Department of
Health, Social Services
and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

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FEEDBACK ON LEARNING ARISING FROM CIRCULARS HSS (PPM) 06/04 AND 05/05 (JULY 2004 – DECEMBER 2005)

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Foreword

Service user and staff safety has become a major priority for health and social services (HPSS) organisations in recent years. It is an issue which has received an increasingly high profile at local, national and international levels and is one that has to be considered in the context of a broader range of quality improvement, modernisation and reform programmes. The Department is committed to ensuring service users receive high quality treatment and care, delivered by motivated and skilled staff in modern settings where risks of an error or adverse incident are minimised.

Each year in Northern Ireland hundreds of thousands of people use the HPSS for a variety of reasons. In the course of one year, one million people attend A&Es, 740,000 inpatient and daycases are treated, 28 million prescription items are dispensed and two million people attend an outpatient appointment. It is inevitable that with such large scale and complex activity errors can and do occur. Some could have or did lead to harm, loss or damage to people, property, environment or reputation. These errors are not necessarily related to individual human error but are often linked to systems faults, work environments, technological failures or may be due to the complex characteristics of the individual patient's or client's condition or circumstances.

Promoting a reporting culture is just one element of a quality improvement programme which requires leadership and commitment of senior management and all staff who work in the

HPSS. Timely and accurate reporting of all adverse incident leads to a greater understanding of what went wrong and an assessment of potential future risk of reoccurrence within the organisation. Most significantly, it helps HPSS organisations and staff learn important lessons. By ensuring there are robust systems in place to identify, investigate and manage adverse incidents and, where appropriate, by taking positive action to ensure they are not repeated, we can all help to minimise future risks to service users.

The Department has established an interim system to report serious adverse incidents (SAIs) to it in a timely and standardised manner. This is just one of a number of local and national reporting systems which have been in place for some years. However, since July 2004, the Department has required the HPSS to report incidents which are serious enough to require regional action to improve safety, or be of major public concern or require an independent review. The fact that more serious adverse incidents have been reported in the last six months of this reporting period is proof of the willingness by HPSS organisations to report and share experiences. By doing so all HPSS organisations can learn from these incidents.

This Report highlights examples of SAI reports that have been the catalyst for change at regional level in areas such as clinical care, social care and mental health services. These changes have included HPSS organisations reviewing their procedures, promoting compliance with existing guidance and the development of new regional guidance. All of these changes have taken place to ensure that the risk of similar incidents occurring is minimised.

HPSS Boards and Trusts are accountable for the quality of care that they commission and provide, and for a continual drive for quality improvement. Much work is already underway at local and regional levels. The Regulation and Quality Improvement Authority, a new organisation set up from April 2005, will be publicly reporting on the quality of care provided by HPSS organisations through clinical and social care governance reviews, specific incident investigations and thematic reviews. Using the recently issued Quality Standards and, in particular, the safe and effective care theme, RQIA will assess how robust HPSS organisations' systems are in reporting, investigating, managing and learning from adverse incidents. As part of the overall assessment of quality of care, in the future, RQIA's report to the Department will cover how well organisations are preventing, detecting, communicating and learning from adverse incidents and near misses.

As part of a broader quality improvement programme, this Report also considers how the Department and the HPSS can further enhance incident reporting systems. In March 2006, further guidance on reporting, including a revised proforma, was issued by the Department. In addition, subject to Minister's approval, the Department is planning to enter into a formal agreement with the National Patient Safety Agency which will include links to their National Reporting and Learning System (NRLS). Once all HPSS organisations are part of the NRLS, the Department will review the need to continue with its current interim reporting arrangements.

The HPSS in Northern Ireland is facing a radical and unprecedented period of change. It is our duty to continue the progress we have made to improve the quality of the service we provide to service users during this transition period. I commend everyone in the HPSS for the efforts they have made to enhance the quality of service. But more can always be done to improve both safety and quality of care. This will require an integrated approach across the whole of the service, including the recognition that service users and the media have an important role in minimising risk and promoting an open and fair culture, which recognises the needs of both services users and staff. It is only in this way that we will be able to build a reporting culture which facilitates learning and promotes change.

Andrew McCormick
Permanent Secretary
DHSSPS

SECTION 1: The objectives and strategic context of the regional serious adverse incident reporting system

1.1 Introduction

The delivery of health and social care is complex. Many treatment and care decisions are made in a busy working day, using a range of technologies, procedures and activities, by many different staff and in a variety of settings. No health and social care environment will ever be one hundred percent safe. Some adverse incidents which occur may be the inevitable complication of treatment or care.

The Department of Health, Social Services and Public Safety(DHSSPS) is committed to ensuring that those who use health and social services are treated or cared for in a way that promotes high-quality care where risks are minimised. ***When adverse incidents occur, it is the responsibility of the HPSS organisations to ensure that the incident is appropriately investigated, managed and action taken to reduce the risk of reoccurrence.***

However, some incidents are of such significance that regional learning and/or action might be required. This interim mechanism of reporting serious adverse incidents to the Department, as described in this Report, is recognition by the Department that more can always be done to improve service user safety and to learn at a local and regional level. This Report will be accompanied by a HPSS workshop, in order to cascade learning and to discuss with HPSS staff how this system might be amended and improved.

In the longer term, the Department recognises that the triangulation of data sources at local and national levels, together with culture change, are necessary to inform quality improvements. These will be addressed through further linkages with the national reporting and learning systems and standard setting bodies, and through embedding quality and safety in the reform and modernisation agenda thus making "quality and safety" a central

role and function of new commissioning and provider organisations emerging from the Review of Public Administration[1].

1.2 Criteria for reporting Serious Adverse Incidents to the DHSSPS

This is the first report of serious adverse incidents (SAIs). It covers incidents reported to the DHSSPS by the HPSS, between July 2004 and December 2005. The reporting criteria was outlined in circular HSS (PPM) 06/04[2] and subsequently updated by HSS(PPM) 5/05[3]. These circulars required HPSS organisations, and family practitioners services (via HSS Boards), to report serious adverse incidents (including near misses) to the Department where the HPSS senior manager considered that the incident was likely to:

- Be serious enough to warrant regional action to improve safety or care within the broader HPSS;
- Be of major public concern; and/or
- Require an independent review.

1.3 Objectives of the Serious Adverse Incident Report

The three principle objectives of this Report are;

(i) to encourage an open and learning reporting culture, recognising that lessons need to be shared in order to improve service user and staff safety;

(ii) to provide feedback on high level analysis and themes arising from reported adverse incidents; and

(iii) to feedback high level emerging learning.

1.4 High levels of HPSS Activity

The Report needs to be set in context. During 2004/2005, the HPSS delivered high levels of treatment and care in a variety of settings[4]. For example, there were:

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[1] http://www.dhsspsni.gov.uk/reviewpublicadmin
[2] http://www.dhsspsni.gov.uk/hssppm6-04.doc
[3] http://www.dhsspsni.gov.uk/hssppm05-05.doc
[4] Source: DHSSPS

- 1 million accident and emergency (A&E) attendances;
- 28 million prescription items dispensed in the community;
- 2 million out-patient attendances;
- 740,000 in-patient and day cases;
- 176,000 people in contact with Social Services;
- 2,500 looked after children;
- 18,000 children referred to Social Services; and
- 1,500 children on the Child Protection Register.

With complex activity taking place on this scale, it is inevitable that some serious adverse incidents occur.

1.5 Who is this Report for?

This Report has been produced to support learning from serious adverse incidents. It is, therefore, aimed at those who work in or manage the HPSS and at those who have an interest in improving the safety and quality of health and social care services.

1.6 Strategic Context

The Report on serious adverse incidents has to be set in the context of other major developments on quality and safety which have been undertaken locally, which have been informed by national and international developments on quality and safety. These include:

(i) A major focus on clinical and social care governance, including risk management processes within the HPSS and the DHSSPS;

(ii) A statutory Duty of Quality[5] on HSS Boards and Trusts;

(iii) Development of a range of standards, including care standards for regulated services, HPSS quality standards, and a suite of controls assurances, including core standards on governance, risk management and financial management;

[5] See Article 34 of the HPSS (Quality, Improvement and Regulation) (NI) Order 2003 (S.I. 2003/431 (N.I. 9))

(iv) Development of *Safety First*[6] (March 2006), a document which sets out the Department's policy on safety and is accompanied by a comprehensive action plan to promote quality and safety improvements;

(v) An extensive work programme by the NI Clinical and Social Care Governance Support Team[7], the Regional Governance and Risk Management Adviser[8] and the Medicines Governance Team[9] to assist HPSS organisations in sustainable quality improvements; and

(vi) Formation of the Regulation and Quality Improvement Authority[10] (April 2005) which registers and regulates a range of services and reports on the quality of care within the HPSS. This will include, where appropriate, thematic reviews of specific aspects of service provision. As the Regulation and Quality Improvement Authority develops its methodology for the reporting on the quality of care to the public and to the HPSS, this will include an assessment of the organisational systems within HPSS organisations and the investigation of specific serious adverse incidents, e.g. a breast screening programme. Under the Safe and Effective Care theme of the Quality Standards[11], produced by the Department and used by the HPSS and RQIA, HPSS organisations are required to have systems in place to prevent, detect, communicate and learn from adverse incidents and near misses.

In addition to the above, through the Regional Governance and Risk Management Adviser, the Department commissioned guidance on how to classify adverse incidents and risk (March 2006)[12]. This is part of a wider project to develop a regional dataset, codes and reporting forms for the HPSS.

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[6] http://www.dhsspsni.gov.uk/index/publications
[7] http://www.dhsspsni.gov.uk/index/hss/governance/governance-clinical.htm
[8] http://www.dhsspsni.gov.uk/index/hss/governance/governance-adviser.htm
[9] http://www.dhsspsni.gov.uk/pas-governance
[10] http://www.rqia.org.uk/
[11] Quality Standards for Health and Social Care: supporting good governance and best practice in the HPSS (March 2006)
http://www.dhsspsni.gov.uk/qpi_quality_standards_for_health___social_care.pdf
[12] See Circular HSS(MD) 12/06, *How to Classify Adverse Incidents and Risk*
http://www.dhsspsni.gov.uk/ph_how_to_classify_adverse___incidents_and_risk_-_guidance.pdf

All of these developments will enhance systems approaches and culture change, with a view to improving service user outcomes and learning from adverse incidents. It will also facilitate linkage with other reporting systems such as the National Reporting and Learning System[13], designed by the National Patient Safety Agency[14] in England and Wales to encourage anonymised reporting, learn from adverse incidents and develop solutions in order to prevent reoccurrence.

1.7 Changing the Culture

Major strategic policy changes, as identified above, are designed to promote a safety and quality culture. But changing the culture of an organisation requires leadership and commitment at senior management level within an organisation. It also needs the proactive involvement of staff, the public and the media. Both service users and staff need open and fair processes to investigate and determine the cause of an adverse incident. For this to happen means that there are special responsibilities placed on the service users, staff media and the public. A system that does not support an open and fair process is to no-one's advantage in Northern Ireland, as it will not encourage open reporting, communication or learning.

[13] http://www.npsa.nhs.uk/display?contentId=2390
[14] http://www.npsa.nhs.uk/

SECTION 2: Frequency of reporting, variation and health and social care settings

2.1 Setting the Scene

An adverse incident is an event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation.

This definition represents the current working definition for adverse incidents in the HPSS, as outlined in the *Safety First: A Framework for Sustainable Improvement in the HPSS.* It recognises that not all errors result in harm to service users and/or staff, but some do. Where an incident is prevented, resulting in no harm, this is called a "near miss". This Report, therefore, includes all types of incidents which meet this criterion and those contained in circular (PPM 06/04).

It should be noted that:

- adverse incidents arise in a variety of settings;
- incident reporting systems are but one method that can be used to detect such events;
- when an incident reporting system is used, the success of it depends on individual/teams/organisations promoting its use in the interests of learning and sharing information;
- there are many local and national systems to which HPSS organisations report; and
- the Department's interim SAI system is dependent on the voluntary reporting by HPSS organisations; this "regional incident reporting" tool does not represent a complete picture of all adverse incidents occurring in organisations either in terms of the frequency or the severity of incidents.

In addition to the above, a number of other challenges emerge regarding the interpretation of the data provided by HPSS organisations which a reader of this report needs to keep in mind:-

(i) the reporting system was solely designed to provide feedback on the three criteria (as defined within the departmental circular); therefore, the data cannot be used for comparative purposes with other more comprehensive local, national or international systems;

(ii) the system is not designed to identify, for any specific incident, the degree of harm caused to the individual service user or the level of severity of the reported incident - this is the responsibility of the HPSS organisation to investigate;

(iii) the information supplied by HPSS organisations is usually limited to a one page proforma; therefore, it is not possible to ascertain whether a service user outcome (e.g. a death) was caused by the safety incident - this is the responsibility of the HPSS organisation to determine; and

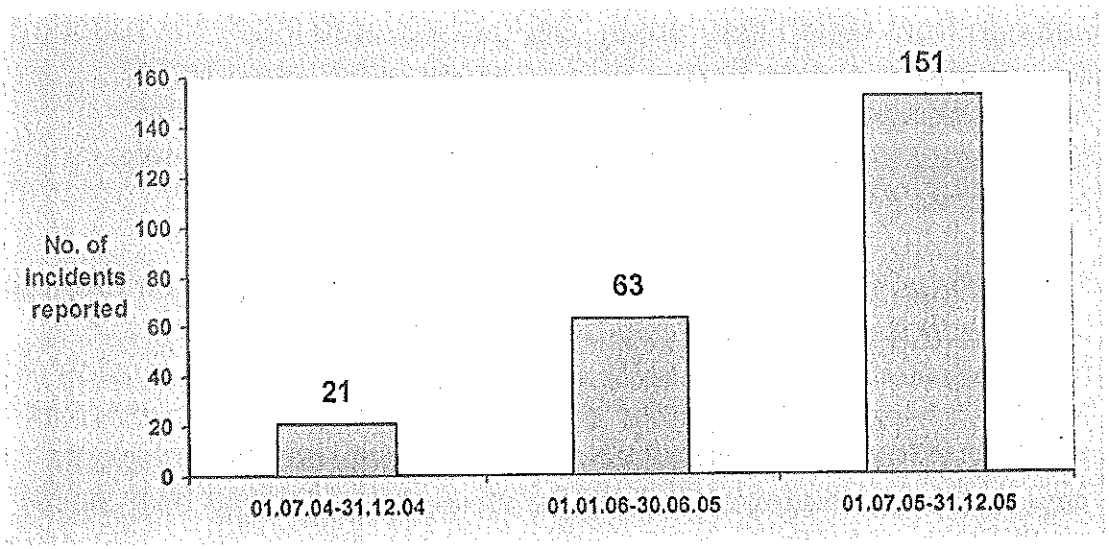
(iv) an organisation which reports many incidents, does not necessarily mean that this organisation is unsafe but rather the converse may be true i.e. the organisation may have achieved more in terms of supporting an open and learning culture, thus levels of reporting are higher than other similar organisations. Equally so, an organisation with low levels of reporting could be an unsafe organisation, as it may not support an open reporting and learning culture.

Within the identified constraints of the system, the following information on the frequency and variation of reporting of adverse incidents is supplied to promote discussion at local level on whether each HPSS organisation supports an open reporting and learning culture and whether individual organisations are assured that staff have knowledge of existing reporting pathways.

2.2 Frequency of reporting

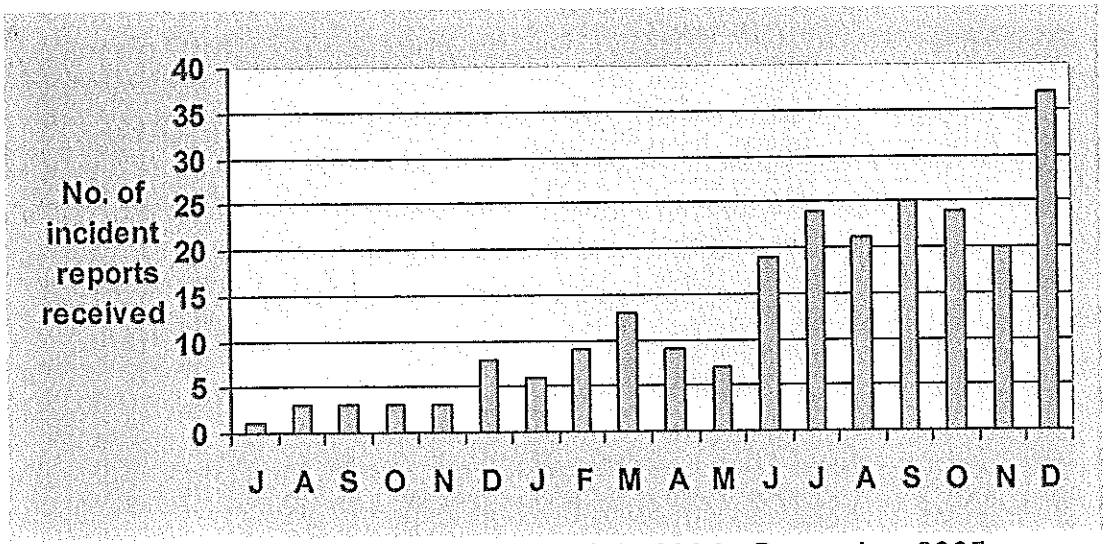
Between 1 July 2004 and 31 December 2005, there were a total of 235 incidents reported to the Department. Figure 1 shows a rise of incident reports to the Department, with the largest number being reported between July and December 2005 (151). This suggests an increasing willingness by HPSS organisations and family practitioner services to report SAIs which have occurred and share learning on a regional basis, where appropriate.

Figure 1: Serious Adverse Incidents (SAIs) 1st July 2004 to 31st December 2005



The growing participation and willingness to report SAIs is further illustrated when analysis is undertaken on monthly basis (Figure 2).

Figure 2: Frequency of Reporting By Month

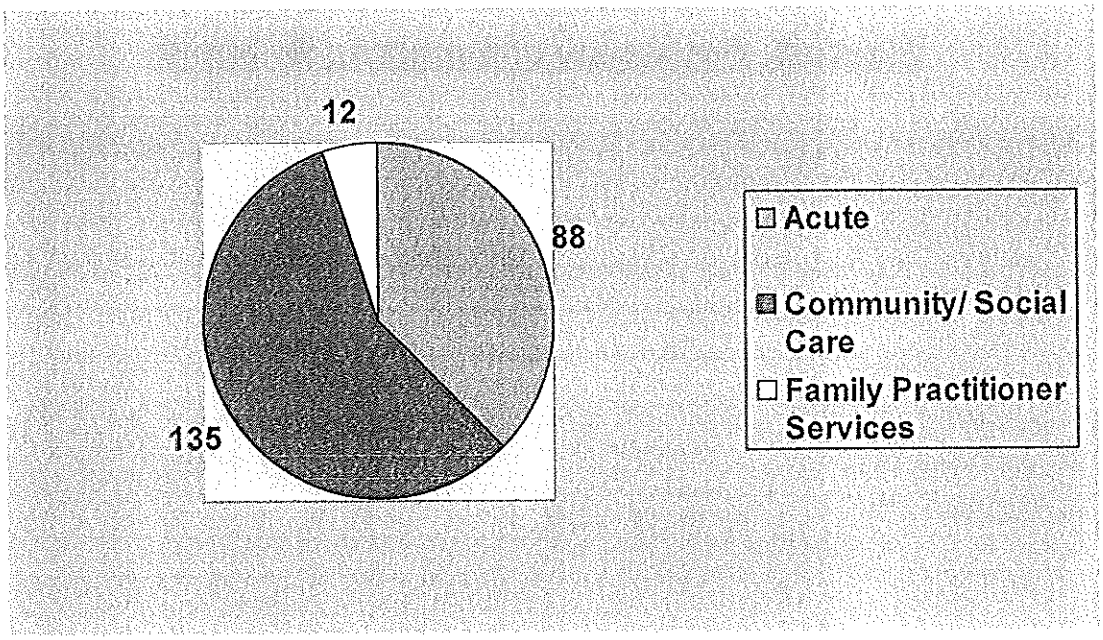


2.3 Reporting from HPSS Health and Social Care Settings

There is a significant variation in the type of reporting and the settings from which they arise. Serious adverse incidents reported include those arising from HPSS services either provided or commissioned. The incidents can be broken down into the following settings – acute, community/social care and family practitioner services.

The settings from which adverse incidents arise may be different to those recorded on other reporting systems; this is, in part, due to the integrated nature of health and social care service provision in Northern Ireland. This profile of service provision is different from the rest of the NHS. For example, the majority of NHS incidents reported to the National Patient Safety Agency[15] arose from acute healthcare settings.

Figure 3: Settings From Which Reported Adverse Incidents Arose (n = 235)



The majority of incidents come from community and social care settings, with relatively few arising from family practitioner services - i.e. GP, community pharmacy, dental and optometry services. In

[15] See the Patient Observatory Report *Building a memory: preventing harm, reducing risks and improving patient safety* (July 2005) http://www.npsa.nhs.uk/site/media/documents/1280_PSO_Report.pdf

addition, more from the acute hospital sector might have been expected.

For acute and/or community HSS Trusts, all trusts reported some adverse incidents, the range being 3 - 55 per Trust, within the specified time period. Figure 4 sets out the origin of the reporting organisations. No firm conclusion can be drawn regarding the quality of care provided by any one HSS Trust. This is because:

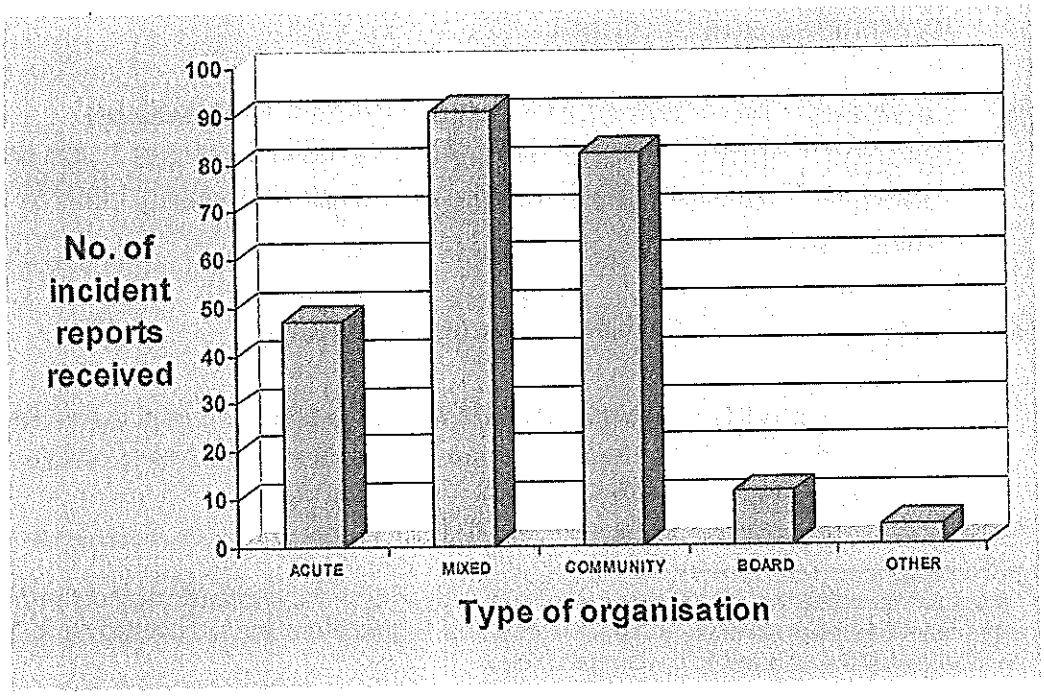
- Not all SAIs may have been captured at local level;
- Not all SAIs, within the remit of circular HSS (PPM) 06/04, may have been reported to the Department.

In addition, the following factors may have a bearing on the quality of care or reporting:

- The profile of care provided by HSS Trusts varies;
- The extent of population coverage varies; and
- There is likely to be underreporting by some Trusts, especially some acute trusts.

In light of this it would render comparisons inappropriate at this time.

Figure 4: Type of Organisation Reporting



SECTION 3: Summary of findings and high level learning

3.1 Summary of Issues Reported

Of the 235 reported incidents, the following represents an overview of the type of issue that was reported to the Department between July 2004 and end December 2005.

(i) Almost one-third of incidents reported involved the death of a person. It should be noted, however, that an SAI report, which documented a death, does not necessarily imply that the circumstances relating to the adverse incident contributed to the cause of the death.

(ii) Nearly two-thirds of these deaths were suspected suicides[16]. Almost all of these, involved people in recent contact with mental health services. There were also a small number of attempted suicides reported; the majority of these people were also in recent contact with mental health services.

(iii) Almost one-fifth of incidents reported involved people who are or had been in receipt of children's services. The majority of these reports related to children absent without leave from residential care or incidents where children in receipt of services either perpetuated a crime or had a crime committed against them.

(iv) Just over one-tenth of incidents reported involved an alleged[17] crime. These covered a range of issues such as homicide, assault, theft, arson and impersonating HPSS staff.

(v) Between 5% and 10% of incidents reported:

a. involved violence against HPSS staff. These events ranged from verbal aggression and threats to physical assault;

[16] It should be noted that in the absence of knowledge of the inquest verdict, all of these cases have been classified as "suspected suicides" regardless of the circumstances in which the individual was reported to have been found.

[17] It is to be noted that criminal investigations will be ongoing on these incidents and allegations may not be proven in all cases

b. involved damage to HPSS/staff property;
c. concerned injuries to people. This covered a range of scenarios such as accidents, assaults, falls and medical equipment malfunction; and
d. contained allegations of professional misconduct, with almost half raising concerns about the competence of locums.

(vi) In 5% of incidents reported there were:

a. references to the possible malfunction of equipment, with just over half relating to decontamination issues; and
b. concerns about procedural errors in the acute sector. These include non-adherence to policies and procedures and delays in carrying out tests or transmitting results to appropriate personnel.

(vii) There were a range of issues which amounted to less than 5% of incidents reported. These include:

a. drawing attention to service pressures and the non-availability of appropriate specialist in-patient beds;
b. involvement of public health related issues e.g. communicable disease; and
c. medication management issues (from primary, social care and secondary care sectors).

SECTION 4: Action and Learning at Regional Level

4.1 Methodology used by the DHSSPS

The regional learning arising from these incidents reported to the Department is multifaceted and, as stated previously, is based on a relatively small amount of information received on each individual serious adverse incident (SAI).

Following receipt of an SAI report, the Department may seek further clarification of the incident from the HPSS organisation, and occasionally may advise the HPSS organisation on the appropriateness of an independent review. It remains the responsibility of the HPSS organisation to ensure that relevant procedures are in place to manage the incident, report it to statutory and/or local/national reporting systems and ensure steps are taken to prevent its reoccurrence at local level.

Under circulars HSS (PPM) 6/04 and 05/05, each case submitted to the Department is shared with relevant policy and professional directorates where comments are sought on the particular circumstances of the incident. These comments are then brought to an internal multidisciplinary review group, chaired by a senior professional officer. The Group considers the submitted proforma and any accompanying policy/professional comments. It then attempts to draw conclusions from the written evidence submitted. This might include whether further action is necessary, especially regional action, to prevent recurrence and to share learning.

The outcome of the discussion might be:

(i) further communication with the relevant HPSS organisation;

(ii) feedback on the particular incident(s) and learning through a workshop(s) organised with HPSS Trusts and Boards;

(iii) referral to a national body for urgent action- e.g. further assessment and investigation by the Northern Ireland Adverse Incident Centre[18](NIAIC) in respect of incidents associated with medical device safety which may be referred

[18] http://www.dhsspsni.gov.uk/niaic

to the Medicines and Healthcare products Regulatory Agency[19];

(iv) commissioning of local guidance e.g. from NI Medicines Governance Team or Clinical Resource Efficiency Support Team[20] (CREST);

(v) cascade of an urgent letter via the chief professional officers or relevant policy directorate and

(vi) increased collaboration with educational providers to enhance understanding of clinical and social care governance and promote the cascade of learning arising from specific incidents.

4.2 Emerging Learning

It is not the intention to drill down into each incident in order to cascade all elements of learning but rather to provide an overview of major areas of risk and learning identified through this process. Many of these categories are linked and often there is more than one contributory factor within a specific incident, thus contributing to the "swiss cheese"[21] effect leading to systems' failure.

In summary, the learning from the incidents reported may be grouped into five main categories. These are:

- Enhanced treatment and care;
- Enhanced professional performance;
- Improved communication procedures;
- Improved human resource policies and procedures; and
- Improved reporting and learning from serious adverse incidents.

4.2.1 Enhanced treatment and care

(i) The need for appropriate assessment and diagnosis of individual patients and service users;

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[19] http://www.mhra.gov.uk/home/idcplg?IdcService=SS_GET_PAGE&nodeId=5
[20] http://www.crestni.org.uk/publications/pubsreply.asp
[21] A model of accident causation – Reason, J. *Managing the Risks of Organisational Accidents.* Ashgate. Aldershot 1997

(ii) Appropriate risk assessment of the environment, in which an individual patient/service user is placed, including community care settings, hospital wards or A/E departments;

(iii) Enhanced assessment, diagnosis, monitoring and post-discharge care of individuals who are known to be at risk of self harm or suicide;

(iv) The need for adherence to protocols and guidance e.g. the management of head injuries, blood transfusions;

(v) Enhanced use of clinical monitoring systems to aid detection and deterioration of seriously ill patients, especially in high pressure areas such as A&E departments or busy hospital wards;

(vi) The need for enhanced co-ordination of services for children and vulnerable adults; and

(vii) The need for full adherence to the Department's child protection guidance – *Co-operating to Safeguard Children*[22].

4.2.2 Enhanced professional performance

(i) Enhanced knowledge and care of common conditions (linked to above);

(ii) The recognition that failures of medical devices and medication errors, may often be due to the inherent design of the product or system, but can also be due to individual operator judgement/error; and

(iii) A need for early detection and intervention on professional performance issues arising from conduct, behaviour, lack of skills/ competencies or ill-health of the individual staff member.

4.2.3 Improved communication procedures

(i) The need for improved communication, for example;

[22] http://www.dhsspsni.gov.uk/safeguard_contents.pdf

a. *Written* - good and legible record keeping and notes, and the sharing of clinical notes between professional groups;

b. *Verbal* – good communication between professionals, particularly in aiding detection and deterioration of patients; and

c. *Organisational level* – good communication between organisations/committees e.g. on interhospital transfer or to Area Child Protection Committees/Department.

4.2.4 Improved human resource policies and procedures

(i) The need for tightening of recruitment procedures, checks and appraisal systems, especially in relation to locum doctors, agency staff, and other health and social care staff providing services to individuals in care settings;

(ii) The need for knowledge and implementation of relevant disciplinary procedures within the HPSS organisation or care setting, including suspension of staff where necessary, and use of the National Clinical Assessment Service[23], where the performance of a doctor or dentist gives rise to concern; and

(iii) The need for support services for staff who were subject to verbal or physical abuse.

4.2.5 Improved reporting and learning from serious adverse incidents

(i) The approach to local root cause analysis needs further development and standardisation in HPSS organisations; and

(ii) The system of reporting of SAIs to the Department and subsequent requests to HPSS organisations for more information needs further development. This is necessary to enhance learning from serious adverse incidents and improve communication.

[23] http://www.ncas.npsa.nhs.uk/

SECTION 5: Regional Examples of Learning and Action

Four examples are provided to demonstrate learning which has generated action at regional level. These examples have been selected to show the spectrum of care and environments where incidents arise, such as:

a. clinical care;
b. mental health services;
c. hospital service pressures; and
d. care settings especially for vulnerable adults and/or children.

5.1 Example 1: Clinical Care – Hyperkalaemia and Insulin Administration in Adults

Adverse Incident

It was intended to draw up 10 units of insulin to mix with 50 mls of 50% dextrose. 10 units of insulin was confused with 10 mls and a standard 10 ml syringe was used to draw up a full ampoule of 100 iu/ml into the syringe. The result of this was that the patient received a 1000 units of insulin.

Regional Action and Learning arising from Example 1

1. Insulin syringes must be used to draw up insulin. Appendix B is an example of a Trust poster which could be adapted for local use.
2. *Recommendations on the safe use of Insulin in Secondary Care in Northern Ireland* was developed by the Northern Ireland Medicines Governance Team and circulated by the Department on 22 December 2005.
3. Guidelines for the Treatment of Hyperkalaemia in Adults were developed by CREST in January 2006 and circulated to Trusts. These include the safe administration of insulin and glucose in the treatment of hyperkalaemia.
4. Guidelines on the Safe and Effective use of Insulin in Adults has been developed by CREST in May 2006.
5. CREST will shortly commence development of guidelines on the safe and effective use of insulin in children, which will be published in early 2007.
6. The Department has convened a group to consider induction training of junior doctors. These will include the recognition that individuals must work within their skills and competencies and seek help, when working outside these limits. In addition, it will emphasise the need for generic induction procedures as well as ward based induction. This guidance will be published in June 2006
7. The Report on the induction programme for junior doctors will be relevant to the induction of other professional groups.

5.2 Example 2: Risk assessment of the environment and provision of emergency care

Adverse Incident

Fall from first floor window requiring on site emergency response.

Risk assessment of the environment, together with the need for care plans, was highlighted in several SAIs, particularly for those patients who were known to be at risk of suicide or self-harm or were confused, due to the nature of their underlying condition. Examples of environmental issues related to falls from windows, plastic pillow covers, anti-vandal smoke detector covers which presented a ligature risk and curtain rails which were all associated with reports covering suicide attempts.

Regional Action and Learning arising from Example 2

1. All HPSS bodies should undertake a regular risk assessment in respect of compliance with guidance and legislation for the built environment and put in place plans to address and/or manage risks. Further information is available on www.dhsspsni.gov.uk/niaic

2. All HPSS bodies should have implemented Professional Estates Letter PEL(03)04: Suicide Risk Associated with Non-Collapsible Curtain Rail Track and other Fixtures http://hea/files/documents/PEL(03)04.doc This PEL was issued as a result of further reports to NIAIC involving fatalities in HSS accommodation and followed on from the guidance contained in Safety Action Notice SAN(NI)98/53 in respect to addressing risks associated with ligature points such as curtain tracks and other fixtures.

3. All Trusts and care establishments should bring to the attention of staff the emergency procedures for the handling of emergencies which happen within their health estate to ensure timely emergency clinical care.

4. A comprehensive suicide prevention strategy called *Protect Life: A Shared Vision, The Northern Ireland Suicide Prevention Strategy and Action Plan* has been issued (March 2006).

5. The NI Clinical and Social Care Governance Support Team, as part of its education programme for 2006/7, will be focussing on improving mental health services.

6. The Department will set up a regional group which will assist the HPSS to take forward improvements in the risk assessment and management processes in mental health services

5.3 EXAMPLE 3: Hospital Service Pressures increasing the risk of an adverse incident

Adverse Incident

Due to pressure on beds in an A&E department, an elderly patient with a complex medical history, was nursed in a bed in the trauma corridor of an A&E department, out of sight of the nursing station. The patient suffered a fall sustaining a head injury.

This particular incident reflects the complexity of human, environmental and service pressures which have the potential to adversely impact on care. In difficult circumstances, staff continue to try and deliver high quality care, but such pressures add to the likelihood of adverse incidents occurring.

Regional Action and Learning arising from Example 3

1. A comprehensive regional reform programme to address hospital access issues is underway. As part of this programme waiting times in A&E will be addressed, supported by robust monitoring arrangements and reforms to existing systems and processes.

2. A public information campaign is currently underway to promote use of other clinical settings for speedy intervention such as at community pharmacies, and Out of Hours Centres, thus reducing pressures in A&E.

3. The placement of patients in non-designated beds spaces should be discontinued, except in exceptional circumstances. Where it occurs, it should be clearly documented in the notes, together with the risk assessment undertaken.

4. An assessment of risk of falling should be carried out on each patient; where bed rails are used these should be correctly engaged.

5. The staff need to ensure that the patient, in such circumstances, can communicate e.g. through a nurse call system or other method of communication.

6. The monitoring, recording of observations and use of a variety of documentation needs to be improved in A&E departments. All entries in clinical notes must be dated, timed, signed and printed.

7. The Department has asked CREST to review the use of early warning scoring systems to improve the early recognition of life threatening events. Such systems could be adapted for use in ward and A&E settings.

8. Head injury guidelines were produced by the Department in 2001; all Trusts should facilitate implementation of these guidelines.

5.4 EXAMPLE 4: Children Absconding from Residential Care

Adverse Incident

A number of SAI reports were received regarding children absconding from residential care. (In some instances the SAI reports received did not actually meet the criteria for reporting to the Department as set out in circulars HSS(PPM) 06/04 and 05/05).

However, the absconding issue reflects the complexity of the high level needs presented by some children in residential care settings.

Regional Action and Learning arising from Example 4

1. The Department recently submitted a proposal to the four HSS Boards to develop greater stability in relation to residential child care. This involves the introduction of Restorative Practices* in all Children's Homes after successful experience in the pilot at Glenmona Regional Centre. Recent research re-emphasises the importance of checking with a child on their return whether sexual abuse was a trigger in their absconding behaviour.

2. The HSS Boards' Fostering Strategy (draft August 2005) will increase the number of foster carers which will provide greater capacity in the looked after system and greater opportunity for more stable placement of children in need.

3. The increase in Intensive Residential Support Units being taken forward via *Children Matter Task Force* will expand the provision to handle those children with higher level needs.

4. The issue of the Department's revised circular HSS (PPM) 02/06 has provided greater clarity regarding notification to the Department when a child is missing from a children's home.

5. The Department has completed draft guidance on the Children's Homes Regulations (NI) 2005 which will further clarify the reporting of such incidents.

6. The issue of reporting incidents about children absconding and possible action will be discussed at the next Chief Inspector, Social Services Inspectorate's meeting with the Directors of the four HSS Boards in June 2006.

* Restorative practices seek to repair damaged relationships and specifically in the case of Looked after Children, prevent them becoming criminalised for acting out behaviours. This should occur preferably at a low level during daily one to one contacts, interpersonal contact, group contacts, but also in relation to serious incidents that cause harm.

Section 6: The Way Forward

Considerable numbers of serious adverse incidents have been reported to the Department through the SAI system. The Department commends those HPSS organisations and family practitioners services which are willing to promote adverse incident reporting and a culture of learning. Over the coming months, the Department will be working with the HPSS to further enhance incident reporting systems.

6.1 Sharing the Learning

A further workshop will be held in June 2006 to promote learning arising from these incidents, and to consider how best to move forward with the process of shared learning.

Subject to Ministerial approval, the Department aims to enter into a formal agreement with the National Patient Safety Agency (NPSA). This will include links to the NPSA's National Reporting and Learning System (NRLS). Once all organisations, including family practitioner services, are part of the NRLS, the Department will review the need for the local reporting of serious adverse incidents under existing arrangements. Meanwhile, in March 2006, the Department issued further guidance which takes account of the experiences of the first 18 months of reporting to the Department. The March 2006 guidance includes a revised proforma[24] which the Department considers will lead to an improvement in the information reported to it.

6.2 The role of RQIA

The Regulation and Quality Improvement Authority (RQIA) will have a pivotal role in reporting on the quality and safety of care both to the public and to the Department. This will focus, not just on HPSS systems, but will also look at health and social care outcomes. It will use the content of the Quality Standards as part of their overall assessment. This includes an emphasis on five themes:

- Corporate leadership and Accountability of Organisations
- Safe and Effective Care;
- Accessible, Flexible and Responsive Services;

[24] http://www.dhsspsni.gov.uk/gpi_unit_sai_reporting_template.doc

- Promoting, Protecting and Improving Health and Social Wellbeing; and
- Effective Communication and Information.

6.3 HPSS Re-organisation

In light of the Review of Public Administration, both the Department and the service are facing unprecedented change. However, it is vital that during the transition period, continued progress is made to improve service quality and learn from serious adverse incidents. In the future, new structures, legislation and ways of working offer the HPSS and the Department an opportunity to further promote and integrate quality and safety into everyday practice.

Acknowledgement

This Report has been made possible by the commitment of staff and senior management, within HPSS organisations and family practitioner services, to report and learn from serious adverse incidents. The Department also acknowledges the role played by the Planning and Performance Management Directorate, other policy directorates and professional advisers, in promoting, collating and learning from the serious adverse incidents.

APPENDIX A

Proforma for submission of serious adverse incidents (SAIs) to the Department from July 2004 (this pro-forma is revised with effect from March 2006)

SERIOUS ADVERSE INCIDENT REPORT
1. Organisation:
2. Brief summary (and date) of incident:
3. Why incident considered serious:
4. Action taken:
5. Is any regional action recommended? (if so, full details should be submitted) Y/N -
6. Is an Independent Review being considered? (if so, full details should be submitted) Y/N -
7. Other Organisations informed **PSNI** Y/N - **Coroner** Y/N - **NIHSE** Y/N - **HSS Board** Y/N - **Other** (please specify) Y/N -
8. Report submitted by (name and contact details of nominated senior manager or Chief Executive)

Completed proforma should be sent, by email, to:

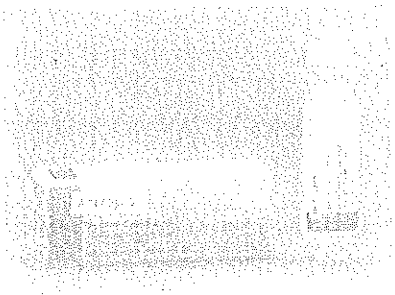
adverse.incidents[redacted]

If e-mail cannot be used, fax to [redacted]

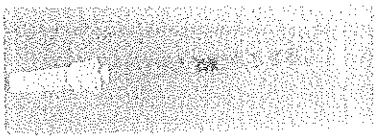
Insulin Safety Information

The dose of insulin must always be specified in units when writing prescriptions

Multi-dose vials of insulin are presented as 10ml vials



Once opened, the multi-dose vials are stable at room temperature/in the pharmaceutical fridge for up to 4 weeks. Contact Medicines Information for further details. Date each vial when opened and discard after the specified time.



use an insulin syringe to draw up any dose of insulin from a vial.

Second check

A second check must be performed during both preparation and administration of subcutaneous, intramuscular and intravenous insulin. must be involved, one of whom must be a registered nurse.

Pens and cartridges

- If a pen is in use for a named patient it should be stored at room temperature in a locked medicine trolley or POD locker (as appropriate) with a patient addressograph attached. Do not store in the pharmaceutical fridge.
- The majority of pens can be stored at room temperature for up to 28 days. Contact Medicines Information for further details.
- All unopened cartridges and pens should be stored in the pharmacy fridge.