C.12 DHSSPS SUBMISSION TO THE INQUIRY INTO HYPONATRAEMIA RELATED DEATHS (IHRD)

The Regulation and Quality Improvement Authority

Contents **Para.**

INTRODUCTION

1. The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 created the legal framework for raising the quality of health and social care services in Northern Ireland, and extended regulation and quality improvement to a wide range of services. In April 2005, the Regulation and Quality Improvement Authority (RQIA) was established as a non-departmental public body of the Department of Health, Social Services and Public Safety (DHSSPS) as the regulator of health and social care services in Northern Ireland.

Regulation of Health and Social Care

2. RQIA has responsibility under Part III of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to regulate (register and inspect) a wide range of services delivered by HSC bodies and by the independent sector.

3. RQIA discharges its regulatory functions in conjunction with the relevant statutory Regulations and the published minimum care standards set by the Department of Health Social Services and Public Safety (DHSSPS).

4. Through its programme of inspections and reviews, RQIA makes an independent assessment of safety, quality and availability of health and social care services. This information is used to highlight good practice, challenge poor performance and identify areas where further improvement is necessary.

5. The functions of the RQIA under Part IV (Article 35) of the 2003 Order include:

    - Conducting reviews of, and making reports on, arrangements by statutory bodies for the purpose of monitoring and improving the quality of the health and personal social services for which they have responsibility;

- Carrying out investigations into, and making reports on, the management, provision of quality of the health and personal social services, for which statutory bodies or services providers have responsibility;
- Conducting reviews of and making reports on the management, provision or quality of, or access to or availability of, particular types of health and personal social services for which statutory bodies or service providers have responsibility; and in this respect -
- Carrying out inspections of statutory bodies and service providers, and persons who provide or are to provide services for which such bodies or providers have responsibility and making reports on the inspections; and
- Such function as may be prescribed relating to the management, provision or quality of, or access to or availability of, services for which prescribed statutory bodies or prescribed service providers have responsibility.

Additional Statutory Responsibilities

6. RQIA performs a range of additional statutory functions, including specific functions prescribed in the Mental Health (Northern Ireland) Order 1998, as amended by the Health and Social Care (Reform) Act (Northern Ireland) 2009, and in respect of the Ionising Radiation (Medical Exposure) Regulations 2010.

7. RQIA is a designated National Preventive Mechanism (NPM) in respect of the United Nations Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), as ratified by the United Kingdom government in 2003.

8. RQIA is also a designated body listed under the provisions of the Public Interest Disclosure (Northern Ireland) Order (1998), to which employees of health and social care organisations may make a whistle-blowing disclosure in the public interest.

9. Responsibility for the regulation of private dental treatment was introduced in April 2011 by an amendment to The Independent Health Care Regulations (Northern Ireland) 2005.

RQIA's Corporate Strategy 2012-15

10. RQIA's mission and strategic priorities are set out in RQIA's Corporate Strategy 2012-15. RQIA's mission is to provide independent assurance about the safety, quality and availability of health and social care services in Northern Ireland, encourage continuous improvement in these services and safeguard the rights of service users.

11. Through its planned programme of inspections and reviews and by publishing the findings of its work programme, RQIA seeks to improve care, inform the population, safeguard rights and influence policy.

12. The recommendations of the Francis Report, the public inquiry into the failings at Mid-Staffordshire NHS Trust, challenge all HSC organisations. A key learning point from the inquiry will be to ensure that the patient experience is clearly considered in the drive for quality and service improvement.

13. It is in the public interest that health and social care services in Northern Ireland are subject to independent, proportionate and responsible regulation. RQIA anticipates that its duties will increase further in the years ahead, taking account of the service delivery model detailed in Transforming Your Care.

REGULATION OF ADULT AND CHILDREN'S HEALTH AND SOCIAL CARE SERVICES

14. RQIA has a statutory duty to regulate (register and inspect) a wide range of health and social care services, maintain a register of all regulated care services, inspect and review these services, and report its findings to the DHSSPS. Any person who carries on or manages a regulated care service must make an application for registration to RQIA. RQIA's inspections are

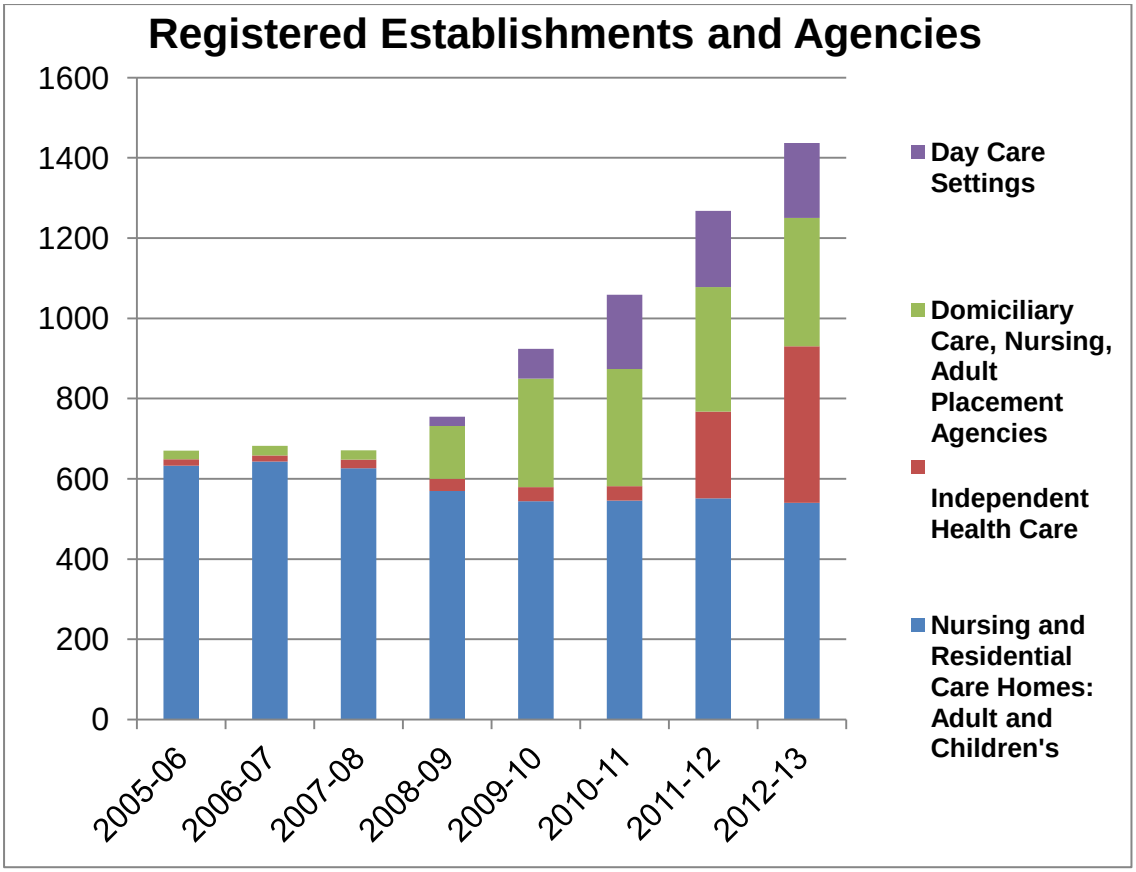
based on regulations and DHSSPS minimum care standards, which ensure that both the public and service providers understand the level of quality expected from care services.

15. In April 2005, with the establishment of the Regulation and Quality Improvement Authority, all services registered with the former health and social care boards' registration and inspection units were deemed registered with RQIA. This included a total of 634 nursing homes and adult and children's residential care homes. During 2005-06 RQIA commenced the registration of nursing agencies and independent health care facilities and services.

16. In 2007 new regulations were published bringing a further range of services under regulation. These were: adult placement agencies; day care settings; domiciliary care agencies and residential family centres. In 2010 voluntary adoption agencies were brought under regulation, with the publication of the Voluntary Adoption Regulations (Northern Ireland) 2010. Currently, there are 504 services in these categories regulated by RQIA.

17. In 2011 an amendment to The Independent Health Care Regulations (Northern Ireland) 2005 brought 364 dental practices providing private care or treatment into regulation.

There are currently 1,474 health and social care services are currently subject to regulation by RQIA,



Registered Establishments / Agencies as at 27 August 2013	
Category	Total
Adult Placement Agencies	4
Children's Residential Care Homes	50
Day Care Settings	189
Domiciliary Care Agencies	305
Independent Clinics	33
Independent Hospitals	12
Independent Hospitals - Dental Treatment	364
Independent Medical Agencies	2
Nursing Homes	268
Nursing Agencies	28
Residential Care Homes	213
Residential Family Centres	2
Voluntary Adoption Agencies	4
Total	**1,474**

18. During 2012-13, RQIA conducted 2,959 inspections of regulated health and social care services, meeting its statutory requirements in relation to the minimum number of inspections for each service. RQIA's inspections may be announced or unannounced, and examine compliance with regulations and minimum standards in the areas of care, medicines management, estates and finance. These inspections are conducted by a team of qualified and experienced nurses, social workers, pharmacists and estates and finance officers.

19. RQIA ensures the timely publication of all its inspection reports, so that the public have up-to-date information in relation to current quality and availability of health and social care services. In its drive for transparency, all RQIA's inspection reports for regulated adult health and social care services are published on its website. At present some 7,500 RQIA inspection reports can be accessed online at www.rqia.org.uk.

20. Under the legislation, RQIA can take a range of sanctions and enforcement measures, which are employed, as necessary, to protect the safety of service users and to drive improvements in regulated care services. Enforcement action is implemented when all other reasonable steps to secure compliance with regulations have failed. In circumstances where there may be significant or immediate risk to the safety and wellbeing of vulnerable people RQIA may impose conditions of registration or exercise its authority to seek the urgent closure of the service. RQIA also operates an Escalation Policy [See Para. 45 & Appendix 2].

21. From 1 April 2012 RQIA began publishing details of all enforcement activity at registered adult health and social care services online.

RQIA REVIEW PROGRAMME

22. Article 35 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 set out the functions of RQIA,

in relation to carrying out inspections and reviews, of health and social services provided by statutory bodies.

23. RQIA is required to review and report on, the management, provision or quality of, or access to, or availability of particular types of health and personal social services, for which statutory bodies have responsibility, and to make reports on its inspections.

Developments in the RQIA Review Programme

24. When established in 2005, RQIA commenced a programme of clinical and social care governance reviews until 2008, in line with the designated functions under Article 35. The initial approaches used were designed in the light of experience of other regulators of health and social care in the United Kingdom.

25. Building on this experience, the focus of reviews was expanded to include thematic reviews relating to the safety, quality and availability of specific services.

26. In 2008, RQIA published the findings of a thematic review, to provide assurance that the actions set out in DHSSPS Circular HSC (SQSD) 20/2007 had been carried out. This circular related to NPSA Safety Alert 22: Reducing the Risk of Hyponatraemia when Administering Intravenous Infusions to Children. In addition, the findings of a follow-up review were published in 2010.

27. In 2009, RQIA introduced a three-year planning approach to its review programme. Themes for planned reviews included in the programme include topics commissioned by the Minister and those selected by RQIA following public consultation. The first three year programme covered the period 2009 to 2012 and RQIA is now carrying out reviews selected for the period 2012 to 2015.

28. RQIA's review programme includes a wide range of themes relating to hospital and community services. For example, in relation to hospital safety, reviews have been published on the care of children under 18 in adult wards, and hospitals at night and weekends. Fieldwork has been completed on a review, commissioned by the Minister, of hospital theatre practice.

29. RQIA reviews are conducted by teams with relevant expertise, and many include professionals from outside Northern Ireland, which brings an important external focus to this activity.

Reviews Commissioned in Response to Emerging Events

30. In addition to its planned review programme, RQIA can be commissioned by the Minister to carry out an immediate review in relation to emerging concerns about services.

31. For example, in 2008, RQIA was commissioned to carry out an independent review of the circumstances leading to a major outbreak of Clostridium difficile infection in the Northern Health and Social Care Trust. This review involved a team with national expertise, to rapidly assess if there were related risks in all trust areas and to recommend measures to ensure the safety of patients. The learning gleaned from this review informed future reviews commissioned in response to emerging concerns.

32. RQIA has been commissioned, by respective Ministers, to carry out reviews relating to concerns about the care arrangements for the McDermott brothers following court proceedings relating to their involvement in sexual abuse (2010); delays in reporting of X-rays in the Western and Southern Trusts (2011); and, the outbreaks of pseudomonas in neonatal units in Northern Ireland (2012).

33. RQIA methodologies have developed continuously over the past eight years in response to emerging challenges to health and social care provision, and evidence from RQIA experience and other regulators about effective regulatory practice. Approaches can include, for example, observation and

audit of practice, focus groups with patients and staff, reviews of relevant documentation or validation of self-assessments carried out by organisations.

INFECTION PREVENTION AND HYGIENE

34. In 2008, following the major outbreak of Clostridium difficile, RQIA was commissioned by the Minister to commence a programme of unannounced infection prevention and hygiene inspections of acute hospitals in Northern Ireland. The inspection programme is part of an overall programme of initiatives designed to reduce healthcare associated infections in Northern Ireland, and to provide public assurance about services.

35. The programme has developed significantly since its initiation. DHSSPS has approved a set of Regional Healthcare Hygiene and Cleanliness Standards, which now underpin the programme. Associated standardised audit tools have also been developed. The inspection programme has been expanded to include other areas, including mental health and learning disability facilities.

36. In early 2012, in parallel with its pseudomonas review, RQIA was commissioned by the Minister to develop a range of specialised audit tools for augmented care settings following the outbreaks of pseudomonas aeruginosa in neonatal units. In partnership with a range of bodies, including the Public Health Agency, RQIA led the development of a suite of audit tools for these care settings. These tools have been endorsed by DHSSPS, and RQIA has recently commenced an extended programme of inspections of augmented care settings such as neonatal and adult intensive care units.

37. The results of all inspections are published on RQIA's website www.rqia.org.uk.

38. In 2012, RQIA's annual overview report for its infection prevention and hygiene programme reported that:

" … in general, there have been significant improvements in the standard of cleaning, the physical environment and healthcare hygiene practices across health and social care facilities in Northern Ireland since the programme of inspections commenced in 2008."

IONISING RADIATION (MEDICAL EXPOSURE)

39. RQIA is designated as the appropriate authority to carry out functions under The Ionising Radiation (Medical Exposure)(Amendment) Regulations (Northern Ireland) 2010. These include monitoring, inspecting and enforcing the regulations, to protect service users against the dangers of ionising radiation in medical settings.

40. RQIA now carries out a programme of inspections of ionising radiation in statutory and independent health care settings. Areas subject to inspection include diagnostic radiology, nuclear medicine and radiotherapy. To ensure that inspections are carried out with expertise available, as appropriate to the area being inspected, inspection teams include both RQIA inspectors, and inspectors contracted from Public Health England (previously Health Protection Agency).

MENTAL HEALTH AND LEARNING DISABILITY

41. In 2009, following amendments to The Mental Health (Northern Ireland) Order 1986, by the Health and Social Care (Reform) Act (Northern Ireland) 2009, RQIA has a range of responsibilities for people with mental ill health and those with a learning disability. These are:

    - Preventing ill treatment
    - Remedying any deficiency in care or treatment
    - Terminating improper detention in a hospital or guardianship
    - Preventing or redressing loss or damage to a patient's property

42. RQIA monitors the appropriateness of all applications for detention and guardianship, in line with the provisions of the Mental Health (NI) Order 1986, through an analysis of all prescribed detention and guardianship forms received from HSC trusts. RQIA also conducts a programme of individual patient experience reviews with people subject to detention under the Mental Health (NI) Order 1986. The information gained through these reviews helps to inform subsequent inspections of these services.

43. Under the Mental Health (NI) Order 1986, RQIA is also responsible for the monitoring and approval of Part II medical officers, and monitoring of Part IV second opinion doctors.

44. RQIA's Mental Health and Learning Disability team takes a human rights-based approach to all aspects of its work. RQIA inspects a wide range of mental health and learning disability services across Northern Ireland. During inspections RQIA engages directly with service users, with relatives and carers, and seeks the views of nursing staff, health professionals, advocates and other agencies. In common with all RQIA's inspection activity, each inspection report provides details of RQIA's findings and includes a quality improvement plan, detailing areas for improvement and associated timescales. The provider is required to provide details of its actions to make the necessary improvements, and this forms an integral part of the published inspection report. RQIA publishes all inspection reports on its website at www.rqia.org.uk.

RQIA ESCALATION POLICY

45. RQIA operates an escalation policy applying to all staff within the organisation, in particular inspectors and reviewers and peer and lay reviewers. The escalation policy applies to the management of serious concerns, direct allegations and/or disclosures and apply in all cases of regulation of establishments and agencies, mental health and learning disability, infection prevention and hygiene, and reviews.

46. During the course of inspection or reviews, issues which are adjudged to present immediate risks to a patient or service user, have the potential to cause significant harm or a significant service failure will be raised by the Chief Executive of RQIA who will bring the matter to the attention of the Chief Executive/Registered Person of the organisation concerned. Follow-up will be by means of a formal letter of escalation providing the necessary information and stipulating what action should be taken and within what time-frame to remedy the situation. All such letters will copy to the Chief Executive of the HSC Board and the relevant officer at the DHSSPS. RQIA's Escalation Policy is attached as Appendix 2.

HUMAN RIGHTS

47. RQIA has adopted a human rights approach, and these principles are embedded in all inspection and review activities. For example, during inspections of regulated services and mental health and learning disability facilities for both adults and children, RQIA inspectors engage directly with service users, relatives and staff with a clear focus on the outcomes for service users.

48. RQIA is designated as a national preventive mechanism (NPM), under the United Nations Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). This international human rights treaty aims to strengthen protection for people deprived of their liberty. OPCAT requires NPMs to carry out visits to places of detention, to monitor the treatment of and conditions for detainees and to make recommendations regarding the prevention of ill-treatment. During 2012-13 RQIA visited a range of services including mental health hospitals, prisons and police custody suites under its responsibilities as a designated NPM.

PRISON HEALTH AND SOCIAL CARE

49. The independent inspection of prisons is part of the mechanism by which the UK fulfils its obligations as a signatory to OPCAT. In partnership with Criminal Justice Inspection Northern Ireland (CJI); Her Majesty's Inspectorate of Prisons (HMIP) and Education and Training Inspectorate (ETI), RQIA has undertaken a range of inspections at a number of prisons/places of detention in Northern Ireland. These included:

    - Ash House Women's Prison
    - Hydebank Wood Young Offenders Centre
    - Maghaberry Prison
    - Police custody suites

50. In December 2012, a report was published detailing the findings of a joint inspection at Maghaberry Prison, which took place in March 2012. The inspection utilised the Healthy Prison Standards, and examined safety, respect, purposeful activity and resettlement. The prison was inspected by a multidisciplinary team of inspectors from RQIA, CJINI, HMIP and ETI. The report concluded that standards had improved in the three years since the previous inspection, and 16 recommendations were made in relation to the provision of health and social care services at the prison.

STATEMENT OF IMPACT

51. Since its establishment, RQIA has conducted a programme of activities aimed at driving improvements across health and social care services in Northern Ireland. This has included its programme of inspection at all regulated health and social care services and a range of mental health and learning disability services. Where RQIA identifies breaches in regulations or significant concerns it takes appropriate enforcement action to ensure these are addressed in a timely manner to assure the safety and wellbeing of all those using a service.

52. Through its programme of reviews, RQIA makes recommendations for improvement in services to the Minister for Health, Social Services and Public Safety. These have led to improvements in the delivery and quality of a wide range of health and social care services in Northern Ireland.

Timeline of Key RQIA Dates/Events Appendix 1

2003

The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

2005

The Regulation and Quality Improvement Authority (RQIA) established as non-departmental body of DHSSPS. Key duties: regulation of nursing, adult and children's residential care homes, independent clinics and hospitals, nursing agencies; and to report on the quality of the health and personal social services through reviews.

2007

Introduction of new regulations bringing adult placement agencies, day care settings, domiciliary care agencies and residential family centres under RQIA's regulatory framework.

2008

RQIA Review of Circumstances Contributing to the Outbreak of Clostridium Difficile in the Northern HSC Trust. The recommendations from this review were accepted in full by the Minister for Health, Social Service and Public Safety.

Commencement of infection prevention/hygiene inspection programme.

2009

Transfer of functions of former Mental Health Commission as prescribed in the Mental Health (Northern Ireland) Order 1998 to RQIA under the Health and Social Care (Reform) Act (Northern Ireland) 2009.

RQIA is one of 18 bodies operating in England, Wales, Scotland and Northern Ireland formally designated as the United Kingdom's National Preventive

Mechanisms (NPMs) under The Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

2010

Transfer of responsibility from DHSSPS to RQIA for the monitoring, inspecting and enforcement of the Ionising Radiation (Medical Exposure) Regulations 2010.

2011

Following an amendment to The Independent Health Care Regulations (Northern Ireland) 2005, establishments providing private dental care or treatment are subject to regulation by RQIA.

2012

Review of Outbreaks of Pseudomonas Aeruginosa in Northern Ireland. The recommendations from this review were accepted in full by the Minister for Health, Social Service and Public Safety.

2013

Commencement of infection prevention/hygiene inspection programme in augmented care settings.

Appendix 2

RQIA Escalation Policy and Procedure

1. PURPOSE AND AIMS

This policy relates to the reporting and management of serious concerns, direct allegations and/or disclosures which have resulted, or are likely to result, in immediate risk to patient safety and/or risk of significant service failure; **and** arise from any governance and thematic reviews in the statutory sector by the Regulation and Quality Improvement Authority (RQIA).

The policy **does not apply** to those services subject to regulation, as they have their own specific pathways as detailed in the related regulation.

This policy outlines the general principles of escalation to be followed by staff who wish to alert senior management of serious concerns, direct allegations and disclosures. It also sets out the procedure to be followed when a matter requires urgent attention by the service provider and the arrangements by which the Authority will draw the matter to the attention of the service provider and to any other person/organisation which, in the opinion of RQIA, should be notified.

The policy addresses the following types of concerns emanating from:

- direct allegations and/or disclosure to a person involved in the inspection and/or review;
- information coming to light through file audit or from the identification of a failure to adhere to regional regulation and/or standards for health & social care; and
- issues related to inspection and/or review practices received at any point during the inspection and/or review.

This policy **should not** be used to raise complaints about the conduct of the inspection or issues about RQIA personnel, including external reviewers, as these should be referred to the RQIA Complaints' Manager. For further details regarding complaints can be found in Section 8 of this policy.

2. BACKGROUND

Under the HPSS (Quality, Improvement and Regulation) Order 2003 the RQIA is required to regulate, inspect and monitor the quality of health and social care services in Northern Ireland.

The RQIA's role is to provide independent assurance about the quality, safety and availability of health and social care services in Northern Ireland, whilst encouraging continuous improvements in these services and safeguarding the rights of service users.

The main purpose of an inspection of an establishment or agency is to ensure that regulations are met and that minimum standards are taken account of.
The main purpose of a review of Health and Social Care (HSC) organisations, such as a Trust, is to assess to what extent DHSSPS Quality Standards are being met.

The regulatory function of the RQIA provides important protection for the public and has a major impact on the business of service providers, including private

6. LEGISLATIVE FRAMEWORK

Staff must take cognisance of relevant professional standards and guidance and other DHSSPS publications including, but not exclusively or exhaustively, the following:

- Reporting of Incidents, Diseases and Dangerous Occurrence Regulation (NI) 1997
- DHSSPS Learning from Serious Adverse Incidents Circular HSC (SQSD) 22/09
- Reporting of Incidents involving use of Medicines and Healthcare products
- The Children (Northern Ireland) Order 1995 and Protection of Vulnerable Children and Adults requirements
- Reporting of violence against staff
- Serious Adverse Blood Reactions and Events (SABRE) and Serious Hazards of Transfusion (SHOT)
- Safety Alert Broadcasts

There are a number of other statutory bodies which have a legislative requirement to investigate specific types of adverse incidents and to provide information, where appropriate, to organisations on how to minimise the chance of recurrence. Their legislative powers extend to also providing evidence to facilitate any independent investigation in situations where there have been serious breaches in legislation. Such bodies include the Health & Safety Executive (N.I.), Police Service Northern Ireland, local Councils, Health Estates and the Department of Health, Social Services and Public Safety.

7. STAGES OF ESCALATION

The chart in **Figure 1** overleaf clearly indicates the pathway to follow when dealing with concerns, direct allegations and/or disclosures. These will need to be initially graded in terms of severity and for agreement of action requirements to reduce/minimise further harm. This is to ensure that the most appropriate personnel are involved in managing the individual categories of concerns, direct allegations and/or disclosures.

In the event that, during the course of inspection and/or review activities, a member of staff of the RQIA becomes aware of any issue which presents an immediate risk to a service user and has the potential to cause significant harm, the staff member will bring this to the attention of his/her line manager. **Appendix A** contains specific advice for Inspectors/Reviewers on dealing with the initial disclosure/allegation.

If the matter is considered to be of such concern that it needs immediate remedial action, it will be brought to the attention of the Chief Executive of the RQIA who will, in turn, bring the matter to the attention of the Chief Executive/Registered Person of the organisation concerned

This will be in the form of a letter of escalation, which will provide the necessary information and stipulate what action should be taken and within what timeframe to remedy the situation.

establishments and agencies, and statutory sector services. These regulatory functions are carried out in an environment of openness, transparency and accountability.

3. POLICY STATEMENT

RQIA promotes an open and positive approach to the reporting and management of concerns, direct allegations and disclosures so as to improve learning, manage risks appropriately and minimise and/or prevent the recurrence of said event/s.

This policy can be applied to all activity including, for example, governance services, thematic reviews and registered statutory sector inspections.

4. DEFINITIONS

This policy relates to the reporting and management of concerns, direct allegations and/or disclosures arising from any inspection and/or review undertaken by the RQIA.

In this policy a **concern** will cover any event or circumstance that has or could lead to harm, loss or damage to people, property, environment or reputation.

A **direct allegation** pertains to any claim or assertion made by an individual about another individual's action or behaviour that is raised during the course of an inspection and/or review.

A **direct disclosure** pertains to any claim or assertion made by an individual about his or her own action or behaviour, raised during the course of an inspection/review.

5. SCOPE AND APPLICABILITY

This Escalation Policy applies to all staff working in the RQIA, in particular inspectors and reviewers. It also applies to all peer and lay reviewers participating in RQIA's inspection and/or reviews.

The principles of this policy apply to the management of serious concerns, direct allegations and/or disclosures and apply to all governance services, thematic reviews and registered statutory sector inspections.
This policy should be read in conjunction with the Enforcement Policy which applies to all regulated services.

Any concerns, direct allegations and/or direct disclosures arising from inspections and reviews carried out under these the auspices of the Mental Health Order (Northern Ireland) 1986 will also be subject to the application of the principles outlined in this escalation policy.

6. LEGISLATIVE FRAMEWORK

Staff must take cognisance of relevant professional standards and guidance and other DHSSPS publications including, but not exclusively or exhaustively, the following:

- Reporting of Incidents, Diseases and Dangerous Occurrence Regulation (NI) 1997
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In the event that, during the course of inspection and/or review activities, a member of staff of the RQIA becomes aware of any issue which presents an immediate risk to a service user and has the potential to cause significant harm, the staff member will bring this to the attention of his/her line manager. **Appendix A** contains specific advice for Inspectors/Reviewers on dealing with the initial disclosure/allegation.

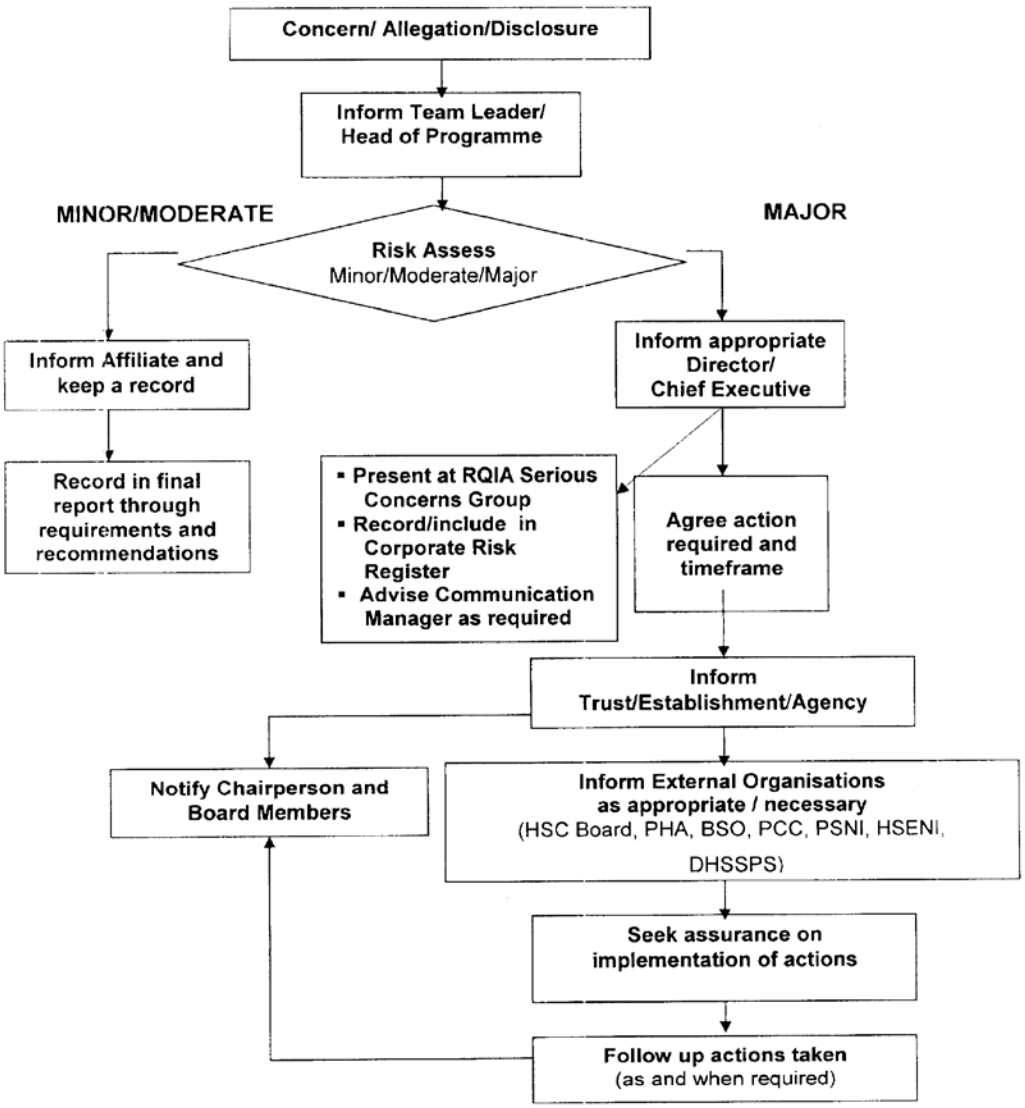
If the matter is considered to be of such concern that it needs immediate remedial action, it will be brought to the attention of the Chief Executive of the RQIA who will, in turn, bring the matter to the attention of the Chief Executive/Registered Person of the organisation concerned

This will be in the form of a letter of escalation, which will provide the necessary information and stipulate what action should be taken and within what timeframe to remedy the situation.

All such letters of escalation will be copied to the Chief Executive of the Health and Social Services Board and to the relevant officer at the Department of Health, Social Services and Public Safety. The Chairman and Board of RQIA will be advised of all such matters at the earliest opportunity.

7.2 Escalation Flow Chart

Figure 1: RQIA Corporate Escalation Policy Flow Chart



7.3 Risk Assessment Grading

Concerns, direct allegations and disclosures may present varying degrees of risk which can be broadly categorised as minor, moderate and major.

Inspectors and Reviewers will need to use their professional judgement, based on evidence and current best practice guidance, to categorise these concerns and determine the degree to which a risk presents an ongoing or current threat to patient / client safety. In any event, all Inspectors and Reviewers will discuss the nature and extent of the perceived risk with their Team/Leader and/or Head of Programme as part of the Escalation Policy flow chart.

The initial assessment of an incident may need be performed quickly, even when all relevant facts may not be immediately available. The decision whether to escalate a matter to Chief Executive level will be taken on the basis of the degree of risk and the likelihood of significant harm being experienced by patients and clients.

Consideration will be given on whether to monitor, though the Corporate Risk Register, those major concerns, direct allegations and/or disclosures that represent a risk to the Authority's reputation.

8. COMPLAINTS

A complainant should be directed to the Inspection and/or Review affiliate who will in turn refer the complainant to the organisation's own Complaints Manager.

Inspectors and/or Reviewers should inform the Team Leader in the first instance. A record of the complaint should be made including the referral to the Inspection/Review affiliate.

RQIA **will not investigate** the complaint, as it is the organisation's responsibility to manage this type of complaint (Stage 1 - Local Resolution). This should be made clear to the complainant.

9. RESPONSIBILITIES

The **Board** has overall responsibility for ensuring that the principles of the Escalation Policy are applied within the legislative framework and in a consistent manner. The Board will be kept informed of any issues requiring escalation.

The **Chief Executive** has responsibility for ensuring that the Escalation Policy is applied within the legislative framework and in a consistent manner. The Chief Executive is also responsible for disseminating any learning.

The **Executive Team** has operational responsibility to ensure that the Escalation Policy is applied at all times. They are also responsible for identifying trends and proactively minimising risk of further harm by informing external organisations as appropriate.

The **Heads of Programme** have responsibility to ensure that all relevant staff are aware of and adhere to this policy, and ensure staff escalate concern, direct allegations and /or disclosures as required. The Heads of Programme will also have responsibility for maintaining a list of all escalated concerns, direct allegations and/or disclosures.

Inspectors/Quality Reviewers have responsibility to adhere to the policy and ensure that they raise any concern, direct allegations and /or disclosures and escalate appropriately.

Administrative Team Supervisors have responsibility for implementing this policy within their respective teams and ensuring that it is understood and adhered to at all times by all members of the administrative team.

10. EQUALITY

This policy was equality screened on 15th May 2009 and was considered to have neutral implication for equality of opportunity therefore, the policy does not require to be subjected to a full equality impact assessment.

This document will be made available on requests in alternative formats, e.g. Braille, disc, and in other languages.

11. REVIEW OF THE POLICY

Appendix 3

Regulation & Quality Improvement Authority – Report to the Inquiry into Hyponatraemia Related Deaths – References to Legislation

Health and Personal Social Services (Quality, Improvement and Regulation (Northern Ireland) Order 2003	**TAB No.**
Article 3 – Establishment of the RQIA	**Tab 1**
Article 8 – Regulation of establishments and agencies delivering health and social care	**Tab 2**
Article 35 – Review functions of the RQIA	**Tab 3**