HSC Health and Social Care

HSC Public Health Agency

ANNUAL LEARNING REPORT APRIL 2020 – MARCH 2021

Learning from Serious Adverse Incidents

EDITION 18

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Background & Introduction

Purpose of the report

When a serious incident or event occurs, it is vital there is a systematic process in place for safeguarding our service users, staff and members of the public. The Health & Social Care Board (HSCB) working in partnership with Public Health Agency (PHA) have a responsibility to effectively share regional learning from these incidents in a meaningful way, ultimately leading to safer, quality services for the population we serve.

The purpose of this report is to provide an understanding of the Serious Adverse Incident (SAI) process and to demonstrate the various mechanisms of regional learning that have been disseminated across our Health & Social Care (HSC) system as a result of SAI reviews during the period 1 April 2020 – 31st March 2021.

What is a SAI – What is the SAI process?

What is a SAI?

Events which are reported as SAIs help identify learning even when it is not clear something went wrong with treatment or care provided. When things do go wrong in HSC it is important that we identify this, explain what has happened to those affected and learn lessons to ensure the same thing does not happen again. SAIs are an important means to do this. Areas of good practice may also be highlighted and shared, where appropriate.

A SAI is an incident or event that must be reported to the HSCB by the organisation where the SAI has occurred. It may be:

- An incident resulting in serious harm;
- An unexpected or unexplained death;
- A suspected suicide of a service user who has a mental illness or disorder; and
- An unexpected serious risk to wellbeing or safety, for example an outbreak of infection in hospital.

A SAI may affect services users, members of the public or staff.

Learning from SAIs will be both local to the reporting organisation and regional, across all HSC Trusts. It is acknowledged HSC organisations will already have in place mechanisms for cascading local learning from SAIs internally within their own organisations. The management of dissemination and associated assurance of any regional learning is the responsibility of the HSCB / PHA.

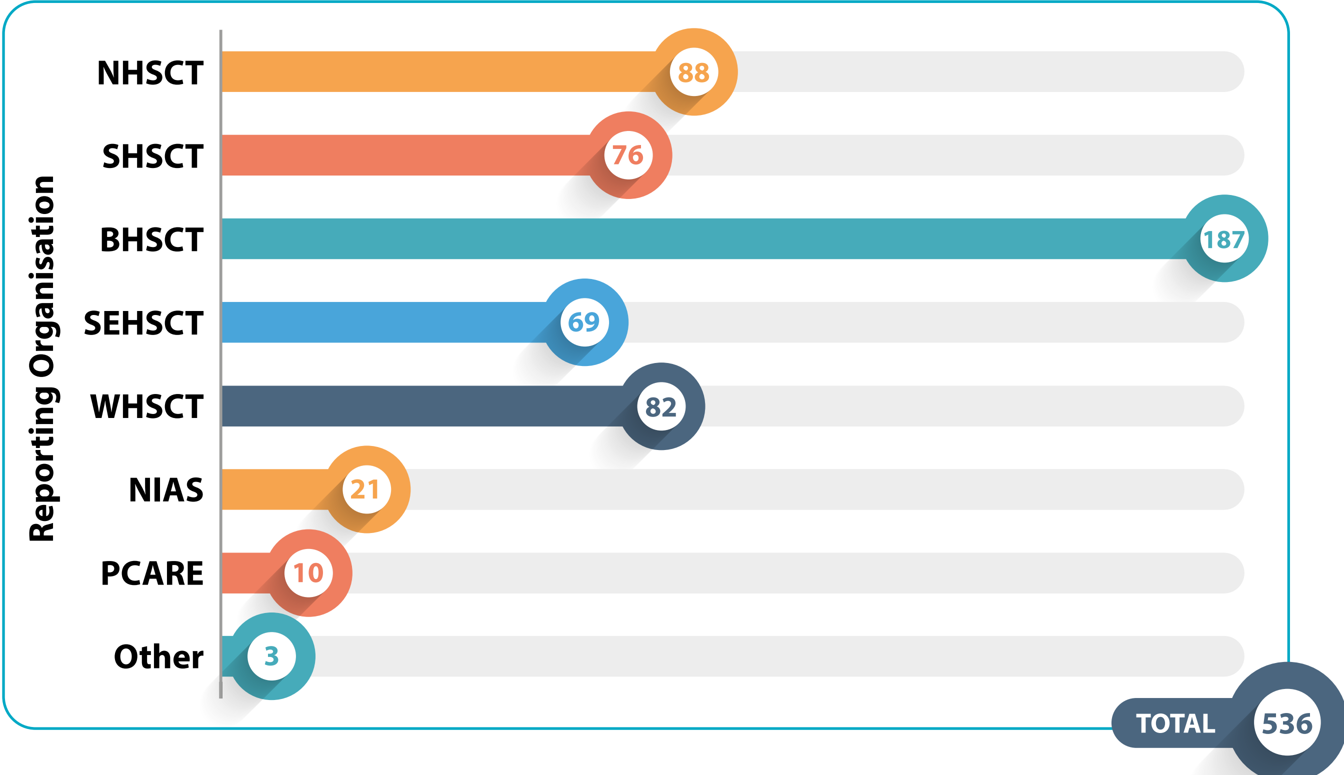
Multidisciplinary groups within the HSCB / PHA provide a role in the surveillance of SAIs to identify patterns / clusters / trends across the region in order to proactively manage risks, hence providing safer services for the population.

The Regional Procedure for Reporting and Follow up of SAIs (2016) ensures there is a clear, regionally agreed approach to the reporting, management, follow-up and learning from SAIs. For more information on the SAI Procedure see link below:

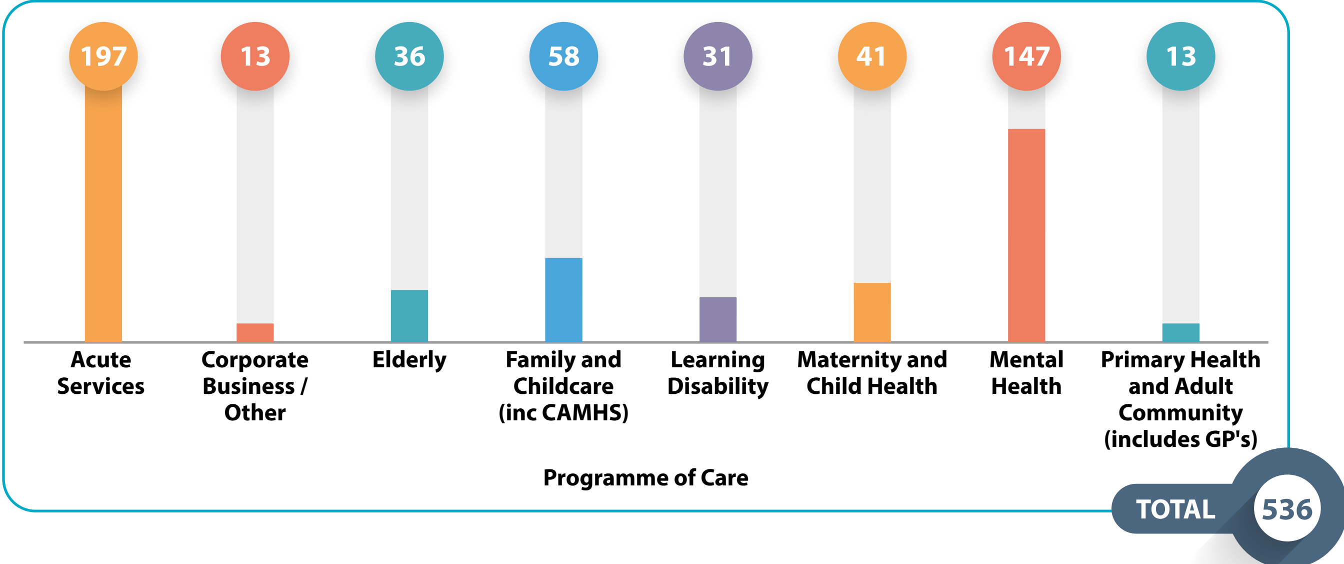
How Many SAIs have been Reported?

During the period 1st April 2020 – 31st March 2021 the HSCB has received **536 SAI Notifications** from across HSC Organisations.

The chart below details the number of SAIs reported during the reporting period by Organisation.

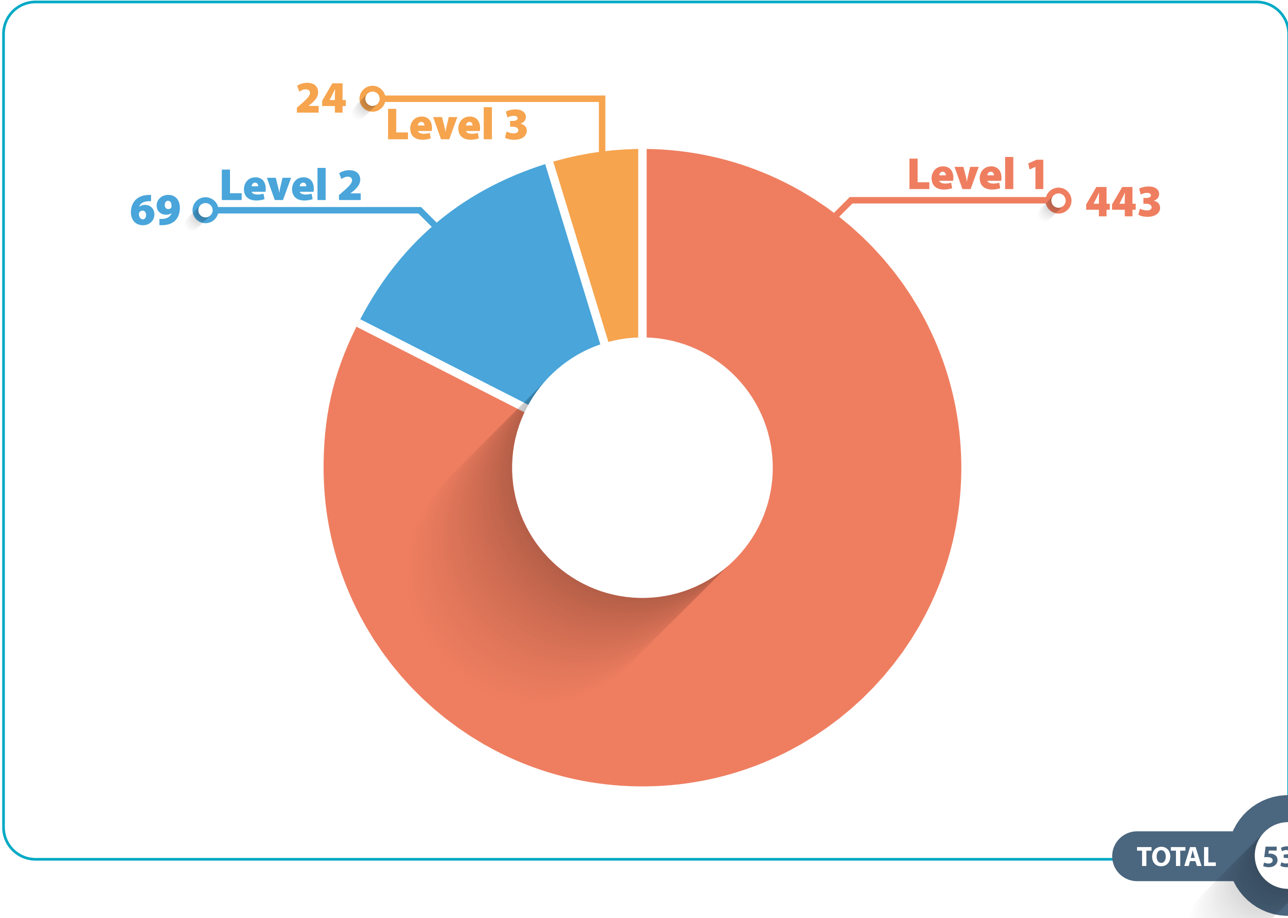


The chart below demonstrates the number of SAIs reported during the reporting period by Programme of Care.



SAIs are conducted at a level appropriate and proportionate to the complexity of the incident under review, they may be Level 1, 2 or 3. Reporting Organisations use a HSC Regional Risk Matrix to determine the level of review to be undertaken.

The Chart below details the total number of SAIs reported during the reporting period by Level of Review.

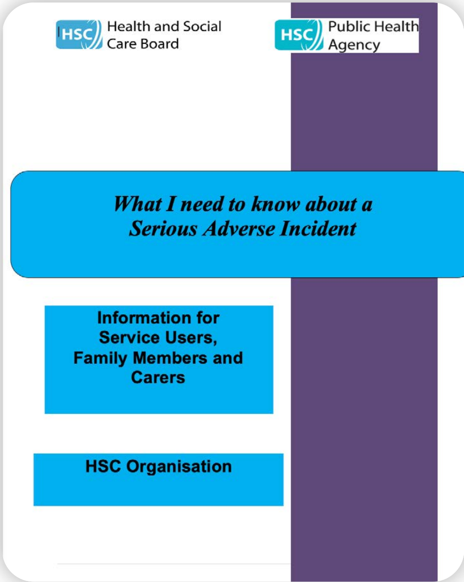


The Importance of Service User / Family Involvement in the SAI Process

When an adverse outcome occurs for a service user it is important that the service user / family (as appropriate) receive timely information and are fully aware of the processes followed to review the incident.

The purpose of a SAI review is to find out what happened, why it happened and what can be done to prevent it from happening again and to explain this to those involved. Being open about what happened and discussing the SAI including any learning promptly, fully and compassionately may help the service user / family come to terms with what has happened.

Communicating effectively with the service user / family is a vital part of the SAI process, can add valuable information to help identify the contributing factors and should be integral to the review process, unless they wish otherwise.



Improvements to the SAI Process?

The review of safety and quality processes within the HSCB and PHA identified that there was a considerable backlog in the review of SAI's within HSCB / PHA and in submitting reports from the HSC Trusts. As a result, the teams were tasked with developing an improvement plan to improve the backlog within HSCB / PHA and work with HSC Trusts to implement a measurement framework to ultimately improve the timescales for submission of reports.

This plan aims to put in place an effective safety and quality structure across the HSCB and PHA supported by a culture of quality improvement. In addition it focuses on the development of a robust measurement framework with a particular emphasis on the management of Serious Adverse Incidents (SAI), Early Alerts and Safety and Quality Alerts (SQA). The plan will be further enhanced by the development of detailed action plans to support the achievement of strategic requirements.

A number of steps have been put in place as a result of this improvement plan. These include:

- Development of a daily report on all notifications monitored by Assistant Director Nursing Q&S and sent to all Directors;
- Implementation of multi professional weekly incident review meeting to review all notifications and take any required action;
- Setting up of a weekly safety brief between the governance and nursing teams with the Director of Nursing and Director of Strategic Planning to bring forward any issues; and
- Streamlining of safety and quality processes within HSCB / PHA.

At the commencement of this work in October 2020 there were 219 SAI reports awaiting action by HSCB/PHA. As of 31st March 2021 there were 61. A 72% reduction.

There were 19 letters awaiting development and issue and by 31st March 2021 there were 7. **A 63% reduction.**

There have been 3 Learning Matters newsletters issued since November 2020.

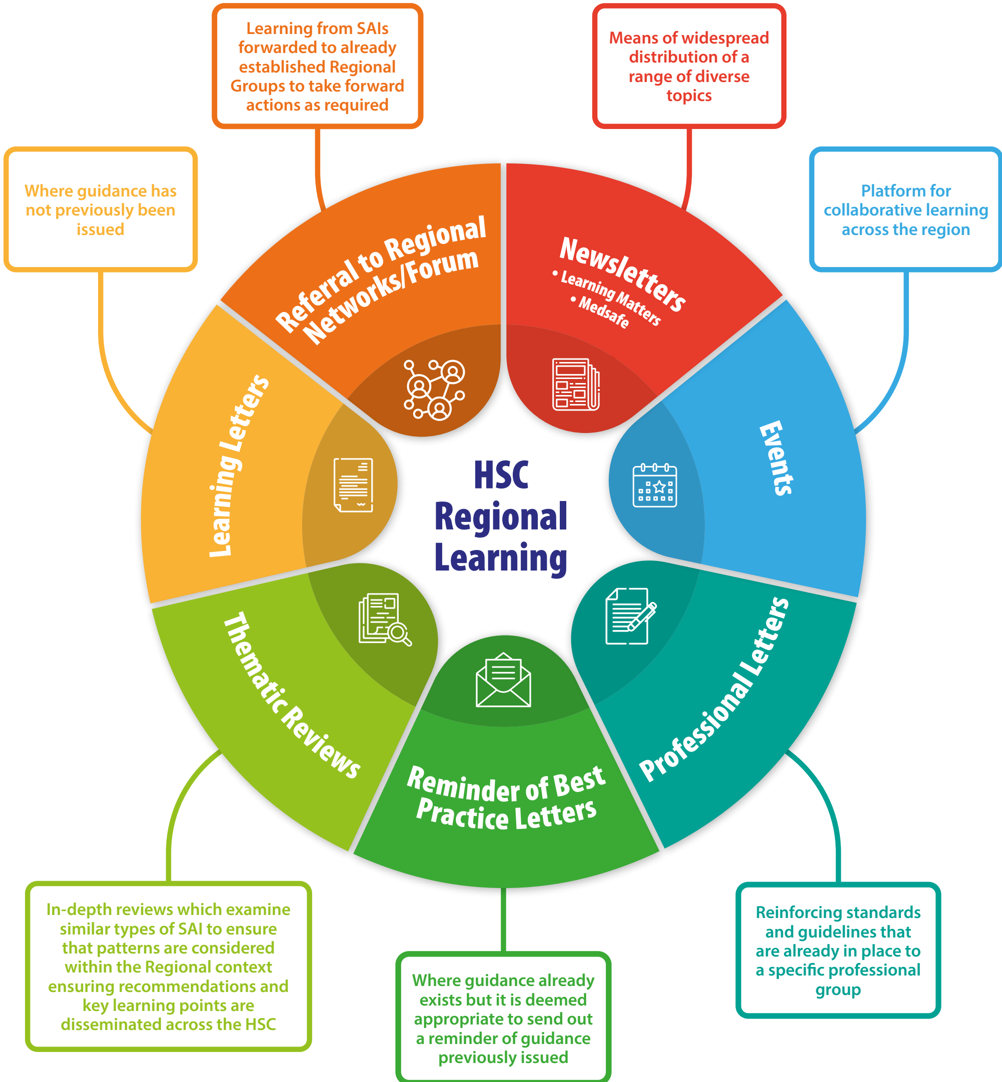
- To further enhance CCS Coding the HSCB / PHA have established a new regional coding system whereby all SAIs are coded by specialty / theme. This allows the HSCB / PHA to be proactive in identifying regional trends and take forward appropriate learning and action as required.

Learning from SAIs

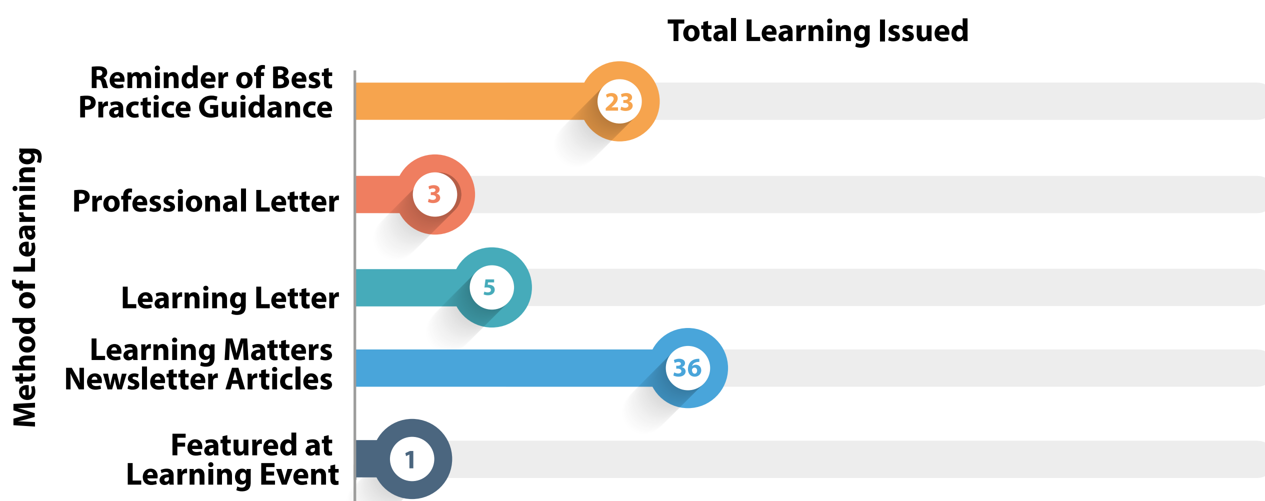
The key aim of carrying out a SAI review is to establish what happened, how it happened and to reduce the risk of the incident recurring and ultimately to improve the safety and quality of services provided both within the reporting organisation and across the HSC as a whole. The dissemination of learning following a SAI review is therefore core to achieving this and to ensure shared lessons are embedded in practice and the safety and quality of care provided.

HSC organisations who have reported the SAI and who are responsible for conducting the review will have in place mechanisms for cascading local learning from SAIs internally within their own organisations In line with the Regional Procedure for the Management and Follow up of SAIs, the management of dissemination and sharing of regional learning is the responsibility of the HSCB / PHA.

Mechanisms used by HSCB / PHA to share learning



Regional learning issued / referred throughout the reporting period



Reminder of Best Practice Guidance Issued:

- Atypical Presentation of Stroke and the need for Expert Assessment of Patients presenting with stroke symptoms;
- Care Home Admission and Initial Review;
- Cold Chain Storage;
- Delayed Diagnosis of Diabetic Ketoacidosis and Type 1 diabetes in children;
- Emergency management of hyperkalaemia;
- Failure to remove stent led to episodes of sepsis;
- Incidents relating to significant or unexpected radiological findings;
- Insulin Pump starts in children. Ensure only one basal pattern is programmed on new pump;
- Investigation and Management of Pulmonary Nodules;
- IV Fluid management and prevention of harm from hyponatraemia;
- Management of Small Bowel Obstruction with Additional Pathology;
- MCH-Maternity and screening;
- Medication handout error associated with use of protective screens and facemasks;
- Need to establish pregnancy status of patient prior to administering treatment drugs;
- Pest Control Devices – Safe Practice;
- Prescribing and supply of High Risk Medications in Out of Hours periods;
- Reducing the risk of oxygen tubing being attached to medical air;
- Risk of serious harm or death from misplaced percutaneous endoscopic gastrostomy (PEG) tubes;
- Risks associated with nitrous oxide waste gases in dental surgeries;
- Rubeosis needs urgent referral and treatment to avoid sight loss;
- Safe storage of epidurals (Controlled Drug and non-Controlled Drug) and checking processes for the administration of Controlled Drug Infusions;
- Substitute Prescribing: Preventing duplicate supply on discharge from secondary care; and
- Unplanned re-attenders to the Emergency Department.

The above Reminders of Best Practice Guidance can be accessed by HSC staff via the intranet using following link:

Learning Letters Issued:

- Accessing Supported Accommodation;
- COVID-19 Hospital and Health Care Facility Acquired Infection Learning Letter;
- Fit Testing;
- Planned Colonoscopy; and
- Process to be followed when preparing syringes for final administration of the Pfizer BioNTech vaccine.

The above Learning Letters can be accessed by HSC staff via the intranet using following link:

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

Professional Letters Issued:

- Guidance for the notification and review of Serious Adverse Incidents (SAI's) relating to COVID-19 outbreaks;
- Potential for staff prescription medication fraud Good governance processes for GP Practices; and
- Concerns raised by the Coroner on lack of digital connection between GPs and Hospitals has been raised along with different hospitals using different computer systems as issues needing to be addressed urgently.

Learning Matters Newsletters published (comprising 36 articles):

Learning Matters_Issue_11 June_2020.pdf (hscni.net)

Learning Matters_Issue_12_special maternity_issue_July_2020.pdf (hscni.net)

Learning Matters_Issue_13_October_2020.pdf (hscni.net)

Learning Matters Issue 14 (2).pdf (hscni.net)

Learning Matters - Special Edition (hscni.net)

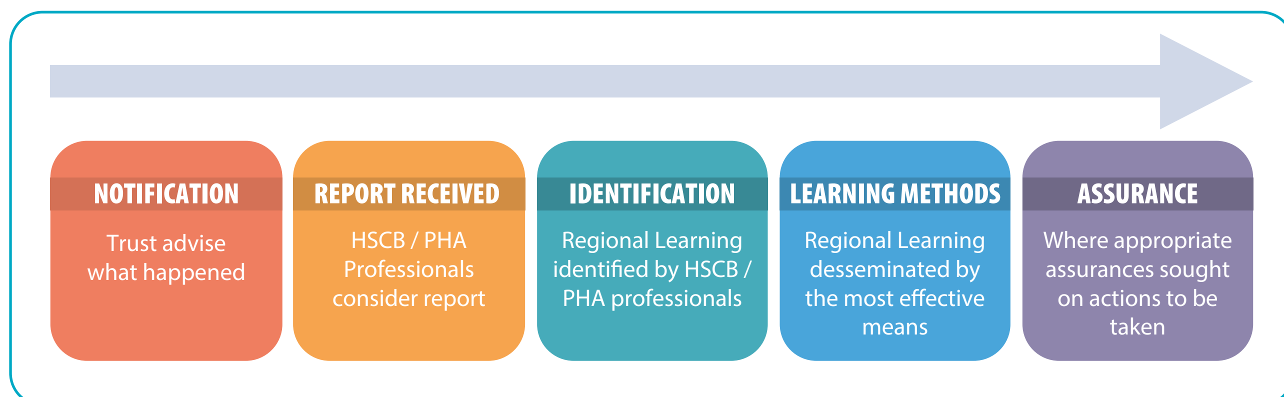
Learning Matters - Special Edition Number 16 (hscni.net)

All editions of Learning Matters are available at:

Learning Matters Newsletters | HSC Public Health Agency (hscni.net)

Learning referred to Regional Networks / Forums:

- Modernising Radiology Clinical Network (MRCN);
- Regional Neonatal Network;
- Regional Paediatric Network;
- Trauma Clinical Advisory Group;
- Pharmacy Medicines Management Team;
- Critical Care Network for NI (CCaNNI);
- Mental Health / Learning Disability Improvement Board;
- Cardiology Network;
- Regional Adult Mental Health Group;
- Maternity Collaborative; and
- NI Cancer Network (NICAN).



Example1 - Reminder of Best Practice Letter

What happened?

A SAI was notified advising of a delay in identification of lung cancer and apparent failure to follow up lung nodule as per published guidelines (BTS or Fleischner).

What did we do?

A full review was conducted by the HSC Organisation who submitted a review report to the HSCB, this report was reviewed by Professional Officers within the HSCB / PHA to identify regional learning.

- Learning from this SAI was referred to Modernising Radiology Clinical Network.
- A Reminder of Best Practice Letter was issued.

What was the key learning?

In this Serious Adverse Incident (SAI) the pulmonary nodule was not followed up as per British Thoracic Society Guidance which led to delay in the diagnosis of lung cancer.

The British Thoracic Society guideline for the investigation and management of solitary and multiple pulmonary nodules (2015) is aimed primarily at physicians, general practitioners, nurses, radiologists, surgeons and other healthcare professionals.

https://thorax.bmj.com/content/thoraxjnl/70/Suppl_2/ii1.full.pdf

The guideline provides useful algorithms on the initial approach to and surveillance of solid pulmonary nodules including:

- Do not offer nodule follow-up for people with nodules <5 mm in maximum diameter or<80 mm3 volume;
- Offer CT surveillance to people with nodules ≥5 mm to <8 mm maximum diameter or ≥80 mm3 to <300 mm3;
- Use composite prediction models based on clinical and radiological factors to estimate the probability that a pulmonary nodule (≥8 mm or ≥300 mm3) is malignant;
- Use the Brock model (full, with spiculation) for initial risk assessment of pulmonary nodules(≥8 mm or ≥300 mm3) at presentation in people aged ≥50 who are smokers or former smokers;
- Consider the Brock model (full, with spiculation) for initial risk assessment of pulmonary nodules (≥8 mm or ≥300 mm3) in all patients at presentation.Learning from the SAI;
- British Thoracic Society Guideline should be followed when clinically appropriate. Radiology reports to clearly specify / recommend on report if a pulmonary nodule requires imaging follow up as per British Thoracic Society Guidelines; and
- It is the responsibility of the referrer to action advice provided in a radiology report.

What happened next?

Assurances sought from HSC Trusts that all learning has been implemented.

Example 2 - Learning Letter

What happened?

A SAI notification has been received from a HSC Trust in respect of Fit Testing of PPE. A number of staff had been informed they had passed their fit test which has now been found to be incorrect based on the UK standard of testing. Previously early alerts had been received from two other HSC Trusts regarding this issue.

What did we do?

As this incident is relevant to all HSC Trusts the PHA commissioned an independent panel to conduct a SAI review, which is currently ongoing. All Trusts and other relevant Organisations will be involved in the review.

The HSCB / PHA issued an urgent Learning Letter. Once the final review report has been received and reviewed there may be further learning issued.

What was the key learning?

All fit testing for PPE should be carried out in line with UK standard. Steps must be taken to ensure fit testing settings for all tests are set to UK requirements. HSC Trusts required to ensure the following:

1. All fit testing is in line with UK requirement, (https://www.hse.gov.uk/pubns/indg479.pdf) ensuring that the competency framework within the HSE INDG 479 standard is met and that all training records are accurate and up to date. To include:
    - When conducting an ambient particle counting fit test the wearer should refrain from smoking (including e-cigarettes) for at least 60 minutes before the fit test;
    - Do not conduct fit tests if there is any hair growth between the wearer's skin and the face piece sealing surface, such as stubble beard growth, beard, moustache, sideburns or low hairline, which cross the respirator sealing surface;
    - Ensure that any type of non-PPE apparel or adornment (e.g. piercing) does not interfere with the fit of the face piece;
    - Inform wearers that they should be clean-shaven in the region of the face seal whenever they wear a tight-fitting face piece at work; and
    - The fit tester should instruct the wearer in the test exercises appropriate to the fit test method used as shown in table below.
2. Prior to each fit testing session an independent check is made to ensure the software setting aligns with UK requirements and that this is proactively 3 recorded.
3. All fit test certificate outcomes are reviewed to ensure the outcomes align with UK requirements.
4. All staff are given a copy of their fit test certificate and the outcome fully explained. It is also important staff are also advised of the arrangement for raising concerns about their fit test.
5. All records for previous fit tests should be secured and be available for the review panel for the SAI.
6. Improve recording of data to be highly traceable both internally and by any external providers.
7. Put in place an end to end monthly fit testing audit programme.

As above urgent learning was issued on notification of this SAI. This was reissued with further information as it became available through the review.

What happened next?

Given the importance of the learning issued immediate assurances were requested and received from all HSC Trusts indicating they were compliant.

Example 3 - Reminder of Best Practice Letter / Learning Matters Newsletter / NPSA Circular

What happened?

There has been a significant increase in the number of incidents reported regionally, where the patient has been inadvertently connected to medical air rather than oxygen. Severe harm or death can occur if medical air is accidentally administered to patients instead of oxygen.

What did we do?

HSCB/PHA professional recognised that urgent learning was required across the HSC.

- Reminder of Best Practice Letter was issued to remind all staff of the dangers for patients who were inadvertently connected to medical air as opposed to oxygen.
- "Special Edition" Learning Matters newsletter was published visually showing the barrier methods available to reduce the incident recurring (see link above).
- NPSA circular issued by the DoH indicating removal of all medical air outlets from clinical areas.

What was the key learning?

Three barriers to human error have already been recommended by the NPSA and British Thoracic Society (BTS) but continuing incidents suggest they have not been universally implemented:

1. Medical air terminal units (wall outlets) are covered with designated caps in areas where there is no need for medical air. Medical air outlets were traditionally built into most clinical areas for the delivery of nebulised treatment but not all areas need them (eg they never have patients who need nebulisers, or they have access to electrically driven compressors or ultrasonic nebulisers).

2. Medical air flowmeters are removed from terminal units (wall outlets) and stored in an allocated place when not in active use. Removing unnecessary equipment is a more effective method of reducing human error than adding labels or warnings alone.

3. Air flowmeters are fitted with a labelled, movable flap. The lettering on the flap is larger and more visible than on the flowmeter itself and this flap has to be lifted to attach a tube. This acts as a further barrier to unintended connection if staff occasionally forget to remove medical air flowmeters after a period of active use.

What happened next?

Assurances were received from all Trusts indicating compliance.

Example 4 - Learning Event

What happened?

A number of SAIs within the Mental Health programme were reported over a period of time. Whilst there was no learning identified from the individual review reports, HSCB / PHA professionals felt that collectively there was elements of learning that could be applied across the region.

What did we do?

The HSCB/PHA commissioned a Regional Mental Health Learning Event held in February 2021, this was a virtual event with over 90 participants from across the HSC.

The event provided an overview of the HSCQI Mental Health Collaborative and focused on the concept of 'All Teach, All Learn,' exploring regional learning arising from SAIs including family engagement and staff support.

What was the key learning?

Part of the event focused on three parallel themed case study learning sessions covering the following topics:

- Application of the Mental Health Order
- Risk Assessment
- Communication & Interface

Example 5 - Professional Letter

What happened?

A GP practice ran a computer search for deleted prescriptions on their clinical system. The search results showed suspicious activity by a staff member whereby prescriptions had been issued, printed and then deleted from a patient's record on the clinical system. There is evidence that the fraudulent activity has been occurring over several years.

What did we do?

A full review report was submitted to the HSCB, this report was reviewed by Professional Officers within the HSCB / PHA who identified regional learning which resulted in a Professional Letter being issued to General Practitioners.

What was the key learning?

Practitioners were reminded that they are responsible for the actions of their employees. As this type of fraudulent activity can go undetected for some time it is important that practitioners make every effort to:

- Familiarise themselves with the computer settings of their computer system and the searches available that identify deleted prescriptions;
- Advice / training where appropriate should be sought from your supplier;
- Ensure security permissions are set at the appropriate level and ensure that regular searches are undertaken for anomalies, reprinted / duplicate, deleted scripts and activity taking place out of hours;
- Make staff aware that clinical systems maintain an audit trail of all computer activity so the systems can be interrogated when required; and
- Employment contracts should cover the disciplinary procedures such actions would incur. To include that fraud is a criminal act and as such all matters will be referred to the police. The employee could therefore be subject to a range of sanctions to include both criminal and disciplinary. Staff should also be made aware of the automatic involvement of the HSCB and the reporting of such activities to the police.

Substantial improvements to Safety and Quality Processes have been made throughout 2020/21 in line with the implementation of the Safety and Quality Improvement Plan.

What Next?

- Ensure any necessary amendments in relation to SAI Policy and/or process have been implemented to allow for a seamless transition as the HSCB migrates to DoH.
- Carry out a review of the Regional Procedure for the Reporting and Follow up of SAIs (2016) in line with DoH Policy which will take account of the RQIA regional review of the SAI Procedure which is due to be issued imminently.
- HSCB/PHA will continue to work collaboratively with HSC Organisations making continued improvements both internally and externally to ensure effective systems are in place to identify and disseminate regional learning across HSC Organisations.
- Work with HSC Trusts to identify training needs in order to fulfil their responsibility in carrying out reviews for all SAIs notified to the HSCB.
- To improve the system of learning to ensure better interaction with the Clinicians / Professionals across HSC. Examples of this are by:
  - Developing a process whereby staff that are involved in the direct provision of care have a role in influencing the development of written learning.
  - Establishing an ECHO Programme (Extension of Community Healthcare Outcomes). Project ECHO NI uses Zoom technology to connect communities of practice. Participants come together in real time to receive updates, new guidance, build relationships and learn from each other. These sessions are interactive so all participants have the opportunity to seek answers to questions and concerns they have. Participants also have the opportunity to learn through anonymised case discussions.
- Develop datasets that provide meaningful information to triangulate and identify learning from SAIs, Complaints and Patient Client Experience.