Health and Social Care Board

Public Health Agency

Learning Report

Serious Adverse Incidents

April – September 2014

December 2014

CONTENTS

SECTION 1

1.0 BACKGROUND AND INTRODUCTION

From 1 May 2010 the responsibility for the management and follow up of Serious Adverse Incidents (SAIs) transferred from Department of Health, Social Services and Public Safety (DHSSPS) to the Health and Social Care Board (HSCB) working jointly with Public Health Agency (PHA) and collaboratively with Regulation Quality Improvement Authority (RQIA). In response, the HSCB issued the Procedure for the Reporting and Follow up of SAIs (the Procedure) to all HSC organisations and Special Agencies.

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

2.0 MANAGING SERIOUS ADVERSE INCIDENTS REPORTED

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

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

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

3.0 SAIs REPORTED DURING PERIOD APR 2014 – SEP 2014

During the period 1 April 2014 to 30 September 2014, the HSCB received 434 SAI notifications. This represents an increase on the previous six months (October 2013 - March 2014) when 300 SAIs notifications were reported to HSCB.

It should be noted that that this is the second reporting period since the revision of the Procedure and the revised SAI reporting criteria (refer to Appendix A), heightened awareness of the revised procedure (following the consultation and implementation),

the HSC training programmes for SEA and RCA along with recent Thematic Reviews undertaken will account for some of the increases in reporting.

A breakdown of these SAIs by reporting organisation and programme of care is detailed at Appendix B.

4.0 DE-ESCALATION OF SAIs

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

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

During the reporting period four (4) SAI notifications received were de-escalated.

5.0 DUPLICATE SAI REPORTING

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

SECTION 2

1.0 LEARNING FROM SERIOUS ADVERSE INCIDENTS

HSCB/PHA STRUCTURE FOR LEARNING FROM SAIS

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

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

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

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

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

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

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

SAI LEARNING MECHANISMS

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

- Local organisation actions;

- Formal learning letter;

- Thematic Reviews: Commissioned by the Regional SAI Sub Review Group and the QSE Group, to review trends, patterns and provide an in-depth analysis. Key learning points are disseminated across the HSC;

- Learning Matters Newsletter: HSCB-PHA have developed a newsletter to ensure that local incidents are shared regionally to drive improvements for patients and services across the HSC.

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

2.0 DISSEMINATION OF LEARNING INITIATIVES

Learning from SAIs is a significant element to improving practice. However the HSCB and PHA are cognisant that each and every SAI has an impact on individuals and families.

For the purposes of this report patient identifiable information has been removed this is not intended to diminish the personal impact that these incidents have.

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

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

In two SAIs where one baby died and another suffered harm, there were some underlying issues which were common to both incidents. Escalation and appropriate action was delayed due to:

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

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

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

New selection criteria, for women, has been agreed for units who do not meet the minimum medical staffing requirements (as above). Revised criteria for these units are now in place.

In addition, Trusts were asked to confirm:

- that staff are trained at least annually in interpreting CTGs;
- that staff competence in CTG interpretation is checked annually;

- that maternity teams conduct regular audits of their adherence to local protocols/policies for induction of labour, and in case reviews of intrapartum care;
- the date of the last audit of induction of labour, or the date of the next planned audit;
- the date of the last case review of intrapartum care, or the date of the next planned review.

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

2.2. HEAD INJURY IN PATIENTS ON WARFARIN – TREAT AS A MEDICAL EMERGENCY - (update from previous report)

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

The second case had similar circumstances. An elderly patient was brought by Ambulance to ED following a fall and with a visible head injury. Triage staff did not use the Trust's head injury proforma and therefore did not identify that the patient was on warfarin. The patient was triaged as Category 4; they had a medical assessment almost 4 hours later and at that point, noted to be on warfarin. A CT scan was ordered but not performed until 1.5 hours later. PCC was ordered when the CT scan showed a subdural haematoma but not administered for a further 45 minutes and therefore almost 8 hours after the patient first presented to ED. The patient subsequently deteriorated and died.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

All HSC Trusts have provided satisfactory responses, indicating substantive actions.

2.3. DISPENSING BETA BLOCKERS – SELCTION ERRORS - (update from previous report)

Over the past year, a small number of adverse incidents have been reported to the HSCB where beta blockers have been inadvertently supplied to patients as a result

of a selection error at the point of dispensing in a community pharmacy. Some of these resulted in patients coming to serious harm. The three most common beta blockers that have been supplied in error were atenolol, bisoprolol and propranolol. Contributory factors to these errors included:

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

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

- Bradycardia
- Hypotension
- Acute cardiac insufficiency
- Bronchospasm.

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

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

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

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

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

Consider:

- Moving beta blockers to a separate storage area

- Marking stock or shelf edges clearly to highlight beta blockers

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

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

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

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

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

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

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

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

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

HSC Trusts have confirmed that the actions below have been completed:

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

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

THE FOLLOWING ITEMS ARE NEW LEARNING ISSUED SINCE LAST REPORT

2.4. MONITORING FOR TWIN-TO-TWIN TRANSFUSION SYNDROME (TTTS)

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

- The mothers of these babies were not monitored during pregnancy for TTTS in line with the schedule recommended by NICE Clinical Guideline 129 'Multiple Pregnancy: the management of twin and triplet pregnancies in the antenatal period'. The NICE guideline recommends that in monochorionic twin pregnancies diagnostic monitoring with ultrasound for feto-fetal transfusion syndrome (including to identify membrane folding) should start from 16 weeks and be repeated fortnightly until 24 weeks;

- There was a lack of clarity as to whether monitoring for TTTS was done at the same time as the ultrasonographer carried out the fetal anomaly ultrasound scan at 20 weeks; or whether a separate appointment with an obstetrician should have been arranged at that time to ensure that the mother was monitored for TTTS fortnightly between 16-24 weeks in addition to having a fetal anomaly ultrasound scan;

- The respective roles and responsibilities of obstetricians and ultrasonographers for monitoring TTTS were unclear;

- Obstetric staff of varying levels of seniority were involved in monitoring for TTTS.

A Safety and Quality Learning Letter LL/SAI/2014/027 was issued on 17 June 2014 which recognised that the events giving rise to this letter occurred only shortly after the NICE CG 129 had been issued to Trusts, and prior to the anticipated full implementation of CG 129 by March 2015. It also acknowledged that the mothers of these cases received frequent antenatal monitoring. Nevertheless there is learning arising from these events regarding the need to further improve antenatal monitoring for TTTS. Prompt implementation of the relevant recommendations in NICE CG 129, and of the specific actions in this learning letter, will ensure a consistency of approach to antenatal monitoring for TTTS across Trusts. The early detection of TTTS in future cases may increase the chances of a better outcome.

It is acknowledged that it will take time to implement NICE CG 129 with full implementation expected by March 2015. Regional work is already underway with Trusts to develop a regional care pathway and service model whereby the five (5) larger maternity hospitals will all have specialist twins clinics. However, the recent cases have highlighted the importance of monitoring for TTTS as per the NICE guideline. Therefore Trusts should give immediate priority to ensuring that monochorionic pregnancies are monitored in line with the NICE recommendations.

The learning letter identified the following actions for HSC Trusts:

- Development of a clear policy that sets out the local arrangements for monitoring multiple pregnancies in line with the schedule recommended by NICE (including a fetal anomaly scan). The NICE CG 129 is available at: http://publications.nice.org.uk/multiple-pregnancy-cg129);

- The Trust policy should be developed by a multidisciplinary team, including ultrasonographers, and must make it clear whose responsibility it is to monitor for TTTS fortnightly from 16-24 weeks in monochorionic multiple pregnancies, and remove all ambiguity regarding the respective roles of obstetricians and ultrasonographers;

- Trusts should ensure that those carrying out monitoring for TTTS are appropriately trained to do so. As far as possible, there should be continuity of staff who carry out the scans. Junior doctors should not be carrying out monitoring scans in multiple pregnancies unless directly supervised by an experienced consultant as part of their training;

- Trust policy should be reviewed and updated once the regional service model/care pathway is in place.

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

1. The Learning Letter is shared with obstetricians, ultrasonographers, midwives, service managers, and other relevant staff;

2. A clear policy is developed that sets out the local arrangements for monitoring multiple pregnancies in line with the schedule recommended by NICE;

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

2.5. PRESCRIBING AND DISPENSING INCIDENTS INVOLVING BUCCAL MIDAZOLAM PRODUCTS

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

Contributory factors to the incidents included:

- Change in buccal midazolam product prescribed
- Poor communication between GP, Community Pharmacist and Trust Specialist Epilepsy Nurse/Consultant

[1] http://www.medicinesgovernance.hscni.net/primary-care/medicines-safety-alerts/

- Lack of knowledge of the range and strengths of products available and how these are administered
- Generic prescribing, which is contrary to HSCB generic exemptions list
- Insufficient patient/carer education and counselling.

To reduce the risk of further incidents, the following key recommendations were made in a Learning Letter LL/AI/2014/028 issued on 20 June 2014:

1. To ensure the intended product is clear, buccal midazolam should be prescribed by brand name. If it is not prescribed by brand name, community pharmacists should check the intended product with the patient and/or prescriber.

2. Prescriptions for midazolam (Schedule 3 CD) must be clearly defined. Directions such as 'As directed' are not acceptable. The full dose should be specified i.e. dose in mg to be used on each occasion. The total quantity must be written in both words and figures. Any queries in relation to intended dose should be discussed with the prescriber.

3. Prescribers and pharmacists should be familiar with the differences between Buccolam® and unlicensed buccal midazolam solutions e.g. Epistatus®. These preparations are not interchangeable and patients should be maintained on the same product.

4. Patients and/or carers must receive appropriate counselling on the use of their buccal midazolam product and on any medication or dose change. This will help to check the patient/carer understands the medicine they are expecting to receive and will also help to verify the accuracy of the prescription and dispensed medication.

5. If any changes are made to a patient's buccal midazolam product, there should be communication:

    - Between the practitioner making the changes and other key healthcare professionals involved in the patient's care (e.g. GP, practice nurse, secondary care specialist/Epilepsy Nurse) to ensure the patient's Care Management Plan and prescription are updated
    - With the patient or their representative to ensure that they understand their medication and how to use it, and ensure that the necessary education and training is provided.

HSC Trusts should:

1. Share the Learning Letter with all staff involved in recommending, prescribing or dispensing buccal midazolam products;

2. Review and as necessary, update processes for managing patients who require buccal midazolam products, taking account of the suggestions in the Transferable Learning section of the letter.

3. Review all patients currently receiving buccal midazolam to ensure the recommendations included in the learning letter are implemented.

4. Confirm by 15 September 2014 to alerts.hscb@hscni.net that actions 1 and 2 have been completed and action 3 is underway.

GP practices should:

1. Share the Learning Letter with all staff involved in recommending, prescribing or dispensing (dispensing practices only) buccal midazolam products;

2. Review and as necessary, update your processes for managing patients who require buccal midazolam products, taking account of the suggestions in the Transferable Learning section of the letter.
3. Review all patients currently receiving buccal midazolam to ensure the recommendations included in the learning letter are implemented.

Community Pharmacies should:

1. Share the Learning Letter with all staff involved in recommending, prescribing or dispensing buccal midazolam products;

2. Review and as necessary, update your processes for managing patients who require buccal midazolam products, taking account of the suggestions in the Transferable Learning section of the letter.

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

2.6. SYSTEMS TO CHECK THE INTEGRITY AND STERILITY OF PACKS OR INSTRUMENTS PRIOR TO USE

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

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

A Safety and Quality Learning Letter LL/SAI/2014/029 was issued on 1st October 2014 and identified the following learning for the Trusts:

To reduce the risk of individual error, Trusts should have robust systems in place to check the integrity and sterility of instruments/packs prior to use. Opportunities for checking include:

- Prior to leaving Sterile Services;

- On receipt from Sterile Services at ward/department level, and;

- At the time they're being used in the clinical/care area.

The Trusts were asked to:

- Discuss this Learning Letter with acute and community medical and nursing staff who use sterile instruments/packs, service managers for those areas, and other relevant staff;

- Review and update your systems for checking the integrity and sterility of instruments/packs prior to use to minimize the risk of individual error.

HSC Trusts were asked to respond by 16 January 2015.

HSC Trust responses will be reviewed by the Safety and Quality Alerts team in March 2015 and an update will be provided in the next SAI Learning Report.

In addition, all GPs and GP Out of Hours Services and Dentists were asked to discuss the Learning Letter with relevant staff in their practice/service and review and update their systems for checking the integrity and sterility of instruments/packs prior to use to minimize the risk of individual error.

RQIA was asked to disseminate the letter to relevant independent sector providers, including independent dentists and NIMDTA to disseminate this letter to doctors in training in relevant specialties.

2.7. COMMUNICATIONS AND ADMINISTRATION

A SAI occurred where an elderly patient with a complex medical history received medication intended for another patient. This was as a result of one page from a Trust clinic letter becoming inadvertently attached to the second page of another patient's discharge letter. The outcome of this was that the patient was prescribed a Beta-blocker in error and also received two ACE–inhibitors. The patient became unwell and was admitted to hospital where he sadly passed away.

The incident highlighted a series of systems failures across several settings - hospital, a GP practice and a community pharmacy.

The SAI report identified learning for all the organisations involved, and appropriate actions were taken by those concerned, including:

- HSC Trust reviewed their fax procedures

- GP practice reviewed and updated its protocols for handling of faxes, issuing and signing of prescriptions, dealing with community pharmacist medication queries and GP locum duties.

- Standard operating procedures for the practice's prescribing processes were drawn up and assigned off Board pharmacist

- Community pharmacy reviewed its Standard Operating Procedure for handling of faxes and prescription queries for GP practices.

- Revised standard operating procedures were drawn up by the pharmacy and signed off

Wider learning from the SAI was disseminated to GP practices and community pharmacies, including:

- HSCB letter to GPs and community pharmacies around good practice when communicating in primary care

- HSCB pharmacists are highlighting key learning issues during practice visits

- Training is planned for sessional doctors around the key issues identified

OTHER LEARNING INITIATIVES TAKEN FORWARD

There are a range of other initiatives across the HSC where learning from SAIs changes practice to reduce the risk of recurrence. Some examples include:

- Hepatobiliary Service are improving protocols and procedures such that all post resection patients are discussed and appropriate communication forwarded to referring Trust;

- The Maternity Quality Improvement Collaborative are producing a regional Vaginal Birth After Caesarean section leaflet for all women suitable for VBAC, this will be available in Spring 2015;

- The Maternity Quality Improvement Group, in collaboration with all HSC Trusts, have produced an antenatal CTG sticker which is now in use in all maternity units;

- The Maternity Community Care sub group of the Maternity Strategy Implementation group will be taking forward work on the use of Customised Growth Charts for monitoring fetal growth in pregnancy;

- The Maternity Quality Improvement Group has recently developed an agreed regional maternity early warning chart for both antenatal and postnatal use, and staff have been given guidance in its use.

SECTION 3

NEXT STEPS

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

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

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

An action plan was developed, to ensure that learning from this review and the workshop is used to inform the improvement of services for older people by identifying existing streams of work or establishing where a new focus of work is required. A report giving an overview of both pieces of work has been finalised and issued to relevant parties.

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

2.0 THEMATIC REVIEWS

Thematic Reviews are commissioned by the HSCB/PHA Quality Safety and Experience (QSE) Group, to review trends and patterns. These in-depth reviews ensure that local patterns are considered within the regional and national context and ensuing recommendations and key learning points are disseminated across the HSC.

Following an in-depth review of SAI reports, the following thematic reviews were undertaken:

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

‘Misidentification of Patients/ Clients’ in HSC services was identified as a theme through SAI analysis, following several reported incidents. The aim of this thematic review was to identify recurrent themes found within reported SAIs and to consider any regional actions that could be implemented to reduce the incidence of “Misidentification of Patients and Clients”.

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

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

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

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

A poster has been has been designed in partnership with the five HSC trust and should be displayed throughout Trust wards and departments to raise awareness across all HSC staff of the importance of patient verification processes at every stage of care.

Distribution of the review was delayed until the poster was complete and both of these will be issued to HSC Trusts and relevant organisations in the coming weeks.

3.0 NEWSLETTER – “LEARNING MATTERS”

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

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

- Act FAST when Stroke suspected.

- Removal of Central Lines.

- Over infusion of IV fluids.

- Ensuring the Safer Use of Bed Rails.

- Development of a key Cardiotocography (CTG) Evaluation Tool.

- The Yellow Card Scheme: Patients can contribute to medicines safety by reporting side effects.

This edition of the newsletter can be viewed at:

http://www.hscboard.hscni.net/publications/Learning%20Matters/index.html#P-1_0

http://www.publichealth.hscni.net/publications/learning-matters-newsletter-2nd-edition-june-2014

SECTION 4

CONCLUSION

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

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

The HSCB/PHA first Annual Quality Report was published on 13 November 2014. Quality reports were a recommendation from Quality 2020, a strategic framework and plan of action that aims to protect and improve quality in Health and Social Care (HSC). The Quality 2020 strategy defines three core elements of quality being safety, effectiveness and patient and client focus.

Recently the HSCB/PHA have participated in Human Rights Inquiry and the Donaldson review and welcome feedback from these to take forward the important lessons for health and social care in Northern Ireland.

Since the last report three learning letters have been disseminated to the relevant HSC organisations. Additionally the “Learning Matters” newsletter was published in June 2014, to compliment the other methods of learning and to provide a forum where local learning from SAIs, reviews and complaints can be shared regionally.

HSCB/PHA has continued to work with HSC Trust Colleagues in relation to enhancing service users/families involvement in the SAI process.

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

APPENDIX A

REVISED CRITERIA FROM 1 OCTOBER 2013

DEFINITION OF AN ADVERSE INCIDENT AND SAI CRITERIA

'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation'.[2] arising during the course of the business of a HSC organisation / Special Agency or commissioned service

The following criteria will determine whether or not an adverse incident constitutes a SAI.

SAI criteria

- serious injury to, or the unexpected/unexplained death of:
  - a service user (including those events which should be reviewed through a significant event audit)
  - a staff member in the course of their work
  - a member of the public whilst visiting a HSC facility;

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

- unexpected serious risk to a service user and/or staff member and/or member of the public;

- unexpected or significant threat to provide service and/or maintain business continuity;

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

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

  by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and known to/referred to mental health and related services *(including CAMHS,*

[2] Source: DHSSPS How to classify adverse incidents and risk guidance 2006
www.dhsspsni.gov.uk/ph_how_to_classify_adverse_incidents_and_risk_-_guidance.pdf

psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident;

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

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

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

APPENDIX B

ANALYSIS OF SAI ACTIVITY APRIL – SEPTEMBER 2014

The HSCB has **received 434 SAI Notifications** from across Health and Social Care (HSC) for the above period. The information[3] below has been aggregated into summary tables with commentary to prevent the identification of individuals.

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

Total Activity	Apr - Sept 13	April - Sept 14
BHSCT	35	101
BSO	1	3
HSCB	0	1
NHSCT	56	118
NIAS	2	2
PCARE	15	12
PHA	0	1
SEHSCT	19	60
SHSCT	28	73
WHSCT	27	63
Totals:	**183**	**434**

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

SAI DE-ESCALATION

SAI reports submitted can be based on limited information at the time of reporting. If on further investigation the incident does not meet the criteria of an SAI, a request can be submitted by the reporting organisation to de-escalate.

In line with the HSCB Procedure for the reporting and follow up of SAIs the reporting organisation provides information on why the incident does not warrant further investigation under the SAI process. This information is considered by the HSCB/PHA Designated Review Officer prior to approving any de-escalation. During the reporting period **four (4) SAI notifications** received were subsequently **de-escalated**.

TOTAL DE-ESCALATED	Apr - Sept 13	April - Sept 14
BHSCT	4	1
NHSCT	4	1
NIAS	1	0
PCARE	2	0

[3] Source- HSCB DATIX Information System

TOTAL DE-ESCALATED	Apr - Sept 13	April - Sept 14
SHSCT	1	0
WHSCT	1	2
Totals:	**13**	**4**

DUPLICATE SAI NOTIFICATIONS

A notification may be received from one or more organisation but relating to the same incident. During the reporting period there were three (3) duplicate notifications received.

TOTAL DUPLICATE	Apr 13 - Sept 13	April - Sept 14
BHSCT	1	2
PCARE	1	0
SHSCT	0	1
Totals:	**2**	**3**

SAI ANALYSIS BY PROGRAMME OF CARE

SAIs are categorised by Programmes of Care as follows:

- Mental Health
- Acute Services
- Family and Child Care
- Learning Disability
- Corporate Business / other
- Maternity and Child Health
- Primary Health and Adult Community (Including General Practice)
- Elderly
- Physical Disability and Sensory Impairment
- Health Promotion and Disease Prevention

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

ACUTE SERVICES

ORGANISATION	April - Sept 13	April - Sept 14
BHSCT	9	23
NHSCT	17	29
NIAS	1	0
SEHSCT	4	10
SHSCT	4	11
WHSCT	6	27
Totals:	**41**	**100**

Current period: One hundred (100) SAIs were reported. The top five groups related to the following classifications/categories. Twenty-two (22) incidents being the most reported in any one category.

Classification/category

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

Since the revised SAI criteria (see Appendix A) were introduced, there has been an increase in the number of reported incidents relating to falls; within the above classification/ catergory: accident that may result in personal injury, 17% of the reported SAIs (n=17) for this programme of care relate to slip, trips, falls and collisions in an acute setting.

MATERNITY & CHILD HEALTH

ORGANISATION	April - Sept 13	April - Sept 14
BHSCT	4	57
HSCB	0	1
NHSCT	4	10
NIAS	0	2
PCARE	0	1
SEHSCT	0	5
SHSCT	2	6
WHSCT	2	12
Totals:	**12**	**94**

Current period: Ninety four (94) SAIs relating to maternity and child health were reported. The revised criteria (Appendix A) included an additional requirement to report 'any death of a child in receipt of HSC services (up to eighteenth birthday)'. 77% of the reported SAIs (n=72) for this programme of care relate to HSC Child Death Notifications.

FAMILY & CHILD CARE

ORGANISATION	April - Sept 13	April - Sept 14
NHSCT	4	4
SEHSCT	1	1
SHSCT	0	4
WHSCT	2	2
Totals:	7	11

Current period: Eleven (11) SAIs relating to family and childcare were reported. The largest classification/category group (n=8) related to 'Abusive, violent, disruptive or self-harming behaviour'.

OLDER PEOPLE SERVICES

ORGANISATION	April - Sept 13	April - Sept 14
BHSCT	0	1
NHSCT	5	37
SEHSCT	1	1
SHSCT	4	26
WHSCT	1	6
Totals:	**11**	**71**

Current period: Seventy-one (71) SAIs reported related to older people services. The largest classification/category group (n=56) related to slips, trips, falls and collisions.

MENTAL HEALTH

ORGANISATION	April - Sept 13	April - Sept 14
BHSCT	13	9
NHSCT	17	22
PHA	0	1
SEHSCT	12	41
SHSCT	14	23
WHSCT	14	11
Totals:	**70**	**107**

Current period: One hundred and seven (107) SAIs relating to adult mental health services were reported. 68% (n=73) related to suspected / attempted suicides* or unexpected deaths.

**Suspected suicide – suicide (completed) whether suspected or proven. It should be noted that in the absence of knowledge of the inquest verdict, all of these cases have been classified as "suspected suicides" regardless of the circumstances in which the individual was reported to have been found.*

LEARNING DISABILITY SERVICES

ORGANISATION	April - Sept 13	April - Sept 14
BHSCT	2	6
NHSCT	2	3
SHSCT	1	0
WHSCT	0	1
Totals:	**5**	**10**

Current period: Ten (10) SAIs relating to learning disability services were reported.

PHYSICAL DISABILITY AND SENSORY IMPAIRMENT

ORGANISATION	April - Sept 13	April - Sept 14
NHSCT	0	2
SEHSCT	1	0
SHSCT	0	1
Totals:	**1**	**3**

Current period: Three (3) SAIs relating to physical disability and sensory impairment services was reported.

PRIMARY HEALTH AND ADULT COMMUNITY (INCLUDING GENERAL PRACTICE)

ORGANISATION	April - Sept 13	April - Sept 14
BHSCT	1	0
NHSCT	1	2
PCARE	12	8
SHSCT	2	0
Totals:	**16**	**10**

Current period: Ten (10) SAIs relating to Primary Health and Adult Community were reported. The largest classification/category group (n=4) was 'Medication'.

CORPORATE BUSINESS

ORGANISATION	April - Sept 13	April - Sept 14
BHSCT	1	2
BSO	1	3
NHSCT	2	8
PCARE	0	3
SEHSCT	0	2
SHSCT	0	1
WHSCT	1	2
Totals:	**5**	**21**

Current period: Twenty one (21) SAIs were reported relating to corporate business. The largest classification/category group (n=6) related to 'Consent, Confidentiality or Communication'.

HEALTH PROMOTION AND DISEASE PREVENTION

No reported incidents