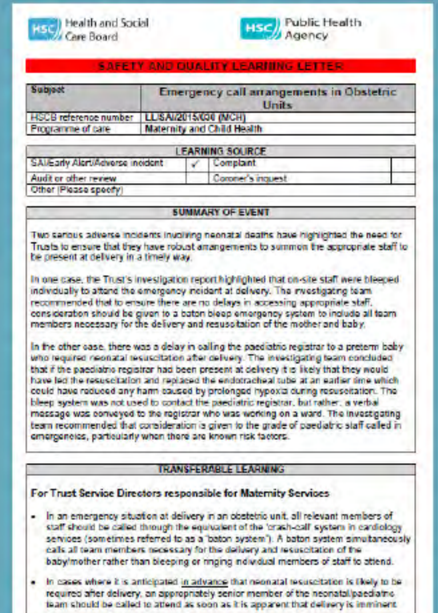
Identification of Learning Cont'd

Step 3 – Referred to SQAT to issue letter and consider if assurance is required

NOTE: Where urgent/immediate learning has been identified, this should be taken forward by the DRO in conjunction with the relevant professional Director and the Governance Team.



Learning Examples



Health and Social Care Board | Public Health Agency

SAFETY AND QUALITY LEARNING LETTER

Subject	Emergency call arrangements in Obstetric Units
HSCB reference number	LL/SAI/2015/030 (MCH)
Programme of care	Maternity and Child Health

LEARNING SOURCE			
SAI/Early Alert/Adverse incident	✓	Complaint	
Audit or other review		Coroner's inquest	
Other (Please specify)			

SUMMARY OF EVENT

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

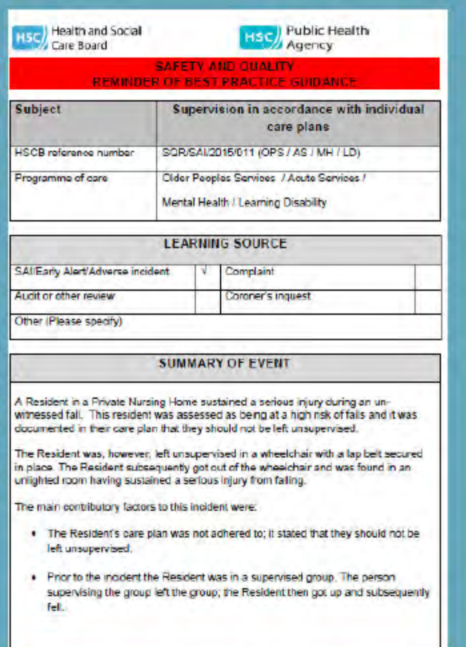
In one case, the Trust's investigation report highlighted that on-site staff were bleeped individually to attend the emergency incident at delivery. The investigating team recommended that to ensure there are no delays in accessing appropriate staff, consideration should be given to a baton bleep emergency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

In the other case, there was a delay in calling the paediatric registrar to a preterm baby who required neonatal resuscitation after delivery. The investigating team concluded that if the paediatric registrar had been present at delivery it is likely that they would have led the resuscitation and replaced the endotracheal tube at an earlier time which could have reduced any harm caused by prolonged hypoxia during resuscitation. The bleep system was not used to contact the paediatric registrar, but rather, a verbal message was conveyed to the registrar who was working on a ward. The investigating team recommended that consideration is given to the grade of paediatric staff called in emergencies, particularly when there are known risk factors.

TRANSFERABLE LEARNING

For Trust Service Directors responsible for Maternity Services

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



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SAFETY AND QUALITY
REMINDER OF BEST PRACTICE GUIDANCE

Subject	Supervision in accordance with individual care plans
HSCB reference number	SQR/SAI/2015/011 (OPS / AS / MH / LD)
Programme of care	Older Peoples Services / Acute Services / Mental Health / Learning Disability

LEARNING SOURCE			
SAI/Early Alert/Adverse incident	√	Complaint	
Audit or other review		Coroner's inquest	
Other (Please specify)			

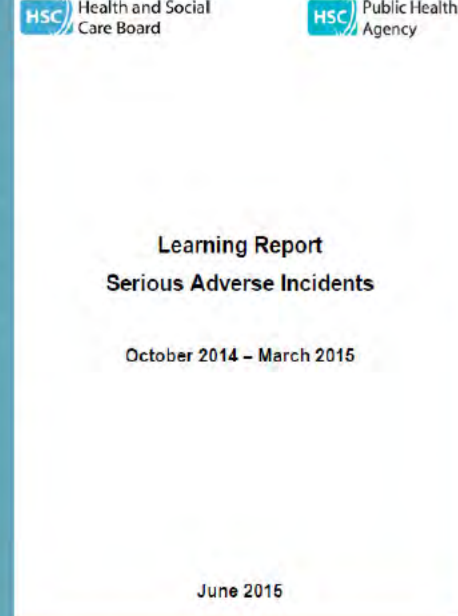
SUMMARY OF EVENT

A Resident in a Private Nursing Home sustained a serious injury during an un-witnessed fall. This resident was assessed as being at a high risk of falls and it was documented in their care plan that they should not be left unsupervised.

The Resident was, however, left unsupervised in a wheelchair with a lap belt secured in place. The Resident subsequently got out of the wheelchair and was found in an unlighted room having sustained a serious injury from falling.

The main contributory factors to this incident were:

- The Resident's care plan was not adhered to; it stated that they should not be left unsupervised.
- Prior to the incident the Resident was in a supervised group. The person supervising the group left the group; the Resident then got up and subsequently fell.



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Learning Report
Serious Adverse Incidents

October 2014 – March 2015

June 2015

Note: Safety and Quality alerts including all learning and reminder letters can be accessed on the HSCB intranet via the following link

http://intranet.hscb.hscni.net/documents/Safety_and_Quality_Learning_Letters.html

DRO Protocol

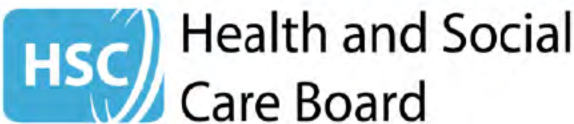
✓ What is a DRO?

A DRO is a senior professional/officer within the HSCB / PHA who has a degree of expertise in relation to the programme of care / service area where a SAI has occurred.

✓ SAI Professional Group

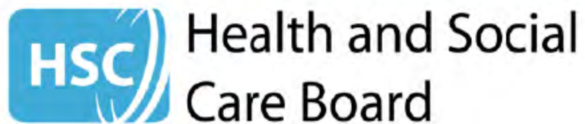
DROs who share the same area of expertise meet and discuss SAI reviews and where relevant identify regional learning prior to closure of the SAI. These professional groups also provide support to DROs when they may require advice in relation to specific SAIs.

- DOIC Group
  - G Meenan (Chair)
  - M Dolan
  - C Logan
  - M McNally (Goverance – support to Group_



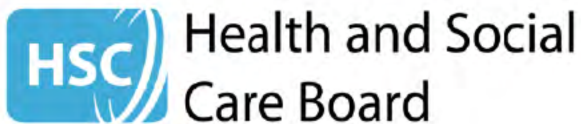
Role of a DRO

- The DRO has a key role in the implementation of the SAI process namely:
  - liaising with reporting organisations:
    - on any immediate action to be taken following notification of a SAI;
    - where a DRO believes the SAI review is not being undertaken at the appropriate level.
  - Agreeing the Terms of Reference for Level 2 and 3 RCA reviews;
  - Reviewing completed SEA Learning Summary Reports for Level 1 SEA Reviews and full RCA reports for Level 2 and 3 RCA Reviews, including service user/family/carer engagement and liaising with other professionals (where relevant);



Role of DRO con'd

- Liaising with reporting organisations via the Governance Team, where:
  - More information is required in relation to a Level 1 summary report. (Whilst the HSCB will not routinely receive the full Level 1 SEA report, these can be requested.)
  - There may be concerns regarding the robustness of the Level 2 and 3 RCA reviews and providing assurance that an associated action plan has been developed and implemented.
- Identification of regional learning, where relevant;
- Surveillance of SAIs to identify patterns/clusters/trends.
- Escalate concerns/issues as necessary to the Director and onwards to the respective Chief Executive as required.



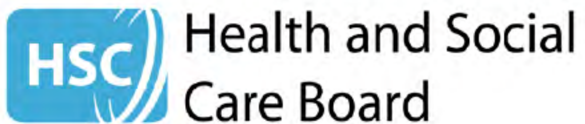
DRO's in DOIC

- Independent to Review
  - DRO should not be line manager
  - Preferably outside of area

- Interface with Secondary care
  - Review team / not DRO unless in relation to learning following receipt of report

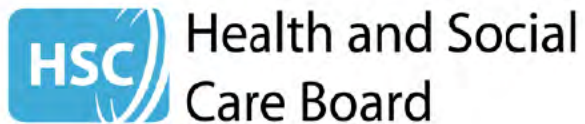
Process (section 6.0 of DRO protocol)

- Notification of SAI
- Immediate Actions
- Submission of Learning Summary/Review Report
- DOIC SAI professional Group Meeting
- Closure of SAI
- Regional Learning Identified



Supporting DRO Process

- DATIX system (being upgraded to DATIX web)
- DROs supporting information
  - Criteria for closure of SAIs (appendix 3 – DRO protocol
  - Supporting information for DROs (appendix 4)
    - Immediate actions
    - On receipt of Report
- Escalation process



INTRANET HUB FOR DROs

Health and Social Care Board *iNTRANET*

vimeo Online HSCB Videos

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Information for DROs

- 001 Access to Safety and Quality Alerts considered by SQAT
- 002 HSCB-PHA Protocol for Safety Alerts
- 003 Options for Disseminating or Implementing Learning
- 004 HSCB-PHA Flowchart fo the approval and dissemination of learning
- 005 Letter to ALBs-Special Agencies - Service User Family Involvement
- 005 Letter to Trust CXs re SAIs - Service User Family Involvement
- 005 SAI Notification Form - Word version
- 005 Service User - Family Involvement
- 006 Outstanding Investigation Reports

For further information or enquires contact:

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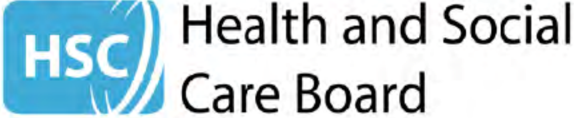
Email: margaret.mcnally@hscni.net
Telephone: **028 9536 2036**

Email: Elaine Hamilton @hscni.net
Telephone: **028 9536 3207**



Serious Adverse Incident (SAI) Training for DROs

SPPG - Anne Kane & Geraldine McArdle
PHA - Denise Boulter & Anne-Marie Phillips

Welcome and Introductions

Aim

To provide an overview of the following:

- Governance & Safety Structure
- Early Alert (EA) Process
- Serious Adverse Incident (SAI) Process
- DRO Role
- Datix Training

Governance & Safety Structure

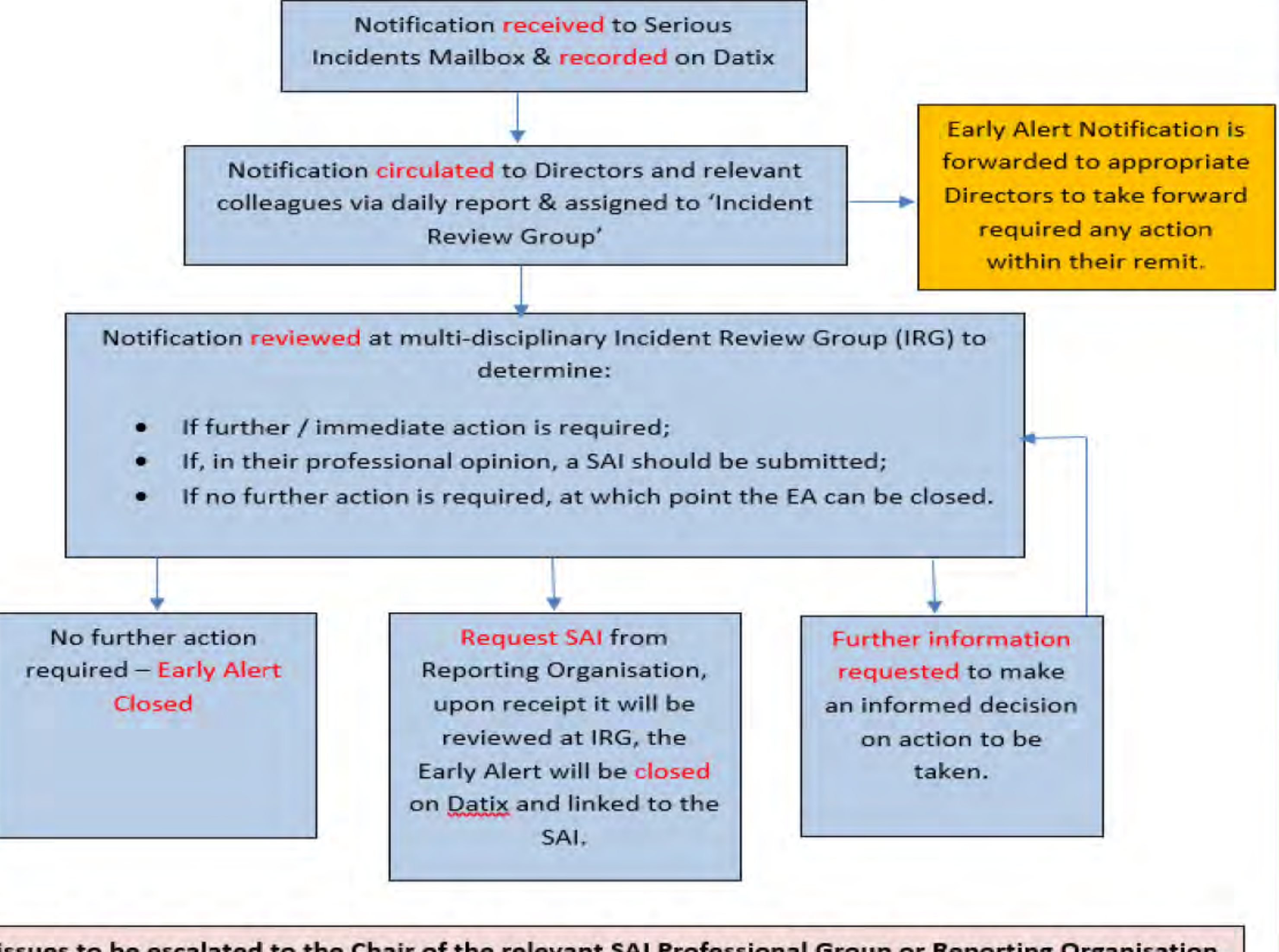
Surveillance Measures and Remit of Groups

Early Alert Process

- Early Alert Protocol for the reporting and follow up of the DoH Early Alert System – 2017

- Purpose
  - Immediate attention / urgent regional action
  - Notifications to DoH copied to Serious Incidents Team

Early Alert - Internal Process



SAI Procedure

- The Strategic Planning and Performance Group (SPPG) in partnership with the Public Health Agency (PHA) has key responsibility for overseeing the management of all SAI's.
- The Procedure for the Reporting and Follow up of Serious Adverse Incidents (2016), provides the mechanism for all DoH Arm's Length Bodies to report the most serious incidents and to effectively share learning from these events in a meaningful way; with a focus on safety and quality; ultimately leading to service improvement for our service users.

SAI Process

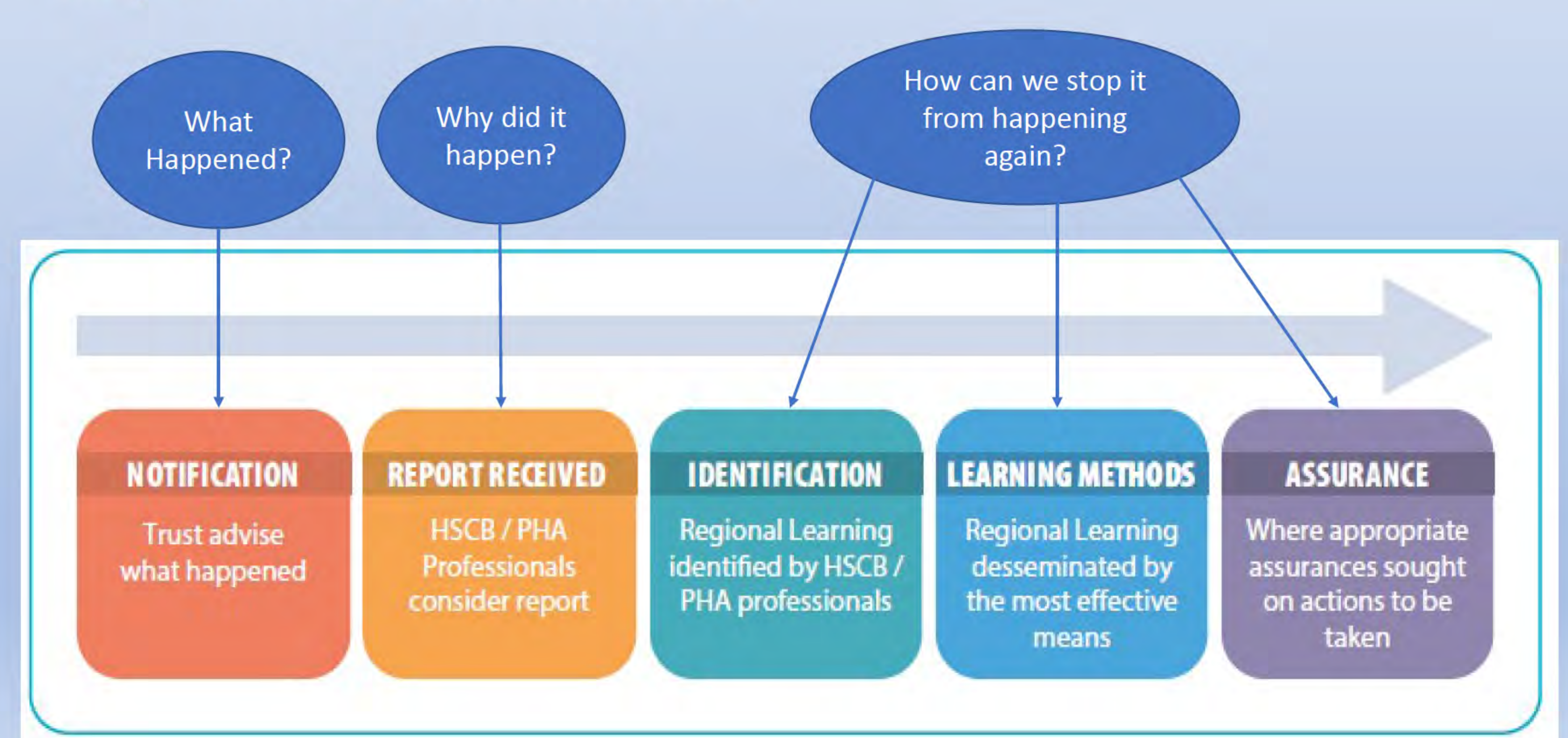
- Responsibility for the management of the SAI Process lies within SPPGs Governance and Safety Team.
- Professional input by clinicians and others into the above processes is provided by colleagues from both the SPPG and PHA, through the role of the Designated Review Officer's (DRO) and the various SAI Professional Groups.
- These include representation from but not limited to:
    - Medical
    - Nursing/Midwifery
    - Social Care
    - Primary care – GMS, Pharmacy, Dental, Ophthalmic

What is a SAI?

- A SAI is an incident or event that must be reported to SPPG by the organisation where the incident has occurred. It may be:
  - An incident resulting in serious harm;
  - An unexpected or unexplained death;
  - A suspected suicide of a service user who has a mental illness or disorder; and/or
  - An unexpected serious risk to wellbeing or safety, for example an outbreak of infection in hospital;

- When things do go wrong in health and social care, it is important that we identify this, explain what has happened to those affected, and learn lessons to reduce the possibility of it happening again. We do this through the SAI process.

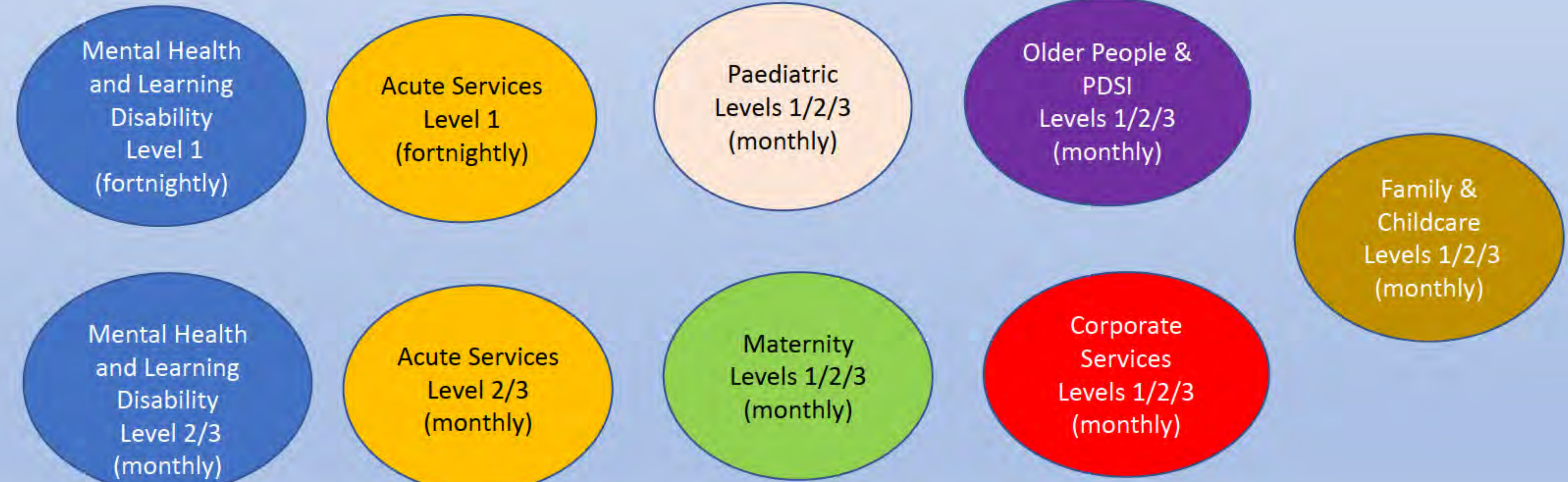
Key Aim of SAI Process



SAI Process: Timescales

Submission of:	Timescales:
SAI Notification	Within 72 hours of the reporting Organisation becoming aware that a incident occurred
Terms of Reference	Level 2 - Within 4 weeks following date of notification Level 3 - submission date to be agreed by DRO / Trust
Review Reports	Level 1 – Significant Event Audit Report (SEA) – 8 weeks Level 2 – Root Cause Analysis Report (RCA) – 12 weeks Level 3 - Root Cause Analysis Report (RCA) – submission date to be agreed by DRO / Trust
RQIA Reports	3 weeks to submit comments on a final review report
DRO Queries	2/3 weeks (depending on complexity)

SAI Professional Groups



Schematic on SAI Process for DROs

Mechanisms used by SPPG / PHA to share learning

Review of Level 1 SAIs

SPPG/PHA responsibility:

- Collective responsibility – identification of Themes / Trends
- Robustness of Report - responsibility of Reporting Organisation
- Queries to Trust – Professional Curiosity
- Action plans – not routinely required / monitored by Reporting Organisation

Review of Level 2/3 SAIs

- Collective responsibility – identification of Themes / Trends
- Review / approve Terms of Reference (ToR)
- Ensure robustness of review / report
- Action Plans:
  - Appropriate recommendations & action plan to address
  - Monitoring by exception – example

Review of SAIs

- Deferred SAIs:
  - Safeguarding / PSNI Investigations – can procced in tandem – DRO to decide
  - Case Management Review – SAI Closed
  - Domestic Homicide Reviews – SAI Closed
- Recommendations for other Organisations
- Corporate Record – Serious Incidents (Inquiries)
- List of Regional Group / Forums

Safety & Quality
is
Everybody's Business!!

Datix Training

- Link to Datix System – Martin Poots Martin.Poots@hscni.net
- Permissions / Read Only Access
- Running Reports – Information Request Form

Supporting Documentation

- Governance Structure – Role and Remit of Groups
- Terms of References for supporting groups
- Protocol for the reporting and follow up of the DoH Early Alert System – 2017
- Early Alert Process (Flow Chart)
- Procedure for the reporting and follow up of SAIs (2016)
- SAI Process (flow chart)
- Datix – How to Guide for DROs
- Information Request Form