Department of
Health, Social Services and Public Safety

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ANALYSIS OF SERIOUS ADVERSE INCIDENTS RECEIVED BETWEEN 1 JANUARY 2006 AND 31 MARCH 2007

(Circulars HSS(PPM) 06/04, 05/05 and 02/06)

DECEMBER 2007

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Foreword

All new HSC organisations have high aspirations for the future; to provide the highest quality of treatment and care and to improve the health and wellbeing of the local community.

The concept of safety first is an integral part of that high quality of care. To promote safety within an organisation requires the commitment of leaders, senior managers, teams and individuals.

This Report covers serious adverse incidents (SAIs) reported to the Department between January 2006 and March 2007. It is being presented to HSC organisations in the interests of promoting safety and learning, so that HSC leaders, educators, teams and individuals can share experiences, learn and use adverse incident reporting as a mechanism to improve organisational performance. This Report, therefore, is about using key adverse incident scenarios to drive improvement in health and social care. In doing so, it is recognised that in any organisation the principles should be "what has happened" and "how can we improve" rather than "who made the error".

A total of 309 SAIs were received in the reporting period. The main categories reported relate to:

Suspected suicides;
Children's services;
Service pressures;
Professional performance;
Medicines management;
Security management;
Public health; and
Violence against staff.

Since commencement of the SAI system in July 2004, the total number of SAIs reported is increasing. This does not mean that care has deteriorated but rather it suggests a willingness of individuals to report and a recognition that such systems-approaches are part of risk management and performance improvement.

The Report contains a number of topic specific sections including, record keeping & documentation; medicines management; communication; mental health issues; clinical treatment & care; recruitment & training; and children's services to highlight learning and to link it with recent guidance and policy documents on related topics. The appendix contains other sources of mainly local information which aims to act as an additional resource for HSC organisations, family practitioners and educators.

Regardless of changes that may occur due to the reorganisation of HSC bodies, the Department is committed to driving forward the agenda on safety and quality improvement. Key elements of this will be an emphasis on:

- performance improvement through effective commissioning and delivery of care;
- promoting leadership, with ownership of safety and quality throughout an organisation;
- development of key performance indicators and service frameworks to drive improvement;
- integration of reporting systems and implementation of specific safety solutions;
- promotion of collaborative approaches to learning through facilitation and support via the newly formed Safety Forum, and the reprioritisation of the Clinical & Social Care Governance Support Team work programme;
- incremental change through "improvement science" techniques, building on local, national and international interventions that are known to save lives;
- recognising the importance of professional engagement through leadership programmes; and
- understanding the pivotal place that patients, clients, families and carers can play in their own health and well-being.

The Department aims to promote this agenda throughout 2007/08 and beyond. Part of this will be re-organisation of the SAI system and the more timely cascade of regional learning arising from adverse incidents.

Martin Bradley
Chief Nursing Officer
Chair SAI Review Group

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Director, Safety, Quality and Standards

SECTION 1

OBJECTIVES OF THE DHSSPS SERIOUS ADVERSE INCIDENTS (SAIs) INTERIM REPORTING SYSTEM

1.1 Introduction

Health and Social Care is not risk free, so we must ensure that risks are identified and managed by changing the culture, and by enhancing systems and working practices to prevent or reduce the risk of injury or harm to patients, clients and staff.

That is why it is important to identify and learn from all adverse events and make improvements in practice, based on local and national experience and learning derived from the analysis of such events.

This is the second annual report on the learning arising from those serious adverse incidents (SAIs) notified to the Department of Health, Social Services and Public Safety (DHSSPS). The report covers the period January 2006 to March 2007 during which a total of 309 incidents were reported.

1.2 Criteria for reporting Serious Adverse Incidents to the DHSSPS

A serious adverse incident including a near miss is defined as those situations where the consequences are likely to:

- be serious enough to warrant regional action to improve safety or care within the broader Health and Social Care system;
- be of major public concern; and/or
- require an independent review.

The reporting criteria for the period 06/07 was outlined in circulars HSS(PPM) 06/04[1], 5/05[2] and 02/06[3]. This requires HSC organisations, and family practitioners services (via HSS Boards) to report serious adverse incidents to the Department.

[1] http://www.dhsspsni.gov.uk/hssppm6-04.doc
[2] http://www.dhsspsni.gov.uk/hssppm05-05.doc
[3] http://www.dhsspsni.gov.uk/qpf_adverse_incidents_circular.pdf

1.3 Management of SAIs within the Department

Each month the Department's Serious Adverse Incident Review Group meets under the Chairmanship of the Chief Nursing Officer. The Group's membership is drawn from social services, mental health, child care and secondary care, and since March 2007 – as a pilot exercise - has representation from each of the four HSS Boards.

Upon receipt in the Department each SAI is logged and views sought from the relevant professional leads and policy directorates, as required. This may result in further clarification being sought from the Trust. When all information has been obtained the case is considered by the SAI Review Group, regional learning, if any, is identified and in certain cases referral is made to the relevant policy or professional lead with a view to the issue of a professional letter, policy, guidance or NIAC alert to the service.

1.4 Identification of Regional Learning

The objectives of the SAI reporting system are to encourage an open and learning reporting culture, acknowledging that lessons need to be shared in order to improve service user and staff safety and apply best practice in assessing and managing risks. It also aims to provide feedback on high level analysis and themes arising from reported incidents and ensure that the service is alerted to emerging learning.

Out of the SAIs considered in this reporting period six main learning themes emerge and are reported on more fully in the body of the report. The themes are:

- Record keeping and documentation;
- Medicines management;
- Communication;
- Mental health issues;
- Clinical treatment and care; and
- Recruitment and training.

1.5 Levels of HSC Activity

While there were 309 reported SAIs, this needs to be set in the context of overall HSC activity. During 2005/2006, the HSC delivered levels of treatment and care in a variety of settings[4]. For example, these were:

- 700,000 accident and emergency (A&E) attendances;
- 29 million prescription items dispensed in the community;
- 1.5 million out-patient attendances;

[4] Source: DHSSPS

- 500,000 in-patient and day cases;
- 181,000 people in contact with Social Services;
- 2,400 looked after children;
- 19,000 children referred to Social Services; and
- 1,600 children on the Child Protection Register.

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

1.6 Strategic Context

Since the statutory duty of quality was placed on HSS Boards and HSC Trusts in 2003, there have been significant national and local developments on quality and safety. During 2006/07, the Regulation & Quality Improvement Authority (RQIA) commenced its governance reviews based on two themes of the *Quality Standards in Health and Social Care*[5] - Corporate Leadership & Accountability and Safe & Effective Care. The annual compliance exercise against controls assurance standards is now in its fourth year. Work on the Safety First Action Plan[6] is substantially completed and it will be reviewed later in the year. Completed actions include the development of Safe & Effective key performance indicators which will assist HSC organisations in driving forward quality improvement.

A HSC Safety Forum has been established to keep pace with international and national developments on patient safety. Its work includes providing support to Trusts as they implement evidence-based patient safety interventions which demonstrate improved outcomes for patients and reduce harm. During this reporting period, HSS Boards have established SAI handling procedures in their respective areas. This helps inform Boards with regard to meeting the statutory duty of quality on the services they commission and also assists in strengthening accountability with Trusts on statutory and delegated functions. The Boards also have protocols in place with family practitioner services for the reporting of adverse events and for onward transmission to the Department by the area Board of those events which meet the SAI reporting criteria.

1.7 Conclusion

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

Safe and effective practice remains the top priority for health and social care in Northern Ireland. The public have a right to expect that every effort will be

[5] http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-standards/spsd-standards-quality-standards.htm
[6] http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-safety/sqsd_safety_safety_first.htm

made to ensure that their care and treatment will be in accordance with best practice and any risks minimised.

This report will be accompanied by a workshop to cascade learning and to discuss with HSC staff how the SAI reporting system might be improved.

SECTION 2

FREQUENCY OF REPORTING; VARIATION; HEALTH & SOCIAL CARE SETTINGS; AND SUMMARY OF ISSUES REPORTED

2.1 Setting the Scene

An adverse incident is "*any event or circumstances 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 HSC organisations, 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 contains a subsection of all adverse incidents – ie. which are classified as serious adverse incidents and which meet the criteria contained in circulars (PPM) 06/04, 05/05 and 02/06.

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 HSC organisations report; and
- The Department's interim SAI system is dependent on the voluntary reporting by HSC 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 HSC 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 circulars); therefore, the data cannot be used for comparative purposes with other more comprehensive local, national or international systems;

(ii) from April 2006, the system requests the initial classification of the incident (ie. catastrophic, major, moderate, minor, insignificant) in order to assess the degree of harm caused to the individual service user or the level of severity of the reported incident – it remains the responsibility of the HSC organisation to investigate the incident fully;

(iii) the information supplied by HSC 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 HSC organisation to determine; and

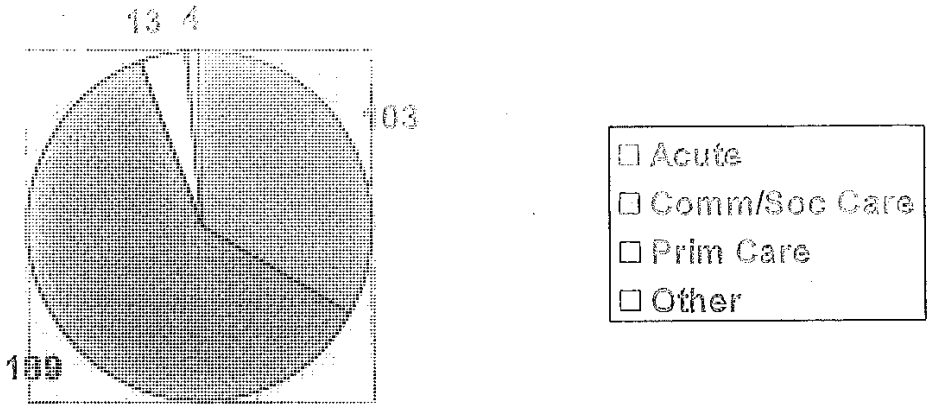
(iv) an organisation which reports many incidents, does not necessarily mean that this organisation is unsafe but rather the converse may be true i.e. the organisation may have achieved more in terms of supporting an open and learning culture, thus levels of reporting are higher than other similar organisations. 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 an adverse incident is supplied to promote discussion at local level on whether each HSC organisation supports an open reporting and learning culture and whether individual organisations are assured that staff have knowledge of existing reporting pathways.

2.2 Reporting from Health and Social Care settings

309* incidents were reported to the Department between 1 January 2006 and 31 March 2007 (*3 incidents were reported twice by different organisations and are therefore only counted once). Due to the integrated nature of health and social care services in Northern Ireland, the settings from which the incidents are recorded are acute, community/social care and family practitioner services.

Figure 1 – Settings from which reported SAIs arose (N=308)

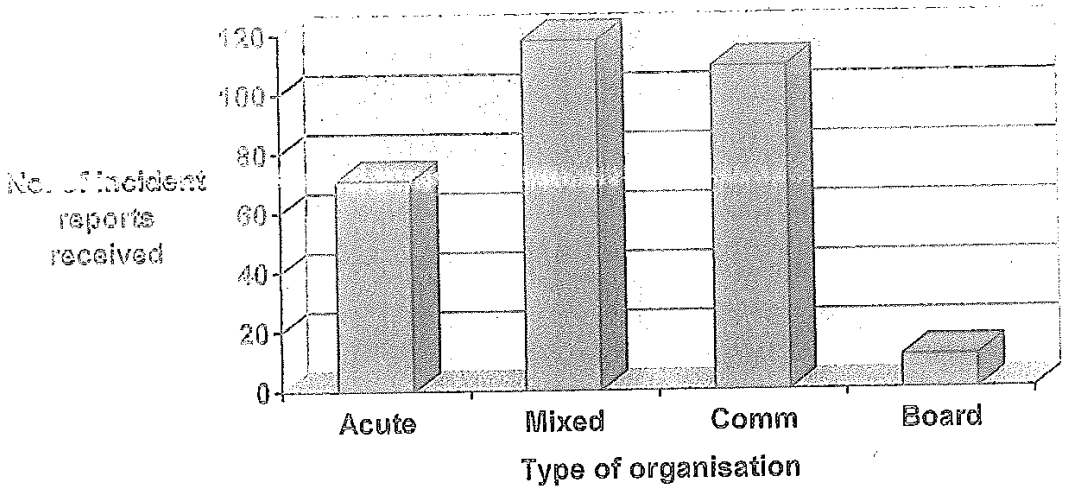


All HSS Boards and HSC Trusts reported at least one SAI. For acute and/or mixed/community Trusts, the range was 1 - 58 per Trust within the specified time period.

Figure 2 sets out the origin for the reporting organisation. Just over 20% of SAIs were reported from an acute trust (almost half of these were from acute mental health services). This would indicate that there continues to be underreporting by acute trusts. In its latest data summary, the National Reporting and Learning System continues to have around 70% of incidents reported from an acute/general hospital setting[7]. However, the 57% overall increase in local SAI reporting suggests an increasing commitment by HSC organisations to report SAIs. This includes an awareness in Family Practitioner Services of the value of reporting adverse incidents.

[7] Quarterly National Reporting and Learning System data summary, Issue 4: October to December 2006 (NPSA, 2007)

Figure 2 – Type of Organisation reporting (January 2006 – March 2007)



No firm conclusion can be drawn regarding the quality of care provided by any one HSC Trust. This is because:

- Not all SAIs may have been captured at local level;
- Not all SAIs, within the remit of circulars HSS (PPM) 06/04, 05/05 and 02/06 may have been reported to the Department.

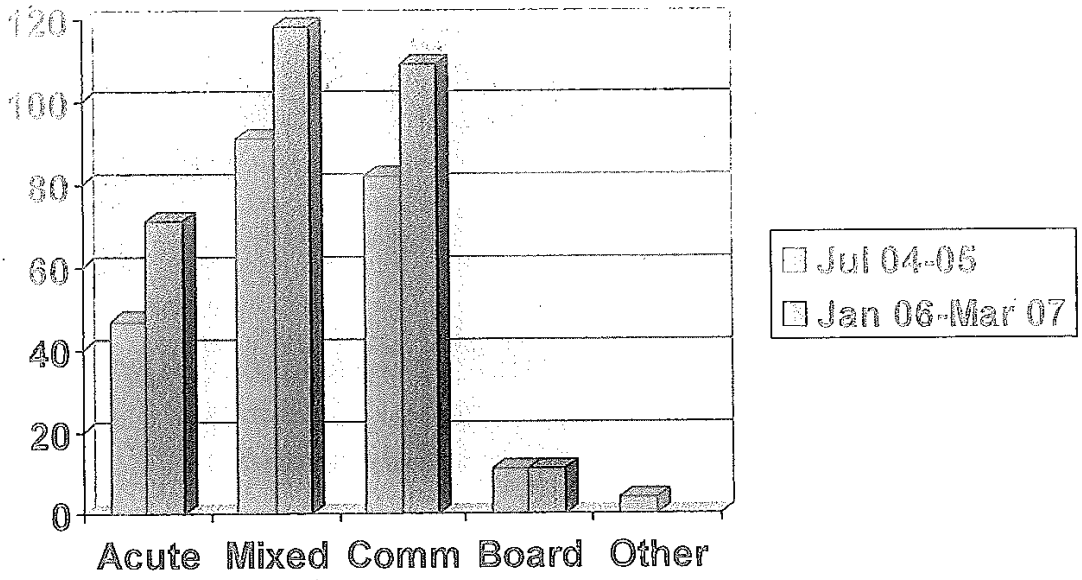
In addition, the following factors may have a bearing on the quality of care or reporting:

- The profile of care provided by HSC 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 3 demonstrates that the profile of origin of organisation reporting has not altered significantly during this period.

Figure 3 – Comparison of Types of Organisation reporting SAIs between July 2004-December 2005 and January 2006-March 2007



2.3 Summary of Issues Reported

Of the 309 reported incidents, the following represents an overview of the type of issue that was reported to the Department between January 2006 and March 2007.

- Almost one-third 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 death.

- Just over two-thirds of these deaths were suspected suicides[8], involving people in recent contact with HSC services.

- Almost one-fifth involved people who are or had been in receipt of children's services. The majority relate 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.

- Between 5% and 10% of incidents reported:

[8] In the absence of knowledge of an inquest verdict, these cases have been classified as "suspected suicides" regardless of the circumstances in which the individual was reported to have been found.

- involved service pressure issues, mainly around the non-availability of appropriate specialist child & adolescent mental health services; and
- addressed professional performance issues.

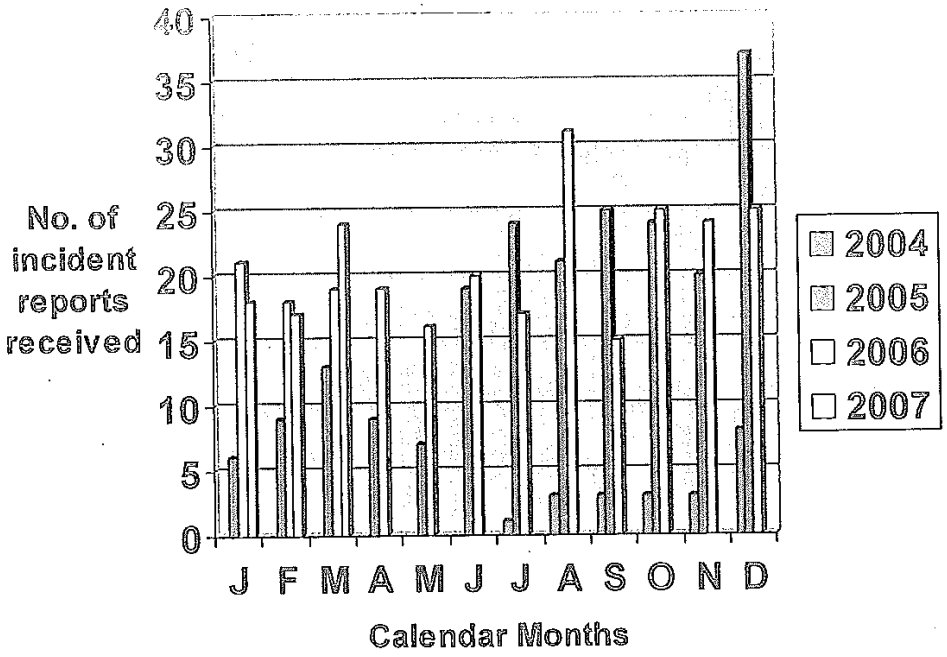
- There were a range of issues which amounted to less than 5% of incidents reported. These include:

  - Medication management issues (from primary, social care and secondary care);
  - Involvement of public health related issues eg. communicable disease;
  - Security management issues, including theft from, and threats against, HSC properties;
  - Violence against HSC staff, ranging from verbal aggression and threats to physical assault; and
  - Concerns about procedural errors in the acute sector, including non-adherence to policies and procedures.

7.4 Frequency of Reporting

Between 1 January 2006 and March 2007, there was a total of 309 incidents reported to the Department. Figure 5 shows that there has been a consistent volume of reports received during the 15 months period.

Figure 5 – Frequency of Reporting by Month (July 2004 – March 2007)



SECTION 3

RECORD KEEPING AND DOCUMENTATION

3.1 Record keeping and documentation is an integral part of good professional practice and helps to protect patients/clients from injury or harm by promoting:

- high standards of care;
- continuity of care;
- better communication and dissemination of information between members of the inter disciplinary teams;
- an accurate account of treatment and care planning and delivery;
- the ability to identify risks and detect problems such as changes in the patient/client condition.

Relevant related guidance is documented at paragraph 3.3 and in the Appendix.

Learning arising

3.2 Issues identified by HSC organisations for ***learning*** that have arisen in this SAI reporting period include:

Clinical records:

- All details in patient's/client's notes (including test results) must be dated, timed, signed and printed before filing.
- All records belonging to patients should have full demographic details
- Where patients are receiving treatment from several specialities it should remain clear and recorded in the notes who is responsible for which aspect of management.
- The format of patient's/client's and other notes should be uniform, consistent and, where possible, combined into one set of patient's/client's notes.
- All clinical contacts with the patient should be documented in the records (including those contacts by telephone).
- All appointments made/referrals should be dated and recorded in records.

Mental Health:

- When assessing a mental health patient, the first assessment should be documented fully and where criteria for detained admission are not met the reasons for this assessment should be written in full.
- A comprehensive social history should be contained in the case file.
- The need for formalised multi-disciplinary care plans to be a formal integral part of care planning, particularly in complex mental health cases. The management of these patients can require the input of a wide range of health and social care professionals and carers. The specific inputs and accountabilities should be clearly identified and documented in the care plan; including the individual professional who is taking the lead in the management of care.

Laboratory results:

- Systems should be in place to ensure a clear and permanent record is kept of results received; date and time received; who received them; to whom they have been communicated; and what action by a named individual has been taken on basis of results.

Early warning systems:

- Observation charts should be standardised across the organisation and incorporate an 'early warning system' score. All staff should be trained in the proper use and completion of observation and fluid balance charts.

Voluntary sector:

It is important to have appropriate communication and reporting systems in relation to supply of information between Trusts and voluntary sector organisations which provide services, with special emphasis on admissions and readmissions, in relation to respite clients. The Trust should ensure that case reviews have representation from the service users' respite provider, where applicable, and minutes issued to the provider.

Last Office Procedures

- Identity bracelets, even if soiled, should not be removed from bodies. If Last Office procedures include fixing identification bracelets these should be in addition to those already being worn by the patient during life.
- The details on the notification of death form should be checked against the identity bracelet both on admission to the mortuary and prior to release to an Undertaker.
- In a situation where more than one body is being dealt with, preparation of the body, including the administrative preparation at the patient's bedside, should be completed on one body before moving to the next body.

3.3 Related guidance:

- Inter-hospital transfer of patients and their records (CREST, August 2006).
- Use of physiological Early Warning Systems (CREST, May 2007)
- Good Management, Good Records (DHSSPS, December 2004)

Summary

3.4 There are a number of factors that contribute to effective record keeping. Patient/client records should:

- be factual, consistent and accurate, recorded in a way that the meaning is clear;
- be recorded as soon as possible after an event has occurred, providing current information on the care and condition of the patient/client;
- be recorded clearly and in such a manner that the text cannot be erased or deleted without a record of change;
- be recorded in such a manner that any justifiable alterations or additions are dated, timed and signed or clearly attributed to a named person in an identifiable role in such a way that the original entry can still be read clearly;

- be accurately dated, timed and signed, with the signature printed alongside the first entry where this is a written record, and attributed to a named person in an identifiable role for electronic records;

- not include abbreviations, jargon, meaningless phrases, irrelevant speculation, offensive or subjective statements;

- be readable when photocopied or scanned.

3.5 Members of the public expect that health and social care professionals will practice high standards of record keeping. Good record keeping is a mark of a skilled and safe practitioner.

3.6 Systems should be in place to ensure that the standard of record keeping and documentation is kept under continuous review.

SECTION 4

MEDICINES MANAGEMENT

4.1 The prescribing, supply and administration of medicines are important aspects of clinical practice.

4.2 Several errors in relation to the administration of medicines were reported as SAIs in 2006/07.

4.3 Good practice indicates that where there are medication-related adverse incidents a pharmacist should be included as part of the investigation team.

Relevant related guidance is documented at paragraph 4.5 and in the Appendix.

Learning arising

4.4 Issues identified by HSC organisations for ***learning*** that have arisen in this SAI reporting period include:

- There is a need for vigilance when dispensing "seldom used drugs". When these are entered onto computer systems they can sometimes move to default settings of more frequently used drugs. To avoid dispensing the incorrect medicine, items should be carefully read and checked against the prescription issued for signature and be aware of similarly named drugs.
- Pharmacists in community pharmacies should bring to the prescriber's attention any medication the identification of which they are not sure about or any dosage which appears inappropriate.
- GPs should be aware that computerised systems, whilst improving safety of prescribing, also introduce new risks such as 'picking' errors with similarly spelt and sounding medicines and should be vigilant against errors.
- All doctors working in Out of Hours services should be aware of the ready availability of pre-filled cardiac medicines to obviate the need for a doctor to prepare medication in an emergency situation.
- Where shortages exist in certain medicines (eg. diamorphine), to

consider having usage/warnings provided regarding alternative strengths of preparation and to have in place procedures for reading labels and dose calculation.

- To ensure that there is clear communication of the medicine dosage to the patient and that any risks associated with the medicine are understood by the patient.
- Registered homes should have a recent photograph of residents placed on each medication kardex to enable clear identification when staff are administering medication. Agency staff should be accompanied by regular staff for purposes of identification/verification of medication.
- Use of Insulin – the storage and labelling of insulin vials and syringes should be accompanied by appropriate signage. Induction training in the use of insulin should be available for junior clinicians. Two qualified members of staff should check all medication for parenteral administration.
- When using a syringe pump, it is important to have regular volume checks where patient controlled analgesia is being used and proper recording of these checks.
- To be aware of differing strength of opiod patches.
- To raise awareness among mental health professionals of the physical side-effects of psychotropic medication and in particular the cardiac side-effects
- To consider bespoke training for A&E staff on risk assessing and providing appropriate care for patients presenting with mental health needs
- The Clinical Pharmacy Standard for medication history taking should be adopted as a working model for charting what medication a patient is currently taking/used, either prescribed or bought .
- Patient referral letters should contain a clearly delineated 'Medication' section specifying,

- All current medication, and
- Any recommended medication changes.

4.5 Related guidance

- CPh2/03 - Guidance on the prescribing and supply of Warfarin Therapy (DHSSPS, April 2003)
- CPh1/04 – Use and controls of Medicines (DHSSPS, May 2004)
- HSS (MD) 46/04 – supply of diamorphine injection (DHSSPS, December 2004)
- HSS (MD) 06/05 – withdrawal of Co-Proxamol Products and Interim Updated Prescribing Information (DHSSPS, January 2005)
- Recommendations to improve the safe use of insulin in secondary care (DHSSPS, December 2005)
- Guidelines on Cyclosporin (Regional Group of Specialist Medicines, 2004, Rev 2006)
- Guidelines for the treatment of hyperkalaemia in adults (CREST, January 2006)
- CPh 2/06 - Regional Kardex Template (June, 2006)
- HSS (MD) 15/06 – Ensuring Safer Practice with High Dose Ampoules of Diamorphine and Morphine (DHSSPS, July 2006)
- Safe and Effective Use of Insulin in Secondary Care: recommendations for treating Hyperglycaemia in adults (CREST, August 2006).
- Newsletter - Medication Safety Today (NI Medicines Governance Team, February 2007)
- HSS(SQSD) 28/07 - NPSA Safe Medication Alerts (DHSSPS, June 2007)

Summary

4.6 When administering medication against a prescription written manually or electronically by a registered medical practitioner or another authorised prescriber, the prescription should:

- be based, whenever possible, on the patient's/client's informed consent and awareness of purpose of the treatment;
- be clearly written, typed or computer generated and be indelible;
- clearly identify the patient/client for whom the medication is intended;
- record the weight of the patient/client on the prescription sheet where the dosage of medication is related to weight;
- clearly specify the substance to be administered, using its generic or brand name, where appropriate, and its stated form, together with the strength, dosage, timing, frequency of administration, start and finish dates and route of administration;

- be signed and dated by the authorised prescriber;
- not be for a substance to which the patient is known to be allergic or otherwise unable to tolerate (all known allergies should be recorded on Kardex);
- in the case of controlled drugs, specify the dose to be taken, the dosage form, the strength of the preparation and either the total quantity (in both words and figures) of the preparation or the number (in both words and figures) of dosage units. If in an out-patient or community setting, the prescription may be hand-written or computer generated but must be signed by the prescriber, and it must be dated.

4.7 Staff in exercising their professional accountability in the best interests of their patient's/clients must:

- know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications;
- be certain of the identity of the patient/client to whom the medicine is to be administered;
- check that the prescription, or label on medicine dispensed by a pharmacist, is clearly printed and unambiguous;
- have considered the dosage, method of administration, route and timing of the administration in the context of the condition of the patient and co-existing therapies;
- check the expiry date of the medicine to be administered;
- check that the patient/client is not allergic to the medicine before administering it;
- contact the prescriber or another authorised prescriber without delay where contra-indications to the prescribed medicine are discovered, where the patient/client develops a reaction to the medicine, or where assessment of the patient/client indicates the medicine is no longer suitable;
- make a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient/client, ensuring that any written entries and the signature are clear and legible. It is also the individual's responsibility to ensure that a record is made when delegating the task of administering medicine;
- clearly countersign the signature of any student who is being supervised in the administration of medicines.

4.8 Some drug administrations can require complex calculations to ensure that the correct volume or quantity of medication is administered. In these situations it may be necessary for a second registrant to check the calculation in order to minimise the risk of error. The use of calculators to determine the volume or quantity of medication should not act as a substitute for arithmetical knowledge and skill.

SECTION 5

COMMUNICATION

5.1 Good and effective communication is one of the essentials for safe and effective practice. This requires the ability to share with patients and clients information that they want or need to know and to do this in a way that they can understand.

5.2 It is also important that relationships with clients are based on openness, trust and good communication which fosters partnership working with patients to address their needs.

Relevant related guidance is documented at paragraph 5.4 and in the Appendix.

Learning arising

5.3 Issues identified by HSC organisations for ***learning*** that have arisen in this SAI reporting period include:

- A patient's ability to communicate with staff should be addressed by easy access to a nurse call system/hand bell/or other communications system.
- To avoid confusing patients with similar names, Out of Hours services should consider identifying calls by a unique call number and secondly by name. It should be stressed to callers the importance of re-contacting the service if for some reason they do not receive a call back from a GP within a reasonable timeframe (usually no more than one hour).
- Health visitors should explain the programme of visits to parents and details of these should be recorded in the 'Red Book'. All Health and Social Care staff visiting homes should carry identification with them.
- Overseas travellers should be provided with written information on malaria medication, emphasising the need for prophylaxis to be region-specific and highlighting the need for co-ordination of medication according to written instructions.
- Protocols for management of clinical risky situations should be developed, easily accessible in clinical areas, available in suitable formats and included in induction (for example, the treatment of

hyperkalaemia and the use of insulin).

- When mental health patients are being considered for passes from hospital, responsibility lies with staff to ensure they get independent feedback from families and carers regarding any concerns or views prior to and after any period of leave.

Handover Arrangements

- Team members should be aware of challenges facing new team members and they should be encouraged to discuss anxieties or concerns with senior staff. Standard protocols for management of multi-disciplinary handovers should be developed.
- Handover arrangements should be formalised and working practices scrutinised to improve continuity of care by all grades of health and social care staff.

5.4 Related Guidance

- *Continuity of Clinical Care* (Royal College of Physicians, 2003).
- *Maintaining Good Clinical Practice* (Royal College of Physicians, 2004)
- Health Visiting Service in NI (DHSSPS News Release, July 2006)
- HSS(SQSD) 10/07 - Warning to travellers who change their travel plans (DHSSPS, February 2007)
- HSC(SQSD) 29/07 – Guidance on strengthening Personal & Public Involvement in Health and Social Care (DHSSPS, September 2007)

Summary

5.5 Staff need to be sensitive to the content of the communication and the situation, need to adopt approaches to the circumstances and be sensitive to language and cultural differences, using interpreters where appropriate.

5.6 To communicate effectively requires the ability to share with patients and clients the information that they want, in a way that they can understand and be in a position to respond to their questions and keep them informed of the progress of their care.

5.7 Health and Social Care records are also a tool of communication within the team and should contain an accurate account of treatment, care planning and delivery. These should be written wherever practicable with the involvement of the client and completed as soon as possible after the event has occurred.

The record should provide clear evidence of the care planned, the decisions made, the care delivered and the information shared.

SECTION 6

MENTAL HEALTH

6.1 The reporting of SAIs from the mental health field make up 43% of all incidents in the reporting period. Of those incidents involving suspected suicides[9], almost two thirds were male and just under half appear in the 15-34 age group. A further quarter appears in the 45-54 age group. Around one third were in receipt of addiction services for drug and alcohol misuse.

6.2 Figures from UK studies suggest that one in 5 adults have a mental disorder and one in 10 a personality disorder[10] and it is estimated that GPs spend one third of their time on mental health issues.

6.3 Suicide trends over the last 10 years show a 27% increase in Northern Ireland compared to a 9% decrease in the UK overall[11].

6.4 It is also known that mental health service users are vulnerable to a number of potential risks. Often these risks are related to their own behaviour or to the behaviour of other patients, (such as self harm, aggression and violence) and may be linked to their mental illness[12].

Analysis of Serious Adverse Incidents

6.5 Since the introduction of the SAI reporting system in July 2004 a significant number arise in mental health services and the learning from these incidents is categorised under the following headings:

- Assessment and Management of Risk;
- Trust Internal Reviews;
- Suicide and self harm.

6.5.1 Assessment and Management of Risk

An analysis of the SAIs coming from the mental health and learning disability services highlight the following areas in relation to the assessment and management of risk:

- Prompt and proactive follow up following discharge from inpatient care;
- Access to ligature points (showers, windows, etc) in inpatient facilities;
- Management of disengagement from services;

[9] 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

[10] Singleton et al 2001; Meltzer et al 1996

[11] http://www.nisra.gov.uk

[12] With Safety in Mind: patient safety in mental health services (NPSA, July 2006)

- Management of alcohol misuse, especially with dual diagnosis;
- Improving compliance with medication;
- Preventing absconding, especially detained patients;
- Access to services/assessments and waiting times;
- Mechanisms to decrease risk to staff from assault;
- Increased staff awareness/training to encourage identification of specific well known risk factors and their management. This should include that clients may be appropriately deemed low risk, with future adverse outcomes not reasonably predictable, and the need for staff support if things go wrong;
- Adequate provision for under 18 year olds.

6.5.2 Trust Internal Reviews

As part of the follow-up of Serious Adverse Incidents, Trusts on occasion, are asked for copies of their Internal Review Reports by the Department. These Internal Review Reports are considered in relation to:

(i) Method of Review

- Membership of Review Team – multi-disciplinary.
- Formal Multi-Disciplinary Review meeting(s).
- Use of independent Chair from outside Directorate/Programme.
- Service user, carer, or advocate involvement and participation.
- Specific reports requested and provided by clinicians.
- A structured information gathering process including one-to-one interviewing.

(ii) Content of Report

- Clear information about the incident addressing gaps or outstanding issues.
- Timeline including contact with professionals.
- Identification of critical issues and contributing factors.
- Analysis of issues and factors.
- Recommendations and action plan (includes cases were recommendation is that no action be taken).
- Review of implementation of actions.
- Staff support considered (not staff being commended or thanked).

The vast majority of Internal Review Reports had evidence of a multi-disciplinary approach with formal Multi-Disciplinary Review Meetings taking place, contained clear information about the incident including a timeline, identified critical issues/contributory factors, and contained an analysis and recommendations.

However in less than a third of the Reports was there evidence of an independent Chair, involvement of a service user, carer or advocate, provision

of reports by clinicians or use of individual one-to-one interviews, a review of implementation of actions or provision of staff support.

The Internal Trust Review Reports also raised the following themes:

- Provision for under 18 year olds admitted to adult wards.
- Services for people with substance misuse problems, in particular alcohol misuse and dual diagnosis.
- Improving assessment and management of risk, both to self and others, with particular focus on sometimes risk factors being identified but not managed prior to 'inevitable' incident.
- Improving communication including around assessment, follow-up and prescribing of psychiatric medication.
- Improving compliance with medication.
- Clients often viewed as low risk on last contact.
- Preventing disengagement from services.
- Potential of involving family and carers to promote compliance with medication or attendance at outpatient appointments, etc.
- Considering bereavement as significant risk factor.

6.5.3 Suicide and Self Harm

Not all suicides or incidents of self harm are preventable, however there is a danger in going from recognising risk in patients as a whole to accepting the inevitability of individual deaths. The National Confidential Inquiry into Suicide and Homicide (NCISH) by People with Mental Illness (England and Wales) 2006[13] suggests that virtually all in-patient suicides could be seen as preventable, unlike suicide in the community where supervision is less immediate.

In this reporting period, from those SAIs involving suspected suicides, over one third died from hanging (mostly in their own home), one tenth drowned and one tenth overdosed. Where information was available on the last contact with mental health services, just over 80% had been in contact with health and social care two months prior to their death and half of these within two weeks of their suicide.

A Regional Steering Group on the Assessment and Management of Risk in Mental Health Services has been established by the Department. Its aim is to improve risk assessment and management for generic adult mental health services by developing appropriate local standards and supporting their implementation by provision of training.

[13] http://www.medicine.manchester.ac.uk/suicideprevention/nci/Useful/avoidable_deaths.pdf

Relevant related guidance is documented at paragraph 6.7 and in the Appendix.

Learning arising

6.6 When considering the *learning* from incidents of suicide and self harm in this SAI reporting period the following has emerged:

- the need to listen to relatives' views and forming a partnership with families and carers in the planning and delivery of the patient/client's treatment;
- the need to establish consistency across HSC units on risk assessment and subsequent management (eg the use of special observation and the ratio of qualified to unqualified staff);
- to drive forward improvements in practice, including through the setting of standards (eg how to manage Do Not Attends. Documented assessment of community/family support structures);
- the need to adopt a standard approach to conducting an incident review so that the report reflects the learning which has taken place and that it has been conducted in line with Mental Health Commission guidance[14] and has the required independence and objectivity;
- the need to be mindful of treating the physical wellbeing of someone with mental health issues and the implications of medicating for a variety of conditions (see Section 4);
- the need to offer appropriate training to staff – to refresh skills and to change the culture (see Section 8);
- to effectively manage transitions (eg interface from acute to community; from young persons to adult services and between mental health and other service, such as childcare).

6.7 Related Guidance

- Discharge from Hospital of Mentally Disordered People, (DHSSPS, 1996, rev. 2004)
- SAN (NI) 98/53 – Curtain Tracks – Points of Ligature (Health Estates, September 1998)

[14] http://www.dhsspsni.gov.uk/mhc_guidance_on_monitoring_untoward_events.pdf

- HTM 55/98 – Building components: windows (Health Estates, 1998)
- HTM 58/05 – Internal doorsets (Health Estates, 2005)
- Guidance - Under 18 Year Olds in Adult Mental Health Facilities (DHSSPS, March 2006)
- HSC(SQSD) 08/2007 – National Confidential Inquiry: 5 year report into suicide and homicide by people with mental illness (NCISH, December 2006)
- MDEA(NI) 2007/61 – Cubical curtain track rails (anti ligature) (Health Estates, June 2007)
- HSC(SQSD) 33/07 – HSC Regional Template and Guidance for Incident Review Reports (DHSSPS, September 2007)

Summary

6.8 Not all deaths from suicide are preventable; however, much can be done to reduce risks. Mental health services should have suicide prevention strategies in place and monitor their implementation. Individual assessment of suicide risk needs to be undertaken for all patients entering the service, particularly those who have attempted suicide or who have self harmed in the past and are expressing suicidal feelings.

6.9 Patients at particular risk are those who are substance abusers and have a mental illness – dual diagnosis patients. Provision for dual diagnosis patients should be central to provision of mental health services and should include staff training in substance misuse management, joint working with drug and alcohol teams, local clinical leadership and enhanced supervision for those with a severe mental illness and a destabilising substance misuse problem.

6.10 Fundamentally staff must develop therapeutic relationships with service users, in which clients who feel suicidal or wish to self harm can talk openly about how they feel and develop strategies together with staff about how to manage self harm feelings and behaviours.

SECTION 7

CLINICAL TREATMENT AND CARE

7.1 This theme covers a range of issues relating to the care and management of patients and clients. Practitioners must keep their knowledge and skills up to date throughout their working lives and should be familiar with relevant guidelines and developments that affect practice. Participation in educational activities that maintain and further develop competence and performance are essential.

Relevant related guidance is documented at paragraph 7.3 and in the Appendix.

Learning arising

7.2 Issues identified by HSC organisations for ***learning*** that have arisen in this SAI reporting period include:

- **Fluid Management** – Current guidelines on the administration of fluids should be available in all departments where children are cared for. Hypotonic sodium containing fluids should not be routinely stored in all areas. They should be kept locked away in designated areas such as Pharmacy and HDU. Paediatric Teams should work to standardise Fluid Management Records for both prescribing and administration.
- **Management of chest pain in A&E** – Trusts should have a protocol in place for the investigation and management of patients presenting in A&E with chest pain. Consideration should be given to a check list proforma completed to assist with diagnosis and appropriate referral.
- **Use of blood products** – Staff should be aware of the procedures relating to transfer of blood products from storage to theatre or wards and the importance of using cool boxes to ensure administration to the patient at the correct temperature.
- **Jaundice in new born babies** – There is a need to be able to identify and be increasingly vigilant about recognition and management of early, prolonged and late onset of jaundice and bleeding in the newborn.
- **Antenatal care of women** – HIV positive results should be forwarded in hard copy to the patient's Obstetric Consultant and the named Lead

Midwife for screening. There should be prompt filing of hard copy results into records. A full range of booking bloods should be taken on unbooked admissions and the labs should be informed that these samples be fast-tracked.

- **Postnatal care of women** – To be particularly vigilant in the management and recognition of sepsis; post-partum haemorrhage; pre-eclampsia/eclampsia; and pulmonary embolism or deep venous thrombosis.
- **Paediatrics patients presenting to A&E with severe headache** – (i) patients (especially those with severe symptoms and signs) require a written differential diagnosis covering the most likely and most severe possibilities, and a management plan; (ii) an inconsistency in presentation or expected clinical course should prompt further reassessment and investigation; (iii) all paediatric patients with high-risk headaches (unusual pattern, neurological signs, severe symptoms) should receive an urgent CT brain scan; (iv) all paediatric patients with a neurological illness admitted for observation should have regular neurological observations using an age-appropriate split GCS scale to detect subtle changes – not simply a single number. This scale is available from the paediatric neurosurgical ward at the Royal Belfast Hospital for Sick Children; (v) all paediatric patients with high-risk headaches (as at (iii) above) should be admitted to an inpatient unit and not discharged until symptoms resolve and the diagnosis is clear; and (vi) all medical and nursing staff caring for children should be familiar with the current best evidence for the treatment of paediatric migraine and its differential diagnosis.
- **Shoulder dystocia in newborns** – To be aware of studies and good practice in this area.
- **Laboratory processing of blood samples for STI screen and confirmation of results** - The importance of confirmatory testing, and proactive follow-up when a potential mismatch has occurred between the initial and confirmatory test on blood samples for HIV. Learning identified

includes:

- the potential for enhancement of record keeping, and a system to improve traceability, to identify the individuals who took the specific blood samples from the patient;
- proactive face to face communication and follow-up with the patient; and
- early use of "identity matching" technique on both the initial and confirmatory blood samples to give focus to where the investigation should concentrate its efforts when considering a recall of other patients or mapping laboratory processes.

- **Bedrails** – when in use, bed rails should be fully engaged and correctly re-engaged after every patient intervention.

7.3 Related guidance

- Focus Group Shoulder Dystocia. In: Confidential Enquiries into Stillbirths and Deaths in Infancy. *Fifth annual report.* London: Maternal and Child Research Consortium; 1998. P.73-9.
- Guidelines – Better use of Blood in NI (CREST, January 2001 – **currently under revision**).
- Wallchart – Any child receiving prescribed fluids is at risk of hyponatraemia (DHSSPS, April 2002)
- Webb S, Bonell, Lindsay K. the investigation of acute severe headache suggestive of probable subarachnoid haemorrhage; a hospital-based study. *Brit J Neurosurg* 2003: 17(6):580-584.
- Hinshaw K. Shoulder Dystocia. In: Johanson, Cox C, Grady K, Howell C, Editors. *Managing obstetric emergencies and trauma: the MOET course manual, London: RCOG press:* 2003. P.165-74.
- HSS(MD) 06/03 – Better Blood Transfusion; Appropriate Use of Blood (DHSSPS, March 2003)
- Finichel G. Headache. In: Fenichel G, editor. *Clinical paediatric neurology.* 5th ed. Philadelphia: Elsevier Saunders, 2005:77-90.
- Royal College of Obstetricians and Gnaecologists, *guideline No.42,* December 2005, Shoulder Dystocia.
- Serious Hazard of Transfusion Report (Annual Report, 2005) http://www.shotuk.org/SHOT%20report%202005.pdf
- Goadsby P. Recent advances in the diagnosis and management of migraine. *Brid Med J* 2006; 332:25-29.
- Prevention of Hyponatraemia in Children (DHSSPS, April 2006)

- MB97-06 – Antenatal infections screening programme: review of management of HIV results (DHSSPS, October 2006)
- HSS (MD) 43/2006 - NICE guidance: Routine Postnatal Care for Women and their Babies (DHSSPS, November 2006)
- HSS(MD) 24/2006 – NI Guidelines for the Antenatal, Intrapartum and Postnatal Care of HIV positive women and management of the HIV exposed infant (DHSSPS, July 2006)
- HSC (SQSD) 20/07 - NPSA Patient Safety Alert 22: Reducing the Risk of Hyponatraemia when Administering Intravenous Infusions to Children (DHSSPS, April 2007)
- HSC(SQSD) 21/2007 – National Patient Safety Agency: Slips, Trips and Falls in Hospital (PSO 3) (DHSSPS, May 2007)
- HSC(SQSD) 22/2007 – National Patient Safety Agency: Safer Practice Notice 17: Using Bedrails Safety and Effectively (DHSSPS, May 2007)
- HSC (SQSD) 30/07 - National Patient Safety Agency: Safer Practice Notice: "Right Patient, Right Blood" (DHSSPS, June 2007)
- Guidelines on blood transfusion - British Committee for Standards in Haematology (BCSH)
  http://www.bcshguidelines.com/publishedHO.asp?tf=Blood%20Transfusion&status=

Summary

7.4 HSC staff have a responsibility to deliver care based on current evidence, best practice and where applicable, validated research when it is available.

7.5 In a system as large as health and social care, accidents and incidents can be repeated over and over in different parts of the system unless information is shared and common lessons learnt.

7.6 Individuals and teams need to assess the quality of the care they provide, using a combination of clinical outcomes, data and measures of patient's or client's experiences. Reflect on this experience, including both successes and failures, and apply the lessons learnt.

SECTION 8

RECRUITMENT AND TRAINING

8.1 Employers have a duty to protect the public by ensuring that newly recruited staff are able to undertake the work they are employed to do. Where registration with a regulatory body is required the employer must check with that body the practitioner's current registration status and take up all appropriate references in relation to previous employment.

8.2 In addition the employer must ensure that all pre-employment checks have been satisfactorily carried out including Protection of Vulnerable Children and Adult (POCVA) checks and occupational health assessment.

8.3 New employees should have:

- a thorough induction into their area of work;
- training and supervision where necessary;
- mentoring;
- ongoing access to professional development;
- clinical supervision.

8.4 Getting the recruitment and initial employment process right is the first line of defence in protecting the public.

Relevant related guidance is documented at paragraph 8.6 and in the Appendix.

Learning arising

8.5 Issues identified by HSC organisations for ***learning*** that have arisen in this SAI reporting period include:

Recruitment

- Forms for pre-employment checks should ask for any previous addresses outside the UK or ROI.
- Trusts to be assured that employment agencies used in the provision of staff, carry out the requisite employment/registration checks.

Induction

- All newly appointed staff, whether substantive or locum should be given a formal induction programme.
- Dealing with emergencies should be included in induction training.

- All junior medical staff should receive a structured induction process regardless of the time of year employment commences.
- Systems should be in place to ensure locums are familiar with Trust protocols and guidelines.

Dealing with Emergencies

- There should be clear procedures on the management of emergencies occurring within HSC premises.
- In the event of an environmental incident, A&E Departments should follow appropriate procedures, which includes contact with the Public Health Department of the area HSS Board (so that it can involve other local agencies as necessary).
- In case of a medical emergency, dental practice staff should have up-to-date life support training and an emergency drug kit which should be regularly checked and replenished.

Primary Care

- All doctors working in Out of Hours service (including those from non-UK countries) should undertake pre-hospital life support training in accordance with UK guidelines.

Surgery

- When junior staff are being supervised it is important that the supervisor is satisfied that they are competent to undertake the task. Senior surgical staff need to be aware of their responsibilities for supervising junior staff.

Medical Equipment

- Staff should not use any surgical device or equipment unless they know how to do so.

Mentoring

- Staff should be encouraged to seek help and advice from senior suitably qualified colleagues in dealing with unfamiliar procedures.

General Training Issues

- No one should perform a procedure that they are not familiar with until they have received suitable instruction from a practitioner with experience.

8.6 Related Guidance

- Choosing to Protect (DHSSPS, April 2005) – Form POCVA(NI) 3: Service Check, as amended (current version February 2007)
- Report on Induction Processes for Medical Staff in the HPSS (DHSSPS, August 2006)
- HSS(TC8) 8/2006 - Interim Arrangements for the Appraisal of Locum Doctors in HPSS Trusts and Boards (DHSSPS, October 2006)
- Good Medical Procedure – General Medical Council, 2006
- CNO/01/2007 – Reminder of the importance to undertake comprehensive pre-employment checks on nurses and midwives (DHSSPS, August 2007)

8.7 All employees should receive regular performance appraisals (at least annually) during which their training needs should be identified. Employers have a responsibility to recognise and reinforce good performance, or to take steps to identify and deal with poor performance.

8.8 If an aspect of practice is beyond the level of competence of the practitioner or outside their area of professional practice, then they must obtain help and supervision from a competent practitioner until the individual and the employer consider that the practitioner has acquired the requisite knowledge and skill.

SECTION 9

CHILDREN'S SERVICES

9.1 The reporting of SAI incidents in relation to children's services make up one-fifth of the total SAIs received in the reporting period. SAI reports received during this period covered the following:

- children absconding from residential care,
- perpetration of criminal damage while in residential care,
- allegations of sexual activity between residents,
- deaths - including suspected suicides of children under 18 years, some of whom had previous involvement with social services, and
- non-compliance with child protection policies and procedures.

Key Themes

Child Protection

9.2 Of the SAI child protection reports received, a Case Management Review (CMR) to establish what learning, if any, can be identified and disseminated regionally was considered in four of the reports (in line with Chapter 10 of Co-operating to Safeguard Children). At this stage, the Department has been notified that the Area Child Protection Committees have agreed the commencement of at least one CMR; with internal reviews underway in the three other cases. Consequently regional learning from these CMR/reviews has not yet been identified but will be taken forward once available.

9.3 In view of the challenges presented by the increase in the number of potential CMRs the Department is currently reviewing the CMR process as currently operated. However, any new proposals will contain a focus on learning and in particular dissemination of regional learning.

Children Absconding from Residential Care and those with Challenging Behaviour

9.4 The majority of SAI reports received were related to the absconding of children from residential care and in particular a problem with persistent absconding regarding children in this category was identified within one Trust area.

9.5 The Department has corresponded with the relevant Trust seeking an urgent review of the cases involved and reassurance that all appropriate strategies and risk management practices have been brought to bear in the cases identified. The Department has sought the submission of a report which will contribute to the regional learning and development strategy for residential child care staff.

9.6 The Department launched a consultation document entitled Care Matters NI: Building a Bridge to a Better Future[15] in March 2007. This document looks at how best we can look at a range of preventative services designed to help children and their families stay together and to improve the experience and the outcomes of children who come into care, through improvements in health, education, career and recreational opportunities. The strategy acknowledges that meeting the needs of children in residential care is a complex process that places demands and pressures on residential staff and makes proposals for actions/outcomes required to achieve the vision for improvements in residential child care. Likewise, the Children Matter Task Force has commissioned a regional review of residential child care focusing on care planning and the strengthening of safeguarding arrangements through the development of a workforce strategy and a range of policies and procedures designed to improve the management of challenging behaviour in line with best practice, standards and guidance.

Interface with Juvenile Justice Centre

9.7 In order to address concerns about the number of young people being admitted to the Juvenile Justice Centre from care the Chief Social Services Officer issued a letter on 11th September 2006 asking that all such placements be reported as serious adverse incidents. From September 2006 to March 2007, a number of SAI reports continue to be received in relation to this issue. The Department will continue to monitor the submission of SAIs in this regard.

Process Issues

9.8 While more timely reporting of incidents when they occur and adherence to the Departmental SAI circular is acknowledged, the following issues have been identified as requiring further attention:

- there are issues regarding the lack of information provided on the initial SAI reporting form, for example in the case of a persistent absconder from

[15] http://www.dhsspsni.gov.uk/care-matters-ni-3.pdf

residential care, as this could reduce the amount of follow-up work needed; and

- the length of time it takes to obtain additional information on individual SAIs, as this can prevent case and regional learning being identified sooner.

9.9 The Department will be reviewing how these areas could be improved and will have further discussions within the Department and with key stakeholders on the management of SAIs and the responsibility for seeking additional information with a view to further streamlining the process.

SECTION 10

CONCLUSION – THE WAY FORWARD

The Department is encouraged by the willingness of HSC organisations and family practitioner services to promote adverse incident reporting and a culture of learning within their environments.

Working closely with HSC colleagues, a number of projects have been completed or are nearing completion. These developments will further enhance the safety and quality of services.

In relation to ***mental health and learning disability services***, there has been the establishment of the Mental Health & Learning Disability Board. This body will act as a champion for patients and clients and will be a driving force in delivering reforms through the Bamford recommendations. Complementary to this will be the outcome from the Regional Steering Group on the Assessment and Management of Risk to produce local standards for the improvement of risk assessment and management for generic adult mental health services. Such standards will also be developed for other mental health and learning disability services.

A model for an ***incident review template*** has been developed in order to standardise the format of reports and to place an emphasis on the learning arising from an adverse incident or near miss. Work on Phases 2 & 3 of the Patient/Client Safety project is concluding. This will produce ***a minimum dataset*** for incident reporting and will standardise ***coding and definitions*** of incidents.

Details on incidents/near misses involving ***medical devices and equipment*** continue to be reported to the NI Adverse Incident Centre for collation and further investigation, where appropriate. The learning from these is the subject of a separate annual report produced by Health Estates.

It is acknowledged that HSC organisations have to report incidents/near misses to a wide range of bodies, depending on the nature of the incident. This can often lead to confusion and duplication for the HSC as reporting systems can serve different purposes and may have different specialist audiences. An exercise has taken place to map these reporting lines; and ***algorithms*** will be developed in order to raise awareness and promote clarity of reporting within the HSC. It is hoped this work will facilitate a streamlined approach to incident/near miss reporting under new RPA structures.

During 2006/07, the first clinical and social care governance reviews were undertaken by the Regulation & Quality Improvement Authority (RQIA). In the first year the focus was on two themes from the Quality Standards for Health and Social Care – namely, Corporate Leadership & Accountability of Organisations and Safe & Effective Care. In the latter theme, organisations' procedures for the prevention, detection, communication and learning from adverse incidents/near misses were

considered. Any gaps identified by RQIA will have to be addressed by the individual organisation through an improvement plan which will be subject to independent monitoring.

The *National Patient Safety Agency* (NPSA) has undergone significant change in the last year with a remodelled National Reporting and Learning System (NRLS) and an extended programme of work. The National Institute for Health and Clinical Excellence (NICE) is also involved in the development of safety solutions. Further work will be done in 2007/08 to align Safety & Quality policy, systems and processes. A significant part of this will be through further development of the Safety Forum to support HSC organisations and promote shared learning in taking forward patient/client safety interventions. Linked to this will be the publication of key performance indicators for Safe & Effective Care to assist HSC bodies to improve the care provided for patients/clients within each organisation.

APPENDIX

LIST OF PUBLICATIONS RELATING TO QUALITY & SAFETY SINCE COMMENCEMENT OF INTERIM SAI REPORTING SYSTEM – 2004 to SEPTEMBER 2007 (MAINLY ISSUED BY DHSSPS)

(This list is not exhaustive.)

Document No	Description / Title	Issued By	Date of Issue
	2004		
	Interim Report into Coronary Artery Bypass Graft	NCEPOD	2004/05
	Standards for the Inspection of Child Protection	SSI	2004
Guidance	Guidelines for Control of Infection in Dental Practice	Dental	2004
PEL(04)01	SARS Contingency Planning: Requirements for Segregation Rooms in all A&E Departments and Minor Injuries Units	Health Estates	23/01/04
	Guidance note- Implementing the Equality Good Practice Reviews on : Access to Information The Handling of Complaints Service User Involvement Promoting positive Staff Attitudes to Diversity	RS & PSD	02/02/04
HSS (PCD)1/2004	Prescribing Incentive Scheme Boards/Practice IPAs 2004/05	PCD	Draft-Feb 2004
HSS (MD) 06/04	Atypical Antipsychotic Drugs and Stroke	CMO's Office	09/03/04
HSS (MD) 07/04	HSS(MD)7/04 PAROXETINE (SEROXAT) Reminder to use the recommended dose	CMO's Office	11/03/04
HSS (GEN1) 1/2004	Campaign to stop violence against staff working in the HPSS - Recording and reporting incidents	HRD	16/03/04
HSS (MD) 08/04	Protecting the blood supply from variant CJD: deferral of donors who have received a blood transfusion	CMO's Office	19/03/04
PEL(04)04	Standards for Space Around the Acute Bed in Wards and Acute Single Rooms in Hospitals	Health Estates	April 2004
HSS (MD) 03/04	Guidance On Antenatal Care - Routine Care For Healthy Pregnant Women	CMO's Office	01/04/04
HSS (MD) 10/04	Good Practice In Consent – Regional Forms And Guides	CMO's Office	02/04/04
HSS (PPM) 4/2004 (Word 442 KB)	AS/NZS 4360: 2004 - Risk Management	PPMD	02/04/04
HSS (MD) 13/04	Anti-D Prophylaxis For Rhesus D Negative Women	CMO's Office	08/04/04
HSS (MD) 14/04	Hospital Services For The Acutely Ill Child In Northern Ireland Report Of A Working Group 1999	CMO's Office	14/04/04
HSS (MD) 15/04	Health For All Children (HALL 4)	CMO's Office	15/04/04

Document No	Description / Title	Issued By	Date of Issue
	Discharge from hospital and the continuing care in the community of people with a mental disorder who could represent a risk of serious physical harm to themselves or others	MH & DSD	May 2004
HSS (MD) 17/04	Reducing the risk of exposure of patients to the agent of CJD through brain biopsy procedures	CMO's Office	17/05/04
CPh1/04	Use and Controls of Medicines	CPO's Office	28/05/04
HSS (MD) 18/04	Incident Involving A Gastroscope At Lagan Valley Hospital	CMO's Office	01/06/04
HSS (PCD)7/2004	Performers List Regulations	PCD	02/06/04
HSS (MD) 19/04	Harley Street Wellman Clinic, 57 Harley Street, London W1G 8QS	CMO's Office	03/06/04
HSS (MD) 20/04	Decontamination Of Endoscopes	CMO's Office	15/06/04
HSS (MD) 21/04	Update On Decontamination Of Endoscopes	CMO's Office	21/06/04
PEL(04)13	Health Estates Decontamination Testing Service	Health Estate	22/06//04
HSS (PPM) 06/04	Reporting and follow-up on serious adverse incidents: interim guidance	PPMD	07/07/04
CPh2/04	Northern Ireland Guidelines On Substitution Treatment For Opiate Dependence	CPO's Office	22/06/04
HSS (PPM) 8/2004 (Word 442 KB)	Governance In The HPSS: Controls Assurance Standards – Update	PPMD	05/08/04
HSS (MD) 25/04	Improving Infusion Device Safety	CMO's Office	05/08/04
Guidance	Decontamination of re-usable medical devices	Dental	05/08/04
HSS (MD) 26/04	Protecting the breathing circuit in anaesthesia - Summary and Conclusions	CMO's Office	12/08/04
	Drug and Substance misuse in Mental Healthcare Settings – Guidance for Service Providers	MH & DSD	Sept 2004
HSS (MD) 29/04	Variant Creutzfeldt-Jakob Disease (vCJD) And Plasma Products	CMO's Office	21/09/04
HSS (MD) 30/04	Modified Pneumoccocal Immunisation Recommendations For Patients With Cochlear Implants	CMO's Office	21/09/04
HSS (MD) 35/04	REFECOXIB (Vioxx/VioxxAcute - Withdrawal Due To Increased Risk Of Thrombotic Events	CMO's Office	01/10/04
Guidance Document	Guidance on drug and substance misuse in mental health care settings and guidance on discharge from psychiatric or learning disability hospital and the continuing care in the community of people with a mental disorder who could represent a risk of serious physical harm to themselves or others	MH & DSD	19/10/04
PEL(04)09	Supplement 1 Crash Call Number	Health Estate	28/10/04
	Draft Standards: Approved Social Workers	SSI	Nov 2004
Guidance	Consent for School Dental Screenings	Dental	01/11/04
HSS (MD) 39/04	Updated Prescribing Advice On The Effect Of Depo-Provera Contraception On Bones	CMO's Office	18/11/04
	Good Management, Good Records (DHSSPS) http://www.dhsspsni.gov.uk/dhs-goodmanagement.pdf	P & CSD	Dec 2004
HSS (MD) 40/04	Safety Of Selective Serotonin Reuptake Inhibitor Antidepressants	CMO's Office	06/12/04
HSS (MD)	Isolation Rooms : Best Practice Standards for Capital	CMO's Office	30/12/04

Document No	Description / Title	Issued By	Date of Issue
41/04	Planning (includes report on Isolation Rooms)		
HSS (MD) 42/04	Advice On The Use Of Celecoxib And Other Selective COX-2 Inhibitors In Light Of Concerns About Cardiovascular Safety	CMO's Office	21/12/04
HSS (MD) 45/04	Withdrawal Of Pregestimil® By Mead Johnson Nutritionals	CMO's Office	22/12/04
Guidance	Guidance on Decontamination of reusable medical devices in General Dental Practice	Dental	22/12/04
HSS (MD) 46/04	Supply of Diamorphine Injection	CMO's Office	29/12/04
	2005		
Report	Abdominal Aortic Aneurysm: A Service in Need of Surgery	NCEPOD	2005
Report	An Acute Problem	NCEPOD	2005
Guidance DB (NI) 2006/02	Adverse Incident Reports	HEALTH ESTATES	2005
Guide	Choosing to Protect – A Guide to Using the Protection of Children, [POC (NI)] Service, DHSSPS		2005
Guidance	Choosing to Protect – A Guide to Using the Protection of Vulnerable Adults, Northern Ireland [POVA (NI)] Service, (DHSSPS)		2005
	Care Standards for Northern Ireland (draft), 2004-05, including draft standards for: • Child Minding • Children's Homes • Creches • Day Care Centres • Domiciliary Care Agencies • Fostering Agencies • Full Day Care • Independent Health Care • Nursing Agencies • Nursing Homes • Out of School Care • Pre-School Session Care • Regulation of Early Years by HPSS Trusts • Residential Family Centres • Residential Homes Draft standards available on www,dhsspsni.gov.uk/governance-careconsultation	PPMD	2005
HSS (PCD)11/2005	General Ophthalmic Services- Payments or continuing Education and Training (CET)	PCD	
HSS (MD) 03/05	Pathway of Care for Patients With Brucellosis	CMO's Office	06/01/05
HSS (MD) 05/05	Drug Alert/Medicines Recall - Bendrofluazde 2.5mg Tablets	CMO's Office	28/01/05
HSS (MD) 06/05	Withdrawal Of Co-Proxamol Products and Interim Updated Prescribing Information	CMO's Office	31/01/05
PEL(05)02	Estate Briefing Number 8 PEL(05)02 Enclosure	Health Estates	Feb 2005
HSS (MD)	Strattera (Atomoxetine) ? Risk of Hepatic Disorders	CMO's Office	03/02/05

Document No	Description / Title	Issued By	Date of Issue
07/05			
HSS (MD) 09/05	Updated Advice on the Safety of Selective COX-2 Inhibitors	CMO's Office	21/02/05
PEL(05)01	Publications CD-ROM Issue 2	Health Estates	Mar 2005
PEL(05)03	Audit Scotland: Hospital Cleaning & National Audit Office for Wales: The Management and Delivery of Hospital Cleaning Services in Wales	Health Estates	21/03/05
HSS (MD) 10/05	Influenza Pandemic Contingency Plan	CMO's Office	02/03/05
CCPD 1/05	Accessing Information from Inland Revenue to assist with enquires about a child's safety and welfare Supplement	CCPD	16/03/05
HSS (MD) 11/05	Guideline - Management of Minor Head Injury in Children	CMO's Office	23/03/05
DS60-05	Managed clinical networks: the way forward	SCD	14/04/05
PEL(05)06	Publications CD-ROM Issue 3	Health Estates	Apr 2005
HSS (MD) 14/05	Update on Appraisal and Revalidation	CMO's Office	18/04/05
HSS (ECCU) 2/2005	Intermediate Care	ECCD	26/04/05
HSS (MD) 16/05	Standards for Newborn Bloodspot Screening	CMO's Office	29/04/05
HSS (MD) 12/05	Acute Illness in Children - New Training DVD	CMO's Office	29/04/05
HSS (MD) 17/05	Publication of Revised Guidance on Transmissible Spongiform Encephalopathy Agents: Safe Working and the Prevention of Infection	CMO's Office	13/05/05
PEL(05)09	Firecode: Fire Practice Note11 Reducing Unwanted Fire Signals in Healthcare Premises	Health Estates	Jun 2005
HSS (MD) 19/05	Correct Site Surgery – Pre-operative Marking and Verification Checklists	CMO's Office	07/06/05
HSS (PPM) 05/05	Reporting of Serious Adverse incidents within the HPSS	PPMD	10/06/05
HSS (PCD) 7/2005	GOS (New arrangements for mobile optical services and direct referral of patients to hospital)	PCD	15/06/05
HSS (MD) 20/05	Good Practice in Consent - European Court of Human Rights Ruling	DCMO's Office	15/06/05
HSS (MD) 22/05	Safety Alert - Prescribing, Supply and Administration of Certain Medicines	CMO's Office	25/07/05
HSS(MD) 23/05	Evaluation Of Medical Appraisal Systems In HPSS Organisations Completion Instructions for Boards Completion Instructions for Trusts Board Question Trust Questions	CMO's Office	28/06/05
HSS (MD) 24/05	Exclusion of Femoral Heads From Living Donors - vCJD Precautions	CMO's Office	29/06/05

Document No	Description / Title	Issued By	Date of Issue
HSS (MD) 25/05	Changes to the BCG Vaccination Programme Follow up letter	CMO's Office	15/07/05
HSS (MD) 26/05	Cardiovascular Safety on NSAIDs - Review of Evidence	CMO's Office	03/08/05
PEL(05)07	The Use of Infra-Red Operated Water Taps	Health Estates	08/08/05
PEL(05)10	HFN 30: Infection Control in the Built Environment	Health Estates	08/08/05
HSS (MD) 27/05	Discontinuation of the Volumatic Spacer Device - Important New Information	CMO's Office	16/08/05
Regulations	The Health and Personal Social Services (Primary Medical Services) (Miscellaneous Amendments) Regulations (Northern Ireland) 2005	Nursing & Midwifery Advisory Group	25/08/05
HSS (MD) 29/05	Commencement Of The Newborn Hearing Screening Programme	CMO's Office	16/09/05
HSS (MD) 28/05	Good Practice in Consent - Student Health Professionals	CMO's Office	19/09/05
HSS (MD) 31/05	New Evidence On The Risk Of Suicidal Thoughts Or Behaviours With Strattera (Atomoxetine) Message from Professor G Duff re Strattera (atomoxetine) Questions and Answers	CMO's Office	30/09/05
PEL(05)13	Cleanliness Matters - A Regional Strategy for Improving the Standard of Environmental Cleanliness in HSS Trusts	Health Estates	12/10/05
HSS (MD) 32/05	Avian Influenza and Pandemic Influenza	CMO's Office	21/10/05
D56/05	Information for the Public and Health Professionals on Pandemic Influenza	CMO's Office	Oct 2005
Guidance	Maintaining High Professional Standards in the Modern HPSS – A Framework for the Handling on Concerns about Doctors and Dentist in the HPSS	HRD	Nov 05
HSS (MD) 34/05	National Patient Safety Agency -Patient Safety Observatory Report And Bulletin	CMO's Office	01/11/05
PEL(05)14	Re-Write of Safe Disposal of Clinical Waste - Consultation Draft 'Safe Management and Disposal of Healthcare Waste'	Health Estates	Nov 2005
HSS (MD) 33/05	Multiprofessional Integrated Care Pathway for Meningitis & Septicaemia in Children RBHSC – Multiprofessional Care Pathway	CMO's Office	18/11/05
HSS (MD) 35/05	Recall Women for Breast Cancer Assessment	CMO's Office	21/11/05
PEL(05)15	Hine Review of Endoscope Decontamination: Rinse Water Testing PEL(05)01 Publications CD-ROM Issue 2	Health Estates	28/11/05
HSS (TC8) 6/2005	Maintaining High Professional Standards in the Modern HPSS – A framework for the handling of concerns about Doctors and Dentists employed in the HPSS	HRD	30/11/05
HSS (MD)	Paroxetine (Seroxat) – Safety In Pregnancy	CMO's Office	07/12/05

Document No	Description / Title	Issued By	Date of Issue
36/05			
HSS (MD) 38/05	Falciparum Malaria in Travellers Returning From the Gambia	CMO's Office	12/12/05
HSS (MD) 37/05	Confidential Enquiry into Maternal and Child Health	CMO's Office	19/12/05
Guidance	Recommendations to improve the safe use of insulin in secondary care http://www.dhsspsni.gov.uk/insulin_recomendations.pdf	CPO's Office	22/12/05
	2006		
Report	The Coroners Autospy -- Do we Deserve Better	NCEPOD	2006
HSS (PCD)12/2006	Generic prescribing policy update	PCD	2006
CPh1/06	Amendments to the Misuse of Drugs Regulations (NI) 2002	CPO's Office	03/01/06
HSS(MD) 01/2006 - 4 January 2006 (PDF 104 KB)	Re-Introduction of Volumatic Spacer Devices - Important New Information	CMO's Office	04/01/06
HSS (F) 04/06	Corporate Governance in Central Departments	FD	23/01/06
Guidance	Establishing an Assurance Framework – A Practical Guide for Management Boards of HPSS Organisations http://www.dhsspsni.gov.uk/assurance_framework.pdf	Permanent Secretary	24/01/06
HSS(MD) 03/2006 - 10 February 2006 (PDF 91 KB)	NPSA Consultation on Hypotonic Fluids in Children	DCMO's Office	10/02/06
HSS(MD) 04/2006 - 17 February 2006 (PDF 40 KB)	Strattera (Atomoxetine) – Conclusions of Risk: Benefit Review	DCMO's Office	17/02/06
HSS (PPM) 02/06	Reporting and Follow-up on Serious Adverse Incidents Within the HPSS	PPMD	24/03/06
HSS (MD) 6/06	Memorandum of understanding. Investigating patient/client safety incidents (unexpected death or serious untoward harm): promoting liaison and effective communications between the HPSS, PSNI, HMC & HSENI.	DCMO's Office	20/02/06
HSS (MD) 07/06	NI Avian Influenza Diagnostic Algorithm	CMO's Office	29/02/06
Guidance	Under 18 Year Olds in Adult Mental Health Facilities	Andrew Hamilton	13/03/06
Standards	Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS	Permanent Secretary	14/03/06
Action Plan	Changing the Culture: An Action Plan for the Prevention and Control of Healthcare Associated Infections (HCAIs) in Northern Ireland 2006/2009	CMO's Office	21/03/06
HSS(MD) 09/2006 23 March 2006	Changing the Culture: An action plan for the prevention and control of Healthcare Associated Infections	CMO's Office	23/03/06

Document No	Description / Title	Issued By	Date of Issue
(PDF 58 KB)	(HCAI's) in Northern Ireland 2006/2009		
Consultation	Suicide Strategy and Action Plan Executive Summary Suicide Prevention Strategy Questionaire Suicide Prevention Strategy Consultation Questionaire Section 75 Analysis of suicide and self-harm in NI		29/03/06
HSS(MD) 10/2006 13 April 2006 (PDF 102 KB)	Control of Tuberculosis in Northern Ireland - Updated Guidance	CMO'S OFFICE	13/04/06
Letter	Prevention of Hyponatraemia in Children	CMO's Office	21/04/06
HSS(MD) 12/2006 24 April 2006 (PDF 64 KB)	Guidance document "How to classify Incidents and Risk"	CMO'S Office	24/04/06
Guidance	Choosing to Protect – A Guide to using the Protection of Vulnerable Adults Northern Ireland [POVA (NI)] Service	CCPD	Apr 05/ Rev Mar 06
Guidance	Re:Ozone (HealOzone) Therapy for Treatment of Dental Caries	CDO's office	25/04/06
Guidance	Choosing to Protect (Children) (PDF 356 KB) A Guide to Using the Protection of Children, Northern Ireland Service	CCPD	Apr 05/ Rev Mar 06
HSS (MD) 13/2006 May 2006	Paroxetine (Seroxat) ? Risk of Suicidal Behaviour in Adults	CMO's Office	08/05/06
HSS (MD) 16/2006 May 2006	Updated Prescribing Advice for Venlafaxine (Efexor/Efexor XL)	CMO's Office	31/05/06
HSS (MD) 17/2006 June 2006	Risk of Pneumococcal Meningitis in Cochlear Implants Patients - Update to Immunisation Recommendations	CMO's Office	06/06/06
CPh2/06	Regional Kardex Template (Circular) Kardex Training Presentation Kardex Template Booklet Kardex Template Card 1 Kardex Explanatory Notes	CPO's Office	20/06/06

Document No	Description / Title	Issued By	Date of Issue
HSS (MD) 18/2006	Transitional Arrangements for New Specialist Training Programmes – August 07 Appendix to HSS (MD) 18/06	CMO's Office	06/06/06
HSS (MD) 19/2006	Good Practice in Consent – 12 Key Points on Consent Consent desk aid – 12 key points	CMO's Office	09/06/06
Guidance	Safety First: A Framework for sustainable improvement in the HPSS	Permanent Secretary	12/06/06
HSS (MD) 20/2006	Good Practice in Consent: Working with Prisoners and Detainees	CMO's Office	14/06/06
HSS (MD) 23/2006	Update on GP Appraisal 2006/2007	CMO's Office	10/07/06
HSS (MD) 15/2006 July 2006	Re: Ensuring Safer Practice with High Dose Ampoules of Diamorphine and Morphine	CMO's Office	10/07/06
HSS (MD) 25/2006	Use of Imported Fresh Frozen Plasma (FFP)	CMO's Office	26/07/06
HSS (MD) 26/2006	Biological Agents: Managing the risks in Laboratories and Healthcare Premises	CMO's Office	27/07/06
HSS (MD) 24/2006	Northern Ireland Guidelines for the Antenatal, Intrapartum and Postnatal Care of HIV Positive Women and Management of the HIV Exposed Infant	CMO's Office	28/07/06
Report	Report on Induction Processes for Medical Staff in the HPSS Cover Letter	HR Directorate	03/08/06
HSS (MD) 2/2006	1. Human Tissue Authority Website 2. Publishing Codes Of Practice 3. Lifting of the Moratorium on the disposal of existing holdings of Post Mortem Material	CMO's Office	08/08/06
HSS (MD) 29/2006	Diabetic Retinopathy Screening Service in Northern Ireland and QOF Requirements	CMO's Office	09/08/06
PEL (06) 17	Strengthening Assurance of HSS Trust Compliance with NIAIC medical device/equipment alerts	Health Estates Agency	09/08/06
HSS (MD) 32/2006	Beclometasone Disproportionate Pressurised Metered Dose Inhaler	CMO's Office	14/08/06
HSS (MD) 33/2006	Guidance and Principles of Practice for Professional Staff: Health for all Children	CMO's Office	23/08/06
HSS (MD) 34/2006	Assessment to be carried out on patients, before certain surgery and endoscopy procedures, to identify patients with, a risk of, CJD	CMO's Office	21/08/06

Document No	Description / Title	Issued By	Date of Issue
HSS (MD) 36/2006	Endoscopic Decontamination	CMO's Office	21/08/06
HSS (MD) 39/2006	Development of an Integrated Plan for the Management of Blood (Red Cell Component) Shortages Integrated Plan	CMO's Office	04/09/06
Letter	Interface between Juvenile Justice Centre and Children in Residential Care	CSSO's Office	11/09/06
	NI Strategy for Surveillance, Prevention and Control of E.Coli O157. Cover Letter Press Release	CMO's Office	27/09/06
AMCC735	Report on the Review of Medical Appraisal in Northern Ireland	Permanent Secretary	02/10/06
MB 97-06	Antenatal Infections Screening Programme – Review of Management of HIV Results	M Mc Bride M Bradley	11/10/2006
AMCC793	RQIA Breast Screening Review	Permanent Secretary	12/10/06
HSS (MD) 41/2006	Safety of Selective and Non-selective NSAID's	CMO's Office	24/10/06
HSS (TC8) 8/2006	Interim Arrangements for the Appraisal of Locum Doctors in HPSS Trusts and Boards	HRD	27/10/06
HSS (MD) 43/2006	Routine Post Natal Care of Women and Their Babies – NICE Clinical Guidelines for Implementation	CMO's Office	23/11/06
	Lessons Learnt in Dentistry	Healthcare Policy Group	30/11/06
NCISH Report	Avoidable Deaths – Five year report into suicide and homicide by people with Mental Illness Report Summary Report	National Confidential Inquiry	Dec 2006
HSS (MD) 44/06	Interim Advice to Health Professionals Regarding the Radioactive Material "Polonium 210" Resulting from a radiological incident occurring in November 2006.	CMO's Office	01/12/06
HSS (MD) 45/06	Diabetic Screening Programme – Regional Information	CMO's Office	06/12/06
HSS (01/06)	Statutory Functions – Lewis Letter Guidance	Chief Social Services Officer	20/12/06
	2007		
HSS (PPMD) (NICE) 01/07	National Institute for Health and Clinical Excellence (NICE) The Interventional Procedures Programme	PPMD	09/01/07
HSS (MD) 2/07	Hepatitis C – Information Pack for Professional, Patients and the Public Action Plan	CMO's Office	17/01/07
HSS (MD) 3/07	Contamination of herbal or 'skunk type' Cannabis with glass beads	CMO's Office	18/01/07

Document No	Description / Title	Issued By	Date of Issue
HSS (SQSD) (NICE) 01/07	NICE Technology Appraisal for Implementation in the HPSS – Psoriatic Arthritis – Etanercept & Infliximab	SQS Directorate	23/01/07
HSS (SQSD) (NICE) 02/07	NICE Technology Appraisal for Implementation in the HPSS – Breast Cancer (early) Trastuzumab (Herceptin)	SQS Directorate	23/01/07
HSS (SQSD) (NICE) 03/07	NICE Technology Appraisal for Implementation in the HPSS – Colorectal Cancer – Laparoscopic Surgery	SQS Directorate	23/01/07
HSS (SQSD) (NICE) 04/07	NICE Technology Appraisal for Implementation in the HPSS – Prostate Cancer (Hormone Refractory) - Docetaxel	SQS Directorate	23/01/07
HSS (SQSD) (NICE) 05/07	NICE Technology Appraisal for Implementation in the HPSS – Breast Cancer (early) - Docetaxel	SQS Directorate	23/01/07
HSS (SQSD) (NICE) 06/07	NICE Technology Appraisal for Implementation in the HPSS – Breast Cancer (early) - Paclitaxel	SQS Directorate	23/01/07
HSS (SQSD) (NICE) 07/07	NICE Technology Appraisal for Implementation in the HPSS – Cardiovascular Disease - Statins	SQS Directorate	23/01/07
HSS (SQSD) 08/07	National Confidential Inquiry: 5 year report into suicide and homicide by people with Mental Illness (NICISH)	SQS Directorate	15/01/07
HSS (SQSD) 09/07	Safety First: A Framework for Sustainable Improvement in the HPSS	SQS Directorate	29/01/07
DS 5-07	Priorities for Action 2007-08	Service Delivery Directorate	02/02/07
AMCC1021	Lessons Arising from the Death of Janine Murtagh	Permanent Secretary	1/02/07
HSS (MD) 5/2007	Gadolinium-Containing Mri Contrast Agents And Nephrogenic Systemic Fibrosis (NSF)	CMO CPO	08/02/07
HSS (SQSD) 10/07	Warning to Travellers who change their Travel Plans	SQS Directorate	20/02/07
HSS (SQSD) 18/07	Conducting Patient Service Reviews /Lookback Guidelines Guidance	Regional Governance Network/SQS Directorate	08/03/07
HSS (MD) 7/07	Healthcare Associated Infection Surveillance	CMO's Office	22/03/07
HSS (SQSD) 19/07	Reporting and follow-up on serious adverse incidents; and Reporting on breaches of patients waiting in excess of 12 hours in emergency care department	SQS Directorate/ Service Delivery Directorate	31/03/07
HSC (SQSD) (NICE) 11/07	NICE Technology Appraisal for Implementation in the HSC – Psoriasis – Efalizumab and Etanercept	OCMO	02/04/07
HSC (SQSD) (NICE) 12/07	NICE Technology Appraisal for Implementation in the HSC – Follicular Lymphoma – Rituximab	OCMO	02/04/07
HSC (SQSD) (NICE) 13/07	NICE Technology Appraisal for Implementation in the HSC – Inhaled Insulin for Treatment of Diabetes Mellitus Types 1 & 2	OCMO	02/04/07
HSC (SQSD) (NICE) 14/07	NICE Technology Appraisal for Implementation in the HSC – Drug Misuse – Methadone and Buprenorphine	OCMO	02/04/07

Document No	Description / Title	Issued By	Date of Issue
HSC (SQSD) (NICE) 15/07	NICE Technology Appraisal for Implementation in the HSC – Drug Misuse - Naltrexone	OCMO	02/04/07
HSC (SQSD) (NICE) 16/07	NICE Technology Appraisal for Implementation in the HSC – Colorectal Cancer – Bevacizumab & Cetuximab	OCMO	02/04/07
HSC (SQSD) (NICE) 17/07	NICE Technology Appraisal for Implementation in the HSC – The Management of Urinary Incontinence in Women	OCMO	02/04/07
HSS (MD) 9/07	Prevention of Infection Caused by Clostridium Difficile Good practice Guide	OCMO CNO	12/04/07
HSS (MD) 10/07	Recommendations of the Expert Working Group on the Prevention of Venous Thromboembolism (VTE) in Hospitalised Patients	OCMO	24/04/07
HSC (SQSD) 20/07	NPSA Patient Safety Alert 22: Reducing The Risk of Hyponatraemia When Administering Intravenous Infusions to Children	OCMO CPO CNO	27/04/07
HSC (SQSD) 21/07	National Patient Safety Agency: Slips, Trips and Falls in Hospital (PSO3)`	SQS Directorate	16/05/07
HSC (SQSD) 22/07	National Patient Safety Agency: Safer Practice Notice 17: Using Bedrails Safely and Effectively	SQS Directorate HEA	16/05/07
HSS (MD) 11/07	Update on seizures of cannabis contaminated with glass particles	OCMO	18/05/07
HSS (MD) 12/07	Decontamination of surgical instruments in light of National Institute for Health and Clinical Excellence (NICE) guidance – patient safety and reduction of risk of transmission of creutzfeldt-jakob disease (cjd) via interventional procedures	OCMO	18/05/07
Guidelines	CREST Guidelines on the Use of Physiological Early Warning Systems	CREST	May 2007
HSC (SQSD) (NICE) 23-07	NICE Clinical Guideline No CG 35 - Parkinson's Disease – Diagnosis and Management in Primary and Secondary Care	OCMO	06/06/07
HSC (SQSD) (NICE) 24-07	NICE Clinical Guideline No CG 38 – Bipolar Disorder - The management of bipolar disorder in adults, children and adolescents, in primary and secondary care	OCMO	06/06/07
HSC (SQSD) (NICE) 25-07	NICE Clinical Guideline No CG 39 – Anaemia Management in Chronic Kidney Disease	OCMO	06/06/07
HSC (SQSD) (NICE) 26-07	NICE Clinical Guideline No CG 44 – Heavy Menstrual Bleeding	OCMO	06/06/07
HSC (SQSD) (NICE) 27-07	NICE Technology Appraisal No TA106 – Peginterferon alfa and ribavirin for the treatment of mild chronic hepatitis C	OCMO	06/06/07

Document No	Description / Title	Issued By	Date of Issue
HSC (SQSD) 28/07	NPSA Safe Medication Alerts	CPO SQS Directorate	04/06/07
HSC (SQSD) 30/07	NPSA Safer Practice Notice: Right Patient, Right Blood	SQS Directorate	13/06/07
Guidance	Promotion of Safe, High Quality Health and Social Care in Undergraduate Curricula Letter Guidance	CMO CNO CSSO CPO CDO	13/06/07
HSC (SQSD) 31/07	Guidance on Complaints in Residential and Nursing Homes	SQS Directorate	22/06/07
HSS (MD) 18/07	Cyanide Poisoning	OCMO	11/07/07
HSC (SQSD) 32/07	NPSA: Safer Practice Notice 16: Early identification on failure to act on radiological imaging reports	SQS Directorate	16/07/07
HSS (MD) 19/07	Update to HIV Post-Exposure Prophylaxis (PEP) Guidance from the Expert Advisory Group on AIDS (EAGA) following the recent recall of Viracept (HSS (MD) 14/07)	OCMO	25/07/07
HSS (MD) 20/07	Risk of Depression and Suicidal Behavior with Acomplia (Rimonabant) Attachment	OCMO	25/07/07
CNO/01/2007	Reminder of the Importance to Undertake Comprehensive Pre-Employment Checks on Nurses and Midwives	CNO	10/08/07
HSS (MD) 24/07	Regional Guidelines for Off-licence use of Recombinant Factor VIIa (Eptacog-Alfa; Novoseven r) in aquired coagulopathy o Recombinant Factor VIIa Regional Guidelines	OCMO	17/08/07
HSC (SQSD) 29/07	Guidance on Strengthening Personal and Public Involvement in Health and Social Care	SQS Directorate	12/09/07
HSC (SQSD) 33/07	HSC Regional Template and Guidance for Incident Review Reports Letter Guidance	SQS Directorate	12/09/07

The NIAIC website contains the following information:

- **HEA and MHRA Device Bulletins can be assessed at** http://www.dhsspsni.gov.uk/index/hea/niaic/niaic_device_bulletins.htm
- **A full range of warning notices (MDEAS, hazard notices, advice notices, safety notices, pacemaker technical notes) can be assessed at:** http://www.dhsspsni.gov.uk/niaic_warning_notices

The CREST website contains the full range of guidance issued by the Team:

http://www.crestni.org.uk/publications/pubsreply.asp