Health and Social Care Board

Public Health Agency

Learning Report

Serious Adverse Incidents

April 2018 - September 2018

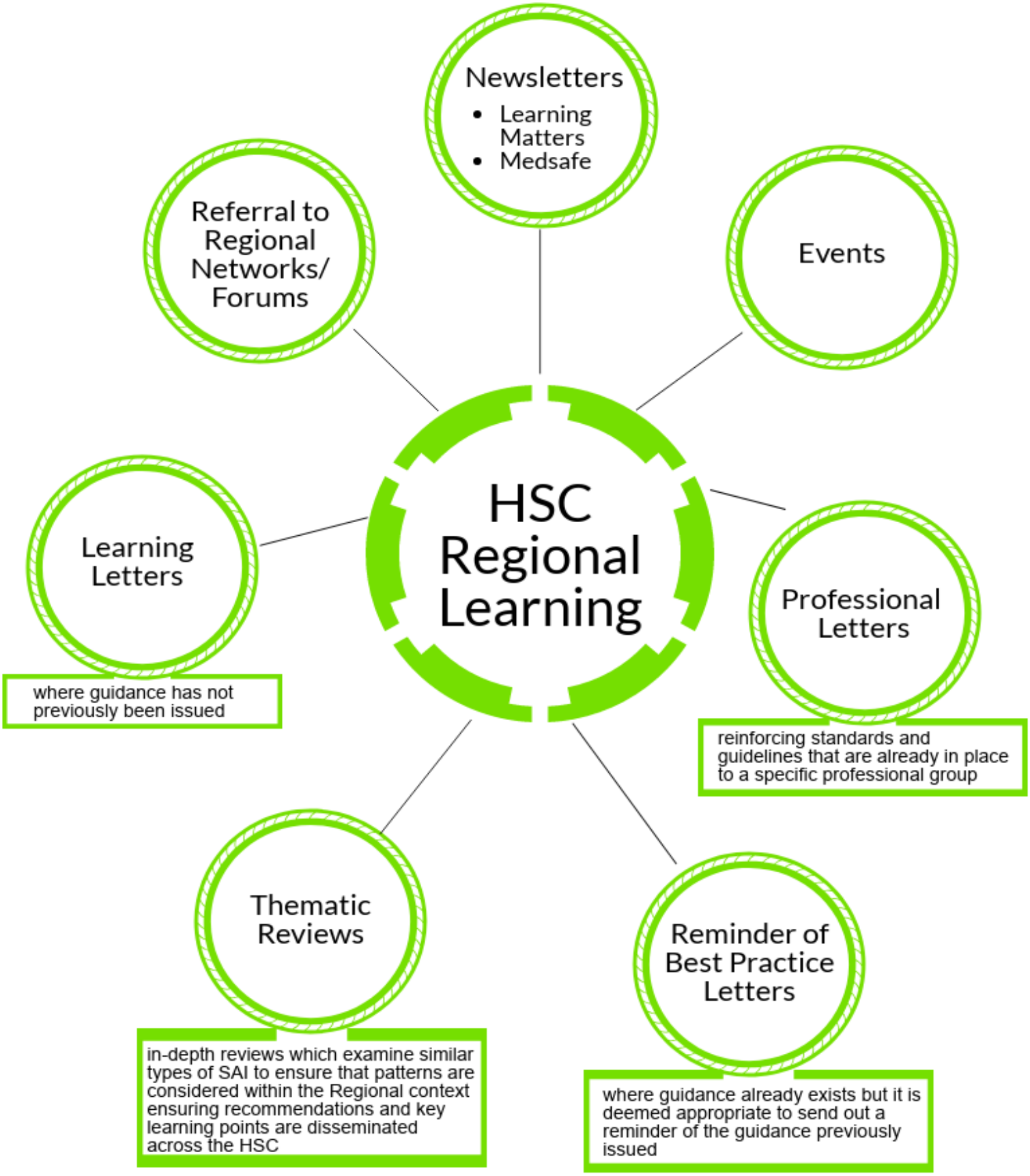
December 2018

Edition 15

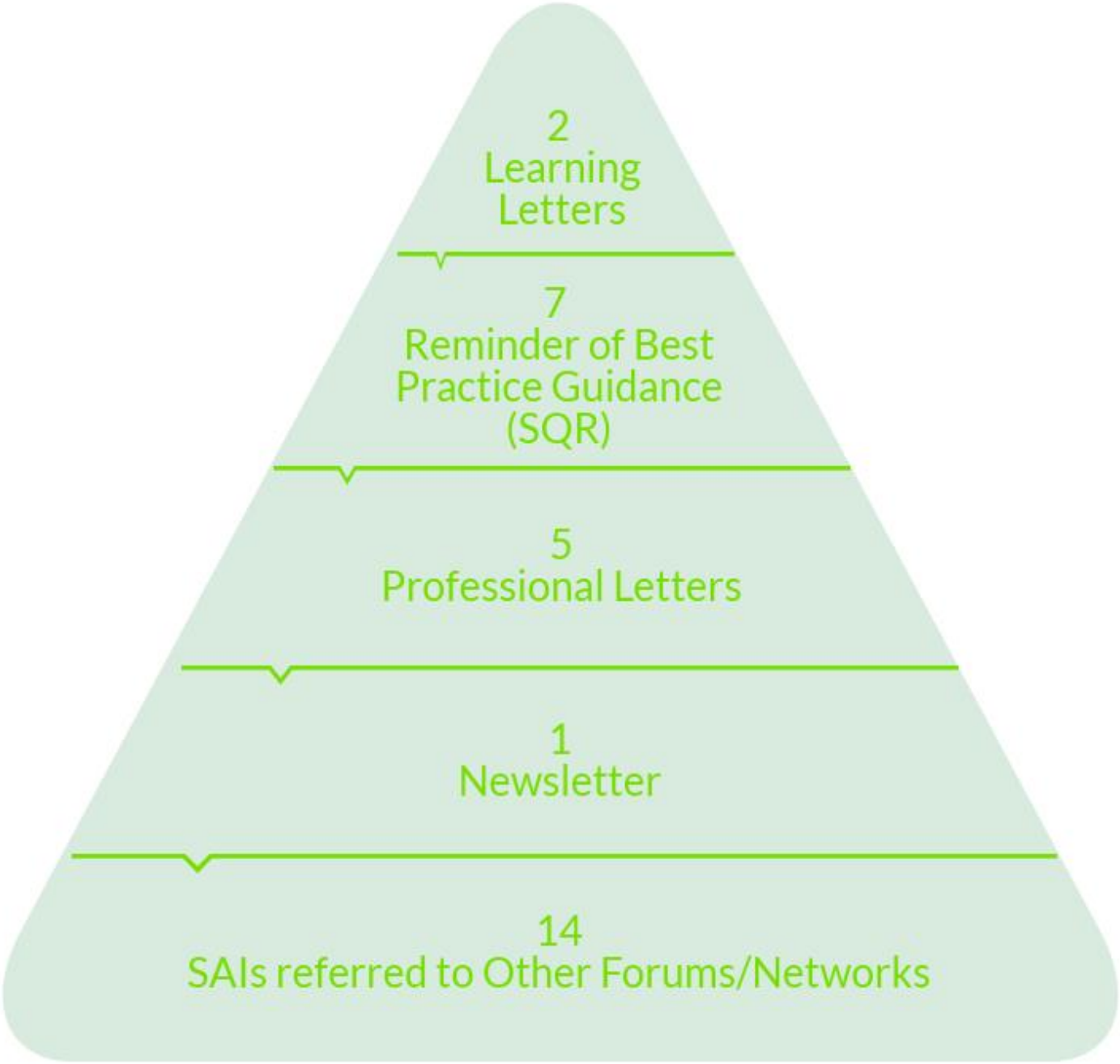
Contents

Types of Learning

Various Methods of How we Disseminate Learning from SAIs



Overview of Learning Disseminated Throughout the Reporting Period



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

Whilst learning from SAIs is a significant element to improving practice, the HSCB and PHA are cognisant that each and every SAI has a personal impact on individuals and families. Therefore for the purposes of this report patient identifiable information has been removed.

Learning Disseminated During the Reporting Period

Learning Letters

- Appointment Letters to Service Users with Literacy Problems - LL/SAI/2018/031 (MH)
- The administration process within the Breast Family History mammography appointment service - LL/SAI/2018/032 (AS)

The above learning letters can be accessed by HSC staff via the following link

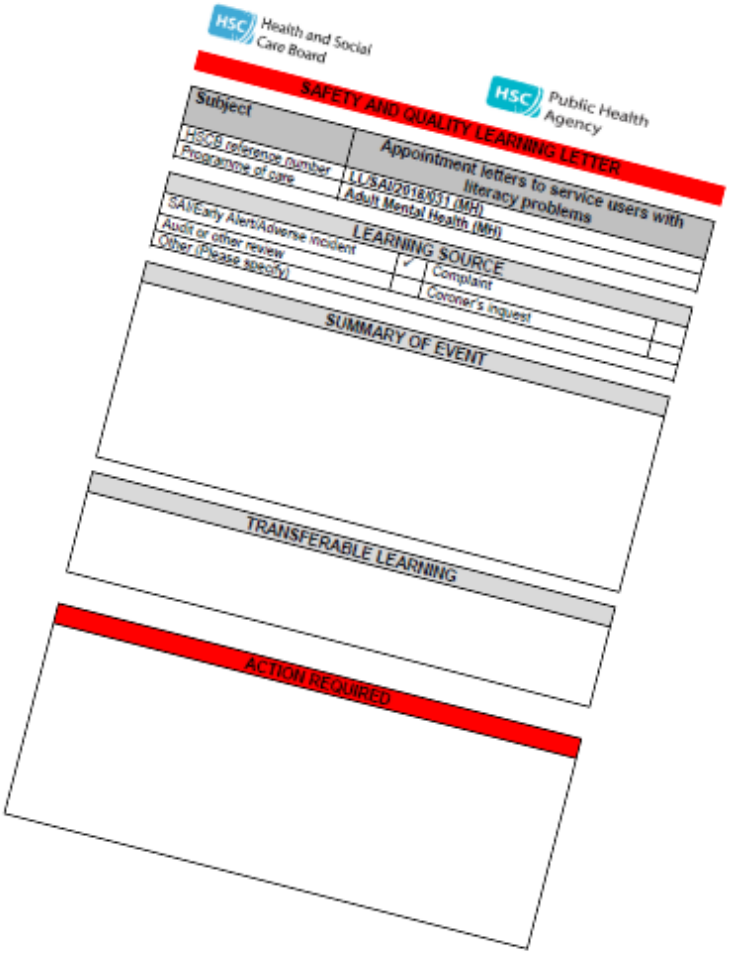
http://insight.hscb.hscni.net/safety/safety-and-quality-learning-letters/

Learning Letter example

During the course of a service user's involvement with mental health services, it was suspected that the service user may have had limited literacy skills, and the review of treatment and care, following this incident, identified that the failure to attend some appointments, might have been due to the service user's inability to read appointment letters.

As a result of the review, the Trust concerned adjusted their procedures to prompt staff to seek permission to copy correspondence to a trusted third party when it is suspected that a service user may have literacy problems.

It was recommended that all HSC Trusts consider a similar adjustment to their procedures and working practices.



Reminder of Best Practice Guidance (SQR)

- Development of Diabetic Keto-Acidosis DKA as an In-Patient - SQR-SAI-2018-035 (AS & MCH)
- Arterial Line Blood Sampling preventing hypoglycaemic brain injury - SQR-SAI-2018-036 (AS & MCH)
- Doctors Ordering Investigations have Responsibility to Follow Up Results - SQR-SAI-2018-037 (All POCs)
- Recruitment and Selection - SQR-SAI-2018-038 (PD&SI & MH)
- Serious Prescribing Error due to Milligram / Microgram confusion at primary care-secondary care interface - SQR-SAI-2018-039 (PCC & AS)
- Prescribing of Liquid and other Sedative Medications for Children and reducing the risk of over use - SQR-SAI-2018-040 (AS & PCC)
- Prescribing, Dispensing and Administration of Oromucosal Midazolam - SQR-SAI-2018-041 (AS MH MCH PHC) -

Reminder of Best Practice example

HSCB has previously issued a number of communications about potential risks and incidents which have occurred with prescribing and dispensing of oromucosal (buccal) midazolam. However incidents continue to be reported and whilst no actual harm has been reported in these cases, there was potential for serious harm to occur. The incidents involved pre-filled syringes either prescribed as a part dose or dispensed with instructions for administration of a part dose. Pre-filled syringes should be administered as a full dose.

The significant contributory factor in recent incidents is attributed to:

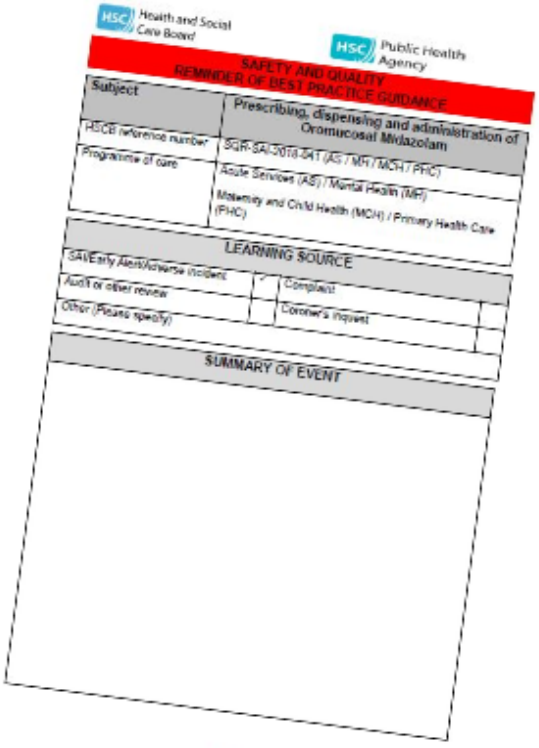
- Lack of knowledge of the range and strengths of pre-filled oral syringe products available, and how these are administered.
  - All oromucosal pre-filled oral syringes provide a standard dose of midazolam for a given age range (i.e. 2.5mg, 5mg, 7.5mg or 10mg).
  - The product prescribed should match the appropriate dose for the patient's age, with the full dose of the pre-filled oral syringe being administered.
  - Part doses cannot be administered and must not be prescribed or dispensed.

An additional contributory factor in one incident was the unavailability of the prescribed product in the community pharmacy at the time the prescription was presented for dispensing.

In line with guidance that was already in place, this Reminder of Best Practice was issued in order to ensure the appropriate product is prescribed, dispensed and appropriately administered in primary care. It also advised that Trusts, GPs including out-of-hours services, and community pharmacists review the information requirements and make changes to their specific area of practice where required.

The above learning letters can be accessed by HSC staff via the following link

http://insight.hscb.hscni.net/safety/safety-and-quality-best-practice-reminder-letters/

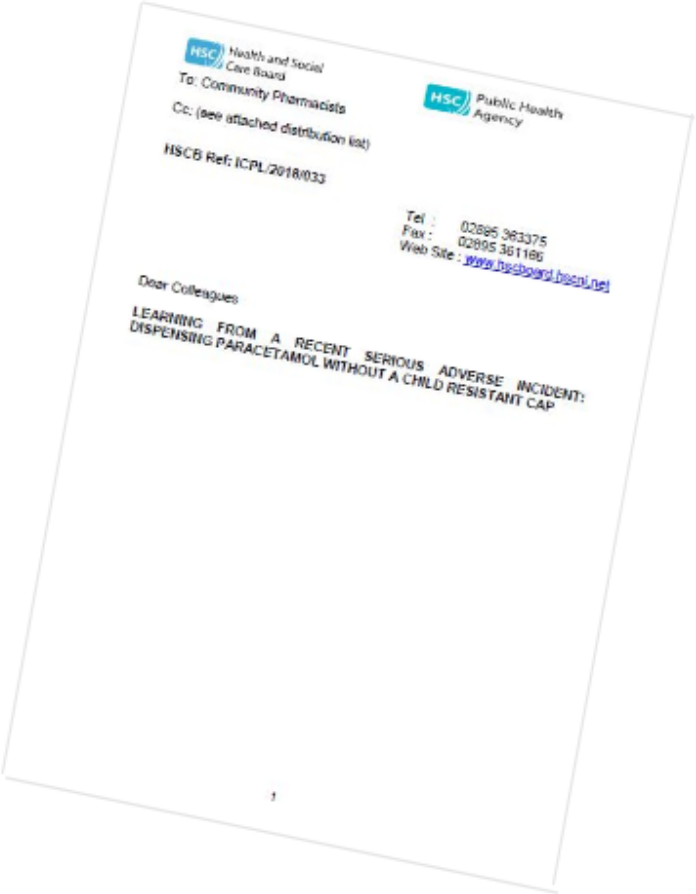


Professional Letters

- Risk of Human Error with Robotic Dispensing Systems in Community Pharmacy - ICPL/2018/029
- Further Serious Adverse Incidents Involving Dispensing of Tacrolimus and Other Immunosuppressants - ICPL/2018/031
- Learning from Recent SAIs: Patients Transferring between Primary Care and Prison Health - ICPL/2018/032
- Learning from a recent Serious Adverse Incident: Dispensing Paracetamol without a Child Resistant Cap - ICPL/2018/033
- Prescription Ordering Arrangements - ICPL/2018/034

Professional Letter example

A child was admitted to hospital and treated for an overdose of paracetamol. Thankfully the child recovered and was discharged after two days but the outcome could have been catastrophic.


Health and Social Care Board
Public Health Agency
To: Community Pharmacists
Cc: (see attached distribution list)
HSCB Ref: ICPL/2018/033
Tel : 02895 363375
Fax : 02895 361186
Web Site : www.hscboard.hscni.net
Dear Colleagues
LEARNING FROM A RECENT SERIOUS ADVERSE INCIDENT: DISPENSING PARACETAMOL WITHOUT A CHILD RESISTANT CAP
1

CONTRIBUTORY FACTORS

- The suspension was dispensed in the original 500ml dispensing bottle which **did not have a child resistant closure.**
- The bottle had been stored by the parent on a high shelf in the fridge but the child still managed to access it.

LEARNING

In line with *Professional Standards and Guidance for the Sale and Supply of Medicines* the following recommendations were issued to Community Pharmacists:

- Packaging is checked to ensure compliance with the standards before hand over to the patient
- Patients are given advice on safe storage of medicines particularly when the product is not dispensed in a child resistant container.
- **Consideration is given to availability of products in child resistant containers when procuring medicines.**

Thematic Reviews

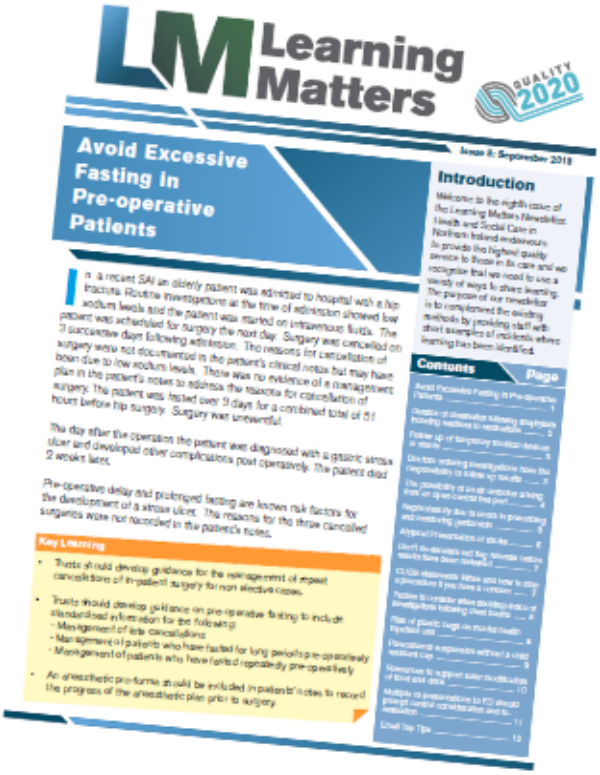
Two thematic reviews have been undertaken and reports will be finalised during the next reporting period. These are:

- Insulin
- Delayed Diagnosis of Cancer

Newsletters

Learning Matters provides a method of sharing learning relating to SAIs, complaints, reviews and patient experience across Northern Ireland. Edition 8 (September 2018) has been issued and features the following topics, all of which relate to learning from SAIs.

- Avoid Excessive Fasting in Pre-operative Patients
- Duration of observation following anaphylaxis including reactions to medications
- Follow up of temporary medical devices or stents
- Doctors ordering investigations have the responsibility to follow up results
- The possibility of an air embolus arising from an open central line port
- Nephrotoxicity due to errors in prescribing and monitoring gentamicin
- Don't de-escalate red flag referrals before results have been reviewed
- CUSS statements When and how to stop a procedure if you have a concern
- Factors to consider when deciding choice of investigations following chest trauma
- Risk of plastic bags on mental health inpatient unit
- Paracetamol suspension without a child resistant cap
- Resources to support safer modification of food and drink
- Multiple re-presentations to ED should prompt careful consideration and reevaluation
- Email Top Tips


LM Learning Matters

Avoid Excessive Fasting in Pre-operative Patients

Introduction

Contents Page

All editions of Learning Matters newsletters can be accessed at:

http://www.publichealth.hscni.net/publications/learning-matters-newsletters

Referral to Other Forums/Networks

HSCB/PHA may request other networks/forums to consider learning that has been identified following the review of a SAI. During the reporting period 14 cases were referred. These Networks/Forums included:

- Falls Group
- Haematology Clinical Reference Group
- MRCN – (Modernising Radiology Clinical Network)
- HSC Safety Forum
- Trauma and the Vascular Groups
- Unscheduled Care Network
- Trauma Network Clinical Advisory Group

Events

Annual Regional Serious Adverse Incidents Learning Workshop

The HSC Safety Forum in partnership with the PHA and HSCB hosted the 4th Annual Regional Serious Adverse Incidents Learning Workshop on the 7 June 2018 for 160 delegates from Trusts, PHA, HSCB, Patient Client Council (PCC), Department of Health (DoH) and Regulation and Quality Improvement Authority (RQIA).

In keeping with the values of Quality 2020 this event provided a shared opportunity for learning across HSC to drive forward improvement in quality and safety of care building on feedback and learning from previous events.

The aim of the event was to use collaborative learning and an open and transparent approach to:

- Share learning from a number of SAIs and identify themes to drive improvement
- Improve our ability to disseminate learning across the system
- Develop and agree a high quality, robust, insightful approach to the review of SAIs across HSC.

The event was primarily aimed at clinical/front line staff from all 6 Trusts, those who manage clinical services and staff involved in SAI review processes. The HSC Safety Forum took the lead in organising the event. A planning group for the event was established which included Trust governance leads to help identify suitable SAIs in order to maximise learning and promote change and improvement.

Dr Anne Kilgallen also provided a presentation on Broader lessons for Improving Safety and in particular lessons learnt from the Hyponatraemia Inquiry and Dr Shelly Jeffcott presented on Enhancing Human Factors and Ergonomics in order to improve our understanding and response to adverse incidents.

Human factors talk very insightful and will be useful in SAI investigation.

Very positively delivered clear presentations useful in content and learning. Really respected peoples openness and honesty to help us learn from very sufficient timelines.

Sharing of the learning and realisation that all areas have similar issues. All working towards improvement together.

Really respected peoples openness and honesty to help us learn

Conclusion

The HSCB/PHA remain committed to identify learning from SAIs, to improve services for patients/clients and their families and to reduce the risks of recurrence by working collaboratively with 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.

As with all areas of practice within HSC, the HSCB/PHA are continuously looking for ways to improve the processes for which they have responsibility. In relation to the management of SAIs, this includes the care for people and /or families following a SAI and during a review as well as the processes to provide the appropriate support for HSC staff.

HSCB and PHA are currently conducting a number of internal reviews relating to the SAI process and in line with the above, this may lead to a revision of some elements of the current procedure over the next 12 months.

In September 2018 an outline business case was approved by the DoH for the Alignment of Adverse Incident Coding and Datix Systems across HSC Organisations. This regional project is being taken forward by the HSCB/PHA in collaboration with Trusts.

As we move forward into 2019/20 it is anticipated that all Trusts, and the HSCB/PHA will be using the same risk management software system for incident reporting and using the same common classification system codes which will enhance consistency and reliability by users, with the ultimate goal being to collect actionable data and facilitate learning through the identification of causality, and important contributing factors resulting in causality.

It is also our intention to establish a link on the HSCB and PHA websites which will allow staff to avail of resources that would assist them when reviewing adverse incidents and/or SAIs.

Appendices

Appendix 1 - Analysis of SAI Activity April 2018 - September 2018

Appendix 2 - Analysis of Checklists Received 1 April 2018 - 30 September 2018

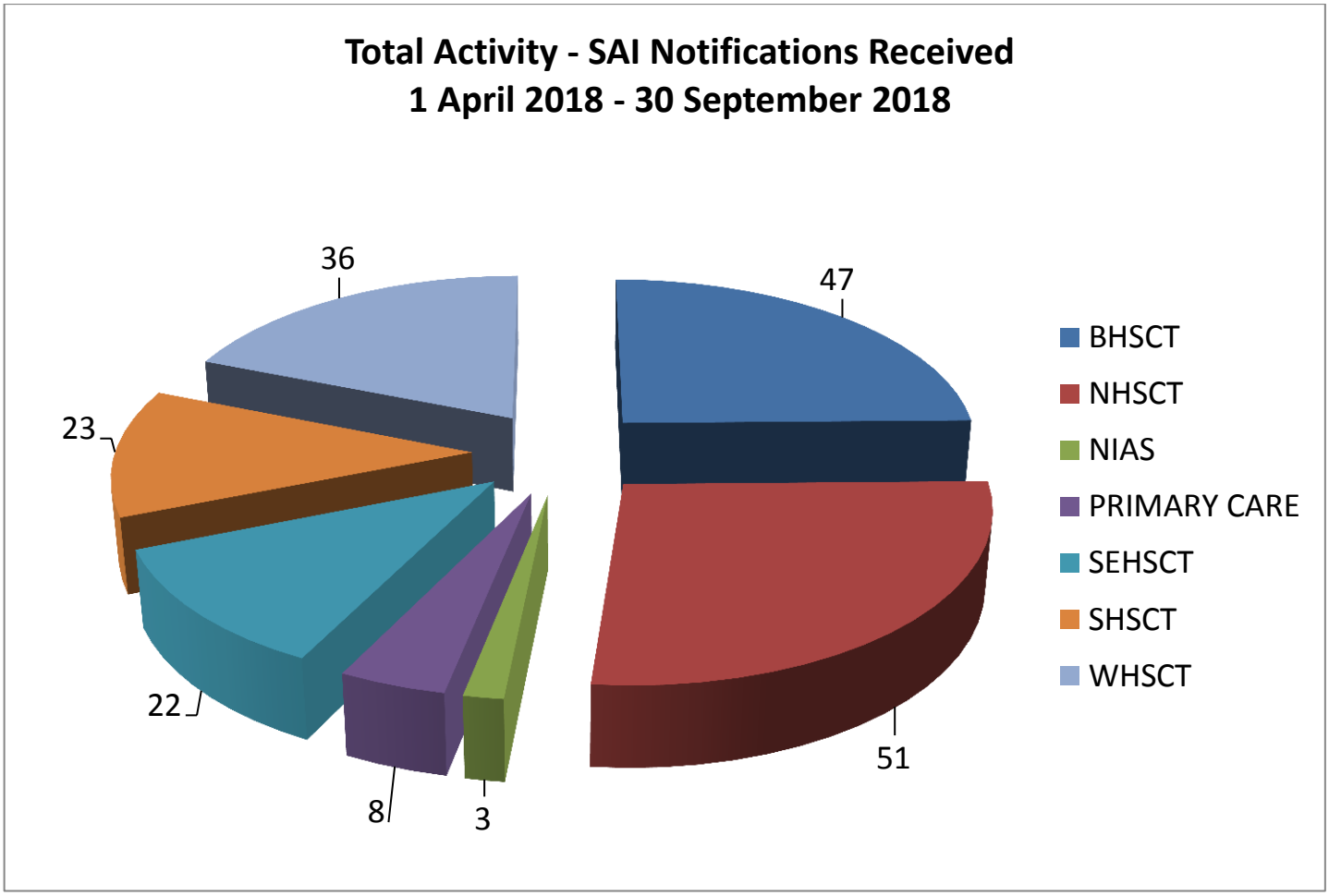
Appendix 3 - Update on User Engagement Information Previously Reported

APPENDIX 1

ANALYSIS OF SAI ACTIVITY APRIL 2018 - SEPTEMBER 2018

The HSCB has **received 190 SAI Notifications** from across Health and Social Care (HSC) for the above period. The information[1] below has been aggregated into summary tables with commentary to prevent the identification of individuals.

Chart 1



[1] Source- HSCB DATIX Information System

Table 1 below provides an overview of all SAIs reported by organisation and includes **comparison** of activity:

- for the previous six months reporting period October 2017 to March 2018
- for the same reporting period (year on year) April 2017 to September 2017

Table 1

TOTAL ACTIVITY	Apr 17 - Sep 17	Oct 17 - Mar 18	Apr 18 - Sept 18
BHSCT	39	49	49
HSCB	2	2	0
BSO	0	1	0
NHSCT	28	29	51
NIAS	3	7	3
PCARE	9	11	8
PHA	1	0	0
SEHSCT	46	23	23
SHSCT	31	17	23
WHSCT	27	45	36
Totals:	*186*	*184*	*193*
Less De-escalations*	7	4	3
TOTAL	**179**	**180**	**190**

**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.*

SAI ANALYSIS BY PROGRAMME OF CARE

SAIs are categorised by Programmes of Care as follows:

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

Chart 2

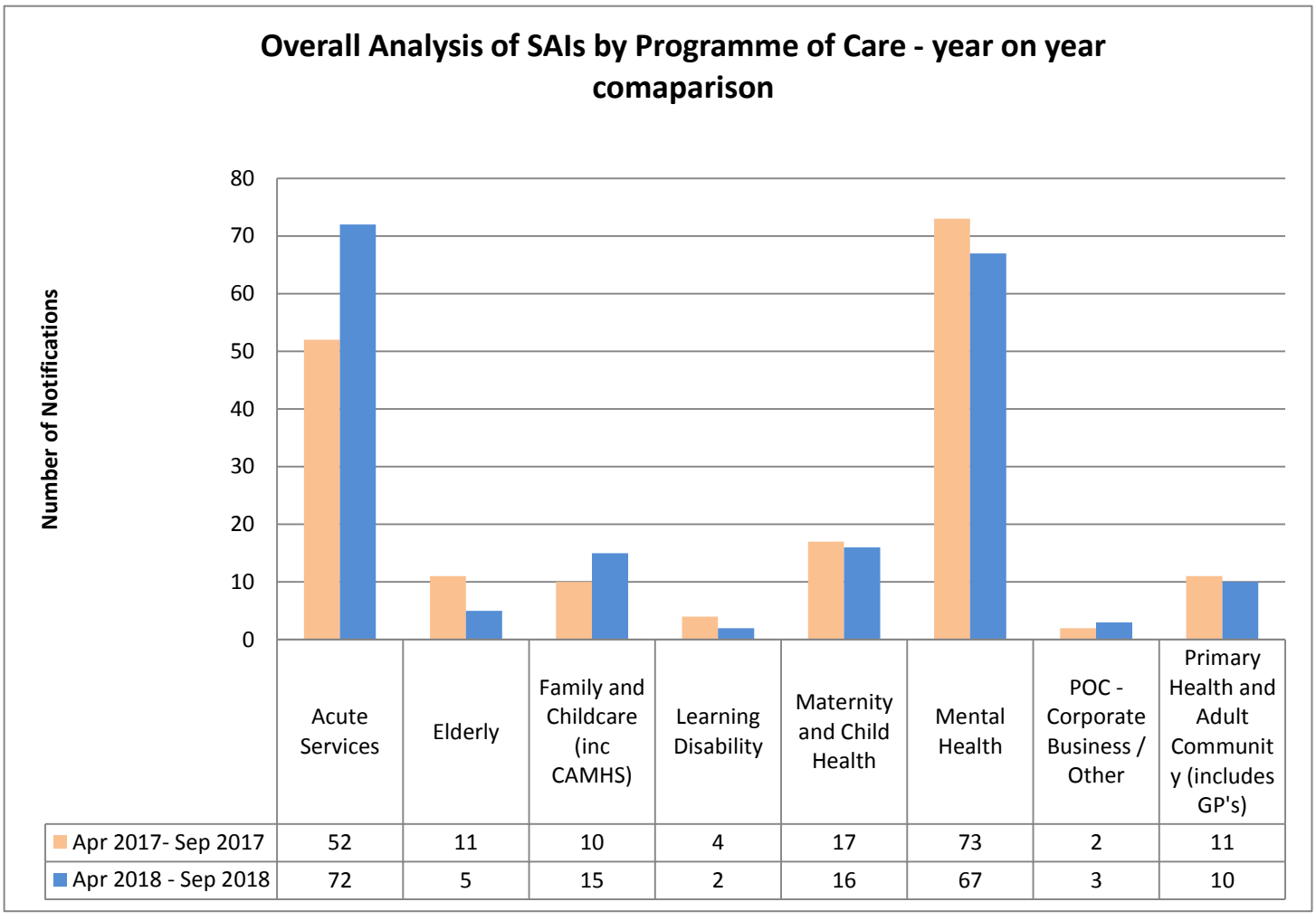
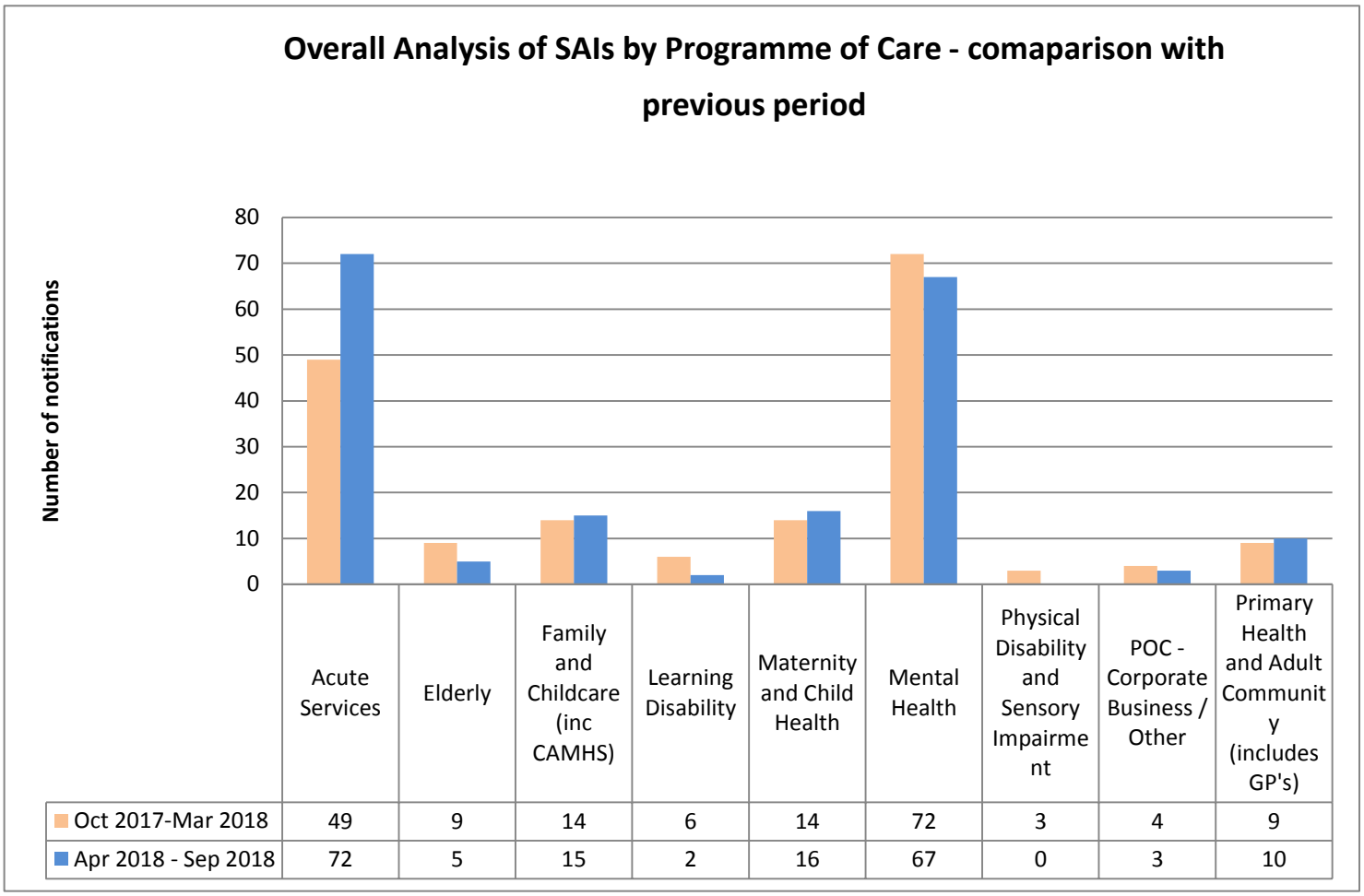


Chart 3



ACUTE SERVICES

ORGANISATION	Apr 17- Sep 17	Oct 17 - Mar 18	Apr 18 - Sept 18
BHSCT	16	13	21
HSCB	1	0	0
NHSCT	3	9	18
NIAS	2	5	3
SEHSCT	5	3	7
SHSCT	7	4	5
WHSCT	15	15	18
Totals:	**49**	**49**	**72**

Current period: 72 SAIs were reported. The top five groups related to the following classifications/categories. 19 incidents being the most reported in any one category.

Classification/category

Treatment, procedure
Diagnosis, failed or delayed
Medication
Access, Appointment, Admission, Transfer, Discharge

MATERNITY AND CHILD HEALTH

ORGANISATION	Apr 17- Sep 17	Oct 17 - Mar 18	Apr 18 - Sept 18
BHSCT	3	4	7
NHSCT	2	2	3
NIAS	0	1	0
SEHSCT	2	0	2
SHSCT	5	1	3
WHSCT	3	6	1
Totals:	**15**	**14**	**16**

Current period: 16 SAIs relating to maternity and child health were reported. All incident categories within this programme had less than five incidents.

FAMILY AND CHILD CARE

ORGANISATION	Apr 17 - Sep 17	Oct 17 - Mar 18	Apr 18 - Sept 18
BHSCT	1	7	7
HSCB	0	1	0
NHSCT	2	4	3
SEHSCT	2	1	2
SHSCT	3	1	1
WHSCT	1	0	2
Totals:	**9**	**14**	**15**

Current period: 15 SAIs relating to family and childcare were reported. In the largest classification/category group, nine SAIs related to 'Abusive, violent, disruptive or self-harming behaviour'.

OLDER PEOPLE SERVICES

ORGANISATION	Apr 17 - Sep 17	Oct 17 - Mar 18	Apr 18 - Sept 18
BHSCT	1	0	0
NHSCT	4	1	2
NIAS	0	1	0
SEHSCT	2	0	2
SHSCT	3	1	1
WHSCT	1	6	0
Totals:	**11**	**9**	**5**

Current period: Five SAIs relating to older people's services were reported. All incident categories within this programme had less than five incidents.

MENTAL HEALTH

ORGANISATION	Apr 17- Sep 17	Oct 17 - Mar 18	Apr 18 - Sept 18
BHSCT	12	18	10
HSCB	0	0	0
NHSCT	14	12	24
PHA	1	0	0
SEHSCT	29	16	8
SHSCT	11	10	13
WHSCT	6	16	12
Totals:	**73**	**72**	**67**

Current period: 67 SAIs relating to adult mental health services were reported. 59% (40) 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

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

Current period: Two SAIs relating to learning disability services were reported.

PHYSICAL DISABILITY AND SENSORY IMPAIRMENT

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

Current period: No reported incidents

PRIMARY HEALTH AND ADULT COMMUNITY (INC. GENERAL PRACTICE)

ORGANISATION	Apr 17 - Sep 17	Oct 17 - Mar 18	Apr 18 - Sept 18
BHSCT	0	0	1
PCARE	2	9	8
SEHSCT	7	0	0
WHSCT	0	0	1
Totals:	**9**	**9**	**10**

Current period: 10 SAIs relating to Primary Health and Adult Community were reported. The top classification/category related to Medication.

CORPORATE BUSINESS

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

Current period: Three SAIs were reported relating to corporate business.

HEALTH PROMOTION AND DISEASE PREVENTION

No reported incidents

Analysis of Checklists RECEIVED 1 APRIL 2018 – 30 SEPTEMBER 2018

Table 1a - Analysis of Engagement with Service User/Family/Carer	BHSCT		NHSCT		NIAS		SEHSCT		SHSCT		WHSCT		TOTAL	
Checklists received	**33**	**100%**	**40**	**100%**	**1**	**100%**	**32**	**100%**	**18**	**100%**	**27**	**100.0%**	**151**	**100%**
Service User/Family/Carer **informed** incident was being reviewed as a SAI	29	87.8%	36	90%	1	100%	28	87.5%	16	88.9%	25	92.6%	**135**	**89.9%**
Service User/Family/Carer **not informed** incident was being reviewed as a SAI	4	12.2%	4	10%	0	0%	4	12.5%	2	11.1%	2	7.4%	**16**	**10.1%**

Table 1b - Analysis of Rationale for Service User/Family/Carer not informed that incident was being reviewed as a SAI	BHSCT		NHSCT		NIAS		SEHSCT		SHSCT		WHSCT		TOTAL	
Not informed	**4**	**100.0%**	**4**	**100%**	**0**	**100%**	**4**	**100%**	**2**	**100%**	**2**	**100%**	**16**	**100%**
Impact on health/safety /security and/or wellbeing	0	0%	1	25%	0	0%	1	25%	0	0%	0	0%	**2**	**12.5%**
No next of kin or contact details	1	25%	1	25%	0	0%	3	75%	1	50%	1	50%	**7**	**43.8%**
Case identified as a result of review exercise	0	0%	1	25%	0	0%	0	0%	0	0%	0	0%	**1**	**6.3%**
Environmental or infrastructure related with no harm	0	0%	0	0%	0	0%	0	0%	1	50%	0	0%	**1**	**6.3%**
Involves suspected /actual abuse by family	1	25%	0	0%	0	0%	0	0%	0	0%	0	0%	**1**	**6.3%**
Other rationale provided	2	50%	1	25%	0	0%	0	0%	0	0%	1	50%	**4**	**25%**

Table 2a - Analysis of Final Review Reports shared/not shared	BHSCT		NHSCT		NIAS		SEHSCT		SHSCT		WHSCT		TOTAL	
Checklists received	**33**	**100%**	**40**	**100%**	**1**	**100%**	**32**	**100%**	**18**	**100%**	**27**	**100%**	**151**	**100%**
Final Review Reports shared	3	9.1%	6	15%	1	100%	10	31.3%	8	44.4%	14	51.9%	**42**	**27.8%**
Final Review Reports **not** shared	30	90.9%	34	85%	0	0%	22	68.8%	10	55.6%	13	48.1%	**109**	**72.2%**

	Table 2b - Analysis of Final Review Reports not shared	BHSCT		NHSCT		NIAS		SEHSCT		SHSCT		WHSCT		TOTAL	
	Final Review Reports not shared	**30**	**100%**	**34**	**100%**	**0**	**100%**	**22**	**100%**	**10**	**100%**	**13**	**100%**	**109**	**100%**
	Case identified as a result of review exercise	0	0%	1	2.9%	0	0%	0	0%	0	0%	0	0%	**1**	**0.9%**
*	**Draft Review Report shared with the Service User/Family/Carer**	**0**	**0%**	**0**	**0%**	**0**	**0%**	**3**	**13.6%**	**2**	**20%**	**1**	**7.7%**	**6**	**5.5%**
	Family participated - Declined Review Report	0	0%	2	5.9%	0	0%	0	0%	0	0%	0	0%	**2**	**1.8%**
	Family withdrew from the process	2	6.7%	1	2.9%	0	0%	3	13.6%	0	0%	1	7.7%	**7**	**6.4%**
*	**Final Review Report to be shared with the Service User/Family/Carer**	**25**	**83.3%**	**26**	**76.5%**	**0**	**0%**	**9**	**40.9%**	**5**	**50%**	**4**	**30.8%**	**69**	**63.3%**
	Impact on health/safety /security and/or wellbeing	0	0%	0	0%	0	0%	1	4.6%	0	0%	2	15.4%	**3**	**2.8%**
	No next of kin or contact details	1	3.3%	1	2.9%	0	0%	3	13.6%	1	10%	1	7.7%	**7**	**6.42%**

Table 2b - Analysis of Final Review Reports not shared	BHSCT		NHSCT		NIAS		SEHSCT		SHSCT		WHSCT		TOTAL	
Involves suspected /actual abuse by family	1	3.3%	0	0%	0	0%	0	0%	0	0%	0	0%	**1**	**0.9%**
No response to correspondence	0	0%	1	2.9%	0	0%	2	9.1%	1	10%	1	7.7%	**5**	**4.6%**
Other rationale provided	0	0%	2	5.9%	0	0%	1	4.6%	1	10%	2	15.4%	**6**	**5.5%**
Review Report discussed with the Service User/Family/Carer	1	3.3%	0	0%	0	0%	0	0%	0	0%	1	7.7%	**2**	**1.8%**

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

*****Readers are asked to note that 68.8% (75) SAI Review Reports (LSR /SEA/RCA Reports) have not yet been shared with the service users / families / carers; however 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.

Appendix 3 provides an updated position on the engagement stats contained in the previous Edition (Edition 14)

UPDATE ON USER ENGAGMENT INFORMATION PREVIOUSLY REPORTED

PERIOD 1 OCTOBER 2017 to 31 MARCH 2018 POSITION AS REPORTED IN HSCB-PHA SAI Learning Report – Edition 14

Table 2a - Analysis of Final Review 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%**
Review Report shared	6	15.4%	6	31.6%	0	0%	8	25%	13	46.4%	2	11.1%	**35**	**25.2%**
Review Report **not** shared	33	84.6%	13	68.4%	3	100%	24	75%	15	53.6%	16	88.9%	**104**	**74.8%**

PERIOD 1 OCTOBER 2017 to 31 MARCH 2018 - UPDATED POSITION

The last report (Edition 14) indicated 25.2% (35) of SAI Review Reports had been shared with service users/families/carers. Following a validation exercise with Trusts where they indicated they planned to share the SAI report 65.5% (91) reports have since been shared with service users/families/carers.

34.5% (48) SAI Review Reports have not been shared. Further engagement is planned for 5.04% (7) and a rationale has been provided for the reasons for not sharing the remainder of the review reports (e.g. family declined/withdrew, no response to correspondence, no next of kin details, impact on health wellbeing, etc)

Analysis of Final Review 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%**
Final Review Report shared	30	76.9%	15	78.9%	0	0%	17	53.1%	18	64.3%	11	61.1%	91	65.5%
Final Review Report **not** shared	9	23.1%	4	21.1%	3	100%	15	46.9%	10	35.7%	7	38.9%	48	34.5%

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