Regional Learning System Project Report

May 2015

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Included for Reference:

Annex1: Names of HSC Participants and other relevant sector/organisation participants
Annex 2: HSC Policy Circular
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Guidance for providers of Regulated Services
Annex 4: Interactive Session Staff Responses

All instances in this report where the writing is presented in italics indicates that these are the spoken or written (post-its) views and opinions of either staff who were interviewed as part of the mapping exercise or staff who took part in the interactive sessions. The interactive sessions views and opinions are documented and segmented by HSC Trust in Annex 1.

Introduction and Background

Quality 2020[1] is Northern Ireland's ten year quality strategy identifying quality under three main headings:

- **Safety** – avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.
- **Effectiveness** – the degree to which each patient and client receives the right care (according to scientific knowledge and evidence-based assessment), at the right time in the right place, with the best outcome.
- **Patient and Client Focus** – all patients and clients are entitled to be treated with dignity. For all these people it is a fundamental expectation that the service provided will be as **safe** as possible.

Quality 2020, whilst acknowledging that things go wrong states that a high quality healthcare service needs to protect and improve by learning from all such occasions and so minimising the chances of them happening again. It further states 'that safety will always be an aspect of quality that needs to be guarded.

The DHSSPS Public Accounts Committee (PAC) – Department of Finance & Personnel memorandum dated 14th June 2013 on the 13th report from the Public Accounts Committee mandate 2011-15 stated in PAC Recommendation 2 that "All health and social care adverse incidents have the potential to generate learning across the sector. The Department of Health, Social Services and Public Safety (DHSSPS) should ensure that its data systems have the capability to identify the underlying causes of adverse incidents, with a view to preventing their repetition. In particular it is important that the DHSSPS establishes an effective reporting and

learning system for near misses (where the patient or client was unharmed) in an attempt to avoid more serious incidents in the future."[2]

In October 2013 in response to recommendation 2 and as a stage in the Regional Adverse Incident Learning System (RAIL) Project, the DHSSPS commissioned a 'task and finish group' to:

- Map out the current reporting systems for adverse incidents;
- Map out the current processes whereby learning from good practice and adverse incidents occur;
- Map out the arrangements that allow learning to be exchanged and disseminated across the HSC sector in Northern Ireland; and
- Identify potential areas to improve the existing arrangements regarding how learning happens; how learning is shared between relevant stakeholders and how assurance is provided that learning is being applied.

Two staff from the Regulation and Quality Improvement Authority (RQIA) were commissioned (Project Leads) to carry out this work from February 2014 to September 2014.

In the course of this project, project leads have met with 305 relevant members of staff at the Department of Health, Social Services and Public Safety (DHSSPS), the Health and Social Care Board (HSCB), the Public Health Agency (PHA), the Regulation and Quality Improvement Authority (RQIA), Health and Social Care Trusts (Trusts), the Health and Safety Executive Northern Ireland (HSENI), the Northern Ireland Adverse Incident Centre (NIAIC), Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) and the Northern Ireland Medical and Dental Training Agency (NIMDTA). This included project leads meeting

with 240 front line staff asking about their current reporting culture, their understanding of the scrutiny and analysis of reporting data, and enquiring what learning takes place (both locally within Trusts and regionally) as a result of their current governance arrangements in relation to adverse incidents.

Methodology

The methodology included the following steps:

1. In the first instance, project leads meeting with key stakeholders gathering information, views and opinions in relation to reporting, analysis and learning:

    - All Trust Governance Leads – Belfast, Northern, Southern, South Eastern, Western and Northern Ireland Ambulance Service (also to ascertain the current governance arrangements for reporting, recording, analysis)
    - HSENI Leads
    - Trust Medical and Nursing Directors
    - HSCB/PHA Chief Executive and Clinical Leads (Annex 1)
    - DHSSPS Clinical Leads and Managers.

2. A further information gathering exercise (interactive sessions) using core questions (Appendix 1) took place with frontline staff from both acute care and the community setting.

    The aim of these sessions (facilitated by project leads) was to listen to frontline staff in relation to their views on current reporting, scrutiny and learning from adverse incidents (and where staff wanted to discuss – SAIs) with suggestions for improvement also collated.

    In total, 44 interactive sessions took place (overall 240 staff attended) between July 2014 and September 2014. In each session, the same 11 questions (see Appendix 1) were asked. Staff opinion and views

were collated and are included in the report ‘ver batim’. In sessions where staff did not document their own views and opinions the facilitators noted these down to ensure all comments were collated for consideration.

3. Publication of a report, with project findings and recommendations.

Executive Summary & Recommendations

This report informs readers of the outcomes of a mapping exercise completed in September 2014 primarily in relation to adverse incidents (AIs), identifying 4 areas for improvement with 18 recommendations. These recommendations relate solely to AIs, however there may be some impact upon Serious Adverse Incidents (SAIs).

1. Governance

i. Review the definition of an adverse incident (DHSSPS/Trusts/HSCB/PHA).

ii. Increase the speed of disseminating learning to provide timely opportunities for learning between teams, across directorates, Trusts and regionally (Trusts/HSCB/PHA).

iii. Services or Teams should develop service or team triggers (Appendix 2 & 3) or prompt lists to enable a standard service approach and understanding as to what should be reported. These should ultimately become regional trigger lists for same services (Trusts/HSCB/PHA).

iv. Develop and agree Regional Adverse Incident Guidelines & Procedures for adoption across the HSC (Trusts/HSCB/PHA).

2. Information Technology

i. Review and agree datasets, including codes and classifications within services and then regionally to ensure consistency of reporting (Trusts/HSCB/PHA).

ii. Consider and, if possible, procure the same patient safety incidents healthcare software and risk management software system for incident reporting and adverse events for all Trusts, HSCB/PHA and

other relevant organisations, agreeing a regional specification including modules and version (Trusts/HSCB/PHA/RQIA).

iii. In the interim period, and for consistency across Trusts, organisations should update to the most recent version of electronic systems used to record and process adverse incidents.

3. Data analysis and scrutiny of incidents

i. Arrangements need to be developed to allow for oversight of AIs regionally, to identify regional clusters and trends, and to facilitate the development of subsequent regional action planning and learning.

ii. HSC organisations should ensure there is expertise in data analysis and adequate financial resources available (Trusts/HSCB/PHA).

iii. It is recommended that inconsistencies in reporting between same type services are identified in Trusts and regionally; and criteria/ types of incidents that should/should not be reported agreed (Trusts/HSCB/PHA).

iv. Each incident should be graded against potential and/or actual harm and risk rated by appropriately trained staff (Trusts).

v. Trusts should produce twice yearly reports to the HSCB/PHA detailing trends and clusters, progress in the management of these and learning. Arrangements should also be put in place to develop and produce twice yearly regional reports to the DHSSPS detailing regional trends and clusters, progress in the management of these and learning.

vi. Trusts must feedback to the reporter or the person who raised the AI report informing them of any outcomes (Trusts).

4. Culture - Learning/Training

i. It is recommended that all HSC bodies continue to proactively improve their culture of openness, support and learning in relation to adverse incident reporting, working and sharing outcomes across directorate services, Trust and sector boundaries to continuously improve patient safety (DHSSPS/HSCB/PHA/Trusts).

ii. Consider changing the name 'adverse incident' to one which more accurately reflects the reason for reporting, which is learning, and develop a clear definition for all HSC staff (HSCB/DHSSPS).

iii. It is recommended that there should be more training in reporting and analysis of adverse incidents for all relevant staff and HSC students in training, with awareness raising sessions for all staff (HSCB/PHA/Trusts).

iv. Develop a structured best practice safety system composed of a continuous or regular reassessment of risk, communication of status and mitigation, and prediction and planning. This system should also be capable of handling the four 'C's[3]:

- Complaints
- Concerns
- Comments
- Compliments

There should be a mechanism developed for regular and frequent dissemination of learning widely (HSCB/PHA/Trusts/other relevant organisations).

v. It is recommended that all HSC bodies should ensure systems pertaining to safety e.g. incident reporting, risk rating, complaints, litigation and whistleblowing, should be synergetic to ensure whole system analysis and learning.

1. Governance

1.1 This section of the report itemises the governance arrangements in all HSC organisations in relation to reporting, managing, analysing and learning from adverse incidents**.** The information and staff views and opinions lead to 4 recommendations which, if adopted, should standardise and improve governance arrangements and communication in relation to adverse incidents.

1.2 The Health and Social Care (Reform) Act (NI) 2009 section 8[4] describes the Regional Board functions:

8 (1) The Regional Board shall exercise on behalf of the Department —

(a) Such functions as are transferred to it by Section 24; and

(b) Such other functions of the Department (including functions imposed under an order of any court) with respect to the administration of health and social care as the Department may direct.

Following the introduction of the above legislation, the DHSSPS set out an assurance framework to document the roles and functions of the various health and social care bodies and the systems that govern their relationships[5].

The DHSSPS produced the above framework documents to meet the statutory requirement placed upon it by the Health and Social Care (Reform) Act (NI) 2009.[4] Section 6.13 (vi) states that the HSCB, working with the PHA, is responsible for monitoring and reporting to the Department on:

- Application by Trusts of lessons from adverse incidents and near misses (including those to be recorded on the PHA-managed RAIL system) and communicating, acting upon and reporting action taken in relation to safety information issued through the Northern Ireland Adverse Incident Centre Safety Alert Broadcast System (SABS).

Circular HSC (SQSD) 08/2010 issued in April 2010[6] (Annex 2) provided guidance on the transfer of SAI reporting arrangements from the DHSSPS to the HSCB, working in partnership with the PHA.

Section 2 (2.2, 2.4, 2.5, 2.12) also provided specific guidance on the revised incident reporting roles and responsibilities of HSC Trusts, Family Practitioner Services, the HSCB and PHA, the extended remit of the RQIA and the DHSSPS:

2.2 HSC Trusts are required to:

- Maintain a system to record and track adverse incidents/near misses in their organisation;
- Adhere to guidance issued by the HSCB/PHA with regards to managing SAIs;
- Take any immediate steps necessary to prevent re-occurrence of harm; and
- Investigate incidents using a method proportionate to the incident (and in compliance with the requirements set out in the joint Memorandum of Understanding between the HSC, Coroner's Service, PSNI and HSENI, on investigating patient or client safety incidents) and complete the investigation report in a timeframe appropriate to the incident. For SAIs the timeframe is typically no

more than 12 weeks from becoming aware of the incident. There are no timescales for AIs.

2.4 Family Practitioner Services are required to:

- Maintain a system to record and track adverse incidents/near misses in their practice; and
- Report to the RQIA and the HSCB all actual or suspected suicides of patients registered with a GP practice and in receipt of secondary mental health care services in the last 12 months.

2.5 In line with HSCB's performance management and accountability functions, it will hold Trusts and Family Practitioner Services to account for the effective discharge of their responsibilities in reporting and investigating adverse incidents and near misses, and will provide assurance to the DHSSPS that these responsibilities are being met and that learning is implemented. In general terms, the HSCB is responsible for maintaining those adverse incident reporting and monitoring mechanisms it considers necessary to enable it to carry out the full range of its commissioning, performance management, and service improvement functions effectively, ensuring appropriate multidisciplinary involvement of HSCB and PHA health and social care professionals.

2.12 RQIA is also a named organisation under the UK's National Preventative Mechanism (NPM) established in accordance with the Optional Protocol to the Convention against Torture (OPCAT). Under the NPM, RQIA is required to visit places of detention, regularly examine the treatment of those persons as well as their conditions of detention and make recommendations to the relevant authorities.

The RQIA will:

- Require HSC Trusts to continue to report adverse incidents to it where there are underlying statutory obligations to do so;
- Require HSC Trusts to share reports of adverse incidents occurring in a mental health and learning disability setting in accordance with discharging it's new functions under the HSC (Reform) Act (NI) 2009; and
- Require the HSCB to share other relevant monitoring information in relation to mental health and learning disability programmes of care.

1.3 Quality 2020 Implementation Plan May 2012[7]

The implementation of Quality 2020 embraces both a strategic agenda and 'context' for quality improvement. Its implementation is not simply about a programme of new projects or strategic initiatives, important as they will be in driving forward necessary change and innovation. It is also about recognising and, where appropriate, endorsing the often self-initiated activity of HSC bodies across a multitude of quality improvement initiatives which they all undertake on an ongoing basis in seeking to fulfil their Statutory Duty of Quality. The achievement therefore of Quality 2020's strategic goals, and thus its vision, will be the combined result of HSC organisations driving forward quality improvements in their own right, as well as engaging collectively in a series of projects strategically aimed at securing necessary change across all sectors.

The strategy will build on and seek to support processes and functions already well-established in the HSC and delivering quality improvement, rather than displace or undermine them.

1.4 Memorandum of Understanding[8]

Investigating patient or client safety incidents (unexpected death or serious untoward harm): Promoting liaison and effective communications between the Health and Social Care, Police Service of Northern Ireland (PSNI), Coroners Service for Northern Ireland, and the HSENI (March 2013).

This Memorandum of Understanding (MOU) focuses on high level/strategic communication and co-ordination with the above named bodies to ensure appropriate organisations work together in the investigation of 'unexpected death or serious untoward harm'. This memorandum is currently under review by DHSSPS in conjunction with Trust staff.

1.5 Confidential Enquiries

Northern Ireland along with counterparts in the rest of the UK has a formal agreement with the Health Care Quality Improvement Partnership (HQIP) for the programme of work for the Confidential Inquiries. HSC Trusts submit data and participate in all four confidential enquiries. The four Confidential Enquiries include:

- Child Health Programme – Child Health Reviews-UK, Royal College of Paediatrics and Child Health.
- Maternal, Newborn and Infant Programme – MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford.
- Medical & Surgical Programme – NCEPOD (National Confidential Inquiry for Patient Outcome & Death)
- Mental Health Programme – NCISH, (National Confidential Inquiry into Suicide and Homicide by Patients with Mental Illness) University of Manchester.

Each Inquiry is supported by an independent Advisory Group and a nominated NI representative sits on each Group. Published Inquiry reports are sent to DHSSPS for consideration and to determine what action is needed. If appropriate, the DHSSPS will write to HSC Trusts to ask them to take forward the recommendations outlined in the report by an agreed date and to forward an assurance to the HSCB that the necessary action has been taken. The HSCB will consider Trust responses and provide an assurance to the DHSSPS that they are satisfied Trusts have taken the necessary action.

1.6 SAI Look Back Review

At the request of the Minister for Health and Social Care and Public Safety there has been work on going - in relation to Serious Adverse Incidents (SAIs), where each Health Trust was required to review the handling of all SAIs reported between 1 January 2009 and 31 December 2013. In order to provide an independent assurance, RQIA were asked to carry out a quality assurance exercise in relation to the Trusts review.

Trusts completed their review by 30 September 2014 after which RQIA carried out an exercise of validation which reported in December 2014.

1.7 The Northern Ireland Adverse Incident Centre (NIAIC)

NIAIC operates as part of Sustainable Development and Engineering Branch (SDEB) within the DHSSPS. The key aim of the NIAIC is to record and investigate reported adverse incidents involving medical devices, non-medical equipment, plant and building items used within the healthcare environment in Northern Ireland and to issue warning notices and guidance to help prevent recurrence and avert patient, staff, client or user injury. As it is part of the DHSSPS it inputs to the development, issue and monitoring of

the implementation of policy, standards and guidance, as appropriate, concerning medical devices and technical estates safety.

NIAIC works closely with the Medicines and Healthcare Products Regulatory Agency (MHRA) in relation to issues concerning medical device safety and also liaises closely with the DoH (GB), Estates and Facilities directorate, Health Facilities Scotland. NIAIC also share information and work with the Scotland and NHS Wales Shared Services Partnership-Facilities Services for safety issues concerning non-medical equipment, plant and building items.

In relation to medical devices, NIAIC initiate investigations of reported adverse incidents with the device manufacturer and instigate corrective action through the manufacturer, to reduce the risk of reoccurrence. Alerts are issued to the HSC via the SABS (Safety Alert Broadcast Systems) to manage risks relating to Medical Devices, non-medical equipment, engineering plant, installed services and building fabric.[9]

In January 2014, NHS England launched the new National Patient Safety Alerting System (NPSAS)[10]. The aim of the new system is to strengthen the rapid dissemination of urgent patient safety alerts to healthcare providers via the Central Alerting System (CAS). This three-stage alerting system also provides useful educational and implementation resources to support providers to put appropriate measures in place to prevent harm and encourage and share best practice in patient safety.

Stage One - Warning Alert

This will be issued to Trusts CEs and governance leads for information and consideration of implications locally. Any regional implications should be fed back through governance leads/professional lines.

Stage Two – Resource Alert

The same action as outlined for Stage One alerts will be followed.

Stage Three – Directive Alert

This will be issued under cover of a DHSSPS circular and will require HSC organisations to take specific action by a required date and provide an assurance to the DHSSPS that this action has been addressed.

1.8 Pharmacy and Prescribing Branch

The Pharmacy and Prescribing Branch, Primary & Community Care Directorate (DHSSPS), Inspection and Investigation Team have statutory responsibility under The Medicines Act[11], Misuse of Drugs Act[12] and Pharmacy Order[13]. These are centered particularly on the areas of misuse, diversion, illegal production and supply and inappropriate storage and record keeping as pertains to medicinal products including controlled drugs.

1.9 Health & Safety Executive Northern Ireland (HSENI)

Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations (Northern Ireland) 1997 (RIDDOR)[14] guidance is contained in "A guide to the Reporting of Injuries, Diseases, and Dangerous Occurrences[15] and "Reporting injuries, diseases and dangerous occurrences in health and social care: Guidance for employers" Health Services Information Sheet 1 (revised) HSIS1 (Rev 3)[16] informs and guides HSC staff as to what is reportable by law to the HSENI.

1.10 Regulation & Quality Improvement Authority (RQIA)

Article 23 (7d) of The Health and Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 states that "Regulations may make provision as to the conduct of establishments and agencies, and such regulations may in particular make provision as to the notification of incidents occurring in establishments or in premises used for the purposes of agencies"[17]. All Regulations in relation to services regulated by the RQIA make provision for the reporting of certain adverse events. All registered services are therefore required to make formal notifications to the RQIA (Annex 3).

RQIA receives 'notifiable events' from registered providers. 'Notifiable Events' are classified as a range of issues that are required to be notified to RQIA and these are set out within the relevant regulations:

Regulation 30 of the Nursing Homes Regulations (NI) 2005[18]
Regulation 30 of the Residential Care Homes Regulations (NI) 2005[19]
Regulation 28 of the Independent Healthcare Regulations (NI) 2005[20]
Regulation 29 of the Children's Homes Regulations (NI) 2005[21]
Regulation 29 of the Day Care Settings Regulations (NI) 2005[22]
Regulation 33 of the Adult Placement Agencies Regulations (NI) 2007[23]
Regulation 20 of the Voluntary Adoption Agencies Regulations (NI) 2010[24]
Regulation 30 of the Residential Family Centre Regulations (NI) 2005[25]
Any incident which has been reported by a registered provider to the Police must be notified to RQIA within 24 hours[26&27]. This should be carried out in accordance with Regulation 15 of the Domiciliary Care Agencies Regulations (NI) 2007[28] and Regulation 13 of the Nursing Agencies Regulations (NI) 2005[29.]

All incidents are recorded in RQIA's Notifiable Events Management System and forwarded to the inspector allocated to the particular registered establishment or agency.

1.11 Table 1: Incidents Reported to RQIA

2010 -2011	10,129
2011-2012	14,569
2012-2013	18,178
2013-2014	19,237

Although the individual service providers have primary responsibility for the investigation and risk management in relation to any adverse events, RQIA has a responsibility to ensure that effective systems are in place to safeguard and promote the wellbeing of service users.

1.12 Mental Health and Learning Disability (MHLD) Directorate RQIA

Functions of the previous Mental Health Commission transferred to RQIA on 1 April 2009. Under the Provisions of Articles 86(2) of the Mental Health (NI) Order 1986[30], the RQIA has a duty to make inquiry into any case where it appears to the RQIA that there may be amongst other things, ill treatment or deficiency in care or treatment. Guidance in relation to reporting requirements under the above Order previously issued in April 2000 was reviewed, updated and re-issued in August 2007. Circular HSC (SQSD) 08/2010[6], issued in April 2010, provided guidance on the transfer of SAI reporting arrangements from the DHSSPS to the HSCB and the extended remit of the RQIA. These included a requirement that all SAIs in MHLD services are notified to the MHLD team at RQIA with collaborative working between HSCB/PHA and RQIA. AIs in MHLD services are managed through each Trust's own governance arrangements.

1.13 Table 2: Serious Adverse Incidents in MHLD Services notified to RQIA

Trust	SAI Notifications 2011-12	SAI Notifications 2012-13	SAI Notifications 2013 -14
Belfast	45	51	35
Northern	33	29	36
South Eastern	38	37	33
Southern	25	25	38
Western	20	30	29
Total	161	172	171

In year 2013/14 MHLD received 171 SAI initial notifications and 200 SAI investigation reports.

In Quarter 1 (1 April 2014 - 30 June 2014) – 89 SAI initial notifications and 90 investigation reports were received.

1.14 HSCB

The Circular HSC (SQSD) 08/2010[6] (Annex 2) issued in April 2010, states that the HSCB is responsible for maintaining those adverse incident reporting and monitoring mechanisms it considers necessary to enable it to carry out the full range of its commissioning, performance management, and service improvement functions effectively, ensuring appropriate multidisciplinary involvement of HSCB and PHA health and social care professionals (Section 2, 2.5). The Policies, protocols and guidance supporting this structure are:

- HSCB/PHA Protocol for Implementation of Safety Alerts 14 January 2013[31]
- HSC Regional Impact Table and Risk Matrix April 2013 (Appendix 14)
- HSCB Procedure for the Reporting and Follow up of SAI October 2013[32.]

The requirement on HSC organisations to routinely report SAIs to the DHSSPS ceased on 1 May 2010. From this date, the revised arrangements for the reporting and follow up of SAIs, transferred to the HSCB working both jointly with the PHA and collaboratively with the RQIA in those instances where SAIs occur in MHLD services in the regulated sector commissioned by the HSC.

An updated procedure was introduced in October 2013 and the process was further updated in April 2014 when the new procedure with the 3 levels of investigation reports (all with different timescales) became fully implemented. (Appendix 5).

As per above procedure, an HSCB/PHA Designated Review Officer (DRO) leads and co-ordinates the SAI management and follow up with the reporting organisation. In respect of MHLD SAIs, although the responsibility remains with the DRO, RQIA also plays a role in the process.

On receipt of an SAI Investigation Report, the HSCB Governance Team forwards to the relevant DRO and where relevant RQIA. The DRO will consider the Investigation Report and liaise with relevant professionals/officers including RQIA (where relevant) to ensure that the reporting organisation has taken reasonable actions and determines if the SAI can be closed. If the DRO is not satisfied that the report reflects a

robust and timely investigation, he/she will continue to liaise with the reporting organisation and/or other professionals/officers, including RQIA (where relevant) until a satisfactory response is received. He/she will then complete an internal DRO Form validating their reason for closure.

On receipt of the internal DRO Form informing of closure, the Governance Team will submit an email to the reporting organisation to advise the SAI has been closed, copied to RQIA (where relevant). The email will acknowledge that any recommendations and further actions required will be monitored through the reporting organisation's internal governance arrangements. Prior to closure there is an analysis to identify regional learning through the SAI review subgroup (HSCB/PHA). A DRO may close an SAI requesting some additional assurances to be provided by the investigation team within a stipulated period of time checking that the action following an SAI has been implemented. In these instances, monitoring will be followed up via the Governance team.

In relation to AIs, the HSCB at present manages AIs within the Family Practitioner Services using the Family Practitioner Services Adverse Incident Process within Directorate of Integrated Care – November 2013[33].
The Directorate of Integrated Care (DOIC) has responsibility for the accountability arrangements in the reporting of adverse incidents from the Family Practitioner Services (FPS) (Appendix 12). FPS incidents are reported using the adverse incident form (AIF1) and the information is recorded on the DOIC AI Database or on the Datix system in the case of Community Pharmacy. Once reported, there is an agreed process whereby a decision is made by a DOIC team who review the AI submitted. In the event of an SAI this is managed by the local team (Local Management Team - LMT). There is an LMT in each of the local areas i.e. Belfast, South

East, North, South and West. They are comprised of a medical, dental, ophthalmic and pharmacy representative on the clinical side and business support staff. Adverse incidents occurring within services provided by independent practitioners within: General Medical Services, Pharmacy, Dental or Optometry, are routinely forwarded to the HSCB Integrated Care Directorate in line with the HSCB Family Practitioner Services Adverse Incident Protocol. On receipt of reported adverse incidents the HSCB Integrated Care Directorate will decide if the incident meets the criteria of a SAI and if so will be the organisation responsible to report the SAI. This is shared with the HSCB/PHA SAI group and the HSCB/PHA Safety & Quality Alerts Team (SQAT). Notification of any regional learning/action is recorded on the DOIC regional summary list.

Although the HSCB/PHA share learning through learning letters, alerts and reports, there has been a recent development in regional communication in relation to serious adverse incidents through the 'Learning Matters Newsletter'. The HSCB/PHA states that the purpose of this newsletter is to complement the existing methods by providing staff with short examples of incidents where learning has been identified. The QSE team in the PHA Nursing and Allied Health Professional Directorate lead on the on-going regional Safety and Quality work e.g. pressure ulcer prevention[34], falls prevention[35.]

1.15 Health and Social Care Trusts

Each Trust has in place governance accountability frameworks, assurance committees and (for some Trusts), sub-committee structures accountable ultimately to their Trust Board (Trust Incident Reporting Policies & Procedures for each Trust are listed in the reference section (no 36-53). The mapping of the teams in place to support these structures and

frameworks reveal that the roles, responsibilities and staffing resource are varied (Appendix 6-11). Some Trust Governance Leads would state that this is historic. Trusts should review these structures and frameworks in order to meet needs especially in relation to the future requirement for specific expertise in information analysis. At present these teams review coding, grading and handle individual queries, they follow up on investigations and closure and provide a variety of reports to managers, clinical leads, teams, directorates, Trust Senior/Executive Management Teams and Boards. They provide further specific reports e.g. fire, security, and medication incidents, and lead on and provide incident reporting awareness training and Datix training for all staff. Other duties include liaison with NIAIC and completing RIDDOR reports as well as maintaining statistics, and further administrative duties.

Each Trust has developed individual Policies and Procedures to support reporting, scrutiny and learning from adverse incidents. Currently these are as follows:

1.16 Belfast Health & Social Care Trust

Adverse Incident Reporting and Management Policy April 2014[36]
Guidelines for Writing a Statement following an Incident June 2014[37]
Procedure for Grading an Incident June 2014[38]
Procedure for Investigating an Incident (excluding SAIs) June 2014[39]
Procedure for Reporting and Managing Adverse Incidents June 2014[40]
Procedure for Sharing Learning June 2014[41]
Serious Adverse Incident (SAI) Procedure June 2014[42]

1.17 South Eastern Health & Social Care Trust

Policy for Completing Form IR1 (Near Miss & Incident Record Form) April 2014[43]

Policy for the Completion of Near Miss & Incident Investigation Proforma (IR2) April 2014[44]

Policy and Procedure for the Investigation and Root Cause Analysis of Incidents, Claims and Complaints April 2014[45]

Policy and Procedures for the Reporting and Management of Incidents April 2014[46]

1.18 Southern Health & Social Care Trust

Draft Incident Management Policy v2.0 March 2013 (Working Draft)[47]

Draft Framework for Morbidity and Mortality June 2014[48]

1.19 Western Health & Social Care Trust

Incident Reporting Policy and Procedures August 2014[49]

1.20 Northern Health & Social Care Trust

Incident Management Policy and Procedure (including Procedure for Serious Adverse Incidents) March 2009[50]

Draft Adverse Incident Management Policy v2_2 September 2014[51]

Interim Guidelines for Morbidity and Mortality Review Meetings 3rd September 2014[52]

1.21 Northern Ireland Ambulance Service Health and Social Care Trust

AI Policy & Procedures NIAS [53]

1.22 The above Trust policies and procedures are in place to manage the information in relation to AIs, and to inform individual Trust Boards and their

Executive Management Teams. With regards to AIs (with the exception of FPS) there is at present no regional analysis or sharing of AI data allowing for a collaborative approach to learning. In relation to SAIs, there is a regional HSCB/PHA SAI Policy and Procedure and a regional HSCB/PHA SAI team holding Trusts to account, supporting governance arrangements and disseminating learning.

The following suggestions (ver batim) in relation to governance are taken from the meetings and interactive sessions held with staff throughout the project. The consensus is that these suggested actions need to take place to allow for a standard, consistent approach to AIs both regionally and locally in Trusts.

1.23 Verbatim Suggestions in Relation to Governance from Staff

Staff opinion and suggestions for improvement:

- *Many frontline staff have stated that the definition of an adverse incident is too wide and not defined enough therefore what one person might report on another would not.*
- *Staff say looking at the current definition they could complete IR1s for ALL who have potential risk of harm by virtue of a diagnosis or by prescription of medication.*
- *Managers and frontline staff in Primary care and Older People's Services stated that there needs to be a consistency in the approach to reporting AIs between Trusts and across the region and clarity around the definition of an adverse incident. Many staff suggested that 'anyone coming through the doors of any HSC establishment' could lead to harm and so could be reported every time. For example, a GP changed a medication for low blood pressure with a side effect*

that could lead to an increase in falls, staff questioned does the prescribing of this medication trigger the reporting of an AI because this circumstance might lead to harm – fall?

- *A group of physiotherapists reflected that every time they work with a patient to support re-enablement (e.g. helping someone to walk again) could be described as an event or circumstance that could lead to harm and so could be interpreted as an AI.*
- *Some pharmacists described how F2 doctors on wards would ask them to tell them the correct dosage of medications they were prescribing. Pharmacists stated that this circumstance could lead to harm as there may be no learning and so prescribing error may still occur and so could be interpreted as an AI.*
- *Some services now use what they describe as trigger lists as way of resolving this issue: Maternity and Surgery services staff interviewed stated that they have developed trigger lists to inform in relation to what is defined as an adverse incident in their particular service, they say that they are clear and have a good understanding of what needs to be reported, these teams reported that they operate in a culture of learning.*
- *Also there would need to be a consistent approach and agreement that is acted upon in all similar services across a given Trust and then agreed and acted upon regionally in all similar services. Custom and practice make things acceptable in one ward or area but may not be acceptable in another – agree standards.*
- *Agree a regional policy and procedure in management of AIs as well as SAIs.*
- *There should be a single portal where all actions, circulars and learning is shared with responsibility for sharing clearly allocated to the*

line manager in each area e.g. Health & Social Care Knowledge Exchange Regional Hub.

- *All services should have a member of staff who has responsibility as clinical governance facilitator (ring fenced time).*
- *Everyone should be clear about their roles and responsibilities at all levels within organisations in terms of reportable AIs.*
- *AI statistics should be provided for Trust Annual Quality Report for information to allow for future benchmarking.*
- *Clear sign-posting for staff linking to key staff who can advise in the reporting and investigation processes.*
- *Clear support for staff involved in AI or SAI (second victim' support) from managers.*
- *All AIs should be reviewed by each team weekly with learning happening in each department locally and in time, with facility made to share beyond departments/directorates and consequently all Trusts.*
- *There should be protected learning time for all staff in relation to AIs.*
- *Timely, regular safety briefings.*
- *All learning should be collated – managers should meet to share learning.*
- *The reporter should complete the AI form with their line manager and agree the content to ensure consistency of reporting/grading before submitting.*
- *Sometimes a complaint is raised first and then when investigated an AI or SAI may have occurred but been not reported. This is seen as a risk and reluctance to report. All Trusts should continue working towards an 'openness' culture as, in the current climate (media interest in reporting complaints and incidents in health and social care) there is and has been a fear of litigation and loss of reputation.*

- *Some teams have reported that they have a good robust process around SAIs where local sharing flows out from Governance meetings to staff – not every Governance Lead is doing this with AIs (some do weekly scrutiny of AIs in service area). At present this is carried out more with SAIs.*
- *There is a need for one policy for AIs across the region and subsequent agreed procedures in Trusts. Governance Leads should compare and contrast their individual Trust policies & procedures, agree the best working processes and adopt as regional.*
- *Governance Leads, consultants, and senior managers describe the difficulties in meeting the level 2 deadline. These difficulties include:*
    - *The time taken for information gathering,*
    - *The time needed to liaise with bereaved families,*
    - *the waiting for reports sometimes from different sectors (Police, clinicians), and*
    - *The wait for post mortem results - usually over the 12 weeks deadline.*
- *Some senior staff participants (as described above) report that each time a 12 week deadline is breached, the Chief Executive of the Trust is notified by the HSC Board. They describe this as demoralising and blaming with no emphasis on learning.*

The project leads have verified with the HSCB that currently (October 2014) 82% of level 1 four week deadline and 51% of level 2 12 week deadline is achieved as per SAI regional procedure.

- *Investigating consultants and manager's interviewed state that there should be an opportunity, if required, for investigators to discuss the issues within a particular investigation at the time with the DRO.*

- *Suggestion that SAIs with regards to children under the age of 18 where children, have life limiting conditions, are reviewed via a different process.*
- *Suggestion that SAIs in relation to suicide and attempted suicide are reviewed via a different process.*
- *If the Governance Team considers that a reported AI should be escalated to an SAI, it is felt there should be early discussions with the reporter prior to further investigation so that panels are not reconvened unnecessarily.*
- *There is a need for further investment in training in investigations of SAIs and clear sign-posting to the governance staff within Trusts.*
- *There should be easy access to feedback from the Risk Team as to the outcome of SAIs so that awareness is raised, learning happens and repetition is avoided.*

1.24 Medicines Governance

Drug errors are among the leading causes of avoidable harm to hospital inpatients and as such the administration of drugs should be regarded as a high risk procedure (Appendix 15). Pharmacists state that medication errors occur at various points including administering, prescribing, and dispensing. When a Nurse or Pharmacist identifies a potential error, it can be difficult to clarify with the prescriber as the Doctor's name is not clear, or up to date. Pharmacists have informed project leads that potential causes for error can include poor handwriting by medical staff, wrong dose prescribing, lack of attention to detail and failure to identify them as the accountable prescriber. They further state that errors in drug administration lead to complications in treatments, increased financial cost of drugs and serious errors in the use of prescribed medicines. 20% of all clinical negligence litigation is as a result of medication error (GAIN 'Making Ward

Rounds Count' 2014[54)]. At present adverse drug reactions (ADR) or suspected adverse drug reactions are reported to MHRA directly using the Yellow Card Scheme.

In relation to Medicines Governance in Northern Ireland there is evidence of good communication between Primary and Secondary care. Primary and Secondary care Medicines Governance Teams meet regularly and learning is also shared across Trusts in conjunction with HSCB/PHA/RQIA in the Medicines Governance Team Safety Sub-group meeting. The Regional Medicines Governance Team for Secondary care collects medication incident data on a quarterly basis. This has been on-going since January 2003 when the team was established to promote medication incident reporting and develop regional safety strategies.

The total number of medication related incidents is collated and analysed to determine the percentage of incidents which resulted in no harm, insignificant harm, minor harm, moderate harm, major harm and catastrophic harm. This more recently has involved Primary care and an anonymous self-reporting system has been developed to encourage reporting by community pharmacists.

Regional learning from the Medicines Governance Team for Primary and Secondary care takes the form of quarterly reports, incident analysis and recommendations as well as safety memos, policy development and audits. The Northern Ireland Medicines Governance Newsletter is a good communication tool and the 'medicinesgovernanceni' website is accessible and user friendly. Issues in relation to medication issues could be addressed more effectively in the HSCB/PHA regional learning newsletter.

Pharmacy links are being developed with the National Reporting Learning System (NRLS) to produce guidance which will match guidance issued by National Patient Safety Agency (NPSA) or National Institute for Health and Care Excellence (NICE) and avoid any duplication. The process of disseminating this information should be through the Regional Learning System. The arrangements for medication incident management are well established and co-ordinated by the Medicines Governance Teams in Primary and Secondary care, and overseen by the Medicines Safety Sub-Group (MSSG).

A regional workshop was held on 25th June 2014 where members of the MSSG attended, along with other key primary and secondary care stakeholders from a Medical, Pharmacy, Nursing and Governance background. The main aim was to review incident management and was led by the Medicines Governance Team Leader for Secondary Care and the Medicines Governance Team Leader for Primary Care. Attendees were asked to consider:

- What works well?
- What could be done better – consider gaps and blocks in the system?
- What are the key enablers to support improving systems?

The feedback from this workshop relates directly to the Regional Learning System Project. Suggestions for improvement included:

Suggestions for improvement from the workshop:

- *Improve and simplify the reporting process, ensuring that the same version of an on-line reporting tool is available across Northern Ireland and is easy to use. Mandatory fields should be reviewed and*

revised e.g. medication name and link to DM&D code. This will also support the Quality Assurance process.

- *Review and revise legislation relating to the potential for criminal action following reporting of a dispensing error.*
- *Consider ways to encourage and increase reporting rates and share best practice regionally about practical measures that can be introduced e.g. increasing reporting from all known low reporting staff groups and changing the reporting culture across the organisation. Staff should be encouraged to provide information on the 'why' as well as the 'what' and be provided with notification / feedback that incident is being considered.*
- *Consider a mechanism to allow patients to report incidents.*
- *A standard should be set which requires that all medication incidents which have resulted in harm are reported, similar to that defined in NHS England's Quality and Outcomes Framework. This would also support future management of the reporting of all medication incidents resulting in harm to MHRA.*
- *Consider the establishment of one repository for all NI reported medication incidents that could be data mined for emerging trends.*
- *Review the time limits set for SAI investigations to ensure that they are properly investigated.*
- *Agree arrangements for the sharing of early learning incident information or advice with the Regional Medicines Governance Teams.*
- *Timeliness of analysis – analysis and actions need to be available as quickly as possible after an incident, but this needs balanced against allowing enough time for the investigation. Consider input from a data analyst to work with Regional Medicines Governance Teams to support trend analysis.*

- *Consider looking at other measures such as the time between events – more sensitive than numbers.*
- *Establish a specialist multi-disciplinary advisory network to support analysis of incidents suitable for regional learning.*
- *Consider establishment of formal links with NHS England's medication safety team and others in Great Britain and Ireland to discuss emerging medication incident trends and agree a strategic approach which supports development and management of safety solutions. Opportunities to join the international medication safety network should also be considered. Review opportunities for Secondary Care input to existing HSCB/PHA processes to broaden depth of strategic management of medication safety and consideration of national and local learning.*
- *Improve the speed of disseminating information. Current processes may be too slow for rapid dissemination of urgent learning for medicines related incidents.*
- *Establish a specialist multi-disciplinary advisory network to support development of suitable regional learning.*

It was agreed that it is very important to have an assurance process to ensure a consistent approach regionally and that actions are taken. It was felt that there are reasonably robust processes in Secondary Care, but less so in Primary Care.

Suggestions for improvement from Medicine Governance workshop:

- *DHSSPS to consider incentivisation schemes to support organisations to implement medication safety directives.*
- *DHSSPS to consider adoption of the NPSA 'Never Event' approach to monitoring safety.*

- *Templates to be issued with assurance requests to support standardisation of assurance responses.*
- *Develop an assurance framework and governance arrangements for Community Pharmacy.*
- *Ensure there are appropriate resources and investment to allow full compliance with safety recommendations, both IT and staff.*
- *Link audit process to incidents that have happened.*

Proposed arrangements for improving reporting and learning for medication error incidents should be part of clinical governance structures in Primary and Secondary care and across all HSC organisations. These structures should ensure that medication error reporting systems are operating effectively, that the quality of incident reports supports learning, that important patient safety issues identified by these systems are adequately addressed locally and that incident reports are submitted in a timely fashion for local, regional and national learning.

1.25 Recommendations

i. Review the definition of an adverse incident (DHSSPS/Trusts/HSCB, PHA).
ii. Increase the speed of disseminating learning to provide timely opportunities for learning across directorates, Trusts and regionally (Trusts/HSCB/PHA).
iii. Services or Teams should develop service or team triggers (Appendix 2 & 3) or prompt lists to enable a standard service approach and understanding as to what should be reported. These should ultimately become regional trigger lists for same services (Trusts/HSCB/PHA).
iv. Develop and agree Regional Adverse Incident Guidelines & Procedures for adoption across the HSC (Trusts/HSCB/PHA).

2. Information Technology

2.1 This section of the report itemises the Information Technology (IT) arrangements in all HSC organisations in relation to reporting, managing, analysing and learning from adverse incidents**.** The information and staff views and opinions lead to 3 recommendations which, if adopted, should standardise and improve IT arrangements and communication in relation to adverse incidents.

2.2 Datix system

The database which is used by all six Health and Social Care Trusts and HSCB to report adverse incidents is the Datix system. Datix is a web–based patient safety and risk management software application that enables users to spot trends as incidents/adverse events occur and reduce future harm by prioritising risks and putting in place corrective actions.

Datix has been used by HSC Trusts since 2001 prior to RPA in 2007. It has undergone several developments and version refinements and consists of various different modules. The modules consist of:

- Incident Reporting
- Risk Register and Assurance Framework
- Safety Alerts
- Complaints Handling
- Claims Management
- Regulatory Standards (CQC in England and Wales)
- Patient Advice and Liaison Service (PALS)
- Inquests
- Requests for Information (FOI)
- Dashboards

- Hotspots.

Not all modules are available and used by trusts currently and at the time of this review the learning module was being developed.

2.3 Table 3 Current Datix Modules used by HSC Trusts in N. Ireland
(informed by Trust Governance Leads)

Datix Module	Belfast	Western	South-Eastern	Southern	Northern	NI Ambulance
Incident Reporting	√	√	√	√	√	√
Risk Register and Assurance Framework	√	√	√		√	√
Safety Alerts	√					
Complaints Handling	√	√	√	√	√	√
Claims Management	√	√	√	√	√	√
Regulatory standards						
Patient Advice and Liaison Service (PALS)	√					
Inquests	√	√	√		√	
Requests for Information (FOI)	√		√		√	
Dashboards						
Hotspots						

The Datix Common Classification System (CCS)[55] enables the classification of incidents that occur throughout the healthcare environment. Its content has been shaped by healthcare professionals for use in all healthcare organisations, big or small. However, the identification of these incidents is through the process of classification. The Datix CCS is designed to permit classification of incidents that affect patients, staff, visitors and organisations.

The CCS classification system is again structured into three tiers consisting of domains, sub-domains and sub-categories. The listing is comprehensive but is not inclusive of all causal and/or contributing factors. Incident classification enables healthcare organisations to efficiently identify, analyse and prioritise incidents. An effective classification system plays a key role in patient safety learning systems, providing a focus for harm reduction strategies and leading to improved safety for patients and others in the healthcare system.

2.4 Table 4 Datix Version currently used by trusts in NI informed by Datix

Trust	Datix Version – Year of release
Belfast	Version 12.2.2 (released September 2013)
Western	Version 10.1.3.1 (released August 2010)
South Eastern	Version 12.2 (released June 2013)
Southern	Version 11.5.1 (released July 2012)
Northern	Version 10.2 (released November 2010 - use

	paper based not Datixweb)
NI Ambulance Service	Version 11.5.1 (released July 2012)

Table 4 shows that Trusts are using different versions of Datix. The most updated version is version 12.2.3 and no NI Trust uses this. Four Trusts use Datix web (online reporting) and South Eastern and Northern Trust currently use the paper- based version. The project leads have found that the process to code harm and use of the matrix to determine severity and likelihood differs between Trusts. Datix report that the most up to date version is used currently throughout the rest of the UK and other regions e.g. British Columbia.

User feedback reports that the most updated version increases functionality, reporting and trend analysis. This can be easily accessed at ward, department and organisational level. Datix also provides dashboards which can be customised for ward, departmental and organisational level and a 'hotspot capability' which provides real time alerts if agreed thresholds are breached.

Data will need to be more reflective of specific service areas and should be categorised as:

- Health & Safety of patients/ clients.
- Health & Safety of staff.
- Data Protection/Confidentiality.
- Medicines related incidents
- Medical Devices related issues
- Fire safety/emergency including fires, fire alarms, bomb scares, emergency evacuation, and civil disturbance

- Environmental-related issues including bad weather, electricity, water, major estate issues, damage to Trust property, theft of Trust Property and public disorder riots.

Project leads compared AI data for Trusts from January 2013 – December 2013. In this time **73,222** adverse incidents were reported. Comparisons reveal that each Trust reported same or similar incidents under different codes. This means that benchmarking in relation to incidents is difficult and learning is not shared.

An example to illustrate this is described in Table 5

2.5 Table 5 – Incidents reported under the category Access, Appointment, Admission, Transfer, Discharge.

Update II	South Eastern	Western	Northern	Belfast	Southern	Total
Access/Appointments/ Admission/Transfer/Discharge	**1046**	**712**	**701**	**1464**	**732**	**4655**
Patient Absconded	476	*	*	*	*	**476**
Access and Availability	19	*	*	*	*	**19**
Admission	211	139	49	86	188	**673**
Appointment	141	20	4	114	85	**364**
Patient AWOL	41	*	*	*	*	**41**
Discharge	57	496	619	1069	366	**2607**

***– classification not recorded in category**

As can be seen in Table 5 'patient absconded' and 'patient absent without leave' (AWOL) are reported by South Eastern Trust whereas the other four Trusts do not report in these categories. This is because the South Eastern Trust use a different version of the CCS from the other Trusts. Instead these are recorded under discharge as this is how level three under the CCS

codes in relation to this are categorised. This shows that comparisons cannot be made between Trusts as a result of the specific use of the CCS codes.

The current coding classification has been updated by Datix to reflect fully all aspects of health and social care and is known as Version 2. Benchmarking can only happen if this is introduced across all Trusts. Once service datasets have been agreed and adopted there will be consistency and standardisation of reporting across the region. An agreed dataset for recording these incidents should provide consistency in the coding of events regionally. This should ensure regional scrutiny and reliability in the analysis of the incidents reported and facilitate benchmarking and learning. As can be observed from the top ten analysis of Trust incidents there is a regional variance among the Trusts (Appendix 15).

The most recent version of Datix links directly to the Patient Administration System (PAS) which, when the reporter enters the unique patient identifier number, patient details are automatically entered. This has the potential to save time and reduces duplication.

2.6 Staff opinion and suggestions for improvement:

The leads, in listening to staff views and opinions in relation to Datix would say that the following would need to take place in order that the system becomes a real learning tool where comparisons can be made across services and Trusts and teams can learn from each other:

- *Initiate a regional project to secure a regional Datix contract upgrading all Trusts to the latest version of Datix.*

- *Review and agree datasets within services regionally to ensure consistency of reporting.*
- *Datix analysis - HSCB to have regional oversight responsibility – scrutiny of AIs in partnership with Trust input – sharing data with Trusts for learning.*
- *All Trusts - reporter (staff member) to input e-report, code and decide on risk and impact (in conjunction with line manager).*
- *Report only once (no duplication to RQIA, Vulnerable Adult VA1).*
- *Datix system to be accessible to all (various permissions – read only etc.)*
- *Datix link to Patient Administration System (PAS) and any other relevant systems.*
- *All frontline staff, both in the acute sector and the community have equality of access to laptops/computers/tablets for ease of reporting, scrutiny and learning.*

2.7 Recommendations

i. Review and agree datasets, including codes and classifications within services regionally to ensure consistency of reporting (Trusts/HSCB/PHA).

ii. Consider and, if possible, procure the same patient safety incidents healthcare software and risk management software system for incident reporting and adverse events for all Trusts, HSCB/PHA and other relevant organisations, agreeing a regional specification including modules and version (Trusts/HSCB/PHA/RQIA).

iii In the interim period, and for consistency across Trusts, organisations should update to the most recent version of electronic systems used to record and process adverse incidents.

3. Data Analysis and Scrutiny of Incidents

3.1 This section of the report itemises the analysis and scrutiny of incident arrangements in all HSC organisations in relation to analysing and learning from adverse incidents (Appendix 1). The information and staff views and opinions lead to 6 recommendations which, if adopted, should standardise those arrangements and increase analysis and scrutiny in relation to adverse incidents.

Dr Carol Peden in her paper 'Measuring and Monitoring Safety: An Acute Care Perspective' (2013) stated that; 'measurement and feedback alone is key to improvement as most staff have no idea that care is so unreliable, demonstrating the scale of the problem, can lead to improvement and that the most frequently stated barrier to reporting for Doctors and Nurses is lack of systematic analysis of reports and feedback.'[56]

An effective reporting system is the cornerstone of safe practice and within a healthcare Trust, a measure of progress towards achieving a safety culture. The use of a Regional Learning System as a learning tool will encourage reporting and help identify hazards and risks, and provide information as to where there are deficiencies. Improvement efforts can then be targeted and shared across the Trust and the region to encourage systems changes to reduce the likelihood of injury to future patients.

With an increased learning culture the reporting of adverse incidents and near misses should increase. All services should have guidance to inform and support staff on how to code incidents that has been agreed across the service and agreed in Trusts and then regionally to increase consistency in reporting and grading.

At present there are two ways to report an incident in Trusts:-

1. Datix-Web on-line reporting – also known as DIF1 form
2. Handwriting an A3 incident report form and submitting to Risk Management Department or inputting on the Datix system.

As per Trust AI policy the line manager checks grading before approving and amends if necessary.

3.2 Table 6 Trust Breakdown of Online Reporting

Trust	**Percentage of staff reporting online (Datixweb)**
South- Eastern	0%
Western	86%
Belfast	92%
Southern	100%
Northern	0%
NI Ambulance Service	0%

The latest version of Datix sends out automatic e-mail alerts to appropriate staff, depending on how an incident is graded, coded (CCS codes), where it happened etc. E-mail alerts are also sent to a variety of staff including directors, assistant directors, ward sisters, facility managers, and staff with corporate responsibility for particular areas. This allows:

- The grade to be reviewed and amended if necessary (lower or higher)
- A check to consider whether anyone else needs to be notified of the incident
- For the incident to be compared against the Serious Adverse Incident criteria, and if necessary reported to HSCB/RQIA

- For consideration of whether the incident needs reporting to any other statutory bodies, e.g. HSENI, NIAIC, etc.

Many incident reports are reviewed by Risk Management staff within Trusts, and if they perceive an incident may have been graded lower they will consult with relevant staff to consider whether to grade higher. It is also possible that it may be reported as an SAI at this stage, however this decision may lie with the relevant director, such as the case with the Belfast Trust. The Governance Teams would state that increased reporting may slow down the process of review. This may be further delayed when information has not been completed at initial report.

Governance Teams have informed the project leads that incident reporters may grade incidents as major or catastrophic which do not meet the criteria in the risk matrix (Appendix 13) and should be of a lower severity. This means that at a given point in time there will be incidents on the system which are inappropriately graded and may skew statistics on internal and external reports. There are a number of mechanisms which may be in place within Trusts to correct inappropriate severity grades. For example, the Belfast Trust process is as follows:

- Monthly and Quarterly reports are provided to Directorates in Trusts for quality assurance.
- Corporate Governance send all major/catastrophic severity and extreme risk incidents to Directorate Quality & Governance Managers as soon as they are approved on Datix and ask them to confirm the grading or amend as required.
- On a monthly basis, all major/catastrophic and death incidents are checked by Corporate Governance and if it is felt that the severity

grade is still incorrect, Directorate Quality & Governance Managers are asked to consider amending to a suggested grade.

- In some Trusts, approved incidents are quality assured by administrative staff within Corporate Governance. In addition to the above steps, staff query those incidents that seem to meet SAI criteria and these are drawn to the attention of appropriate Directorate staff for consideration in relation to meeting SAI status.

3.3 Table 7 –Trust Reported Major/Catastrophic classification of Adverse Incidents 1 January 2013 - 31 December 2013

Trust	Major	Catastrophic	Total of Major and Catastrophic	SAIs reported to HSCB	Overall total of Incidents
South-Eastern	69	13	82	57	16132
Western	315	75	390	53	9609
Belfast	47	125	172	84	26191
Southern	166	33	199	57	10650
Northern	160	37	197	131	11402

All Trusts provided statistics for the project leads for 2013 where incidents were classified as major or catastrophic. The above table demonstrates the difference between the number of adverse incidents reported within Trusts graded as major and catastrophic and the number of Serious Adverse

Incidents reported to the HSCB. Trusts have reported that this was due to a number of factors:

- The incident was reported on potential harm (near misses) and as no harm was caused there was no investigation and these were not reported as SAIs.

- The incident may have been reported initially as major /catastrophic and although was later downgraded, this was not amended in the Datix system accordingly.

For Trusts which have a Datix system which has outcome codes for incidents, the system outcome code had not been updated e.g. following a fall the immediate outcome may be admission to hospital, however days later the outcome may be death and as the system is not updated this may not be recorded as such.

3.4 Procedure for Grading an Adverse Incident

HSC Regional Impact Table and Risk Matrix April 2013 (Appendix 14) was produced to assist staff in assessing severity and risk grade as objectively as possible, however staff agreed that the process involves a degree of subjectivity. It is recognised that not all incident scenarios fit neatly into one or other of the domains and staff should use their judgement using the table as a guide to assist them towards effective and consistent grading.

All adverse incidents should be investigated commensurate with the actual severity (actual harm, loss or damage) and/or the potential risk grading. The grading assists in deciding what level of investigation is required and at what level. An initial assessment of the incident severity and risk grade is

undertaken to allow staff to progress appropriately. This is then reviewed following further investigation and amended accordingly.

Table 2 of the Severity Matrix (Appendix 14) refers to the likelihood of the incident recurring which is subjective and open to interpretation and may be dependent on the knowledge, skills and experience of the individual as well as having access to all the facts and circumstances relating to the incident. If a near miss is not graded appropriately (potential for harm) as serious the learning from the incident may not be identified.

Coding requires to be reviewed and the individual who determines the risk would need to be suitably trained and experienced in using this rating scale. The coding will depend on staff judgement and their professional background. If this is done by a qualified clinician e.g. Ward Manager or Consultant as opposed to an administrator within Datix/Governance there may be more objective analysis of the risk rating. For example in relation to pressure ulcers the grading is determined by professionals (tissue viability Nurses) and medicines related incidents mostly by Medicines Governance Pharmacists.

In most instances the severity and risk grade is decided initially by the reporter in conjunction with their line manager but may be subject to review by the supervisor (e.g. Ward Manager) in conjunction with the Governance Department as part of the quality assurance process. As a result of this the reporter is involved in reviewing the grading. However, in some Trusts, the reporter never grades the incident and this requires to be addressed. This will improve the culture of learning and empower individuals, increasing expertise in incident reporting and grading.

3.5 Staff Opinion and Suggestions for Improvement:

The leads, in listening to staff views and opinions in relation to data analysis would say that the following would need to take place in order that analysis of AIs becomes part of a clinician/practitioner's day and so learning is timely and untoward harm is prevented:

- *Ensure there is expertise in data analysis and adequate financial resources available to allow for meaningful analysis of reports where there is appropriate and clear interpretation and scrutiny of the Datix data (for their team/service area) alerting directorates/teams of possible trends and clusters would greatly assist learning at local level.*
- *Identify the inconsistencies in reporting between same type services regionally and agree criteria/ types of incidents that should/ should not be reported.*
- *Incident reporting to be electronic (e-reporting), happens once, is coded and risk rated by the line manager in conjunction with reporter (other professionals if required).*
- *Trust Information Analyst personnel to provide managers with readable, clear reports evidencing trends and clusters in directorates, and across the Trust.*

This will allow for continual improvement and learning where first line managers and staff can:-

- *Search for clusters and themes.*
- *Scrutinise their area of work in relation to AIs.*
- *Plan with staff, learning with an outcome of agreement of new ways of working.*

- *Improve IT and analytical skills to assist in leading on, supporting and monitoring agreed new ways of working.*
- *Report improvement through trend data (in the short term and over time).*
- *Make summary report of learning and improvement available to all relevant services within the Trust, for the region and to the public.*
- *Datix system accessible to all (various permissions – read only etc).*
- *Datix link to Patient Administration System (PAS).*

Staff will then have ownership of the incidents they have reported on, they will pro-actively search for trends and clusters for themselves and share outcome data with their Trust Governance Team to allow more accurate reporting with senior managers, other directorates, other Trusts, RQIA and the HSCB/PHA.

3.6 Recommendations

i. Arrangements need to be developed to allow for oversight of AIs regionally, to identify regional clusters and trends, and to facilitate the development of subsequent regional action planning and learning.
ii. HSC organisations should ensure there is expertise in data analysis and adequate financial resources available (Trusts/HSCB/PHA).
iii. It is recommended that inconsistencies in reporting between same type services are identified in Trusts and regionally, and criteria/types of incidents that should/should not be reported are agreed (Trusts/HSCB/PHA).
iv. Each incident should be graded against potential and/or actual harm and risk rated by appropriately trained staff (Trusts).

v. Trusts should produce twice yearly reports to the HSCB/PHA detailing trends and clusters, progress in the management of these and learning. Arrangements should also be put in place to develop and produce twice yearly regional reports to the DHSSPS detailing regional trends and clusters, progress in the management of these and learning.

vi. Trusts must feedback to the reporter or the person who raised the AI report informing them of any outcomes (Trusts).

4. Safety Culture - Learning/Training

4.1 This section of the report explores current learning arrangements and culture in all HSC organisations in relation to adverse incidents (Appendix 1). The information and staff views and opinions lead to 5 recommendations which, if adopted, should develop processes that will lead to an increased learning culture in Trusts. This will further support and encourage managers and staff within the HSC to prioritise reporting, and focus on delivery of continuous improvement in relation to patient safety.

The primary purpose of patient safety reporting systems is to learn from experience and improve outcomes for patients (Keogh 2013)[57]. Corporately in all organisations the language of learning and support must supersede that of performance management and targets so that people feel more valued and respected for what they do and are supported, listened to and responded to appropriately. The overarching vision must be to deliver on the prime directive as described by Keogh "the needs of the patient come first" (2013).

Although not statistically representative, all staff who gave an opinion and feedback talked about a need to continue the progressive move away from a blame culture towards a proactive learning culture in their organisations; where incident reporting is encouraged and seen by all frontline staff as a learning opportunity, where there is relevant communication culminating in demonstrable continuous improvement in service delivery leading to best outcomes for service users.

Some staff reflected that there may be merit in considering a change to the name of *adverse incident* to a less emotive and negative one. Opinions were expressed that the current definition implies that a mistake or error has

always been made and if the name was changed to a less negative one this would encourage reporting. Frontline staff reported that the term adverse incident in a climate of blame has put them off reporting. The term *learning event* or *patient safety incident* might generate a more positive, proactive response. The NPSA defines a *patient safety incident* as 'any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS funded healthcare'. The term 'patient safety incident' is used to describe 'an adverse incidents/events' or 'clinical errors', 'no harm events' and 'near misses'. The NPSA definition of patient safety is the 'identification, assessment, analysis and management of patient-related risks and incidents in order to make patient care safer and minimise harm to patients'.

Nevertheless the project leads found many instances and examples of how organisations currently share good practice both locally and regionally. The following are staff examples of good communication and learning for frontline teams as a result of scrutiny of incidents:

- *Daily Safety Briefings – discussing adverse incidents on a daily basis.*
- *Frustration Tree - Staff describe this is where a cut out of a tree is placed in the team tea room and staff physically add post-its [anonymously] writing up their frustrations, maybe an event that they want to be considered as an adverse incident. These are discussed and dealt with daily so by the end of the week all the frustrations have been dealt with.*
- *White Board Communication – staff note their concerns and issues on the meeting room whiteboard. These whiteboard issues are discussed weekly at the team meeting and resolved or actions planned to improve with staff taking responsibility for actions. The*

white board is then wiped clean for the next week. Quick, easy, and timely.

- *Lunch & learn Sessions.*
- *Ground up support, peer and management support to report.*
- *Risk (medical) Consultant – picks up on recurring themes in incidents and link to G.Ps and other relevant professionals across sectors where applicable.*
- *Respectful working relationships nurtured between Nursing and Medical staff.*
- *Rotation of Nursing staff to maintain skills and learn about new innovation and practice in a timely fashion.*
- *Team AI dashboards, linked to divisional dashboards, linked to corporate dashboard.*
- *Ward Safety Calendar displayed on wards informing staff, patients, carers and relatives of the safety record on a particular ward in relation to pressure ulcers rates and infection rates.*
- *Staff in more than one area where there is a clinical governance facilitator resource, report that they feel encouraged to report, receive feedback from reporting, are informed on a regular basis of adverse incident clusters and involved in the discussions to improve. They are also made aware in time of SAIs and their outcomes in relation to their area. Staff state that the facilitators review the incidents, notice clusters, encourage reflection with staff on the data and support an open and honest culture.*
- *Competency checks – where senior staff test junior staff on identified areas for improvement (clinical skills) to ensure accepted competency level is achieved and to monitor that competency in knowledge and skills is sustained.*

- *Mortality & Morbidity Meetings are introduced into all Trusts now, some more developed than others; most Trusts plan the meetings to coincide with GAIN Audits. Most Trusts have now invited Nursing and AHP colleagues to attend to ensure multi-disciplinary approach to the review.*
- *Team effectiveness away days.*
- *Trust Newsletters/Bulletin - 'Share to Learn' (Western); 'Continuous Improvement': 'Improve, Inspire, Innovate' (Southern); 'Lessons Learnt' (South Eastern); 'Medications Safety' (South Eastern); 'Safety, Quality, Experience (SQE) Newsletter' (South Eastern); 'Northern Insights: Learn, Inform, Improve' (Northern); 'Safety Matters' (Belfast);*

4.2 The following are staff examples of good communication and regional learning from adverse incidents data:

- DHSSPS sharing information out to trusts from the National Patient Safety Alerting System (NPSAS) – 3 stage response alerts.
- Safety Alert Broadcast System (SABS).
- HSCNI Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 Guidance for employers and employees Health Services Information Sheet 7.
- HSC Knowledge Exchange Website.
- SAI Learning Letters sent out to all Trusts with required actions for Trusts.
- Regional Newsletter in relation to learning from SAIs – 'Learning Matters'.
- Regional Medicines Governance Newsletter.
- Northern Ireland Regional Liaison Psychiatry for Older People Forum.
- GMS Update - HSCB General Practice Newsletter (sent to all GPs).

- HSCB/PHA SAI Thematic reviews e.g.
    - Review of Venous Thromboembolism (VTE) Incidents Reported to Health and Social Care Board as Serious Adverse Incidents January 2014[34]
    - HSCB/PHA SAI Thematic Review - Report on the Regional Review of Patient Falls in Hospitals March 2014[35]

The following are examples of learning leading to change in practice and reduction in adverse incidents:

4.3 A prescribing project (Western Trust 2013) was undertaken by a Doctor in training as part of the Co-operation and Working Together (CAWT) patient safety programme aiming to reduce paediatric prescribing errors by 50% in a 6 month period. This was delivered with the outcome of a reduction in errors from the start of the process from 27 to 10 on the last audit of the project, a 63% reduction in errors. There were at the start of the project 10 different types of error initially reduced to 4 on last audit. The data and information which lead to the identification of the need for improvement, was taken from Medicines Governance data and an initial baseline audit. Action taken to share learning included:

- Monthly audit results are shared with staff on the ward.
- The Improvement Project was presented at the Junior Doctors Audit Completed in May 2014.
- The project will be presented as part of Junior Doctors Teaching Session and at the Western Trust Quality Improvement Showcase Day in October 2014.

4.4 In 2011 the Southern Trust identified that there was a need to raise the awareness of and enhance the prevention & management of Pressure Ulcers on their wards (Regional Programme in Pressure Ulcer Prevention).

There was evidence of under & inappropriate reporting of incidents of Pressure Ulcers. It was also recognised that the existing documentation was inadequate.

A Pressure Ulcer Improvement Team was set up led by Tissue Viability Nursing Leads. The aim was to:

- Enhance identification of 'at risk' patients & Record Keeping.
- Implement the SKIN Care Bundle.
- Increase knowledge & skills in relation to Pressure Ulcer Classification.
- Raise awareness of individual wards 'acquired' Pressure Ulcer Rate.
- Improve Patient Outcomes.

This is now achieved in all acute hospitals with inpatient facility – Craigavon Hospital, Daisy Hill Hospital, Lurgan Hospital and South Tyrone Hospital.

4.5 Qlikview is an information management system used by South Eastern Trust which collates audit information in relation to compliance of identified key quality indicators including pressure areas, food and nutrition and early identification of deterioration in a patient. These indicators relate to the most reported incidents across the region. Staff members enter data via a specific survey tool and access their results via Qlikview.

This allows teams and individuals to review their scores in line with incident data to inform next improvement steps.

4.6 Culture within HSC organisations

As stated previously the consensus opinion from staff across the HSC in Northern Ireland consulted as part of this report is that, at present, the managerial focus at all levels is on meeting targets and performance

managing staff first when targets are not met as opposed to proactively consulting and listening to staff to find out why. Staff interviewed, suggest that it may be that the targets whilst possibly achievable at one time are now not achievable due to factors beyond frontline staff control e.g. change in policy direction without proper resource. Many staff voiced their frustration, in the interactive sessions across the Trusts, at having to manage larger caseloads with no extra staffing resource both in the acute and community sector whilst continuing to deliver quality service. The discussion further revealed staff awareness of the external public and media culture of focusing on perceived errors and mistakes in the HSC, where staff expressed concern that managers may look to blame rather than support staff in what they described as very stressful working environments. Contributing factors include blame culture, low staffing levels, increased hospital admission and discharge of frail elderly patients and increased workload where health and social care following discharge (delivered to both paediatric and elderly patients) takes more time and is more complex, delivering care that would have previously taken place in hospital.

There is no quick fix to changing the culture from one of blame to one of learning from incidents, errors, near misses, mistakes or omissions. This culture can be organisational, service, directorate, or even team and the leads have experienced conversations with staff where they state they are reluctant to report incidents and staff who report incidents as a matter of course. However many staff in the interactive sessions stated to the leads that they would be concerned that there would be a risk to their professional reputation or registration as a result of reporting, and that they might be blamed. Senior staff in organisations also stated that they perceived the overall culture was one of performance management.

There is not a universally accepted definition of a safety culture in healthcare but it is essentially a culture where individuals and teams have a constant and active awareness of the potential for things to go wrong. It is also a culture that is open and fair and one that encourages people to speak up about mistakes. King et al 2010[58] recognised that patients have been shown to report accurate observations of medical errors and adverse events. Best practice would be to ensure that patient reporting is built into any future adverse incident reporting system.

The NRLS patient engagement workshop[3] (London July 2014) delegates agreed that the key move for the new system (NRLS) should be to create a way of patients reporting all experience. Rather than predetermining what the eventual learning might be, what kinds of follow-up might be needed, and who would be responsible for that follow-up, delegates wanted a system capable of handling the four 'C's':

- Complaints.
- Concerns.
- Comments.
- Compliments.

Safety First: A Framework for Sustainable Improvement in the HPSS - DHSSPS March 2006[59] endorsed the approach that all organisations should have an informed safety culture which should be given the highest priority at senior management level and promoted throughout as 'everyone's business'. The four major sub-components are:

- A reporting culture.
- A just culture.
- A flexible culture.
- A learning culture.

In his report on the failings in the Mid Staffordshire Hospital Trust 2013[60], Francis stated that central to his analysis was evidence of a large-scale failure of control and leadership at multiple levels from the 'blunt end' of the system where decisions, policies, rules, regulations, resources and incentives are generated through to the 'sharp end', often known as the 'frontline', where care is provided to patients. He stated that it was useful to recognise how the blunt end, by shaping the environment where care is delivered, may create the 'latent conditions' that increase the risks of failure at the sharp end, but may equally generate organisational contexts that are conducive to providing high quality care. Culture can be described as groups sharing basic assumptions, norms, and values and repeated behaviours into which new members are socialised, to the extent that culture becomes 'the way we do things around here' (Schein's influential approach)[61].

The Berwick Report[62] reflected that "In some organisations, in the place of the prime directive, 'the needs of the patient come first', goals of (a) hitting targets and (b) reducing costs have taken centre stage."

The project leads have listened to a wide variety of HSC staff and staff in related sectors e.g. HSENI; and the overwhelming view is that Trusts and HSC bodies need to further focus their efforts on the shift to a learning culture for all.

The 'Call to Action Summit' (2014)[63] stated that "the need for leadership is not about top-down leadership but is about a more distributed leadership that draws on health leaders from across the NHS and especially clinical professionals and that without active clinical leaders, many thought transformation unachievable."

Staff demonstrating leadership qualities that support a learning culture and support empowerment should model for those staff who do not demonstrate those qualities. This way of working and culture should be encouraged and audited for outcomes. This will lead to a growing workforce of staff and managers where those leadership qualities become the norm with the emphasis on learning and improvement.

Senior managers state that learning from AIs needs to be shared across Trusts. It is felt that a simple system should be developed where sharing is quick and timely and the right people take the learning and ensure improvement actions are adopted to ensure consistency across Northern Ireland.

In interactive sessions, project leads listened to staff discussing adverse incidents in their own areas focusing on reporting, scrutiny of adverse incidents (core questions see Appendix 1). The leads collected staff views and opinions in relation to what happens on a day to day basis. The following staff views, opinions and suggestions for learning are taken from those sessions:

4.7 Learning from Adverse Incidents – Staff opinion and suggestions for improvement:

- *A lot of learning is disseminated and emailed out, this is not learning but sharing of information electronically. There needs to be time allowed to access this information and discuss regularly so that learning can actually happen and actions can be taken as a result of what we talk about.*
- *Agree a training timetable and train all front line managers to:*
    - *enable them to support their staff in reporting AIs; and*
    - *enable them to support their staff in scrutinising data.*

- *Adverse incident learning should happen in time and on the front line with staff (multi-disciplinary) and managers working together. Staff should support each other to provide patients/clients and relatives with an explanation of the incident (at the time of the incident) and action plan. In this way, patients and relatives feel valued, learning happens quickly and practice is changed. Learning should be shared both locally and regionally so that the risk of a similar incident happening in the future is reduced or even avoided.*
- *Trend data needs to be made available to the team on a regular basis, if this is already available; staff need to be trained in how to input and access data. The evidence provided will allow the line manager and teams to tailor changes in practice appropriately, monitor changes and demonstrate improvement. The team will have ownership and hold themselves accountable, the response to AIs is discussed and actioned and learning is immediate and continuous.*
- *Incidents and learning should be discussed openly using a variety of means (safety briefings, learning hubs, support meetings, e-forum/blog etc.) ensuring change in practice (in similar areas across Trusts).*
- *Incidents and learning should be shared with colleagues across sectors, directorates, disciplines and Trusts using agreed learning hub (e.g. HSC Regional Knowledge Hub).*
- *Mandatory adverse incident reporting training (as per future regional policy and procedure).*
- *Datixweb training for all staff.*
- *Audit in relation to staff interpretation of the datasets, coding and risk matrix. This will decrease wide variance in interpretation over time.*

- *Regular safety meetings to discuss cases, learn from case studies of previous incidents, discuss learning newsletters and learning letters leading to a reduction in variance of reporting.*
- *Experienced investigators to share their knowledge, develop confidence and competence in management of incidents, encourage learning, reduce variance and encourage staff to strive for consistency in dealing with AIs and SAIs .*
- *Staff should be facilitated to attend adverse incident case study discussions (comprising staff from same services within Trusts) within their own service areas. Staff attending should include experienced staff, Designated Review Officers (DROs) and investigation chairs to increase knowledge and develop consistency of approach in managing AIs/SAIs.*

Although examples of good practice have been discussed earlier in the report, many frontline staff at all grades stated that there was a lack of effective communication when it comes to reporting and learning from adverse incidents stating that this was not prioritised or sometimes even considered in the working week. It was voiced that this is ultimately down to the team/service culture and leadership.

Across the sectors many staff state that outcomes from regional or corporate 'learning' is forwarded by email. Staff say they rarely get a chance to look at their emails during their working day however, are still expected to find time to read and learn from these emails. They say this is not learning but communicating information. They state that learning will not happen unless time is set aside to read, meet, discuss the information communicated and share opinions and views in relation to effecting change to reduce incidents.

What staff said:

- *An educational culture means that reporting and learning needs to be part of your working day, you have a captive audience – why wouldn't you? It can't be in your spare time, it won't happen.*
- *If you report an AI you need to get feedback and to be involved in the learning and changes to reduce incident happening again.*
- *The reporting of AIs is a one way system and we rarely get feedback.*
- *You need to see changes implemented or be involved in developing the changes from reporting.*
- *I do not have a trust email address.*
- *We are not allowed to use the computers, managers believe we would use it to go on the internet and not work! – I think this is disrespectful, how can we learn if this is the only chance we get to learn?*
- *There should be brief weekly safety meetings, with actions only written instead of minutes.*
- *AIs should be an agenda item in every team meeting (with dashboard).*
- *We live in a litigious society, we are very worried about our reputation, we need strong, visible support from managers.*
- *Develop patient safety experts on the front line with time built in to support staff, to encourage reporting, review data, share and discuss with staff on a timely basis.*
- *An educational culture means reviewing your staffing levels and ensuring that there are enough staff on duty to include the release of staff for training, we don't get released for training due to not enough staff on duty.*

- *Build on relationships across disciplines and teams whose work impacts the other to resolve incidents and share learning e.g. Nurses, F2s and Pharmacists.*
- *Ensure there is a user friendly system we can all access and can input learning and actions.*
- *Filter learning that is only relevant to your own area and people will be more interested.*
- *Job workloads are increasing as a result of more demand from clients with better technology and more complex treatments and care packages in the community. Workforce planning should ensure there are correct staffing levels to allow staff to learn.*
- *The community sector should have Clinical Governance Facilitators - caring for patients, clients and residents in the community is huge (especially Mental Health [dementia etc.]) in older people % population over 85 increasing daily – the community sector at present has no Governance Managers and so the managers and the front line staff are having to manage, and process all AIs/SAIs and consequent investigations with no support, this takes experienced staff away from frontline caring for patients.*
- *Develop culture that is conducive to sharing of learning and to learning.*
- *Face to face encouragement, managers of all disciplines to show leadership by being present, seeing senior managers on the front line, role modelling required behaviours, encouraging a learning culture and discouraging blame.*
- *We should all have Trust email addresses and so if we were allowed time to learn at least we could access the learning.*
- *Team meetings (some staff said they rarely have them).*

- *Watch DVD of staff talking about their incidents, case studies. It would be good if they were of a similar service and we could do the same, then we could all learn from each other (Share on regional learning hub).*
- *Need HSCAI learning hub – the Belfast Telegraph for the region.*
- *HSCB/PHA needs to promote learning at our level and become more connected to us.*

4.8 Evaluation and Audit of Learning

Patient safety is paramount to treating, caring for, and delivering services to all service users and therefore all teams should build in appropriate, timely safety briefings to ensure learning is shared and continuous improvement actions are taken to eradicate adverse incidents.

Tools used by staff in Trusts for service user assessment and identification of risk leading to prevention of harm are audited in every service on an on-going basis. This checks that staff are trained in the use of the tools, ensures that documents are completed appropriately, actions are taken and care plans changed and followed appropriately when risks are identified, and new practice is embedded e.g.

- Malnutrition Universal Screening Tool (MUST)
- National Early Warning Score (NEWS)
- FallSafe Care Bundle
- Pressure Ulcer 5 step Prevention Model (SSKIN)

Audit results assist managers in supporting those staff who require further assistance, support and training, evidence improvements in practice and service delivery in each area allowing for benchmarking and over time demonstrate a reduction in incidents.

4.9 Recommendations

i. It is recommended that all HSC bodies continue to proactively improve their culture of openness, staff support, and learning in relation to adverse incident reporting, working and sharing outcomes across directorate, Trust and sector boundaries to continuously improve patient safety (DHSSPS/HSCB/PHA/Trusts).

ii. Consider changing the name 'adverse incident' to one which more accurately reflects the reason for reporting, which is learning, and develop a clear definition to all HSC staff. (HSCB/DHSSPS).

iii. It is recommended that there should be more training in reporting and analysis of adverse incidents for all relevant staff and HSC students in training, with awareness raising sessions for all staff (HSCB/PHA/Trusts).

iv. Develop a structured best practice safety system composed of a continuous or regular reassessment of risk, communication of status and mitigation, and prediction and planning. This system should also be capable of handling the four 'C's'[3]:

- Complaints
- Concerns
- Comments
- Compliments

There should be a mechanism developed for regular and frequent dissemination of learning widely (HSCB/PHA/Trusts/other relevant organisations).

v. It is recommended that all HSC bodies should ensure systems pertaining to safety e.g. incident reporting, risk rating, complaints, litigation and whistleblowing, should be synergetic to ensure whole system analysis and learning.

Conclusion

The project leads concur with Trust Governance Leads that the system currently used to report all incidents in relation to health and social care is not being fully utilised at present. Following meetings with frontline staff and stakeholders there is overwhelming support for Trusts to agree and procure the same patient safety incidents healthcare software and risk management software system for incident reporting and adverse events. There is also agreement on the proposal to reduce the number of Datix codes and make them more meaningful to staff. Datix codes and categories should be easily understood by staff. There should be consistency in the local application of the codes used by Trusts culminating in regional consistency. Individuals and groups interviewed wished to receive reports from Datix and this should be shared with staff in a culture of learning.

Incident classification enables healthcare organisations to efficiently identify, analyse and prioritise incidents. An effective classification system plays a key role in patient safety learning systems, providing a focus for harm reduction strategies and leading to improved safety for patients and others in the healthcare system.

During this project the leads listened to comments from key stakeholders and feedback was sought from frontline staff to determine what changes were required to be made in order to improve reporting and learning. There were many similarities in the comments from staff in relation to the length of time taken to report an incident, the lack of feedback following initial reporting and the absence of learning and service improvement as a result.

Project leads recognise that there needs to be a proactive shift by all staff, teams and HSC bodies to a learning culture where near misses are reported and acted on appropriately with an emphasis on service improvement. This should start with front line staff and may require awareness training and a more streamlined and efficient process for initial reporting and feedback. There should be an emphasis on learning from near misses and not what went wrong. If incidents are to be reported on-time and accurately the system needs to be responsive and user-friendly. Taking a whole system approach to learning in an open culture can reduce the incidence of needless harm to patients as well as secondary harm to healthcare staff as a result. The work on culture transformation to a 'no blame' culture is challenging and perhaps changing the definition of 'adverse incident' to a 'learning event' might be embraced more positively.

Staff interviewed expressed confusion about actual and potential harm as this is not fully explicit in the guidance. If the incident is categorised based on actual harm then near misses where the consequences could be major/ catastrophic but no actual harm was caused to the patient may not be coded correctly and therefore the opportunity for learning from the incident may not be realised.

It is well documented that one of the greatest contributors to accidents in health care is human error. However, saying that an accident is due to human error is not the same as assigning blame because most human errors are induced by system failures. A system that responds readily to incidents which are reported in order to facilitate a culture of learning is to be welcomed and will assure patient, staff and public safety. It will also respond quickly to incidents reported to ensure that the learning does occur as a result to make the culture safer for all. Oversight and benchmarking

should happen if all Trusts use the same system with consistent application of the codes. This will enable comparisons to be made across the region and the timely identification of trends and clusters which will encourage learning to be shared as a result.

Dixon-Woods et al 2013[64] concluded that a safety culture will ensue if organisations put the patient at the centre of all they do, get smart intelligence, focus on improving organisational systems, and nurture caring cultures by ensuring that staff feel valued, respected, engaged and supported.

Recommendations should produce a regional system (inclusive of processes and procedures) that ensures continuous learning happens, that successful solutions are shared and those solutions are agreed and adopted across the HSC delivering a reduction in adverse incidents and risk of harm to service users.

During the mapping process over 300 staff were interviewed and participated willingly in the project. Project Leads wish to express their thanks and gratitude to all those who contributed in face to face meetings, evidence gathering and providing information to the mapping process. The views of staff, particularly frontline staff who report incidents were very helpful and the project leads are extremely grateful to those who gave up their valuable time to make a positive contribution to this report.

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Appendix 1

Regional Learning System Project Core Questions used in the Interactive Sessions:

1. What would need to happen to ensure a consistent approach to reporting AIs?

2. What are your views on the impact table and risk matrix used currently?

3. Who is best placed to review, standardise and agree Datix codes/categories regionally?

4. Who is best suited to reflect on AI data in Trusts noticing clusters, analysing trends and reflecting on the implications and action plans to reduce incidents?

5. Who would be the best suited to reflect on the AI data regionally, noticing gaps in reporting, groups or clusters of AIs, and analysing trends?

6. How could this information be shared between Trust/professional groups?

7. What would need to happen to ensure sharing of good practice locally?

8. What would need to happen to ensure sharing of good practice regionally?

9. What type of reports would assist in service improvement and learning? How could information be used more effectively?

10. What would encourage reporting?

11. Any others ideas or innovations in relation to improvements in management of and learning from AIs?

Attendees at Workshop Held on 25th June 2014

- Joe Brogan, Assistant Director, DOIC, Head of Pharmacy and Medicines Management, HSCB
- Angela Carrington, Regional Medicines Governance Team Leader for Secondary Care
- Brenda Bradley, Pharmacy Lead, Medicines Governance and Public Health, HSCB
- Briegeen Girvin, Medicines Governance Pharmacist, HSCB
- Anne Friel, Head of Pharmacy, WHSCT
- Ashley Warnock, Co-Chair Medication Incident Review Group SEHSCT
- Alex Lynch, Corporate Risk Manager (obo Suzanne Pullins), NHSCT
- John Collins, Representative, NIMDTA
- Dr Gillian Clarke, Medical Advisor (obo Maria Dowds),HSCB
- Tracey Boyce, Head of Pharmacy, SHSCT
- Sharon O'Donnell, Medicines Governance Pharmacist, (obo Eimear McCusker), BHSCT

- Mark Timoney, Chief Pharmaceutical Officer, DHSSPS
- Jill Macintyre, Head of Pharmacy, SEHSCT
- Mike Scott , Head of Pharmacy, NHSCT
- Roisin McSwiggan, Lead Nurse for Governance and Patient Experience, NHSCT
- Sara O'Connor, Corporate Risk Manager (obo Therese Brown), WHSCT
- Anna Lappin, Medicines Governance Pharmacist, NHSCT
- Aine Liggett, Medicines Governance Pharmacist, SEHSCT
- Daryl Connolly, Medicines Governance Pharmacist, WHSCT
- Jillian Redpath, Medicines Governance Pharmacist, SHSCT

Appendix 2

South Eastern Health and Social Care Trust

Maternity Triggers

Maternal

- Undiagnosed breech
- Self presentation more than 3 times
- Eclamptic fit
- Prolapsed cord
- Established labour > 18 hours
- 2nd stage of > 4 hours
- Uterine rupture
- Failed instrumental delivery
- Delay of > 30 minutes performing emergency C/S

- Shoulder dystocia
- 3/4th degree tears
- BBA
- Anaesthetic complications
- Vulval haematoma
- Blood loss more than 1500mls
- Caesarean hysterectomy or post delivery laparotomy

- Return to theatre following C/S or ERPOC
- Extended hospital stay for medical reasons
  - > 5 days after vaginal delivery
  - > 7 days after C/S
- Readmission of mother
- Significant urinary retention
- Hb < 8g/dl postpartum
- Non access visit x 2 in community
- Home birth transfer to hospital

- Venous thromboembolism
- Pulmonary/amniotic embolism
- Maternal cardio-respiratory arrest
- HDU/ITU admission
- Maternal death
- Any mother less than 16 years of age.

Fetal/Neonatal

- Non adherence to the 'Safeguarding childrens' Policy'
- Delay in securing neonatal cot
- In utero transfer
- Apgar score < 7 at 5 minutes
- Birth trauma eg. fractures, cephalhaematoma
- Laceration at C/S
- Cord pH < 7.05 arterial or < 7.1 venous
- Unexpected IUGR < 5th centile
- Undiagnosed fetal anomaly
- Unexpected admission to the Neonatal Unit
- Other fetal/neonatal incident
- Baby incident eg. Wrong ID
- Neonatal seizure
- Infant transfer (LVH only)

- Stillbirth >500g
- Neonatal death.

Organisational Incident

- Delay in responding to call for assistance
- Inadequate staffing levels
- Unavailability of labour ward or maternity bed when required
- Unavailability of health record
- Faulty equipment

- Conflict over case management
- Potential service user complaint
- Retained swab or instrument
- Hospital acquired infection

- Non adherence to local protocol/policy
- Security incident (vandalism, abuse to staff etc.)
- Personal accident (fall, needle stick)
- Breach in confidentiality.

For medication errors a **Medicine Incident Form** must be filled out.

Record all near misses and incidents on an **Incident Form**.
Record only facts and action plan needed following the incident.

Copy to: **Risk Management**

Copy to: **Pamela Redmond, Clinical Governance Facilitator, Ulster Hospital**

Appendix 3

South Eastern Health and Social Care Trust

Gynaecology Triggers

- Diagnostic or surgical damage (eg. bowel, ureter)
- Delay or missed diagnosis (eg. ectopic pregnancy)
- Anaesthetic complications
- Venous thromboembolism
- Failed procedures (eg. abortion, sterilization)
- Unplanned intensive care admission
- Omission of planned procedures (failure to insert a planned intrauterine contraceptive device after a hysteroscopy)
- Unexpected operative blood loss > 500ml
- Procedure performed without consent (eg. removal of ovaries at hysterectomy)
- Unplanned return to theatre
- Unplanned return to hospital within 30 days
- Under 16 years admission
- Postnatal admission
- Neonatal death.

Organisational Incident

- Delay following call for assistance
- Faulty equipment
- Conflict over case management
- Potential service user complaint
- Retained swab or instrument
- Hospital-acquired infection
- Inappropriate violation of local protocol
- Security incident (vandalism, abuse to staff etc)
- Personal accident (fall, needle stick).

Medication Errors

For medication errors a **Medicine Incident Form** must be filled out.

Record all near misses and incidents on an **Incident Form**.

Record only facts and action plan needed following the incident.

Copy to: **Risk Management**

Copy to: **Pamela Redmond, Clinical Governance Facilitator, Ulster Hospital**

Appendix 4

Definitions

Adverse Incident: 'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation.'
(How to Classify Adverse Incidents and Risk, HPSS 2006) [67]

Harm is defined as 'injury (physical or psychological), disease, suffering, disability or death.' In most instances can be considered to be unexpected if it is not related to the natural cause of the patient illness or underlying condition. (Doing Less Harm. NHS. National Patient Safety Agency 2001)[68]

A Serious Adverse Incident (SAI) is an adverse incident that must be reported to the HSCB because it meets at least one of the criteria as defined by the HSCB within 'Procedure for the Reporting and Follow-up of Serious Adverse Incidents (SAI's), Oct 2013'.

Appendix 5:
The Three Levels of Investigation (SAI)

Investigation Report Levels

Initial reports should be reported within 72 hours of the incident being discovered using the SAI Notification Form.

Level 1 Investigation – Significant Event Audit (SEA)

Most SAI notifications will enter the investigation process at this level and an SEA will immediately be undertaken to:

- Assess why and what has happened
- Agree follow up actions
- Identify learning.

The possible outcomes from the investigation may include:

- Closed – no new learning
- Closed – with learning
- Requires Level 2 or 3 investigation.

(refer to Appendix 5 guidance on SEA investigations)

If it is determined this level of investigation is sufficient, an SEA report will be completed and sent to the HSCB within 4 weeks (6 weeks by exception) of the SAI being reported.

If the SEA determines the SAI is more complex and requires a more detailed investigation, the investigation will move to either a Level 2 or 3 investigation. In this instance the SEA report will still be forwarded to the HSCB within 4 weeks (6 weeks by exception) of the SAI being reported with

additional sections being completed to outline membership and Terms of Reference of the team completing the Level 2 or 3 investigations.

Level 2 – Root Cause Analysis (RCA)

As stated above, some SAIs will enter at Level 2 investigation following a SEA. When a Level 2 or 3 investigation is instigated immediately following notification of a SAI, the reporting organisation will inform the HSCB within 4 weeks, of the Terms of Reference (TOR) and Membership of the Investigation Team for consideration by the HSCB/PHA DRO. This will be achieved by submitting sections two and three of the investigation report to the HSCB. (Refer to Appendix 6 – template for Level 2 & 3 investigation reports).

The investigation must be conducted to a high level of detail. The investigation should include use of appropriate analytical tools and will normally be conducted by a multidisciplinary team (not directly involved in the incident), and chaired by someone independent to the incident but who can be within the same organisation.

Level 2 RCA investigations may involve two or more organisations. In these instances, it is important a lead organisation is identified but also that all organisations contribute to, and approve the final investigation report (Refer to Appendix 12 Guidance on joint investigations).

On completion of Level 2 investigations, the final report must be submitted to the HSCB:

- within 12 weeks from the date the incident was discovered, or
- within 12 weeks from the date of the SEA.

Level 3 – Independent Investigation

Level 3 investigations will be considered for SAIs that:

- are particularly complex involving multiple organisations;
- have a degree of technical complexity that requires independent expert advice; and
- are very high profile and attracting a high level of both public and media attention.

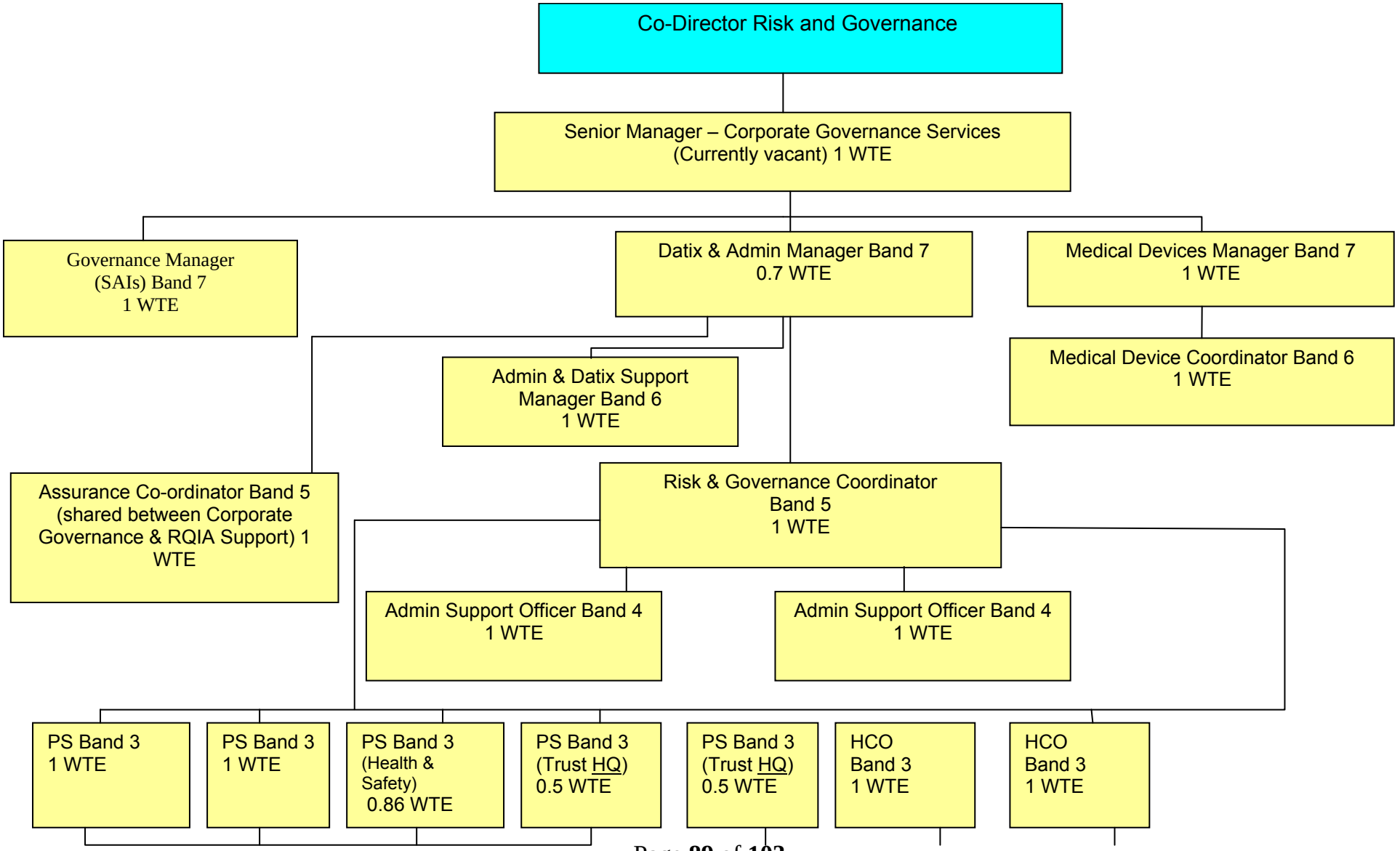
In some instances the whole team may be independent to the organisation/s where the incident/s has occurred.

The timescales for reporting, Chair and Membership of the investigation team will be agreed by the HSCB/PHA DRO at the outset.

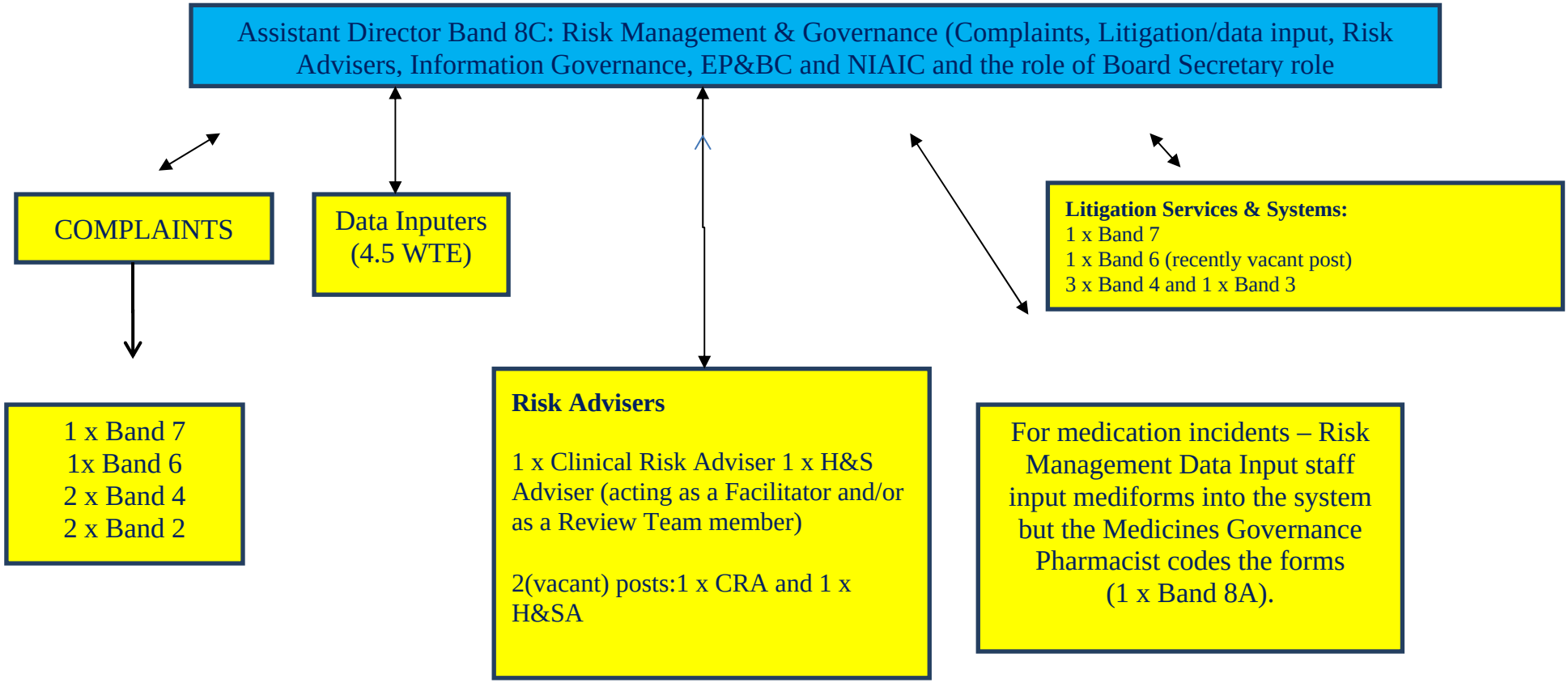
The format for Level 3 investigation reports will be the same as for Level 2 investigations.

For any SAI which involves an alleged homicide by a service user who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and known to/referred to mental health and related services (including Child and Adult Mental Health Services (CAMHS), psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident, the Protocol for Responding to a SAI in the Event of a Homicide, issued in 2010 and revised in 2013 should be followed.

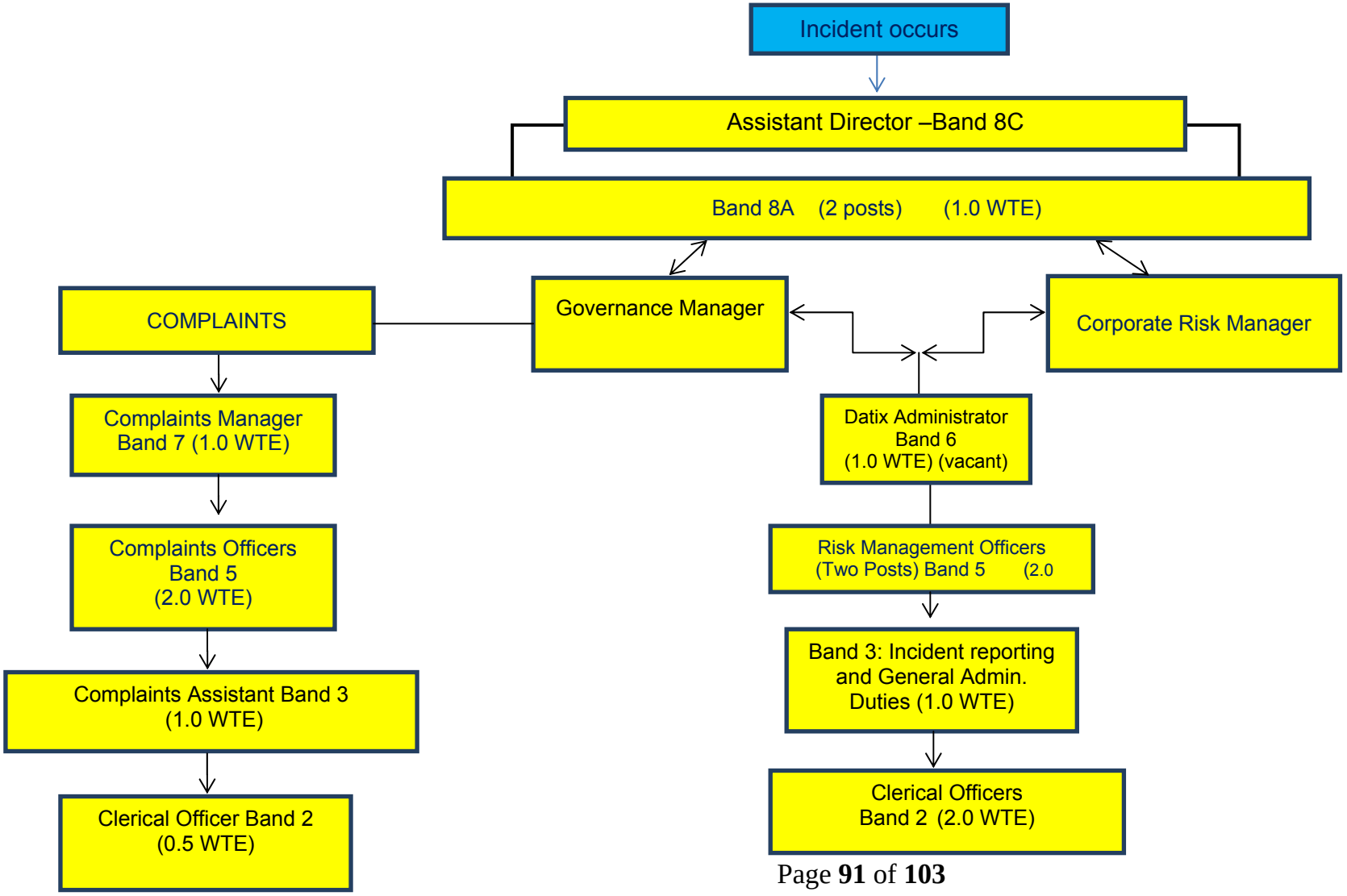
Appendix 6: Belfast Trust Corporate Governance Staffing Structure



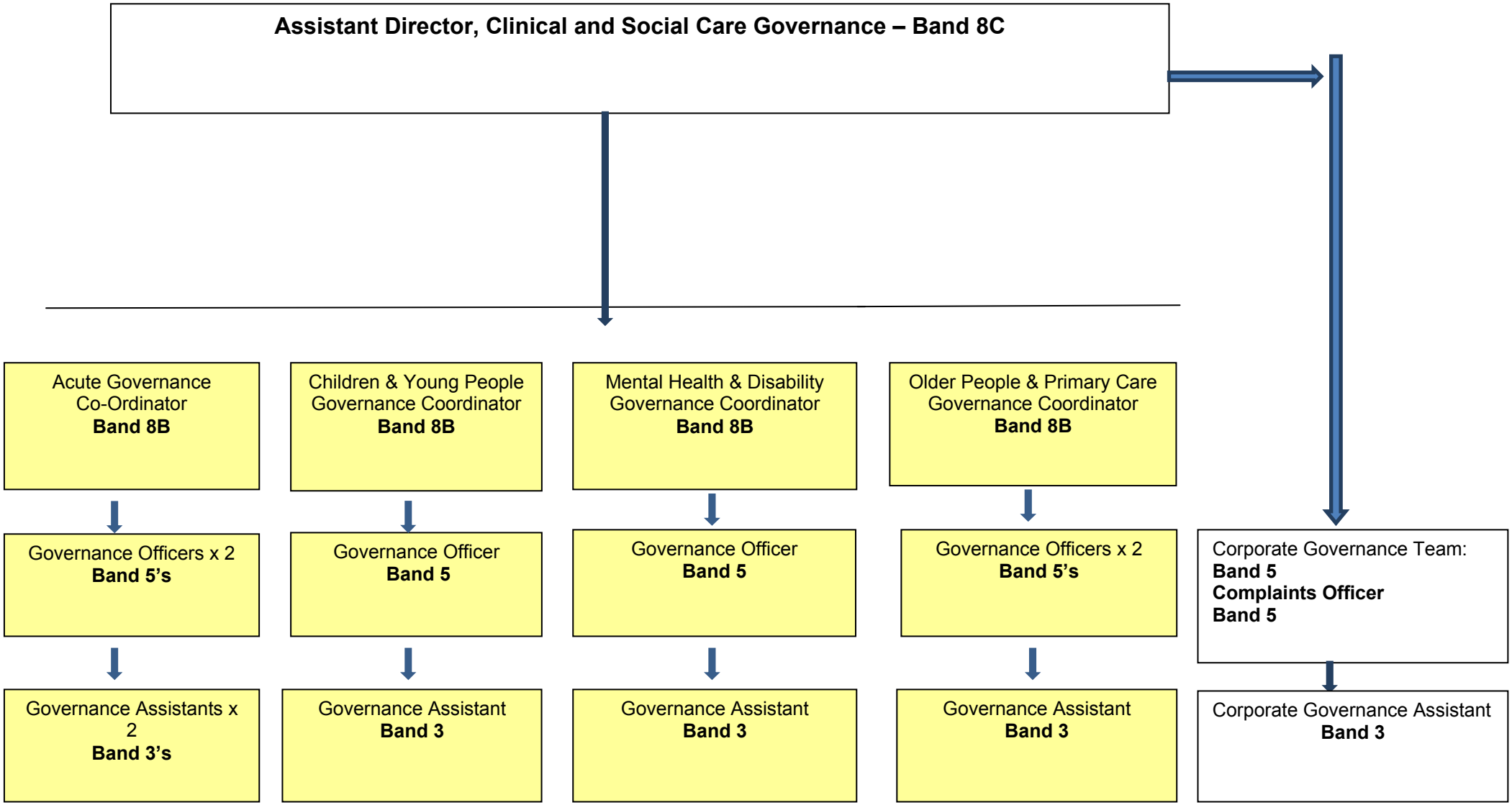
Appendix 7: South-Eastern Trust Corporate Governance Staffing Structure



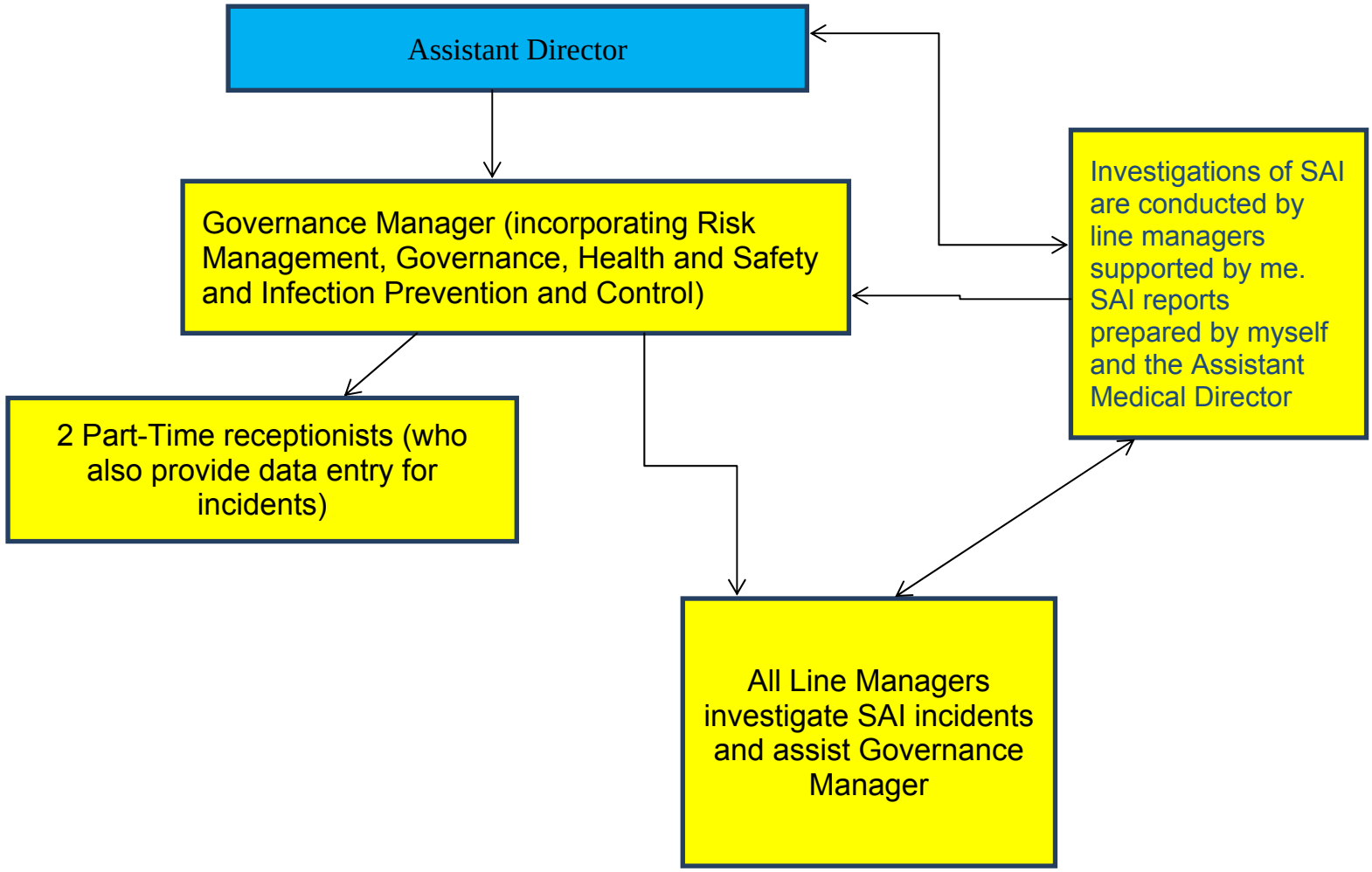
Appendix 8: Western Trust Corporate Governance Staffing Structure



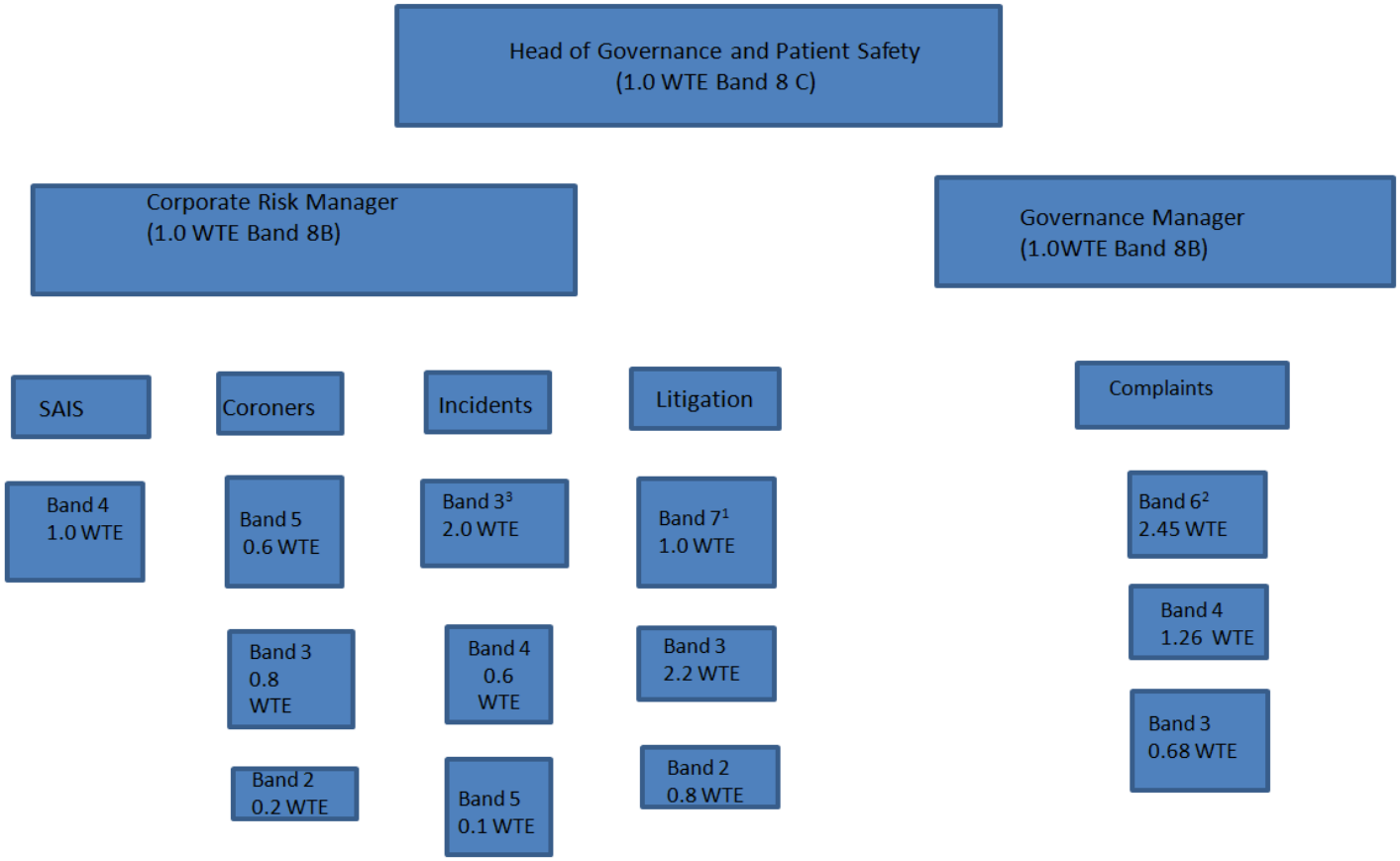
Appendix 9: Southern Trust Corporate Governance Staffing Structure



Appendix 10: Northern Ireland Ambulance Service Trust (N.I.A.S.)
Corporate Governance Staffing Structure

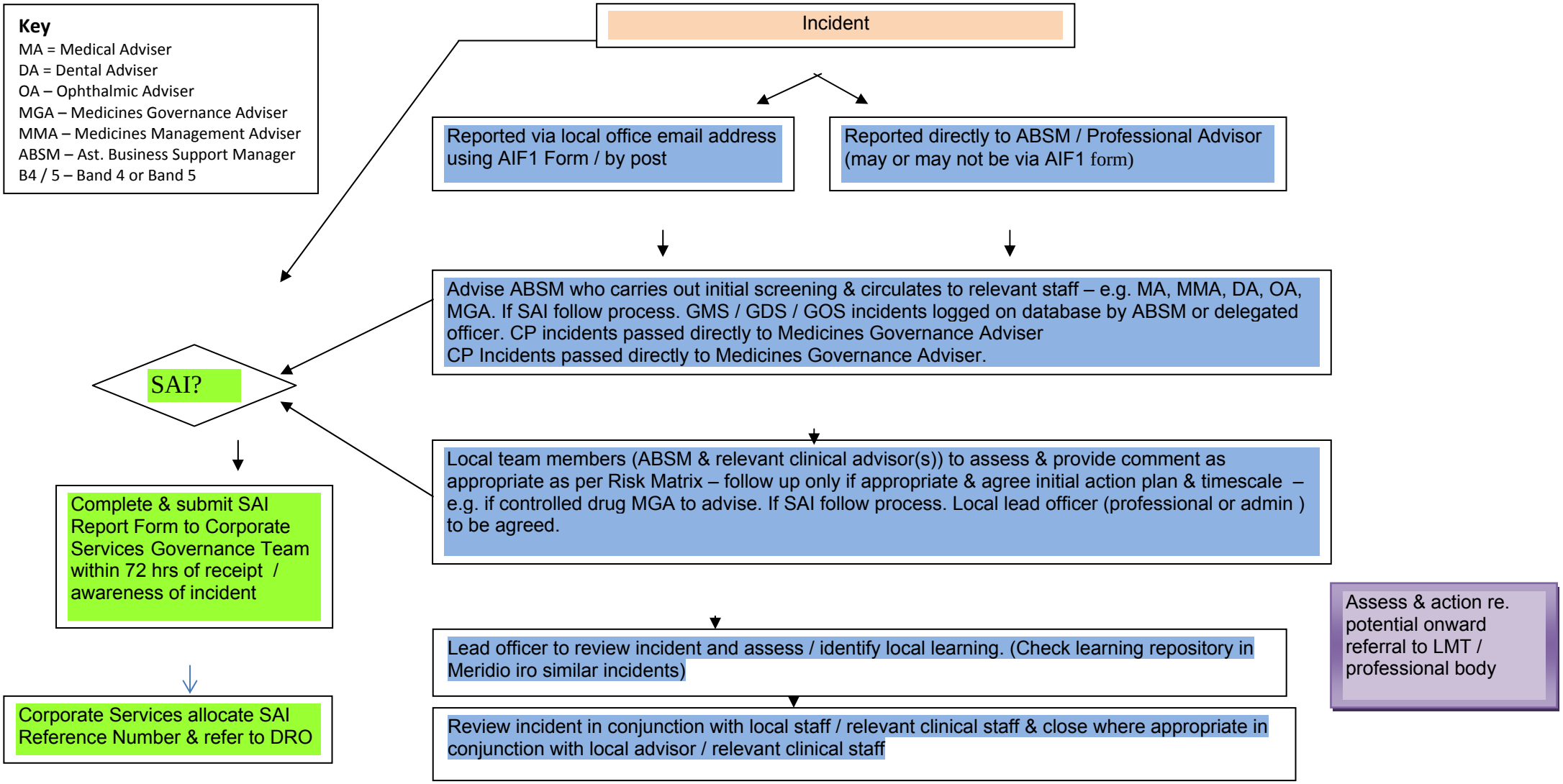


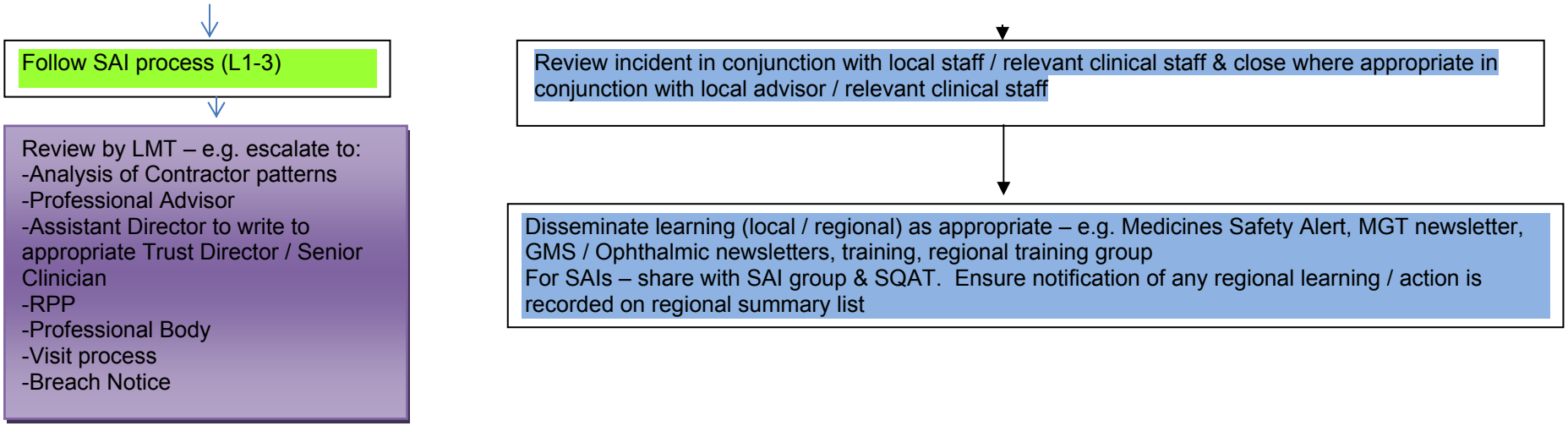
Appendix 11: Northern Trust Corporate Governance Staffing Structure



[1] Band 7 – In addition manages Corporate Risk Register and oversees Datix System
[2] Band 6 – 1.0 WTE Resides in Acute Directorate
[3] Band 3 – Data input for all incidents recorded on datix following incident of incident reporting form

Appendix 12: DOIC: Reporting and Management of Adverse Incidents and Serious Adverse Incidents




Follow SAI process (L1-3)
Review by LMT – e.g. escalate to:
-Analysis of Contractor patterns
-Professional Advisor
-Assistant Director to write to appropriate Trust Director / Senior Clinician
-RPP
-Professional Body
-Visit process
-Breach Notice
Review incident in conjunction with local staff / relevant clinical staff & close where appropriate in conjunction with local advisor / relevant clinical staff
Disseminate learning (local / regional) as appropriate – e.g. Medicines Safety Alert, MGT newsletter, GMS / Ophthalmic newsletters, training, regional training group
For SAIs – share with SAI group & SQAT. Ensure notification of any regional learning / action is recorded on regional summary list

Appendix 13: Risk Matrix Table

	SEVERITY / CONSEQUENCE LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Minimal injury requiring no/ minimal intervention. • Non-permanent harm lasting less than one month (1-4 day extended stay). • Emotional distress (recovery expected within days or weeks). • Increased patient monitoring	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Increase in length of hospital stay/care provision by 5-14 days.	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (e.g., Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss

	SEVERITY / CONSEQUENCE LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

Appendix 14: HSC Regional Risk Matrix – with effect from April 2013

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency** (How often might it/does it happen?)	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

Appendix 15: Top Ten Incidents Reported by Trusts

1.1.2013 – 31.12.2013

South- Eastern Trust: "Top 10" incidents

1.	Slips, trips, falls and collisions	3461
2.	Abuse of staff by patient	2137
3.	Medication error during prescription process	943
4.	Abuse – other	882
5.	Abuse of patient by patient	841
6.	Accident caused by some other means	802
7.	Self- harm during 24hr care	789
8.	Administration or supply of medication from a clinical area	619
9.	Patient absconded	476
10.	Fire, fire arms and fire risks	293

Western Trust: "Top 10" incidents

1.	Slips, trips, falls and collisions	2572
2.	Abuse of staff by patient	1196
3.	Abuse of patient by patient	630
4.	Discharge	496
5.	Pressure sores/ decubitus ulcers	427
6.	Self-harm during 24hr care	361
7.	Accident caused by other means	315
8.	Administration or supply of medication from a clinical area	219
9.	Abuse – other	208
10.	Medical device./equipment	207

Northern Trust: "Top 10" incidents

1.	Slips, trips, falls and collisions	3716
2.	Abuse of staff by patient	1334
3.	Other	998
4.	Discharge	619
5.	Accident caused by other means	490
6.	Abuse of patient by patient	401
7.	Communication between staff , teams and departments	290
8.	Administration or supply of medication from a clinical area	278
9.	Self-harm during 24hr care	262
10.	Pressure sores/ decubitus ulcers	216

Belfast Trust: "Top 10" incidents

1.	Slips, trips, falls and collisions	5301
2.	Abuse of staff by patient	2963
3.	Abuse of patient by patient	1682
4.	Abuse - other	1265
5.	Medical device./equipment	1220
6.	Discharge	1069
7.	Medication error during prescription process	992
8.	Self-harm during 24hr care	942
9.	Accident caused by other means	726
10.	Pressure sores/ decubitus ulcers	683

Southern Trust: "Top 10" incidents

1.	Slips, trips, falls and collisions	2077
2.	Abuse of staff by patient	2033
3.	Abuse of patient by patient	787
4.	Administration or supply of medication from a clinical area	579
5.	Medication error during the prescription process	408
6.	Discharge	366
7.	Adverse effect that affect staffing levels	356
8.	Medical devices/equipment	311
9.	Self-harm during 24hr care	283
10.	Accident caused by some other means	222