Health and Social Care Board

Public Health Agency

Learning Report

Serious Adverse Incidents

October 2017 - March 2018

June 2018

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.

Two revisions to the procedure have since been undertaken, the first of which was issued in October 2013 and the most recent in November 2016.

2.0 MANAGING SERIOUS ADVERSE INCIDENTS REPORTED

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

- Regional reporting system for all SAIs;
- SAIs are reviewed by senior professional officers; in addition, the HSCB senior management team receives and considers all SAIs on a weekly basis;
- SAIs are allocated to a nominated professional officer, who is the Designated Review Officer (DRO) responsible for reviewing learning summary reports for level 1 SAI reviews and quality assuring reports for both level 2 and 3 SAI reviews; in conjunction with the relevant DRO professional group within the programme of care;
- DRO Professional Group meet to consider learning summary and SAI review reports and identify themes and trends from within the programme of care where the SAI has occurred;
- SAI Review Sub Group (SAIRSG) meetings to consider reports, identify themes and learning;
- Overarching HSCB-PHA Quality Safety and Experience (QSE) Group to consider the issues identified by the SAIRSG and agree actions and assurance arrangements;
- The Safety and Quality Alerts (SQA) Team provide an assurance mechanism for any actions to be taken forward as a result of regional learning;
- Escalation if required in respect of:
    - timescales for receipt of SAI and review reports
    - assurances on action being taken forward by reporting organisations following the incident review.

3.0 SAIs REPORTED DURING PERIOD OCT 2017 - MAR 2018

During the period 1 October 2017 to 31 March 2018, the HSCB received 184 SAI notifications, this represents a similar reporting level on the previous six months (April to September 17) when 186 SAI notifications were reported to the HSCB. Appendix B provides breakdown of SAIs by reporting organisation and programme of care.

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 review 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 or withdraw the SAI, however, the decision to approve the de-escalation/withdrawal will be made by the HSCB/PHA Designated Review Officer.

During the reporting period four (4) SAI notifications received were de-escalated/ withdrawn.

5.0 SAI NEVER EVENTS

DoH circular HSC (SQSD) 56/16 (Never Events), introduced a never events process based on the NHS England list of never events. Information relating to these events are captured as part of the SAI process. During the reporting period two (2) SAI notifications received which were classified as never events.

6.0 DUPLICATE SAI REPORTING

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

During the reporting period no duplicate SAI notifications were received.

SECTION 2

1.0 LEARNING FROM SERIOUS ADVERSE INCIDENTS

HSCB/PHA STRUCTURE FOR LEARNING FROM SAIs

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

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

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

The HSCB and PHA 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. The process to identify learning from SAIs is also supported by a range of professional groups which have been developed for the following programmes.

- Paediatrics and Child Health
- Maternity
- Mental Health
- Acute
- Integrated Care
- Adult Services
- Children's Services
- Corporate Services

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

The SQAT group, 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.

The process is overseen by a joint PHA/HSCB SQAT which is a multidisciplinary group 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 DHSSPS, HSCB, PHA and other organisations. This provides a mechanism for gaining regional assurance that

alerts guidance have been implemented or that there is an existing robust system in place to ensure implementation.

The HSCB/PHA SQAT issue a Bi-annual Report on Safety and Quality Alerts. This report provides an overview of the alerts reviewed by the SQAT in the reporting period and details key safety / quality improvements following the issue of alerts. The latest edition and previous issues of the PHA/HSCB Report on Safety and Quality Alerts are available to access using the following link:

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

- **Regional Links**

Governance Officers from the HSCB, the PHA and the six HSC Trusts, meet on a bi-annual basis to share experiences, best practice and to consult on a range of issues in relation to the reporting and follow up of SAIs across the HSC.

SAI LEARNING MECHANISMS

Possible **learning actions** following the review of SEA / RCA review reports:

- **Local organisational actions**

- **Regional actions**

  - ***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

  - ***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

2.0 DISSEMINATION OF LEARNING INITIATIVES

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

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

THE FOLLOWING ITEMS ARE NEW LEARNING ISSUED SINCE LAST REPORT:

REMINDER OF BEST PRACTICE GUIDANCE (SQR):

- **SQR/SAI/2017/030 (Acute) -** Management of Needlestick Injuries in Patients presenting to Emergency Departments (Linked to ICPL/2017/024);
- **SQR/SAI/2017/031 (Acute & MCH)** - Risk of accidental overdose of IV paracetamol;
- **SQR/SAI/2017/032 (Acute & Social Care)** - Acute Hospital Accommodation for Patients with Learning Disability;
- **SQR/SAI/2018/033 (PHC & FCC) -** Fire risk associated with use of product to treat head lice. (Linked to ICPL/2018/026);
- **SQR/SAI/2018/034 (OPS) -** Provision of services for people in their own homes.

PROFESSIONAL LETTERS:

- **ICPL-2017-024 -** Needlestick Injury Policy (Linked to SQR-SAI-2017-030)
- **ICPL-2018-025 -** Community Pharmacy Security Assessment
- **ICPL-2018-026 -** Immediate Learning regarding Fire risk with Hedrin 4% Cutaneous Solution. Linked to SQR/SAI/2018/033 - further details below;
- **ICPL-2018-027 -** Standardisation of the most common liquid medicines in Paediatrics - further details below;
- **ICPL-2018-028 -** Fraudulent attempts to obtain medicines via alteration of communications from secondary care;

SAFETY AND QUALITY BEST PRACTICE REMINDER LETTERS RELATING TO THE ABOVE ARE AVAILABLE TO ACCESS USING THE FOLLOWING LINK:

http://intranet.hscb.hscni.net/documents/Learning_Letters/Safety%20and%20Quality%20Best%20Practice%20Reminder%20Letters/index.html

LEARNING FROM SAIs WITHIN FAMILY PRACTITIONER SERVICES (FPS)

There are a range of other initiatives across the HSC where learning from SAIs is shared with FPS practitioners to reduce the risk of recurrence. There have been a number of SAI related learning communications issued to FPS including the following:

- Following a SAI related to cervical screening, learning has been shared and a number of actions have been taken to embed lessons learned in practice and safety and quality of care:

    - A professional letter was issued in December 2015 (ICPL / 2015 / 010) to practices
    - NI Training and Audit Requirements for Cervical Smear Takers issued May 2016
    - Northern Ireland Standards for Nurse and Midwife Education Providers: Cervical Screening Sample Taking issued Dec 2016
    - Reporting Recommendations for cervical cytology issued by the various laboratories in August 2016
    - HSCB is updating the Audit of Abnormal Smear Follow Up in General Practice

    Further actions are detailed below:

    - The practice has updated its policies which could be used as a template for other practices
    - A practice protocol for cervical screening template was drafted in April 2017 and is currently being evaluated by the PHA cancer screening primary care QA group.

- In July 2015, The Medicines Regulatory Group (DoH) was undertaking routine community pharmacy inspections and noted an unusually high number of private prescriptions being dispensed for 'Z' drugs (controlled drugs prescribed for insomnia). This is not considered to be normal practice and is contrary to HSCB advice. The following learning has been identified and shared:

    - Early learning letter issued to community pharmacies and GPs across the primary care system - April 2016
    - Professional letter issued to all GP practices, GPs and sessional doctors – Private Prescriptions for HSC patients – Regulatory Investigation – 05 April 2016
    - Professional letter issued to community pharmacists: Supply of Controlled Drugs – Responsibilities for Dispensing – 5th April 2016
    - Professional letter issued to all locums employed at practices involved since 2011, outlining their contractual and ethical responsibilities for the treatment of patients under health service arrangements.
    - GMS Newsletter article regarding learning relating to GP locum signatures

    http://primarycare.hscni.net/download/DocLibrary/GMS/GMS%20newsletter/GMS-Update-summer-2017.pdf

    Further action was advised as follows:

    - Requirement regarding GP locum signatures should be included by general medical practices in their GP locum packs

- A number of medication incidents have been notified regarding an ADHD clinic which highlighted 2 issues:
    - Failure of clinic staff to complete medication summary properly
    - An agreed shared care guideline was not available at the time of the incidents. This meant that the roles and responsibilities for monitoring Guanfacine (an amber drug) in primary and secondary care were not clear.

  There is a risk of similar incidents occurring in the period between a drug becoming available and a shared care guidelines being developed.

    - The learning has been shared with the medicines management group in HSCB for consideration of further action to reduce / prevent similar incidents occurring in future

- Patient prescribed and dispensed cellcept 1mg daily instead of 1g bd from 4/1 until 18/2. The patient was then correctly prescribed cellcept 1g bd but dispensed one tablet (500mg) bd for 3 weeks. The SAI highlighted an important issue in relation to Transplant Medication that is a high risk drug. The learning identified includes:

    - Special Edition Newsletter – regional learning to be included in a special edition newsletter to GPs and pharmacists focusing on transplant medications that are high risk drugs

- Routine checking of a patient's medications following their admission to hospital found that a box of Atenolol 100mg tablets had been wrongly labelled by a community pharmacy as Allopurinol 100mg. The patient had taken 1 tablet of atenolol (a beta blocker) and required hospital admission which lasted for several days.

  Following review, it was discovered that the prescription included allopurinol 100mg x 56 tablets. The Allopurinol 100mg was misread in the dispensary and atenolol 100mg was incorrectly gathered and labelled. On checking the medication against the prescription, the pharmacist did not see that the label did not match the box of tablets being dispensed – i.e. a label for allopurinol was on an atenolol box. The patient then left with the dispensed medication.

  The learning identified includes:

    - Positioning of Beta Blockers - should be separated from main stock in the dispensary
    - Issue to be referred to Pharmacy Networking Group to discuss other options for action
    - Community Pharmacy Newsletter article to be drafted and this issue will be a standing item to update on increase / decrease of such incidents

- There have been three dispensing incidents regarding the selection of Prograf. A best practice reminder letter was issued in June 2015 regarding

Prescribing and Dispensing High Risk Drugs. Two of the incidents occurred in year and are outlined below:

- A patient who had a kidney transplant and receiving immune-suppression medication was admitted to Nephrology Unit for an elective procedure. On admission, patient stated there had been an error in dispensing their immune-suppression medication from their community pharmacy. The patient had been prescribed Prograf 5mgby their GP but Prograf 0.5mg had been dispensed by the pharmacy. This had been labelled as 5mg. The patient realised the error and did not take the incorrect dose. The consequences had the patient taken incorrect medication would have been a drop in tacrolimus levels and a potential for kidney transplant rejection.
- A second dispensing issue regarding prograf was also reported. The patient attended the renal transplant clinic. The patient informed the consultant nephrologist that there had been an error in dispensing their immune-suppression medication from their community pharmacy. The patient had been issued with Prograf 5mg capsules but some of the blister strips were Prograf 0.5mg. The patient recognised that the capsules were the incorrect strength and did not take the medication. The consequences would have been as above with the potential of a kidney transplant rejection.

Learning from these incidents has been identified and actioned as follows:

- Regional learning is to be included in a special edition medicines management newsletter to GPs and pharmacists focusing on transplant medications that are high risk drugs
- Referral to MSSG to consider supply arrangements

- An elderly patient was dispensed 2 different brands of digoxin 250 mcg from community pharmacy with directions to take 1 in the morning. One box was Activis and one box was Lanoxin. The 2 boxes of digoxin had different packaging. The patient was confused and for a number of days (12) took 1 tablet from each box. Following a digoxin level reported as 3.0ug/l, the patient was referred to A&E by GP OOH. The patient was managed by cardiology, her digoxin stopped and she was commenced on a beta blocker. The learning identified includes:

  - Need for GP practices to complete a computer search for elderly patients on high doses of digoxin to check renal monitoring - GMS newsletter http://primarycare.hscni.net/download/DocLibrary/GMS/GMS%20newsletter/GMSU-Winter-2018.pdf

  - Need to raise awareness among community pharmacies of potential for confusion in elderly or vulnerable patients where different boxes / suppliers of the same drug are dispensed by pharmacy

  - Article included in PRN Newsletter to raise awareness of Pharmacy Forum's NI Clinical Check Guidance (issued in June 2016) http://niformulary.hscni.net/PrescribingNewsletters/PDF/PharmRegNews/PRN%20Jan%202018.pdf

- Controlled Drugs Missing / Unaccounted For – the pharmacy delivered a prescription to a patient's neighbour as per previous verbal authorisation from patient. The neighbour's son denied taking temazepam, diazepam, and gabapentin from the prescription delivery. The incident was reported to the police and to the pharmacy who made changes to their delivery procedures.

    - A PRN article was published in January 2018 to raise awareness of the reporting requirements for community pharmacists for any incident involving a Controlled Drug. http://niformulary.hscni.net/PrescribingNewsletters/PDF/PharmRegNews/PRN%20Jan%202018.pdf

- A failure in the referral process led to a patient being lost to follow up. In August 2012 a patient attended A&E complaining of neck pain. A CT scan of thoracic spine was performed. This showed an incidental pulmonary nodule requiring a follow up CT scan. A CT chest scan was arranged by A&E. Approximately 4 weeks later, the CT chest scan reported a 3mm nodule R apex and a repeat CT was recommended in 1 year. The patient appears not to have been successfully referred by the GP for the repeat CT chest scan in 2013 as recommended.

  In November 2015 the patient was referred to the chest clinic with a 4 month history of cough and haemoptysis. The patient was subsequently diagnosed with lung cancer and was admitted as an inpatient to the hospice late 2017. The learning from this incident was identified and was included in the Winter 2018 GMS newsletter for awareness raising purposes:

    - Need for GP practices to have robust protocols in place to manage hospital recommendations for a GP referral for a specified follow up investigation at a future point in time

    - GPs need to be aware that they can arrange a referral for a scan on receipt of a hospital request for same at some point in future time. http://primarycare.hscni.net/download/DocLibrary/GMS/GMS%20newsletter/GMSU-Winter-2018.pdf

- A professional alert letter was issued in January 2018 on the fire risk with a certain head lice treatment. The primary audience was Community Pharmacists and their staff. This was an early response to an SAI reported elsewhere in the system. Through subsequent processes additional communications were issued including a Safety and Quality Reminder of Best Practice Guidance and an article in Pharmacy Regional News. As a direct result of the work in Northern Ireland the MHRA subsequently issued UK wide advice on this matter in March 2018 and included it in their publication Drug Safety Update.
  www.medicinesgovernance.hscni.net/primary-care/medicines-safety-advice-letters/
  www.gov.uk/drug-safety-update/head-lice-eradication-products-risk-of-serious-burns-if-treated-hair-is-exposed-to-open-flames-or-other-sources-of-ignition-eg-cigarettes

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 method of sharing learning relating to SAIs, complaints, reviews and patient experience across Northern Ireland. A Special Edition for Regulated Services was issued in March 2018 and covered the following topics:

- Management of Insulin
- Denture Care
- Caution with meal packaging
- Equipment related issues
- Falls in Nursing and Residential Homes
- Security at Care Homes

Previous editions of the newsletter can be viewed at:

http://www.publichealthagency.org/publications/learning-matters-newsletters

Edition 8 is currently being produced.

THEMATIC REVIEWS

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

During this reporting period the regional review of Adult SAIs and Adverse Incidents (AIs) relating to choking on food, was issued to inform future regional safety work.

The aim of this Thematic Review: 'Report on the Regional Choking Review Analysis; February 2018' was to identify recurring themes, consider regional learning, highlight areas of good practice and to determine if regional actions are required to reduce/prevent reoccurrence of these incidents.

An inter professional review team was established with representation from the Public Health Agency (PHA), Health and Social Care Board (HSCB), HSC Trusts, the Regulation and Quality Improvement Authority (RQIA), a service user and other members of staff from across the HSC also contributed.

This review was undertaken of all SAIs reported between May 2010 and April 2016 where choking on food was associated with actual or potential harm. Qualitative analysis was carried out to identify the key themes. Themes identified by HSC Trusts from reported AIs, within the same period, were also considered.

The number and proportion of SAIs in this review that resulted in death, emphasises the scale of the problem and the risks associated with dysphagia. The potential risk is also highlighted by the volume of regional related AIs.

The themes identified through analysis of SAIs and AIs, reinforce a need for co-ordinated efforts to facilitate learning and inform future quality improvement work with an aim of prevention or reduction of risk of choking in future.

The Regional Dysphagia Group, led by PHA has been asked to take forward the next steps outlined in the report.

A copy of this report is available on the PHA website at:

http://www.publichealth.hscni.net/publications/report-regional-choking-review-analysis-thematic-review

HSC SAFETY FORUM

In addition to facilitating the Annual Regional SAI Learning Event, the HSC Safety Forum welcomes information on key themes arising from SAIs to inform their improvement work. The Forum also provides assistance on specific SAIs on request.

Within the Safety Forum QI programmes, HSC Trust improvement teams are encouraged to present the learning from SAIs to inform change. Current areas of Safety Forum work influenced by specific SAIs, or themes from groups of SAIs, include communication and handover, sepsis, medication safety in paediatrics and recognition of the deteriorating patient (including early warning scores and escalation), developing a culture of reflective practice within mental health services and improving communication with mental health service users, families and carers. The Maternity collaborative have used this forum to share individual and thematic learning from SAIs through a range of approaches including reflective presentations and incorporating recommendations into revised protocols and documentation.

OTHER LEARNING ACTIONS

There are a range of other learning actions, which existing work streams or groups are taking forward or have been asked to consider by the HSCB/PHA, as a result of learning identified from SAIs. Examples include:

- Regional Falls Group
- Modernising Radiology Clinical Network (MRCN)
- Networks - Pathology / Diabetic / Paediatric / Neonatal/ Information Governance
- Elective Care Reform Group
- Regional Medicines Safety Group
- Regional Bed Management Group
- Pharmacy Networking Group
- Regional Information Governance Advisory Group
- HSC Information Governance Steering Committee

- Heads of Estates Forum
- HSC AD Forum Children
- Critical Care Network Northern Ireland (CCaNNI)

ANTICOAGULANTS AND/OR ANTIPLATELETS

A regional task and finish group, with provider organisations, has been convened to focus on safety issues relating to anticoagulants and/or anti platelet therapy. The group has met on three occasions and has medical, pharmaceutical and nursing representation from each Trust and an improvement plan has been agreed.

SECTION 3

NEXT STEPS

1.0 THEMATIC REVIEWS

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

- ***REVIEW OF SAIs RELATING TO THE PRESCRIBING, SUPPLY AND ADMINISTRATION OF INSULIN***

A review was undertaken of SAIs relating to the prescribing, supply and administration of insulin since October 2010. The report will identify key themes, regional learning and will be accompanied by an action plan to reduce/prevent occurrence of similar incidents.

- ***REVIEW OF SAIs RELATED TO DELAYED DIAGNOSIS OF CANCER***

A review of SAIs involving delayed diagnosis of cancer from March 2010 to March 2016 has been completed, to assess key characteristics (e.g. tumour type), highlight key common failures and identify possible preventive measures.

A common theme identified was failure to follow-up imaging, especially in acute settings and a recommendation was made to build failsafes into referral systems to ensure images requiring urgent follow-up are acted on. The review findings have been presented to Quality Safety and Experience group and are to be presented to the Senior Management Team.

2.0 SAI LEARNING EVENTS

- ***HSC SAFETY FORUM ANNUAL LEARNING EVENT***

The fourth Annual Regional SAI Learning Event is planned for Thursday 7 June at Craigavon Civic Centre. It is aimed at clinical staff, those who manage clinical services and staff involved in SAI review processes.

This will be an interactive all-day workshop which will build on the success of previous SAI events and provide an opportunity to share learning regarding SAIs in our Health and Social Care system and develop reliability in reviews, learning and change.

The workshop programme, developed in partnership with HSC Trust governance leads, draws together learning including from SAI case studies, human factors and ergonomics subject matter knowledge and broader lessons from the hyponatraemia inquiry. The aim is to use collaborative learning to:

- Improve how we collectively learn from SAI reviews across the system
- Improve how we translate learning into actions and change.

SECTION 4

CONCLUSION

Within the HSCB/PHA there is a continued commitment to learn from SAIs, to improve services and to reduce the risks of recurrence, both within the reporting organisations and across the HSC as a whole. The dissemination of learning following SAIs and ensuring that quality improvements are embedded into practice remains a key priority for the HSCB/PHA.

This report demonstrates actions planned and achieved in the period from April 2017 to September 2017. It also highlights the broad range of work that is routinely undertaken and reaffirms our commitment to safety, effectiveness and patient and client focus.

Since the last report, five learning letters/reminders of best practice and 5 professional letters have been disseminated to the relevant HSC organisations. The next “Learning Matters” newsletter is in draft and will be issued in the coming months and a further maternity/paediatric edition is currently being produced, to compliment the other methods of learning and to provide a forum where learning from SAIs, reviews and complaints is shared regionally and in a format that reaches all levels of staff across the wider HSC.

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 FEBRUARY 2016

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'.[1] 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 a Looked After Child or a child whose name is on the Child Protection Register and 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;

- 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/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

[1] 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

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

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

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

APPENDIX B

ANALYSIS OF SAI ACTIVITY OCTOBER 2017 – MARCH 2018

The HSCB has **received 184 SAI Notifications** from across Health and Social Care (HSC) for the above period. The information[2] below has been aggregated into summary tables with commentary to prevent the identification of individuals.

Table 1 and Charts 1 & 2 below provide an overview of all SAIs reported by organisation and includes **comparison** of activity:

- for the previous six months reporting period and April to September
- for the same reporting period (year on year) October to March

TOTAL ACTIVITY	Oct 16 - Mar 17	Apr 17 - Sep 17	Oct 17 - Mar 18
BHSCT	49	39	49
HSCB	0	2	2
BSO	0	0	1
NHSCT	36	28	29
NIAS	1	3	7
PCARE	11	9	11
PHA	1	1	0
SEHSCT	40	46	23
SHSCT	18	31	17
WHSCT	24	27	45
Totals:	**180**	**186**	**184**

Table 1

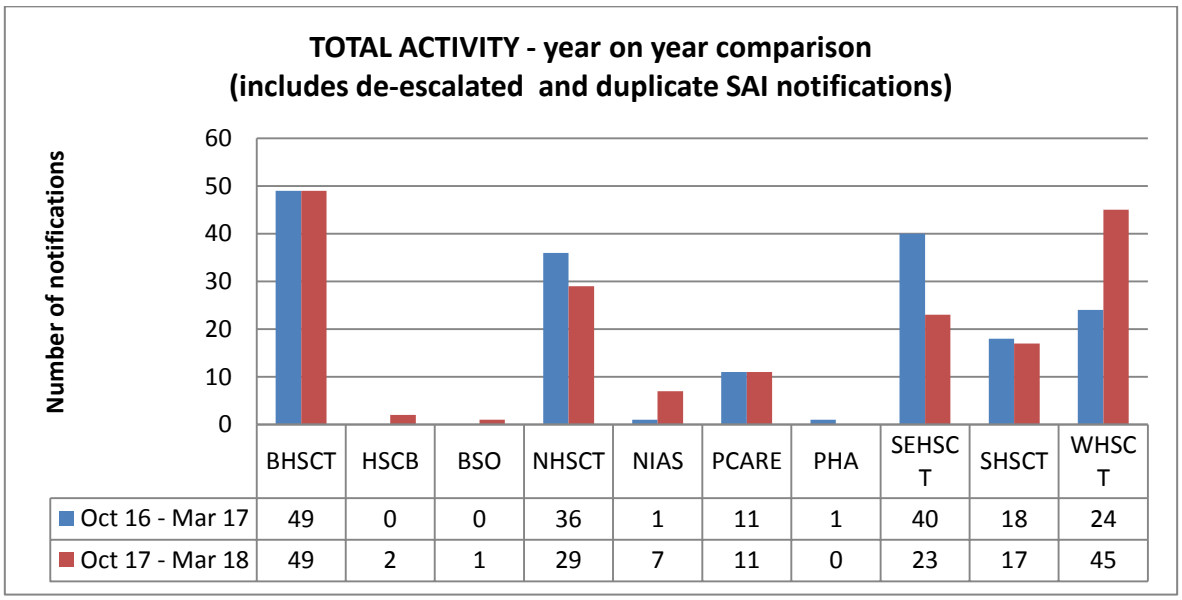


Chart 1

[2] Source- HSCB DATIX Information System

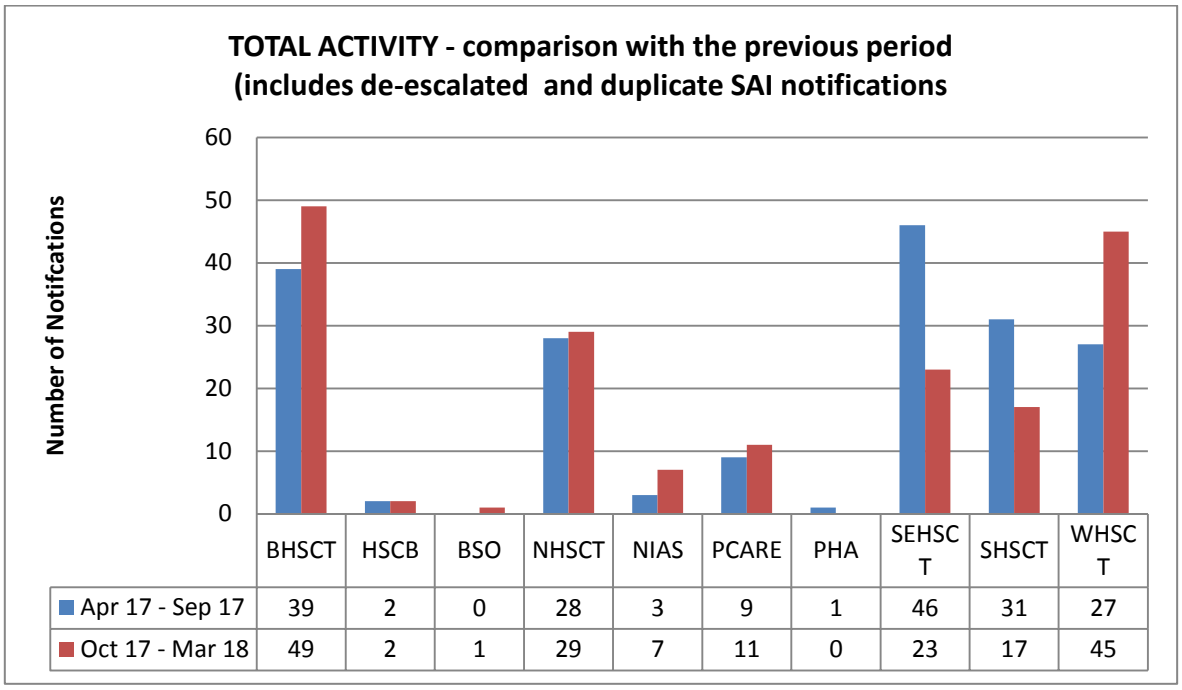


Chart 2

SAI DE-ESCALATION

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

In line with the HSCB Procedure for the reporting and follow up of SAIs the reporting organisation can provide information on why the incident does not warrant further review under the SAI process. This information is considered by the HSCB/PHA DRO prior to approving any de-escalation.

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

TOTAL DE-ESCALATED/WITHDRAWN	Oct 16 - Mar 17	Apr 17 - Sep 17	Oct 17 – Mar 18
BHSCT	0	1	1
NHSCT	1	1	0
NIAS	0	1	0
PCARE	0	1	2
SEHSCT	0	3	0
WHSCT	0	0	1
Totals:	**1**	**7**	**4**

DUPLICATE SAI NOTIFICATIONS

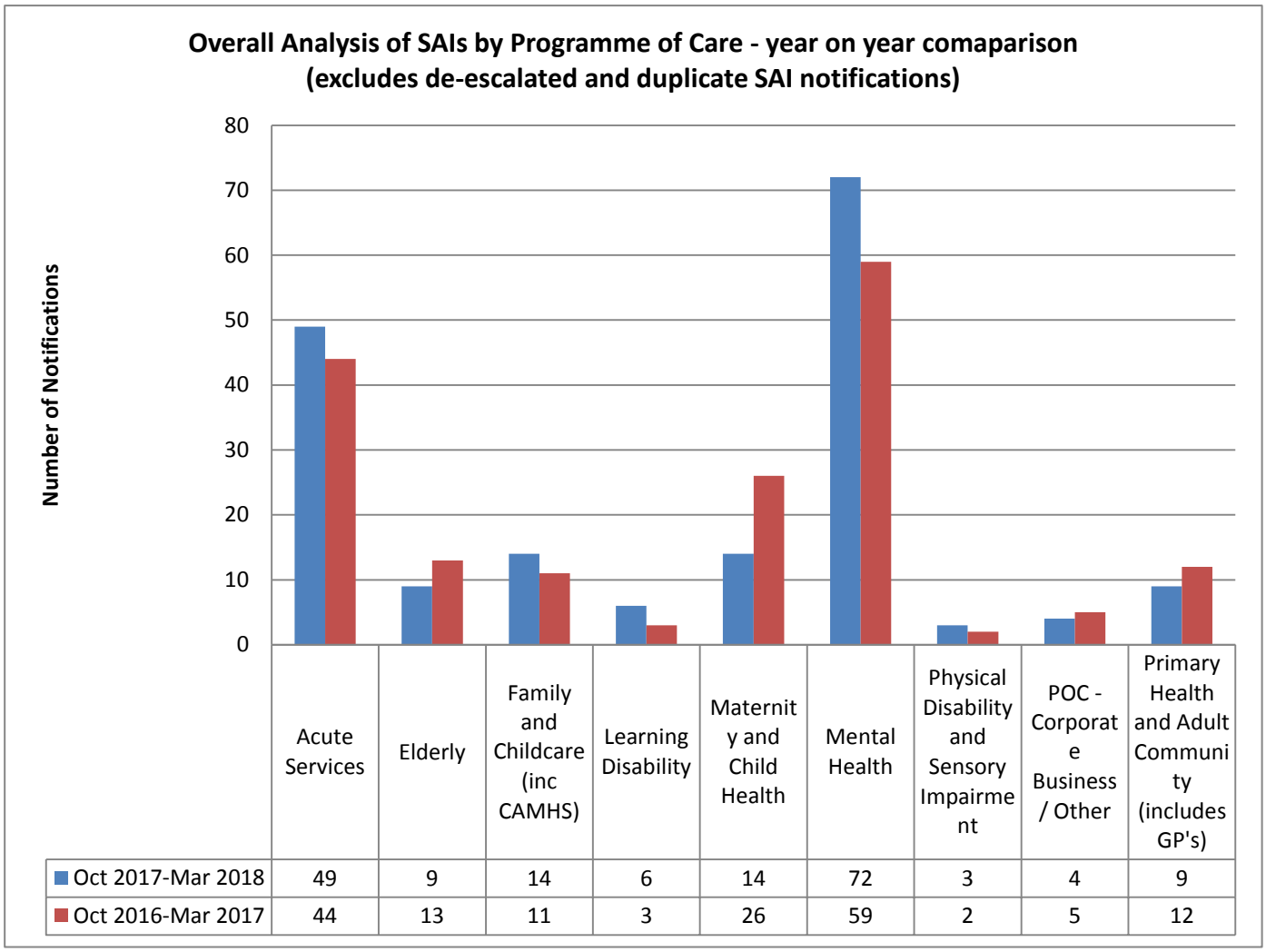
A notification may be received from one or more organisation but relating to the same incident. During the reporting period no duplicate SAI notifications were received.

SAI ANALYSIS BY PROGRAMME OF CARE

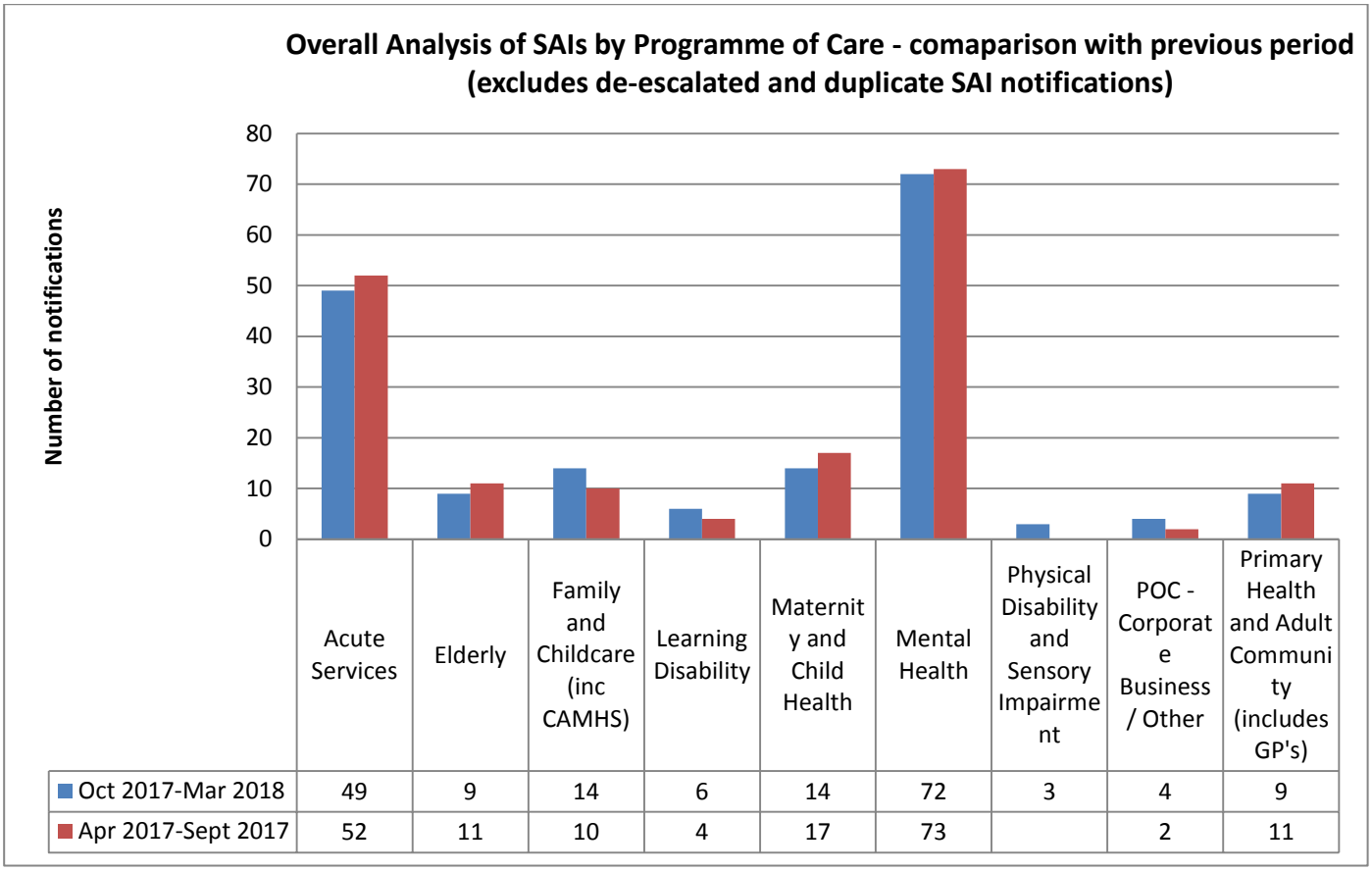
SAIs are categorised by Programmes of Care as follows:

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



	Acute Services	Elderly	Family and Childcare (inc CAMHS)	Learning Disability	Maternity and Child Health	Mental Health	Physical Disability and Sensory Impairment	POC - Corporate Business / Other	Primary Health and Adult Community (includes GP's)
Oct 2017-Mar 2018	49	9	14	6	14	72	3	4	9
Oct 2016-Mar 2017	44	13	11	3	26	59	2	5	12



ACUTE SERVICES

ORGANISATION	Oct 16 - Mar 17	Apr 17- Sep 17	Oct 17 - Mar 18
BHSCT	15	16	13
HSCB	0	1	0
NHSCT	6	3	9
NIAS	1	2	5
SEHSCT	8	5	3
SHSCT	4	7	4
WHSCT	10	15	15
Totals:	**44**	**49**	**49**

Current period: Forty-nine (49) SAIs were reported. The top five groups related to the following classifications/categories. Eleven (11) incidents being the most reported in any one category.

Classification/category

- Diagnosis failed or delayed
- Access, Appointment, Admission, Transfer, Discharge
- Clinical assessment (investigations, images and lab tests)Treatment, procedure
- Implementation of care or ongoing monitoring/review
- Accident that may result in personal injury

MATERNITY & CHILD HEALTH

ORGANISATION	Oct 16 - Mar 17	Apr 17- Sep 17	Oct 17 - Mar 18
BHSCT	14	3	4
NHSCT	6	2	2
NIAS			1
SEHSCT	4	2	
SHSCT	1	5	1
WHSCT	1	3	6
Totals:	**26**	**15**	**14**

Current period: Fourteen (14) SAIs relating to maternity and child health were reported. The largest classification/category group (n=4) related to Labour/Delivery

FAMILY & CHILD CARE

ORGANISATION	Oct 16 - Mar 17	Apr 17 - Sep 17	Oct 17 - Mar 18
BHSCT	4	1	7
HSCB			1
NHSCT	1	2	4
SEHSCT	2	2	1
SHSCT	2	3	1
WHSCT	2	1	
Totals:	**11**	**9**	**14**

Current period: Fourteen (14) 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	Oct 16 - Mar 17	Apr 17 - Sep 17	Oct 17 - Mar 18
BHSCT	1	1	
NHSCT	3	4	1
NIAS			1
SEHSCT	8	2	
SHSCT	1	3	1
WHSCT	0	1	6
Totals:	**13**	**11**	**9**

Current period: Nine (9) SAIs reported related to older people services. The largest classification/category group (n=5) related to slips, trips, falls and collisions.

MENTAL HEALTH

ORGANISATION	Oct 16 - Mar 17	Apr 17- Sep 17	Oct 17 - Mar 18
BHSCT	11	12	18
HSCB	0	0	
NHSCT	16	14	12
PHA	0	1	
SEHSCT	14	29	16
SHSCT	9	11	10
WHSCT	10	6	16
Totals:	**60**	**73**	**72**

Current period: Seventy two (72) SAIs relating to adult mental health services were reported. 72% (n=52) related to suicide (completed), whether proven or suspected

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

LEARNING DISABILITY SERVICES

ORGANISATION	Oct 16 - Mar 17	Apr 17 - Sep 17	Oct 17 - Mar 18
BHSCT	1	0	5
NHSCT	1	1	
SEHSCT	1	1	1
SHSCT	0	2	
WHSCT	0	0	
Totals:	**3**	**4**	**6**

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

PHYSICAL DISABILITY AND SENSORY IMPAIRMENT

ORGANISATION	Oct 16 - Mar 17	Apr 17 - Sep 17	Oct 17 - Mar 18
BHSCT			1
NHSCT	1	0	1
SEHSCT	1	0	
WHSCT			1
Totals:	**2**	**0**	**3**

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

PRIMARY HEALTH AND ADULT COMMUNITY (INC. GENERAL PRACTICE)

ORGANISATION	Oct 16 - Mar 17	Apr 17 - Sep 17	Oct 17 - Mar 18
PCARE	11	2	9
SEHSCT	1	7	
Totals:	**12**	**9**	**9**

Current period: Nine (9) SAIs relating to Primary Health and Adult Community were reported. The top two groups related to the following classifications/categories:

- Medication
- Security incident related to Premises, Land or Real Estate

CORPORATE BUSINESS

ORGANISATION	Oct 16 - Mar 17	Apr 17 - Sep 17	Oct 17 - Mar 18
BHSCT	3	1	1
BSO			
HSCB	0	1	1
NHSCT	1	0	
SEHSCT	0	0	2
PHA	1	0	
WHSCT	0	0	
Totals:	**5**	**2**	**4**

Current period: Four (4) SAIs were reported relating to corporate business.

HEALTH PROMOTION AND DISEASE PREVENTION

No reported incidents

APPENDIX C

Analysis of Checklists RECEIVED 1 OCTOBER 2017 – 31 MARCH 2018

Table 1a - Analysis of Engagement with service user/ family/carer	**BHSCT**		**NHSCT**		**NIAS**		**SEHSCT**		**SHSCT**		**WHSCT**		**TOTAL**	
Checklists received	**39**	**100%**	**19**	**100%**	**3**	**100%**	**32**	**100%**	**28**	**100%**	**18**	**100.0%**	**139**	**100%**
Patient/Service User/Family **informed** incident was being reviewed as an SAI	37	94.9%	19	100%		0%	28	87.5%	27	96.4%	14	77.8%	**125**	**89.9%**
Service User/Family **not informed** incident was being reviewed as an SAI	2	5.1%		0%	3	100%	4	12.5%	1	3.6%	4	22.2%	**14**	**10.1%**

Table 1b - Analysis of Rationale for service user/ family/carer not informed that incident was being reviewed as an SAI	**BHSCT**		**NHSCT**		**NIAS**		**SEHSCT**		**SHSCT**		**WHSCT**		**TOTAL**	
Not informed	**2**	**100.0%**			**3**	**100%**	**4**	**100%**	**1**	**100%**	**4**	**100%**	**14**	**100%**
Impact on health/safety /security and/or wellbeing		0.0%				0%	3	75%		0%	1	25%	**4**	**28.6%**
No NOK or contact details	1	50%			3	100%	1	25%	1	100%	1	25%	**7**	**50.0%**
Other rationale provided	1	50%				0%		0%		0%	2	50%	**3**	**21.4%**

Table 2a - Analysis of SEA/ RCA Reports shared/not shared	BHSCT		NHSCT		NIAS		SEHSCT		SHSCT		WHSCT		TOTAL	
Checklists received	**39**	**100%**	**19**	**100%**	**3**	**100%**	**32**	**100%**	**28**	**100%**	**18**	**100%**	**139**	**100%**
LSR /SEA/RCA Report shared	6	15.4%	6	31.6%		0%	8	25%	13	46.4%	2	11.1%	**35**	**25.2%**
LSR /SEA/RCA Report **not** shared	33	84.6%	13	68.4%	3	100%	24	75%	15	53.6%	16	88.9%	**104**	**74.8%**

Readers are asked to note that whilst 74.8% (104) SAI Review Reports (LSR /SEA/RCA Reports) have not currently been shared; further engagement is planned and this position will be subject to change. An updated position will be reported upon in the next edition of this report.

Table 2b - Analysis of SEA/RCA Reports not shared	BHSCT		NHSCT		NIAS		SEHSCT		SHSCT		WHSCT		TOTAL	
Report not shared	**33**	**100%**	**13**	**100%**	**3**	**100%**	**24**	**100%**	**15**	**100%**	**16**	**100%**	**104**	**100%**
Case identified as a result of review exercise		0%		0%		0%		0%		0%	1	6.3%	**1**	**1%**
Draft Review Report shared with SU/FAM		0%		0%		0%	3	12.5%		0%	1	6.3%	**4**	**3.8%**
Family participated - Declined RR	1	3%		0%		0%	3	12.5%		0%		0%	**4**	**3.8%**
Family withdrew	1	3%		0%		0%		0%		0%		0%	**1**	**1%**
Final Review Report to be shared with SU/FAM	28	84.8%	12	92.3%	1	33.3%	9	37.5%	10	66.7%	9	56.3%	**69**	**66.3%**
Impact on health/safety /security and/or wellbeing		0%	1	7.7%		0%	5	20.8%		0%		0%	**6**	**5.8%**
No NOK or contact details	1	3%		0%	2	66.7%	1	4.2%	1	6.7%	1	6.3%	**6**	**5.8%**
No response to correspondence		0%		0%		0%		0%	3	20.0%	2	12.5%	**5**	**4.8%**

Table 2b - Analysis of SEA/RCA Reports not shared	BHSCT		NHSCT		NIAS		SEHSCT		SHSCT		WHSCT		TOTAL	
Other rationale provided		0%		0%		0%	2	8.3%	1	6.7%	2	12.5%	**5**	**4.8%**
Review Report discussed with SU/FAM	2	6.1%		0%		0%	1	4.2%		0%		0%	**3**	**2.9%**

NOTE: The data recorded in the above tables are reported from a 'live' database and will be subject to change following planned/further engagement

APPENDIX D

UPDATE ON USER ENGAGMENT INFORMATION PREVIOUSLY REPORTED

PERIOD 1 APRIL 2017 to 30 SEPTEMBER 2017 POSITION AS REPORTED IN HSCB-PHA SAI Learning Report – Edition 13

Analysis of SEA/ RCA Reports shared/not shared	BHSCT		NHSCT		NIAS		SEHSCT		SHSCT		WHSCT		TOTAL	
Checklists received	**38**	**100.0%**	**37**	**100.0%**	**1**	**100.0%**	**34**	**100.0%**	**24**	**100.0%**	**27**	**100.0%**	**161**	**100.0%**
LSR/SEA/RCA Report shared	**2**	**5.3%**	**12**	**32.4%**		**0.0%**	**6**	**17.6%**	**13**	**54.2%**	**10**	**37.0%**	**43**	**26.7%**
LSR/ SEA/RCA Report **not** shared	**36**	**94.7%**	**25**	**67.6%**	**1**	**100.0%**	**28**	**82.4%**	**11**	**45.8%**	**17**	**63.0%**	**118**	**73.3%**

PERIOD 1 APRIL 2017 to 30 SEPTEMBER 2017 - UPDATED POSITION

The last report (Edition 13) indicated 26.7% (43) of SAI Review Reports had been shared with service users/families/carers - following further planned engagement the updated position (detailed in the table below) indicates 65.2% (105) reports have been shared with service users/families/carers.

For those SAI Review Reports not shared is 34.8% (56) further engagement is planned for 3.7% (6) and for the remainder, which have not been shared, rationale has been provided for not sharing these review reports (e.g. family declined/withdrew, no response to correspondence, no NOK details, impact on health wellbeing etc)

Analysis of SEA/ RCA Reports shared/not shared	BHSCT		NHSCT		NIAS		SEHSCT		SHSCT		WHSCT		TOTAL	
Checklists received	**38**	**100%**	**37**	**100%**	**1**	**100%**	**34**	**100%**	**24**	**100%**	**27**	**100%**	**161**	**100%**
LSR / SEA/RCA Report shared	26	68.4%	22	59.5%		0%	19	55.9%	19	79.2%	19	70.4%	105	65.2%
LSR /SEA/RCA Report **not** shared	12	31.6%	15	40.5%	1	100%	15	44.1%	5	20.8%	8	29.6%	56	34.8%

NOTE: The data recorded in the above tables are reported from a 'live' database and will be subject to change following planned/further engagement