Norris, Hilary

From: Carson, Ian
Sent: 01 April 2004 11:45
To: Hamilton, Andrew; Sullivan, Dean
Cc: McCann, Noel; Campbell, Dr Henrietta; O'Brien, Anne; Briscoe, Maura; Bill, Jonathan
Subject: FW: SAFETY GROUP - ADVERSE INCIDENTS LETTER

Andrew/Dean,
Further to our discussions regarding the proposed letter to Sperrin Lakeland Trust, I have attached below a 'letter' which is presently in draft form which will be issued to the HPSS in due course. This adverse 'incident letter' is being worked on by Noel McCann and colleagues in response to concerns shared by the CMO and myself regarding variable approaches and standards being adopted by Trusts to the local investigation of 'incidents/adverse events'. In addition to the present need for some guidance to be issued to the service, the Safety in Health & Social Care Steering Group believe that the development of core standards in this area, and the development of agreed regional processes for handling such issues, will be best served by developing a formal relationship (SLA) with the National Patient Safety Agency (NPSA). This is currently being worked on by members of the Group in conjunction with Jonathan Bill. The purpose of this email is to inform you of the preparation of the communication documented below.
Yours, Ian.

-----Original Message-----
From: McCann, Noel
Sent: 31 March 2004 09:38
To: Baird, Billy
Cc: Bill, Jonathan; Carson, Ian
Subject: SAFETY GROUP - ADVERSE INCIDENTS LETTER

Billy

As discussed, grateful if you would get this to Jonathan at the safety group meeting. It would be best to run off some copies.

Jonathan - As I indicated yesterday, I had undertaken to pull together a first draft of a letter about adverse incident reporting and follow-up. I should be grateful if the attached can be tabled for discussion at the Safety Group today. In light of the Lucy Crawford case, and the fact that it will be some time yet before the Safety Group can conclude its work, I think it is essential that we get something out into the system as early as possible.

NOEL

adverse.incidents.letter.doc

DHSSPS

002-001-001

DRAFT

For action:

Chief Executives of HSS Trusts

For information:

Chief Executives of Boards
Chief Officers, HSS Councils

April 2004

Dear Colleague

ADVERSE INCIDENTS: NOTIFICATION AND FOLLOW-UP ACTION

Introduction

1. Various measures are in place at present to ensure that the Department is made aware of adverse or untoward incidents in the Health and Personal Social Services. Existing guidance covers, in the main, untoward events in mental health hospitals (Circulars HSS4 (CS)1/73 and HSS (THRD) 1/97 and the Northern Ireland Adverse Incident Centre (NIAIC) is the focal point for the reporting of adverse incidents involving medical devices, non-medical equipment, plant and buildings used by health and social care bodies.

2. This Circular sets out interim guidance for HSS organisations on the reporting and investigation of adverse events.

Background

3. The consultation paper *Best Practice Best Care*, published by the Department in April 2001, recognised the need for more effective arrangements for monitoring adverse events. As a result, a Safety in Health and Social Care Steering Group was established by the Department with a remit to develop a strategic approach to the reporting, recording and investigation of adverse events and 'near misses' and the promotion of good practice to minimise risk.

4. As part of its work, the Steering Group is also undertaking an evaluation of the effectiveness of systems used to identify and manage adverse incidents and near misses, including NIAIC. It operates a voluntary system for reporting and investigating adverse incidents in the HPSS and issues alerts and other material on the safety of devices and equipment

5. It is hoped that the Steering Group will conclude its work later this year, following which definitive guidance will be issued to the HPSS, following discussion with the HPSS.

Defining Adverse Incidents

6. The work being done by the Safety in Health and Social Care Steering Group will lead to a clear and comprehensive definition of adverse incidents. For the present, an **adverse incident** is defined as any event or circumstance arising during health or social care that led or could have led to unintended or unexpected harm, loss or damage. Incidents that actually lead to harm are referred to as **adverse events**, while those incidents which had the potential to harm but did not do so, are referred to as **near misses**.

Managing Adverse Incidents

7. Depending on the seriousness of the adverse incident and the circumstances in which it arose, a range of follow-up action may be appropriate. This may include, for example, a discussion of the issues with the patient or client, the introduction of new procedures or checks, training or retraining of staff or requesting someone from outside the Trust to undertake an independent case review.

8. It is also essential that, where a significant adverse event has taken place, the Department is informed about it as early as possible. Trusts will need to make a judgement as to what constitutes a significant adverse event: clearly those events which have led to a fatality or serious injury should be reported to the Department. Further guidance in this area will be issued one the Safety in Health and Social Care Steering Group has concluded its work.

Independent Case Reviews

9. Where a Trust decides that an independent case review may be appropriate, it is imperative that those conducting the independent appraisal of events are seen to be completely independent of the Trust. In addition, it will usually be appropriate for such reviews to be conducted by a multi-professional team rather than one individual.

10. Before an independent case review is undertaken, advice should be sought, in the first place, from the relevant Chief Professional Officer in the Department, who will advise on handling and other issues.

Action

11. Pending the development of comprehensive guidance on foot of the work being done by the Safety in Health and Social Care Steering Group, HSS Trusts should ensure that the following action is taken:

- Any adverse event which led to a fatality or serious injury should be reported to the Department [where? Possibly to relevant Policy directorate?]
- adverse incidents involving medical devices, non-medical equipment, plant and buildings should be reported to NIAIC.
- [others?]

Enquiries

12. Any general enquiries about this Circular should be made, in the first place, to XXX.

Yours sincerely

[?] NOEL McCANN

DHSSPS

002-001-005