Health and Social Care Board

Public Health Agency

Learning Report

Serious Adverse Incidents

October 2018 - March 2019

September 2019

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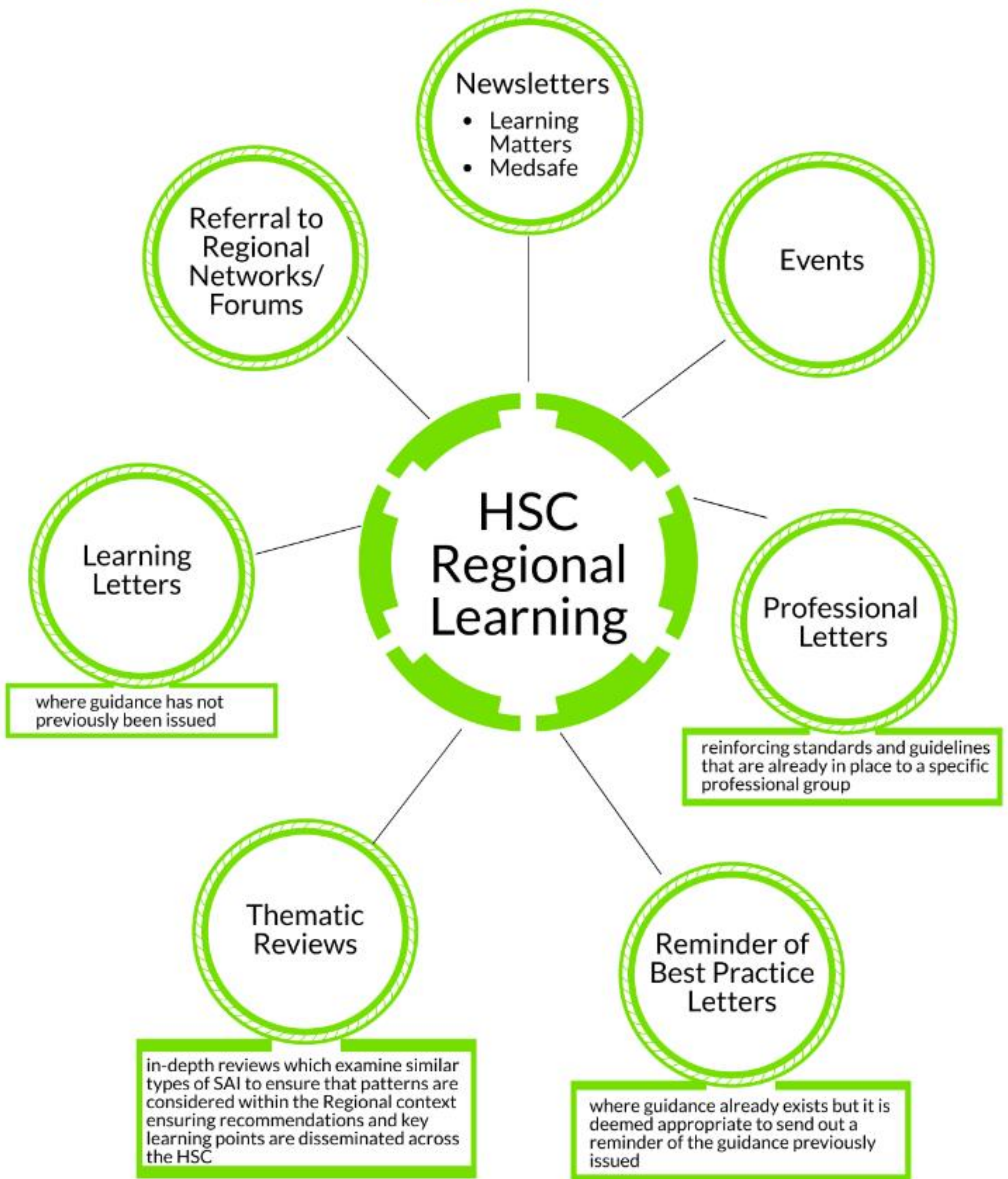
Types of Learning

Learning from SAIs

October 2018 - March 2019

- Learning identified by the Health and Social Care Board (HSCB)/Public Health Agency (PHA) following the review of SAI reports
- Updates on associated work relating to the SAI process
- Key features/events

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

LL/SAI/2018/033 (MH)- Use of plastic bags on mental health in-patient wards

LL/SAI/2018/034(MCH&AS) - Use of Standard (Male) Length Catheters in Female Pregnant Patients

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/

Use of plastic bags on mental health in-patient wards

This case involved the use of a plastic bag in an act of self-harm. In this incident, the plastic bin liner in the patient's bedroom had been removed, as a risk had already been highlighted however access to the plastic bag came from patients / visitors bringing bags onto the ward, after shopping/ visiting.

As a result a learning letter was issued to the wider HSC. The PHA and HSCB worked with Trusts to ensure:

- The letter was brought to the attention of all relevant staff, including Infection control Departments.
- The review and updating of Trust policies and arrangements for the use of plastic bags on mental health in-patient wards, taking account of the good practice from a local Trust.

HSC Health and Social Care Board

HSC Public Health Agency

SAFETY AND QUALITY LEARNING LETTER

Subject

HSCB reference number

Programme of care

LEARNING SOURCE

SAI/Early Alert/Adverse incident ✓ Complaint

Audit or other review Coroner's inquest

Other (Please specify)

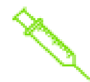
SUMMARY OF EVENT

TRANSFERABLE LEARNING

ACTION REQUIRED

Reminder of Best Practice Guidance (SQR)

- Staff (paid and voluntary) and Access NI Checks - SQR-SAI-2018-042 (All PoCs)
- Recommendation from Independent Inquiry (2017) - SQR-SAI-2018-043 (MH)
- Management of Risk for Patients with Mental Health Conditions in the General Hospital Setting - SQR-SAI-2018-044 (MH/AS)
- Misdiagnosis of Diabetic Ketoacidosis in Children - SQR-SAI-2019-045 (AS/MCH)
- Mismatched Incompatible components in elective orthopaedic joint replacement surgery - SQR-SAI-2019-046
- Endometrial Thermoablation - SQR-SAI-2019-047
- NI Flowchart for management of suspected ST Elevation MI or Acute Posterior MI in a hospital setting - SQR-SAI-2019-048



Management of Risk for Patients with Mental Health Conditions in the General Hospital Setting

This case involved a patient who died following a non-accidental fall within an acute hospital facility. The patient attended the emergency department and was admitted to the Acute Medical Admission ward. The patient left the ward following which, the tragic incident occurred. The patient was also known to the Trust mental health services.

As a result a Reminder of Best Practice Guidance letter was issued to the wider HSC. The PHA and HSCB worked with Trusts to ensure:

- The letter was brought to the attention of relevant staff.
- Trusts developed guidelines for the management of people with mental health conditions in general hospital settings, which also included an agreed risk assessment form and PSNI liaison form.

Misdiagnosis of Diabetic Ketoacidosis in Children

The learning issued related to two cases of misdiagnosis of Diabetic Ketoacidosis (DKA) in children aged 5 and under in Northern Ireland. In both cases the children presented with abdominal pain, raised blood sugar and a metabolic acidosis. Both children were initially treated as DKA but their clinical condition did not respond to treatment. They were subsequently transferred to the Belfast Trust and required abdominal surgery. In neither case were blood ketones measured at the time the clinical diagnosis of DKA was made.

As a result a Reminder of Best Practice Guidance letter was issued to the wider HSC. The PHA and HSCB worked with Trusts to ensure:

o The letter was brought to the attention of all clinical areas where children are cared for in hospital and community settings;

o That the diagnosis of DKA in children follows BSPED and NICE guidance;

o The availability of ketone meters in all clinical settings where children are looked after in hospital settings, that staff have been trained in their use and that these meters are included in Trust quality assurance programs for near patient testing.

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/

Newsletters

Learning matters provides a method of sharing learning relating to SAIs, complaints, reviews and patient experience across Northern Ireland. No newsletters were issued during the reporting period however edition 9 is scheduled to be issued soon and will feature the following topics, all of which relate to learning from SAIs

- Interaction of Selective Serotonin Re-Uptake inhibitors (SSRIs) with Monoamine-oxidase Inhibitors (MAOIs)
- Risks of Nasogastric (NG) Tube Insertion
- Blunt Trauma to superior mesenteric artery
- Delays in diagnosing Aortic Dissection
- Sepsis article
- Right patient, Right drug: Intravenous infusions
- Cerebral empyema – a rare complication of sinusitis
- Missed fracture of femoral shaft
- Contact the haematology doctor on call at the Belfast City Hospital (BCH) if a patient, with congenital bleeding disorders under the care of the NI Haemophilia Comprehensive Care Centre BCH, presents acutely out of hours
- Always check the allergy box on the Kardex before prescribing or administering any medication
- Management of Risk for Patients with Mental Health Conditions in the General Hospital Setting
- Use of Adrenaline in Anaphylaxis
- Delay or Omission of medicines
- Focus on Falls
- National Patient Safety Alerts

All editions of Learning Matters newsletters can be accessed at:

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

Thematic Reviews

Thematic Reviews are in-depth reviews which examine similar types of SAI to ensure that patterns are considered within the Regional context ensuring recommendations and key learning points are disseminated across the HSC. A thematic review in relation to **Mixed Gender Accommodation** was undertaken during the reporting period

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 11 cases were referred. These Networks/Forums included:

- **Medicines Management Information Team**
- **Tacrolimus Incident and Supply Review Group**
- **Maternity Collaborative**
- **Regional Pressure Ulcer Prevention Group**
- **Anticoagulant Group**

Events

Planning is in process for the Regional Serious Adverse Incident (SAI) and Complaints Learning Workshop which will be held on Wednesday 29 May 2019. Topics to feature at the event will include:

• Managing a patient with a complex condition – the family's perspective

• Lessons from the Healthcare Safety Investigation Branch

• Improving medication safety in Northern Ireland – responding to the WHO Challenge 'Medication Without Harm'

• Sense-making patients and their families

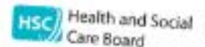
• Parallel Sessions – Learning from SAI Case Studies – will run with Case Studies presented and Q&A sessions focusing on

o Human Factors and Simulation

o Dealing with Complexity

o Never Events/Other

This will be followed by an interactive plenary session – Improving how we Learn



Regional Serious Adverse Incident (SAI) and Complaints Learning Workshop
A just culture – How we learn
Craigavon Civic Centre
Wednesday 29 May 2019

TIME	TITLE		SPEAKER
09:30 – 10:00	Registration – Tea/coffee/scones		
PLENARY SESSION – Chair: Dr Maria O'Kane			
10:00-10:15	Welcome and Opening Remarks		Mary Hinds
10:15-10:30	Ice-breaker		Lovette Lamb
10:30-10:50	Jaimie's Story – Managing a patient with a complex condition – the family's perspective		Jim, Jaimie's father
10:50-11:30	Lessons from the Healthcare Safety Investigation Branch		Dr Kevin Stewart
11:30-12:00	Tea, coffee and networking		
12:00-12:20	Improving medication safety in Northern Ireland – responding to the WHO Challenge 'Medication Without Harm'		Cathy Harrison
12:20-13:00	Sense-making, patients and their families		Dr Dawn Benson
13:00-13:50	LUNCH		
PARALLEL SESSIONS – Learning from SAI case studies			
	Human Factors and Simulation – Dr Ann Hamilton & Dr Jackie McCall	Dealing with Complexity – Mary McElroy & Briege Quinn	Never Events / Other – Liz Fitzpatrick & Anne Kane
13:50-15:00	Case studies and Q&A	Case studies and Q&A	Case studies and Q&A
PLENARY SESSION			
15:00-15:30	Interactive Session – Improving how we learn		Shane Devlin
15:30	Reflections and close		Shane Devlin

The 'Regional Serious Adverse Incident and Complaints Learning Event' has been approved by the Federation of the Royal Colleges of Physicians of the United Kingdom for 5 category 1 (external) CPD credits.

Specific Learning

Following a particular level 3 review into a case of double homicide work has commenced with the family of the victim to increase awareness of the need to engage all those involved in the SAI process including families of victims in order to ensure appropriate support is provided, and the learning from all those involved is identified, disseminated and results in changes in practice where required. As a result of this work the SAI process is being redrafted to make it a more straightforward version and easily accessible. This will include a more public facing web page on NI Direct and the PHA/HSCB websites with simple information and links for all those involved, including patients, families, staff and the public, giving information on the process, involvement and the various levels of review.

Conclusion

The HSCB and PHA remain committed to identify learning from SAIs, in order to improve services for service users 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.

The HSCB/PHA are continuously looking for ways to improve processes and during the reporting period as a result of learning from SAIs have commenced a redrafting of the SAI process. This will lead to a revision of some elements of the current procedure over the next number of months with a particular focus on the needs of those affected by SAIs and the need to make the process clearer and more straight forward for staff and service users to understand.

The revised procedure will be simplified to avoid any ambiguities and will make clear the need for all service users, families/carers, victims and their families to be invited to participate and engage in SAI reviews, respectful of appropriate permissions and protection of personal data.

It is also the intention to establish a new SAI link on both HSCB/PHA websites. This will allow for easy access to information on the SAI process for all those affected by SAIs and also allow staff to avail of tools and resources that would assist them when undertaking SAI reviews.

Appendices

Appendix 1 - Analysis of SAI Activity October 2018 - March 2019

Appendix 2 - Analysis of Checklists Received 1 October 2018 - 31 March 2019

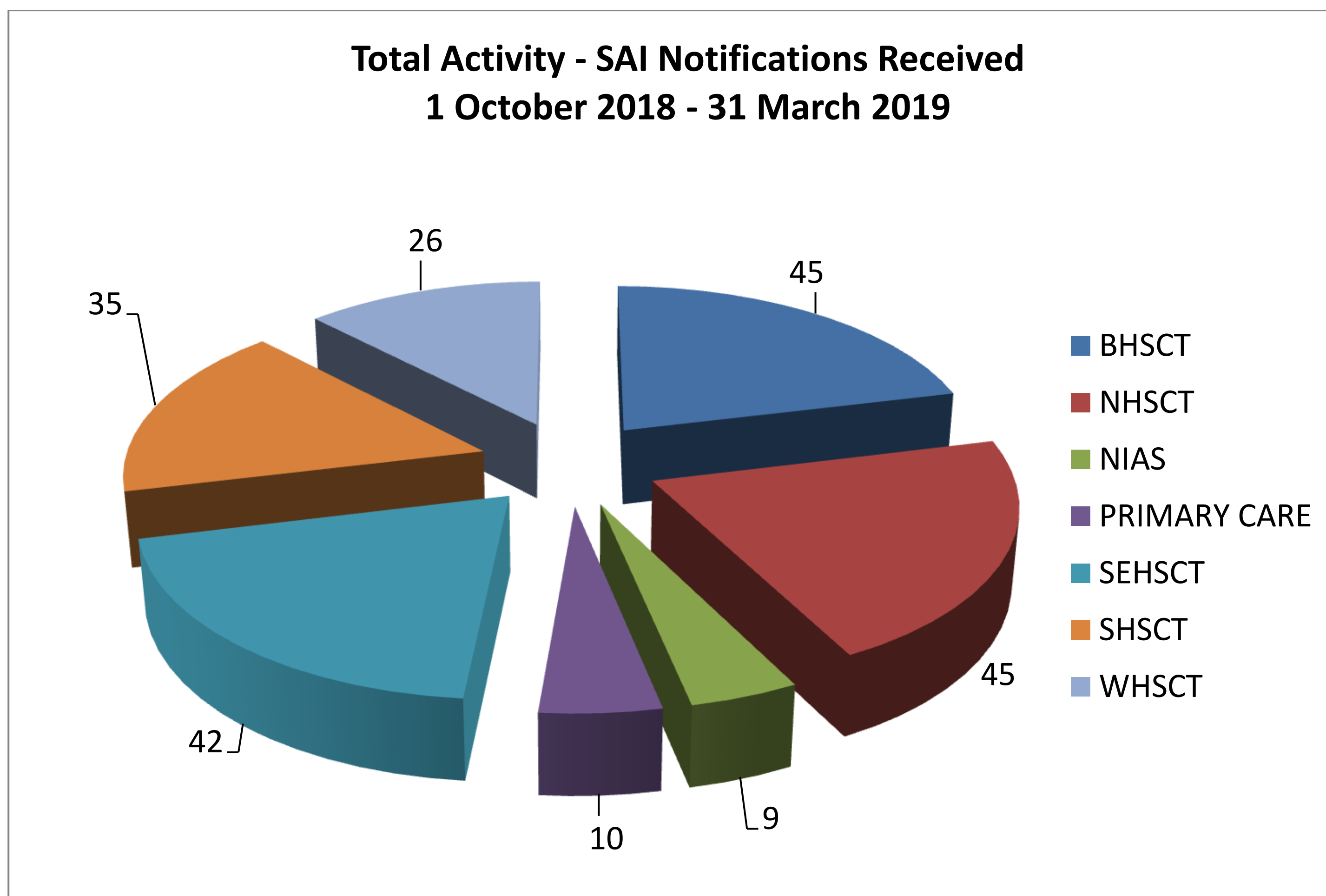
Appendix 3 - Update on User Engagement Information Previously Reported

APPENDIX 1

ANALYSIS OF SAI ACTIVITY OCTOBER 2018 - MARCH 2019

The HSCB has **received 212 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 provide an overview of all SAIs reported by organisation and includes **comparison** of activity:

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

Table 1

TOTAL ACTIVITY	Oct 17 - Mar 18	Apr 18 - Sept 18	Oct 18 - Mar 19
BHSCT	49	49	46
HSCB	2	0	0
BSO	1	0	0
NHSCT	29	51	45
NIAS	7	3	9
PCARE	11	8	10
PHA	0	0	0
SEHSCT	23	23	42
SHSCT	17	23	36
WHSCT	45	36	26
Totals:	*184*	*193*	*214*
Less De-escalations*	4	3	2
TOTAL	**180**	**190**	**212**

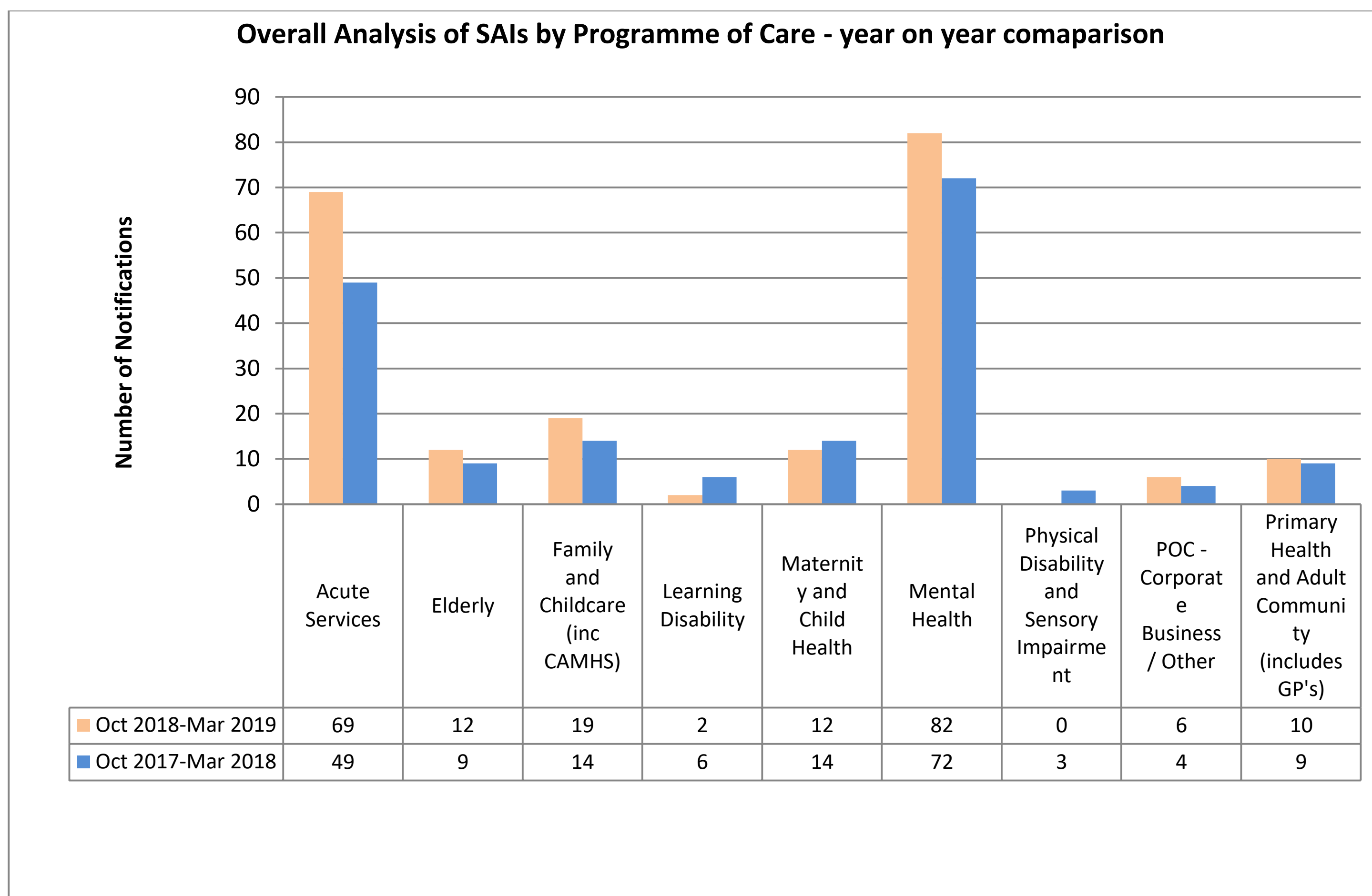
**SAI reports submitted can be based on limited information at the time of reporting. If on further review the incident does not meet the criteria of an SAI, a request can be submitted by the reporting organisation to de-escalate or withdraw the SAI.*

SAI ANALYSIS BY PROGRAMME OF CARE

SAIs are categorised by Programmes of Care as follows:

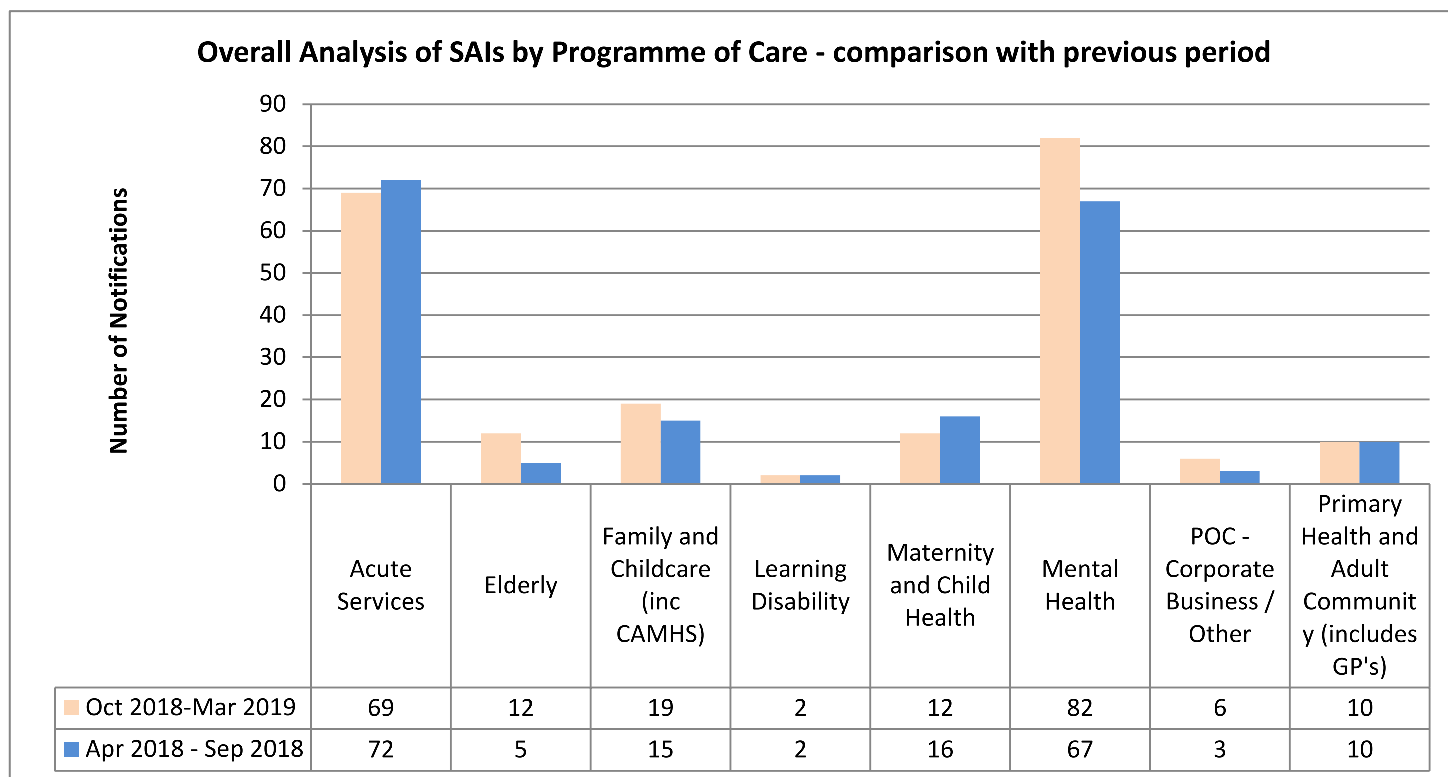
- Acute Services
- Maternity and Child Health
- Family and Child Care
- Elderly
- Mental Health
- Learning Disability
- Physical Disability and Sensory Impairment
- Health Promotion and Disease Prevention
- Primary Health and Adult Community (Including General Practice)
- Corporate Business / other

Chart 2



	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 2018-Mar 2019	69	12	19	2	12	82	0	6	10
Oct 2017-Mar 2018	49	9	14	6	14	72	3	4	9

Chart 3



ACUTE SERVICES

ORGANISATION	Oct 17 - Mar 18	Apr 18 - Sept 18	Oct 18 – Mar 19
BHSCT	13	21	20
NHSCT	9	18	11
NIAS	5	3	9
SEHSCT	3	7	9
SHSCT	4	5	9
WHSCT	15	18	11
Totals:	**49**	**72**	**69**

Current period: 69 SAIs were reported. The top three groups related to the following classifications/categories. 27 incidents being the most reported in any one category.

Classification/category

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

MATERNITY AND CHILD HEALTH

ORGANISATION	Oct 17 - Mar 18	Apr 18 - Sept 18	Oct 18 – Mar 19
BHSCT	4	7	6
NHSCT	2	3	1
NIAS	1	0	0
SEHSCT	0	2	0
SHSCT	1	3	4
WHSCT	6	1	1
Totals:	**14**	**16**	**12**

Current period: 12 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	Oct 17 - Mar 18	Apr 18 - Sept 18	Oct 18 – Mar 19
BHSCT	7	7	5
HSCB	1	0	0
NHSCT	4	3	6
SEHSCT	1	2	2
SHSCT	1	1	4
WHSCT	0	2	2
Totals:	**14**	**15**	**19**

Current period: 19 SAIs relating to family and childcare were reported. In the largest classification/category group, 15 SAIs related to 'Abusive, violent, disruptive or self-harming behaviour'.

OLDER PEOPLE SERVICES

ORGANISATION	Oct 17 - Mar 18	Apr 18 - Sept 18	Oct 18 – Mar 19
BHSCT	0	0	5
NHSCT	1	2	3
NIAS	1	0	0
SEHSCT	0	2	3
SHSCT	1	1	0
WHSCT	6	0	1
Totals:	**9**	**5**	**12**

Current period: 12 SAIs relating to older people's services were reported. All incident categories within this programme had less than five incidents.

MENTAL HEALTH

ORGANISATION	Oct 17 - Mar 18	Apr 18 - Sept 18	Oct 18 – Mar 19
BHSCT	18	10	8
NHSCT	12	24	22
SEHSCT	16	8	25
SHSCT	10	13	16
WHSCT	16	12	11
Totals:	**72**	**67**	**82**

Current period: 82 SAIs relating to adult mental health services were reported. 80% (66) 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	Oct 17 - Mar 18	Apr 18 - Sept 18	Oct 18 – Mar 19
BHSCT	5	1	0
NHSCT	0	0	1
SEHSCT	1	0	0
SHSCT	0	0	1
WHSCT	0	1	0
Totals:	**6**	**2**	**2**

Current period: 2 SAIs relating to learning disability services were reported.

PHYSICAL DISABILITY AND SENSORY IMPAIRMENT

ORGANISATION	Oct 17 - Mar 18	Apr 18 - Sept 18	Oct 18 – Mar 19
BHSCT	1	0	0
NHSCT	1	0	0
WHSCT	1	0	0
Totals:	**3**	**0**	**0**

Current period: No reported incidents

PRIMARY HEALTH AND ADULT COMMUNITY (INC. GENERAL PRACTICE)

ORGANISATION	Oct 17 - Mar 18	Apr 18 - Sept 18	Oct 18 – Mar 19
BHSCT	0	1	0
PCARE	9	8	10
WHSCT	0	1	0
Totals:	**9**	**10**	**10**

Current period: Ten SAIs relating to Primary Health and Adult Community were reported. All incident categories within this programme had less than five incidents.

CORPORATE BUSINESS

ORGANISATION	Oct 17 - Mar 18	Apr 18 - Sept 18	Oct 18 – Mar 19
BHSCT	1	0	1
HSCB	1	0	0
NHSCT	0	1	1
SEHSCT	2	1	3
SHSCT	0	0	1
WHSCT	0	1	0
Totals:	**4**	**3**	**6**

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

HEALTH PROMOTION AND DISEASE PREVENTION

No reported incidents

APPENDIX 2

Analysis of Checklists RECEIVED 1 OCTOBER 2018 – 31 MARCH 2019

Table 1a - Analysis of Engagement with Service User/Family/Carer	**BHSCT**		**NHSCT**		**NIAS**		**SEHSCT**		**SHSCT**		**WHSCT**		**TOTAL**	
Checklists received	**31**	**100%**	**34**	**100%**	**6**	**100%**	**33**	**100%**	**5**	**100%**	**19**	**100.0%**	**128**	**100%**
Service User/Family/Carer **informed** incident was being reviewed as a SAI	28	90%	28	82%	1	17%	28	85%	5	100%	16	84%	**106**	**83%**
Service User/Family/Carer **not informed** incident was being reviewed as a SAI	3	10%	6	18%	5	83%	5	15%	0	0%	3	16%	**22**	**17%**

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	**3**	**100.0%**	**6**	**100%**	**5**	**100%**	**5**	**100%**	**0**	**100%**	**3**	**100%**	**22**	**100%**
Impact on health/safety /security and/or wellbeing	0	0%	1	17%	1	20%	0	%	0	0%	1	33%	**3**	**14%**
No next of kin or contact details	2	67%	0	%	2	40%	1	20%	0	0%	0	%	**5**	**23%**
Case identified as a result of review exercise	0	0%	0	%	1	20%	0	0%	0	0%	1	33%	**2**	**9%**
Involves suspected /actual abuse by family	0	%	1	17%	0	0%	0	0%	0	0%	0	0%	**1**	**4%**
Not applicable	0	0%	1	17%	0	0%	0	0%	0	0%	0	0%	**1**	**4%**
Other rationale provided	1	33%	3	50%	1	20%	4	80%	0	0%	1	33%	**10**	**46%**

Table 2a - Analysis of Final Review Reports shared/not shared	**BHSCT**		**NHSCT**		**NIAS**		**SEHSCT**		**SHSCT**		**WHSCT**		**TOTAL**	
Checklists received	**31**	**100%**	**34**	**100%**	**6**	**100%**	**33**	**100%**	**5**	**100%**	**19**	**100%**	**128**	**100%**
Final Review Reports shared	3	10%	11	32%	1	17%	13	39%	1	20%	10	53%	**39**	**30%**
Final Review Reports **not** shared	28	90%	23	68%	5	83%	20	61%	4	80%	9	47%	**89**	**70%**

Table 2b - Analysis of Final Review Reports not shared	**BHSCT**		**NHSCT**		**NIAS**		**SEHSCT**		**SHSCT**		**WHSCT**		**TOTAL**	
Final Review Reports not shared	**28**	**100%**	**23**	**100%**	**5**	**100%**	**20**	**100%**	**4**	**100%**	**9**	**100%**	**89**	**100%**
Case identified as a result of review exercise	0	0%	0	0%	1	20%	0	0%	0	0%	1	11%	**2**	**2%**
* **Draft Review Report shared with the Service User/Family/Carer**	**0**	**%**	**2**	**9%**	**0**	**0%**	**0**	**0%**	**0**	**0%**	**0**	**0%**	**2**	**2%**
Family participated - Declined Review Report	0	0%	5	22%	0	0%	1	5%	1	25%	0	0%	**7**	**8%**
Family withdrew from the process	0	%	2	9%	0	0%	1	5%	0	0%	2	22%	**5**	**6%**
* **Final Review Report to be shared with the Service User/Family/Carer**	**22**	**78%**	**7**	**30%**	**1**	**20%**	**7**	**35%**	**1**	**25%**	**4**	**44%**	**42**	**47%**
Impact on health/safety /security and/or wellbeing	0	%	1	4%	1	20%	1	5%	0	0%	1	11%	**4**	**5%**
No next of kin or contact details	1	4%	0	%	2	40%	1	5%	1	25%	0	%	**5**	**6%**
Involves suspected /actual abuse by family	0	%	1	4%	0	0%	0	%	0	0%	0	%	**1**	**1%**

Table 2b - Analysis of Final Review Reports not shared	BHSCT		NHSCT		NIAS		SEHSCT		SHSCT		WHSCT		TOTAL	
No response to correspondence	2	7%	1	4%	0	0%	3	15%	1	25%	0	%	**7**	**8%**
Other rationale provided	1	4%	4	18%	0	0%	6	30%	0	%	1	11%	**12**	**13%**
Review Report discussed with the Service User/Family/Carer	2	7%	0	0%	0	0%	0	0%	0	0%	0	%	**2**	**2%**

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 49.4% (44) 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 15)

APPENDIX 3

UPDATE ON USER ENGAGEMENT INFORMATION PREVIOUSLY REPORTED

PERIOD 1 APRIL 2018 to 30 SEPTEMBER 2018 POSITION AS REPORTED IN HSCB-PHA SAI Learning Report – Edition 15

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%**

PERIOD 1 APRIL 2018 to 30 SEPTEMBER 2018 **- UPDATED POSITION**

The last report (Edition 15) indicated 27.8% (42) 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 64% (96) reports have since been shared with service users/families/carers.

36% (55) SAI Review Reports have not been shared. Further engagement is planned for 15% (10) 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	**33**	**100%**	**40**	**100%**	**1**	**100%**	**32**	**100%**	**18**	**100%**	**27**	**100%**	**151**	**100%**
Final Review Report shared	17	52%	27	67%	1	100%	22	69%	12	67%	17	63%	96	64%
Final Review Report **not** shared	16	48%	13	33%	0	0%	10	31%	6	33%	10	37%	55	36%

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