Department of
Health, Social Services
and Public Safety
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# A SUMMARY OF KEY THEMES AND LEARNING ARISING FROM SERIOUS ADVERSE INCIDENTS REPORTED TO DHSSPS BETWEEN 1 APRIL 2007 AND 30 APRIL 2010

**(Circulars HSS (PPM) 06/04, 05/05 and 02/06, HSC (SQSD) 19/07 and 22/09)**

**September 2011**

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## Foreword

Each year, in the period covered by this report, there were nearly 600,000 in-patient and day-case admissions to hospitals in Northern Ireland. Over 1.5 million patients were seen at consultant-led services within hospitals. That is to say nothing of all the care in the community and family practitioner services, such as GP consultations, available through health and social care. It is against a typical volume of some 15 million such patient events each year and variety of care that the 1,023 serious adverse incidents (SAIs), reported to the Department between 1 April 2007 and 30 April 2010 covered in this report should be viewed.

Advances in knowledge, technology, and treatment regimes, along with the rapid turnover of patients, continues to combine to create increasingly complex healthcare systems.

Similarly in the social care domain, the management of more and more complex cases in community care settings, and the decision to intervene in individual or family life to safeguard children or vulnerable adults, is difficult, pressurised work that requires an understanding of diverse needs.

This complexity brings with it risks, and we must ensure that those risks are identified and managed by the use of processes and working practices that prevent or reduce the possibility of harm.

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

In this, the final Supporting Safer Services report, we acknowledge the commitment, contribution and determination of organisations and staff across all levels of the HSC in driving forward the patient/client safety agenda. By continuing to work together, we can all make HSC services in Northern Ireland safer and more effective.

This Report provides an overview of SAIs reported to the Department between April 2007 and April 2010. It does not deal with individual SAIs or the learning arising in individual cases. It is being made available to HSC organisations in the interests of promoting safety and learning, and to promote the concept of incident reporting as a tool to improve organisational performance.

The focus of the report is on general principles, i.e. "what has happened?" and "how can we improve?", rather than seeking to attribute individual blame, or "who made the error?"

The period covered by this report has seen a significant and fundamental restructuring of the HSC system in Northern Ireland. Changes have included a reduction in the number of Trusts from 19 to 6: the replacement of 4 existing HSS Boards with a single regional body, the HSC Board; the establishment of the Public Health Agency and Business Services Organisation; the creation of the Patient and

Client Council and the dissolution of the Mental Health Commission, with transfer of its functions to the Regulation and Quality Improvement Authority.

This new landscape has meant fundamental changes to accountability arrangements and governance structures. These new structures, together with the findings of a review carried out in 2008 of the existing serious adverse incident reporting system, led to the introduction in May 2010 of new interim arrangements for incident reporting, pending the implementation of a new model for incident reporting – the Regional Adverse Incident and Learning (RAIL) system.

Under these interim arrangements, all Serious Adverse Incidents, since1 May 2010, are reported to the HSC Board. The Board works in partnership with the Public Health Agency and RQIA to ensure that incidents are reported and investigated in an appropriate manner. They also have responsibility to ensure that trends, best practice and learning is identified, disseminated and implemented in a timely manner.

The Department is committed to protecting and improving quality within the HSC and will shortly be launching "*Quality 2020: a 10-year quality strategy for health and social care in Northern Ireland*". The strategy defines quality in three dimensions:

- safety;
- standards/effectiveness; and
- the patient/client experience.

An effective system to ensure that lessons are learned and repetition is avoided when things go wrong is an integral component of a high quality health and social care system. I commend this summary report to you as a valuable tool for disseminating such learning.

***Dr Jim Livingstone***
***Director, Safety, Quality and Standards***
DHSSPS

# 1. DHSSPS SERIOUS ADVERSE INCIDENTS (SAIs) INTERIM REPORTING SYSTEM

## Introduction

1.1 By its nature, a Health and Social Care (HSC) system cannot be risk free. Advances in knowledge mean an ever greater range of treatments and interventions are now possible. While these improvements benefit us all and are undoubtedly to be welcomed, HSC practitioners and their patients/clients must weigh up the potential advantages of an individual programme of treatment or care against the risks involved.

1.2 Similarly, decisions about when and how to intervene in individual or family life to protect the vulnerable or to ensure their safety is complex and difficult work, which requires the highest levels of skill, integrity and dedication. The HSC system as a whole must therefore continually 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 while having regard to the safety of others.

1.3 For these reasons it is imperative that organisations identify and learn from all adverse events and make appropriate improvements in practice, based on local and national experience and on learning derived from the analysis of such events.

1.4 This is the third and final 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 April 2007 to April 2010, during which time a total of 1023 incidents were reported.

1.5 With effect from 1 May 2010 SAIs were no longer reported to DHSSPS. In line with the new roles and accountability arrangements established following the second stage of implementation of the Review of Public Administration in the HSC, responsibility for managing SAI reporting transferred to the HSC Board, working in partnership with the Public Health Agency (PHA) and the Regulation and Quality Improvement Authority (RQIA). These are interim arrangements, which will remain in place until the proposed new Regional Adverse Incident and Learning (RAIL) system is established, at which point they will be reviewed.

## Context

1.6 Since the statutory duty of quality was placed on HSC (then HPSS) bodies in 2003, there have been significant national and local developments on quality and safety. During 2007/08, the RQIA completed a second governance review based on the *Quality Standards in Health and Social Care*[1]. It has also produced a series of thematic reviews under its review programme 2009 – 2012. The annual compliance exercise against controls assurance standards

[1] http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-standards/spsd-standards-quality-standards.htm

is continuing. The work on the 2006 Safety First Action Plan[2] has been substantially completed and the evaluation of this work has helped to inform the development of a new 10-Year Quality Strategy for the HSC.

1.7 A HSC Safety Forum supports Trusts and Family Practitioner Services as they implement evidence-based patient safety interventions that demonstrate improved outcomes for patients and reduce harm. During this reporting period, legacy HSS Boards continued to maintain protocols with family practitioner services for the reporting of adverse events, with each legacy Board in turn notifying the Department of those events which met the SAI reporting criteria. This function has now been taken over by the HSC Board.

1.8 In 2008 the Department, in partnership with the HSC, carried out a detailed review of adverse incident reporting and learning within the HSC. The review recommended the establishment of a new regional adverse incident and learning system for the HSC. The model was approved by the Minister in 2009 and is currently being developed under the leadership of the PHA.

**Levels of HSC Activity**

1.9 It is important that the 1023 SAIs reported during the period April 2007 to April 2010 are viewed in the context of overall HSC activity. During 2009/2010, for example, the HSC was responsible for delivery of treatment, care and services across a wide range of settings[3], including:

- 727,000 accident and emergency (A&E) attendances;
- 34 million prescription items dispensed in the community;
- 1.5 million out-patient attendances;
- 580,000 in-patient and day cases;
- 2,600 looked after children;
- 24,000 children referred to Social Services;
- 2,400 children on the Child Protection Register;
- 1,574 adult protection referrals and some 1,059 care and protection plans put in place;
- 1326 applications for assessment under the Mental Health Order made by Approved Social Workers; and 33 new applications for Guardianships, with 61 Guardianships in Trusts at the year's end;
- during a typical week[4], an estimated 235,559 contact hours of domiciliary care provided by HSC Trusts for adults in Northern Ireland; and
- around 9,500 older people supported by HSC Trusts in 490 registered residential care and nursing homes throughout Northern Ireland.

1.10 With complex activity taking place on this scale, it is inevitable that things will occasionally go wrong, and this may sometimes result in serious adverse incidents occurring.

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[2] http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-safety/sqsd_safety_safety_first.htm
[3] Source: DHSSPS
[4] 20-26 September 2009

## Reporting Arrangements

1.11 For reporting purposes, in the period covered by this report, DHSSPS defined a serious adverse incident as any incident (including a near miss), where the consequences were 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.

1.12 The reporting criteria for the period covered by this report were set out in a series of Departmental circulars. These required HSC organisations, and family practitioners services (via the legacy HSS Boards), to report serious adverse incidents to the Department. A further circular (HSC (SQSD) 22/09) introduced some modifications to these reporting arrangements as part of the transition to the new Regional Adverse Incident and Learning System, and also to reflect the transfer of functions from the Mental Health Commission to RQIA in April 2009.

1.13 The Department's Serious Adverse Incident Review Group met monthly in the period covered by this report under the joint Chairmanship of the Chief Nursing Officer and the Director of Safety, Quality and Standards. The Group's membership included representation from social services, mental health, child care and secondary care from within the Department, as well as representatives from legacy HSS Boards, and from the new HSC Board following its establishment on 1 April 2009.

1.14 Once reported to the Department, each SAI was recorded and views sought from the relevant professional leads and policy directorates, as appropriate. Further clarification on the detail of incidents was sought from the reporting Trust, where required. When all relevant information had been obtained, the case was listed for consideration by the SAI Review Group, who identified any regional learning emerging. If necessary in particular cases, further referral was made to relevant policy or professional leads, with a view to disseminating any relevant learning to HSC organisations, for example through the issue of a professional letter, policy guidance or NIAIC alert to the service.

## Objectives

1.15 The objectives of the DHSSPS SAI reporting system were to encourage an open reporting culture, which acknowledged that lessons need to be shared in order to improve service user and staff safety and to apply best practice in assessing and managing risks. It also aimed to provide feedback on analysis and themes from reported incidents, and to ensure that the service was made aware of emerging learning.

1.16 Out of the SAIs considered in this reporting period, the key learning identified for HSC organisations from specific incidents has been grouped under the following thematic headings, which emerged from an analysis of reported incidents:

- Record Keeping and Documentation, including security of patient/client information (Section 3);
- Communication (Section 4);
- Mental Health (Section 5);
- Clinical Treatment and Care (Section 6);
- Medicines Management (Section 7); and
- Children's Services (Section 8)

1.17 This report has been produced to support and promote the implementation of learning identified from serious adverse incidents. It is aimed at those who work in, or manage, health and social care services, and at those who have an interest in improving the quality of care and service provision.

1.18 Safe and effective practice remains a top priority for health and social care in Northern Ireland. Service users and the public have a right to expect that every effort will be made to minimise risk and to ensure that their care, treatment and services will be person-centred, rights-based and provided in line with best practice.

## 2. KEY DATA

### Background

2.1 An adverse incident is defined as "any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation".

2.2 This remains the current working definition for adverse incidents in HSC organisations. It recognises that not all errors will result in harm to service users and/or staff, but some will. Where an incident is prevented, and no harm results, this is called a "near miss".

2.3 The learning identified in this report arises from a specified subset of all adverse incidents – those classified as serious adverse incidents, which were considered to meet the criteria set for reporting such incidents to DHSSPS as set out in Departmental circulars (PPM) 06/04, 05/05 and 02/06, HSC(SQSD) 19/07 and HSC(SQSD) 22/09.

2.4 It is important to acknowledge that:

- Adverse incidents may arise in a variety of settings;
- Incident reporting systems are only one method that can be used to detect such events;
- When an incident reporting system is used, its success depends on individuals/teams/organisations promoting its use in the interests of learning and sharing information;
- There are also a number of other local and national systems to which HSC organisations report certain categories of incident; and
- The Department's interim SAI system was dependent on voluntary reporting by HSC organisations, and the statistical information generated by this "regional incident reporting" tool should not therefore be interpreted or viewed as a complete picture of all adverse incidents occurring in HSC organisations, either in terms of the frequency or the severity of incidents.

2.5 In addition to the above points, a number of other factors also need to be borne in mind when considering the information provided by HSC organisations.

(i) The DHSSPS SAI reporting system was solely designed to provide feedback on those incidents which were considered to meet the three criteria defined within the departmental circulars in force at the time; the data it has generated should not therefore be used to draw comparisons with other more comprehensive local, national or international reporting systems.

(ii) With effect from April 2006, incidents were classified (catastrophic, major, moderate, minor, insignificant) according to either the assessed degree of harm caused to the individual service user or the level of

severity of the reported incident. Notwithstanding this classification, it remained the responsibility of the HSC organisation to investigate the incident appropriately and effectively.

(iii) The initial information supplied by HSC organisations when individual incidents were notified was usually limited to a one-page proforma, meaning that it was not always possible to determine with any degree of certainty whether a service user outcome (such as a death) was a direct outcome of the incident – this was the responsibility of the reporting HSC organisation to determine through its subsequent investigation.

(iv) A comparatively high reporting rate within one organisation should not be interpreted as an indication that that organisation's services are inherently unsafe - in fact the converse may be the case, as a high reporting rate often reflects an organisation that supports an open and learning culture, and is consequently safer than an equivalent organisation with lower levels of reporting. It is also important to bear in mind that reporting rates may vary according to the range and complexity of services offered by individual organisations.

**Reporting from Health and Social Care settings**

2.6 Since the introduction of the SAI reporting system in July 2004, the overall number of SAIs reported on an annual basis has shown a year-on-year increase. It is important to remember, however, that this increase does not mean that standards of care or treatment have deteriorated, but rather reflects a greater awareness and willingness on the part of individuals within organisations to report incidents, and also a growing organisational recognition that establishing effective reporting arrangements represents an important and integral part of managing risk and improving overall performance.

2.7 In total 1,023 SAIs were received by the DHSSPS in the reporting period April 2007 to April 2010. There were 264 incidents reported between April and December 2007; 397 in 2008; 287 in 2009; and 75 up to 30 April 2010. Figure 1 (page 12) sets out the annual reporting rates from 2005 until April 2010 (A factor contributing to the decrease in reported incidents in 2009 is the changes introduced by Circular HSC (SQSD) 22/09, which removed from SAI reporting certain categories of incident (suspected suicides and admissions of under-18s to adult mental health wards) from the DHSSPS SAI reporting system).

2.8 Reflecting the integrated nature of health and social care services in Northern Ireland, the main settings from which the incidents are recorded were acute/general hospital, acute mental health/learning disability, community/social care and family practitioner services (Figure 2 on page 13).

2.9 The community/social care category encompasses all incidents that happened in the community or in community-based settings, and includes reports of suspected suicides of people who had contact with mental health services in the two years preceding the suicide.

2.10 The majority of incidents reported were in relation to the following:

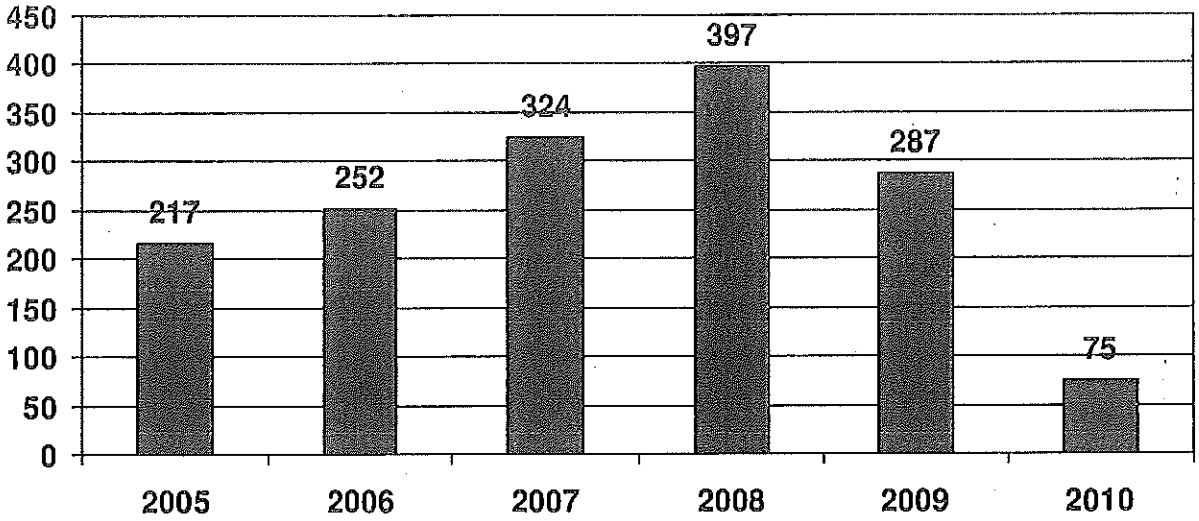
- Death of a person, including suspected suicides;[5]
- Children's services, in particular the interface with juvenile justice services, and children's absences without leave;
- Service pressures;
- Public health;
- Medicines management issues;
- Procedural errors in the acute/general hospital sector;
- Violence against staff;
- Security management issues related to HSC properties; and
- Information governance.

2.11 The key learning identified reflects the range of incidents reported to the Department in this period, and is set out thematically in the Report under the following headings;

- record keeping & documentation (Section 3);
- communication(Section 4);
- mental health (Section 5);
- clinical treatment and care (Section 6)
- medicines management (Section 7); and
- children's services (Section 8).

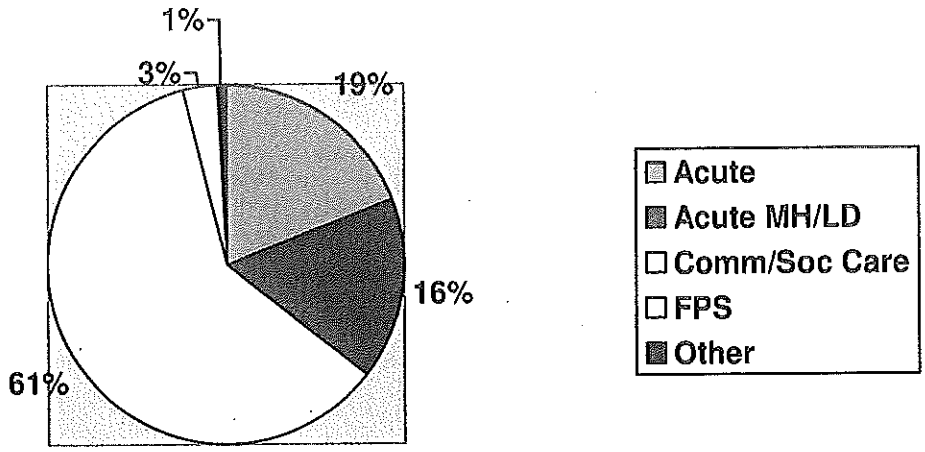
[5] In the absence of knowledge of an inquest verdict, these cases have been classified as "suspected suicides" regardless of the circumstances in which the individual was reported to have been found.

Figure 1 – Annual SAI Reporting Rates




2.13 The figure for 2007 includes the 60 SAIs reported during the period January to March 2007 covered by this current report. The figure for 2010 covers the period January 2010 to 30 April 2010, after which responsibility for managing SAI reporting was devolved to the HSC Board, working in partnership with the PHA and RQIA. A factor contributing to the decrease in volume of incidents reported in 2009 compared to 2008 reflects the removal of certain categories of incident from the DHSSPS SAI reporting system, effective from April 2009.

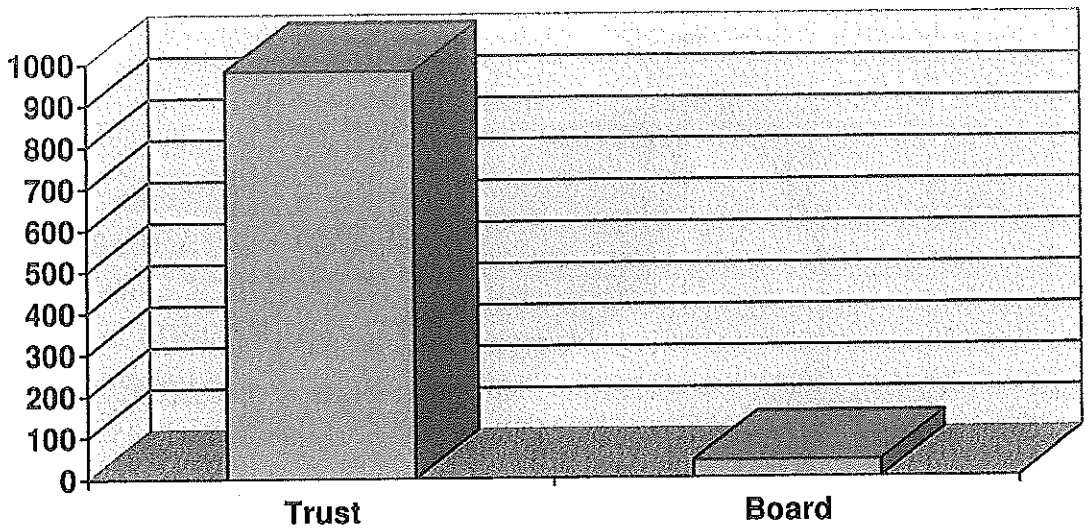
Figure 2 – Settings from which reported SAIs arose




2.14 The data summary available from the National Reporting and Learning System in 2009 showed almost three-quarters of incidents reported in England and Wales to be from an acute/general hospital setting.[6] Comparing this with the reporting pattern locally would imply that there continues to be under-reporting of incidents from this setting in Northern Ireland. Nevertheless, the year-on-year increase in local SAI reporting (taking account of the removal of certain categories of incident reporting with effect from 1 March 2009) suggests an increasing awareness of, and commitment to, SAI reporting on the part of HSC organisations.

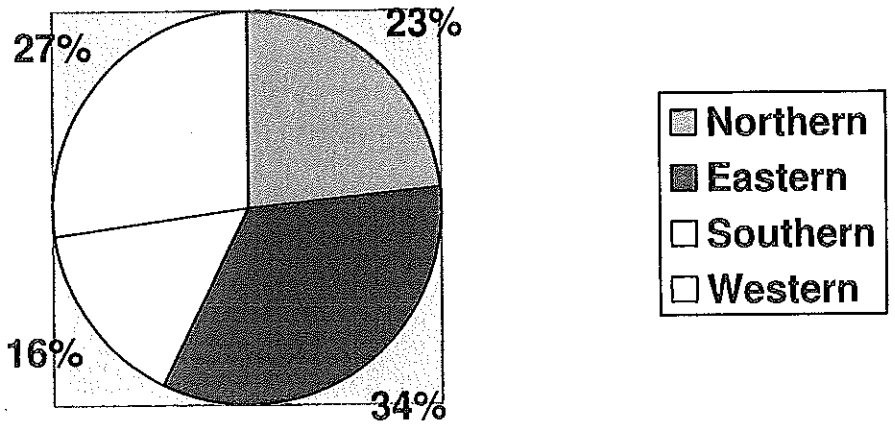
[6] Quarterly National Reporting and Learning System data summary, Issue 14: July 2009 to September 2009 (NPSA, November 2009)

Figure 3 – Type of Organisation reporting (April 2007 – April 2010)




2.15 All legacy HSS Boards and HSC Trusts reported at least one SAI in this period.

**Figure 4 – Reporting by Legacy HSS Board area**



2.16 Reports were received in the period from across all four legacy Board areas. For the purposes of this analysis, reports from the Northern Ireland Ambulance Service are included as part of the Eastern area.

2.17 It is important to exercise caution in attempting to draw any definitive conclusions from these figures in relation to the quality of care provided by individual HSC Trusts, as not all SAIs may have been captured at local level, or reported to DHSSPS. In addition, incidents involving suspected suicides and admissions of under-18s to adult mental health wards were no longer reported to the Department after 1 April 2009.

2.18 The numbers of incidents reported by individual HSC Trusts will also vary depending on the profile of treatment, care and services they provide. Reporting rates may also be influenced by variations in the size of population served across Trusts, particularly where regional services are provided, and overall reporting rates will be affected by any under-reporting in particular specialities, such as the acute/general hospital sector.

**Summary of Main Issues Reported**

2.19 Of the 1023 incidents reported to the Department between April 2007 and April 2010:

- Approximately one-third involved the death of a person. However it should be noted that an SAI report which documents a death does not necessarily mean that the circumstances of the incident contributed to the cause of that death.
- Around 45% of these deaths were suspected suicides[7], involving people who had had contact with HSC Mental Health services in the two years preceding the incident (suspected suicides were no longer reported to the Department with effect from 1 April 2009, as per Circular HSC (SQSD) 22/09).
- Just over 25% involved people who are, or who had been, in receipt of children's services. The majority relate to children's services interfacing with the juvenile or criminal justice system and to children absent without leave from residential care;
- Approximately 12% of incidents reported involved service pressure issues, which were mainly in relation to the non-availability of appropriate specialist child & adolescent mental health services (these were no longer reported to the Department with effect from 1 April 2009, as per Circular HSC (SQSD) 22/09);

[7] Pending 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.

- The remaining 18% covered a range of other issues . These include:
    - Involvement of public health related issues e.g. communicable disease;
    - Medicines management issues, including prescribing errors, inadequate labelling and the security of controlled drugs;
    - Concerns about procedural errors in the acute sector, including non-adherence to policies and procedures;
    - Violence against HSC staff, ranging from verbal aggression and threats to physical assault;
    - Security management issues, including theft from, and threats against, HSC properties; and
    - Information governance issues, involving loss or theft of patient/client data.

## 3. RECORD KEEPING AND DOCUMENTATION

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

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

3.2 The sub-optimal assessment of patients for signs of clinical deterioration and the subsequent response has led to the development of early warning tools for tracking and responding to these situations. Such tools can provide support and guidance to decision making, but ultimately it is the clinical skill, and collaboration of other team members, along with the escalation of concerns to more senior staff that determine optimal care.

3.3 Records should contain an accurate account of treatment, care planning and delivery. These should be written as soon as possible after the event has occurred, and provide clear evidence of the decisions made, care delivered and information shared.

**Security of Patient/Client Information**

3.4 There has been an increase in the number of reported incidents involving the loss or theft of pen drives or lap-tops containing the personal details of patients. Extra diligence is required to ensure that all such information is secure, and pen drives/lap-tops and other portable storage devices are not left unattended, and are secured out of sight at the end of the working day and over weekends.

**Learning arising**

3.4.1 Issues identified by HSC organisations for learning in relation to record-keeping and documentation that have arisen in this SAI reporting period include:

**Clinical records:**

- Clinicians should ensure accurate recording of the diagnosis, treatment and care provided, as well as the date and time at which clinical intervention took place. Clinicians should also ensure accurate recording

of fluids administered, on the fluid balance charts provided.

- Where a clinical case review is required, immediate access to patient records should be secured and a photocopy of notes made before any handover to external agencies, such as the PSNI or the Coroner's Office. Record Keeping Protocols for the handing over of hospital clinical case notes should be put in place and all clinical staff made aware of these. Adherence to such protocols should be the subject of regular audit.
- Clear documentation to identify the lead professional for care is important in maternal notes, especially if obstetric care is required for a midwifery led patient. Guidelines regarding supervision of midwives performing scans should be reviewed to ensure they include countersigning of supervisee entries on patient records by the midwife supervising.
- All medical staff are reminded of the importance of recording all episodes of treatment and care in patient's medical notes, as well as decisions taken regarding a patient's plan of care.
- As far as possible, all successful and unsuccessful interventions should be recorded on a single form to ensure a complete record of the complexity of an individual patient's condition and thus better informed clinical decision making.
- When a patient is admitted to hospital or referred to a team for initial assessment, every effort should be made to determine previous contacts, if any, through the EPEX system. One set of case notes should follow the service user from first contact. If case notes are unavailable at this stage, the record which has commenced should be filed in the original notes.

**Mental health records**

- Trusts should develop appropriate mechanisms to ensure that inter-team referrals within mental health services are recorded by the referring team, and acknowledged by the receiving team. These should include dates of any recent or imminent assessments. If a patient has an imminent appointment, staff should ensure that any recent relevant assessments

are communicated to the appropriate mental health professional to ensure they have a full picture of the patient's recent history.

- When a patient engaging with mental health services indicates their desire to take their own discharge contrary to medical advice, the possibility of detention should always be considered and the outcome should be recorded in the patients' notes.
- Crisis plans for patients engaging with mental health services should include a section to record comments from the family/carer/patient and be signed accordingly. Assessment documentation should include a section for consideration of hospital admission to be clearly documented and signed by the person undertaking the assessment.
- The absentee notification form for absconding patients should incorporate a risk assessment section to better communicate the patient's level of risk to himself and others.
- A summary sheet should be placed at the front of patient's case notes documenting risk, self-harm attempts and warnings to support risk assessment and management of risk.

**Transfer of records**

- Sealed boxes should be used to transport medical records. Protocols should be agreed for the transfer of records between sites.
- Documentation should be reviewed on transfer of patients between care environments, with particular attention paid to the frequency of intervals of physiological interventions.

**Early warning systems**

- Staff should be trained in the proper use of Physiological Early Warning Scores including adding scores at each set of observations, acting on the score and documenting actions taken.
- Trusts should review all observation charts to ensure that there is no duplication of charts that could increase the risk to patient safety.
- The importance of completing Modified Early Warning System (MEWS) documentation on a consistent basis is emphasised.

### Out of hours

- Organisations should ensure that there is a system in place for easy access to patients' notes and documentation during a bank holiday period.
- All clients using the on-call service on an ongoing basis should have a multi-disciplinary review care and treatment plan. All teams should have a system in place to record the reasons for cancelling appointments.

### Community care

- New HSC organisations should ensure appropriate steps have been taken across legacy teams to standardise protocols and processes for documentation, record keeping and storage.

### Contact with family members

- The names and contact details of the client/patient and key family members should be recorded accurately and reviewed throughout contact with services to ensure they are kept up to date.

### Staff

- Staff should be trained in the importance of documenting their own involvement, in the form of a written report, as soon as they hear of an adverse outcome.
- Staff should be reminded of their professional responsibility to adhere to current NMC and GMC Guidelines on Records and Record Keeping. Trusts should ensure that all recommendations from the Regional NIPEC Record Keeping Audit are effectively implemented.

### Security of Patient/Client Information

- Staff should be aware of their responsibilities in relation to safekeeping of patient records when travelling to outlying facilities. Staff must also recognise the importance of reporting in a timely fashion any loss of sensitive personal patient information.

- Trusts should ensure that all staff receive up-to-date training on information governance issues. Clear guidance should be provided for staff on organisational arrangements for encryption of IT equipment. Any data relating to patients or clients that is maintained electronically, for example on pen drives or memory sticks, should be treated as patient/client records, and consequently must be handled and stored securely in accordance with organisational records management and IT security guidance.

## 4. COMMUNICATION

4.1 Clear and effective communication remains a recurring theme in reported incidents within this period, both with patients/clients and their carers/family, and between staff. It is one of the essentials for safe and effective practice, and is a positive indicator of the culture of an organisation and the teams within it.

4.2 It requires relationships based on openness and trust, and communications that foster partnership working in the interests of patients/clients and carers/family. Poor working relationships within the clinical environment or service setting can pose a risk to patient/client safety, and potentially to carer/family well-being.

**Learning arising**

4.3 Issues identified by HSC organisations for learning in respect of effective communication that have arisen in this SAI reporting period include:

- Staff working in mental health services should be reminded of the importance of an appropriate and supportive response to the family of a patient following a suicide.
- When a death has been notified, administrative staff should be informed to ensure no further letters or appointments are sent that might cause further distress to family members. All letters and appointments should be dated.
- In circumstances where patients fail to engage with follow-up services following repeated presentations for emergency assessments and/or in-patient admissions, a multi-disciplinary case review should be convened to explore alternative interventions aimed at maintaining contact.
- Relatives/carers of patients attending psychiatric in-patient services should be informed of any leave arrangements/plans for the patient. A contact number for the ward should be included on relatives/carers visiting cards.
- Ill patients require multidisciplinary input and good liaison between different specialities. A system should be in place to ensure that requests for opinions on seriously unwell patients are responded to promptly by all specialities.

- Families of seriously ill patients should have a single designated point of contact with medical staff to ensure clear, consistent and up-to-date information is given. Information given to relatives should be recorded.
- Trusts should consider arrangements for alerting GP practices, A&E departments and out-of-hours primary care services regarding the leave status of patients from mental health hospitals, particularly where there is a history of abuse of prescribed medication.

**Handover arrangements**

- Acute and community mental health teams should ensure that they have effective protocols in place to manage referrals from other health and social care professionals.
- Trusts should ensure that formal discharge plans are communicated between acute and community services.
- Clinical staff should take appropriate account of handover information when considering appropriate investigations.
- Ward day and night staff should carry out a joint morning and evening check to ensure patients' well-being at shift handover time.
- Patients who are significantly unwell should have care led by a single consultant. Any change in lead consultant, either within a unit or on transfer between units, should include clear handover and discussion of the patient's management plan at the senior level of consultant to consultant.

**Communication after an incident has occurred**

- Debriefing of all staff involved in serious clinical incidents should happen as soon as possible after the incident and should be a routine part of the governance process. This will enable staff to talk about what happened, share their anxieties and receive mutual support from colleagues who were involved.

- The findings of Trust investigations into incidents should be shared with family members and also the staff involved in the care of patients.
- Staff must be supported and given feedback on the outcome of serious adverse incidents.
- Patients and their family require timely, sensitive communication during and after any incident. This should be co-ordinated through one member of staff.

## 5. MENTAL HEALTH

5.1 Suicide continues to make up the single largest category of reported incidents. As highlighted in previous Supporting Safer Services reports, not all suicides or incidents of self harm are preventable. However caution should be taken to ensure that acknowledging this does not translate into an acceptance of any individual death as inevitable. The National Confidential Inquiry into Suicide and Homicide (NCISH) by People with Mental Illness (England and Wales) 2006 suggests that virtually all in-patient suicides could be seen as preventable, unlike suicides which occur in the community, where supervision is less immediate.

5.2 This reporting period has also seen several cases of suicide in women with post-natal depression. Professionals caring for pregnant women need to take full and accurate medical histories and be alert to the risks for women with a previous history of mental illness and, in particular, bi-polar disorder. A training programme to raise awareness on these issues is being developed.

5.3 This period also saw the publication of a combined Independent Inquiry/Case Management Review Report on the death of a mother and her child, which, among other things, lead to DHSSPS commissioning and publishing Filicide: A Literature Review, a review of the content and uptake of child protection training and commencement of work on a joint protocol designed to manage the interface between mental health and child care services. These recommendations are currently being taken forward.

5.4 To address recurrent issues in relation to mental health services identified from previously reported SAIs, the Department has developed "Promoting Quality Care', guidance on risk assessment and management in Mental Health and Learning Disability services, and is also piloting the "Think child, think parent, think family" concept, which is designed to improve the interface between mental health and children's services.

5.5 In relation to vulnerable individuals being seen in A&E departments, the" card before you leave" scheme was launched in 2010.

**Learning arising**

5.6 When considering the learning from incidents of suicide and self harm in this SAI reporting period the following recommendations have emerged, which are currently at various stages of implementation:

- Staff should recognise the importance of consultation with patients' families during an in-patient stay, in particular at admission, discharge and where the patient has a dependent child or children.

- The need for a joint protocol designed to manage the interface between mental health and child care services.
- Protocols for discharging patients from a service should be clear and should include the principle of informing the referral agent, the patient's GP and other professional colleagues involved in the care of the patient.
- Parental mental health is integrated into all stages of the new Northern Ireland Assessment Framework for Children (Understanding the Needs of Children in Northern Ireland).
- Development of guidance that would lead to the implementation of consolidated assessments in mental health to underpin improvements in risk assessment, key working/case co-ordination, multidisciplinary working, care planning and discharge planning.
- Development and implementation of bed management policies.
- Development and implementation of a policy in relation to identifying and recording 'next of kin' information.
- Provision of support to families bereaved by suicide.
- Inter-hospital transfer of patients and their records and subsequent discharge arrangements.
- Arrangements to secure all relevant documents and files in relation to sudden and unexplained deaths.

**Inpatient services**

- Mental Health Inpatient Unit staff must seek and record information from professionals involved in the admission, transfer or return of patients to the Unit following a period of leave.

- Search policies and procedures when voluntary in-patients in Psychiatric Units go missing should be reviewed to ensure roles and responsibilities are clear. A policy on the use of mobile phones by in-patients should be developed. A review of in-patient access to potential ligatures and removal of property that could be used in this way from patients on their admission, and on discontinuation of special observation arrangements, should be undertaken.

- Trusts should recognise the potential contribution families/carers can make to the care planning process for clients by identifying key supportive relatives and liaising with them as appropriate and with the consent of the client.

**General medical ward environment**

- Staff should be aware of the need for appropriate risk assessment of the ward environment to minimise any potential environmental risks when dealing with patients with self-harm or suicidal tendencies, with a particular emphasis on areas where the patient may be unobserved, even for a short time, such as clinical cubical spaces. Any such assessment should take account of the potential for harm which may arise from the presence of otherwise unremarkable clinical equipment, e.g. bandages.
- All staff should be trained on assessment skills for patients who self-harm, including appropriate questioning techniques.
- Trusts should consider the development of guidance for hospital services, addiction services and mental health services, to deliver a joined-up approach to the management of people who are opiate dependent and who require admission or treatment in general hospitals.

**Security on Ward**

- The use of plastic covers or bags for pillow cases or duvets should be prohibited on wards. Patients who are at risk of self-injury or suicide and are subject to higher level of observation should have restricted access to plastic bags. This may mean removal of these bags from their proximity.
- Decisions taken as a result of risk assessments should be reviewed on a regular basis, and should also take account of any learning identified from adverse incidents.
- When a child attends an Accident and Emergency department having self-harmed, a referral should be made to the hospital Social Work Team and notification sent to the Health Visitor.

- Accident and Emergency staff should be aware of the need to enquire, and record responses, regarding domestic violence where there is a history of relationship difficulties.
- Mental Health assessment following self-harm should take place prior to discharge from Accident and Emergency.
- Consideration should be given to whether Family and Childcare Social Work Team should be notified by CAMHS when a child presents with self-harm.

**Maternity services and self harm**

*(It should be noted that regional perinatal mental health services are currently being reviewed by a group led by the Public Health Agency)*

- All maternity units receiving an urgent referral giving a history of self-harm should convene a multi-disciplinary meeting to plan the care needed. As a minimum, this should include the hospital and community midwives, hospital social worker, health visitor and GP. Special consideration should be given to inviting those whose postnatal care falls beyond the Trust providing antenatal and intrapartum care.
- At first knowledge that a pregnant woman has a history of self-harm, consideration should be given to whether a referral should be made to Family and Childcare Social Services in the hospital setting. This should be done in conjunction with the hospital social worker. The decision and rationale should be recorded in the patient/client notes. Referrals must be made in accordance with Safeguarding Procedures.
- In addition to written information, where there are specific concerns regarding a mother, a verbal handover should be given by the community midwife to the health visitor. This should be recorded in the notes.
- Antenatal notifications should be sent immediately following booking to the relevant community midwives and health visitors, and include specific information such as a history of self-harm.
- The provision of Safety First assessments for all service users presenting with self harm within 7 days of discharge from hospital is sound

professional practice arising from the National Confidential Inquiry into Suicide and Mental Health Safer Services report and should be extended as standard practice across Trusts. Additional and refresher training should be offered to all mental health professionals engaged in the Safety First follow-up assessments or in emergency duty assessments to try to capture the initiative when the crisis occurs.

**Referral Arrangements**

- Staff should be reminded that it is the responsibility of a professional, when making a referral to another service, to ensure that the referral is recorded and followed up.
- Trusts should have systems in place to ensure that information regarding out-of-hours work is disseminated in a timely manner to other professionals involved.

## 6. CLINCIAL TREATMENT AND CARE

6.1 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.

**Learning arising**

6.2 Learning identified by HSC organisations in relation to clinical treatment and care in this SAI reporting period includes the following:

- The roles of the Accident and Emergency consultant and surgical and medical teams in care of a patient in the emergency setting should be clearly defined, as should the role of the Accident and Emergency consultant in coordination of patient care in the accident and emergency setting.
- Where differences of opinion exist between surgical and medical staff, the relevant consultants must be involved to ensure correct clinical diagnosis, effective communication between all clinicians and clear coordination of care, particularly of the acutely ill patients in the accident and emergency setting.
- Trusts should review their pain relief policies and procedures to ensure effective analgesia is maintained, especially during transfer of an acutely ill patient to another unit.
- Where oncology patients present at A&E, advice should be sought from the Cancer Centre on the management of the patient before any treatment other than stabilisation is given.
- Triage in Accident and Emergency setting should not be performed by administrative staff.
- Any specific requests recorded in post operative instructions should give definitive guidance on the nature and duration of follow-up care.

- Trusts should take account of any potential implications for service delivery in cases where they are providing services to patients who are also healthcare professionals or, where appropriate, their families.
- Existing policies on labelling of fluid lines, infection control in relation to disconnection of lines, and on reconnecting fluids must be followed. Basic checks – right patient, right drug and right time – must also be adhered to when administering medications.
- Wards should have in place a protocol to guide decision making on the appropriate placement of patients transferring from ICU, which takes appropriate account of the condition of the transferring patient and the conditions of other patients already on the ward.
- Trusts should develop a policy on the frequency of observations of patients with femoral lines, setting recommended intervals of observation and the location of documented records of these.
- Trusts should ensure that staff are clear about the process in relation to equipment isolation where it has been involved in a serious incident, and their responsibilities in relation to investigations of patient safety incidents, as set out in the Memorandum of Understanding on Investigation of Patient Safety Incidents.
- Staff should be aware that snoring can be indicative of partial airway obstruction caused by opiates, anaesthetic or sedative drugs or alcohol.
- Trusts should ensure consistent use of PCA infusors including producing guidelines and training staff in their use.
- Trusts must ensure that guidelines in the Memorandum of Understanding on the Investigation of Patient Safety Incidents are implemented, especially those on the need to retain clinical equipment that was attached to a patient in the event of his/her death.
- Trusts should ensure that they have implemented National Patient Safety guidance on correct site surgery, including use of the World Health Organisation surgical checklist.

## Maternity Services

- Trusts should produce a clear Trust-wide multiprofessional shared vision and maternity services strategy, including leadership structure and style.
- Trusts should develop an overall patient pathway or design for maternity services that makes best use of existing resources to deliver efficient, safe care. This should include appropriate use of the skills of midwives and obstetricians.
- Trusts should establish multiprofessional Labour Ward forums in which obstetricians, midwives, neonatologists, anaesthetists, nurse, managers and others can come together to continuously review and improve the maternity service e.g. through review of near misses, adverse incidents, samples of electronic fetal monitoring tracings.
- The leadership and management structure of maternity services should have clear accountability at Directorate, Ward, Labour Ward and Clinic levels. The structure and leadership style need to create open constructive challenge and an evidence-based environment in which safety, efficiency and best practice will flourish.
- Trusts should develop effective Maternity Services Liaison Committees that include staff, service users, commissioners and other stakeholders to design, review and develop maternity services.
- Maternity services should have clear links to Trust governance arrangements and robust monitoring of safety and risk management. services should be able to demonstrate improvements arising from issues reported by any member of staff.
- Maternity services should have one designated person to co-ordinate, record and audit multiprofessional training. Senior managerial support is required to develop training in multiprofessional teams and strengthen working relationships.
- All policies and procedures should be developed and reviewed annually by a multi-professional working group.

- Statutory supervision of midwives is a unique part of ensuring safe practice and protection. The recommended ratio of one supervisor to fifteen midwives must be achieved in order to comply with the annual supervision arrangements.
- Regular review of staff and skill mix should be undertaken to ensure that there are adequate staffing levels to address and meet the needs of the service.
- Midwives should be trained to insert IV cannulae and administer IV antibiotics.
- Midwifery staff should rotate regularly to maintain their skills and knowledge. This applies particularly to permanent night staff.
- Trusts should consider developing a high dependency area in the labour ward for ill or potentially ill women who do not need intensive care. Midwives should be trained to support these women.
- Trusts should develop and implement protocols for the emergency in-utero transfer of high risk women, to include potential transfer outside Northern Ireland via air ambulance. The protocol should also cover arrangements for the transfer of mother and baby back from units outside Northern Ireland.

## 7. MEDICINES MANAGEMENT

7.1 Medicines are the ubiquitous treatment within the HSC with some 35m prescription items dispensed annually in primary care and a total cost of the drugs bill (primary and secondary care) of £500-550m per year. The extensive use of medicines increases the possibility for errors associated with their use to occur, and the potency of some agents markedly increases the risk of serious adverse incidents if they are used in error.

7.2 Medicines Management describes the processes whereby medicines are procured, selected, prescribed, dispensed, administered and monitored ultimately for the benefit of the patient. Errors may occur at any point in this medicines management chain.

7.3 Errors in prescribing may involve the wrong choice of therapy, incorrect duration of treatment, mistakes in dosage calculations, wrong route of administration or errors in correct patient identification.

7.4 Dispensing of medicines and their administration constitutes further potential opportunities for risk and errors can be precipitated by poor standard operating procedures, inadequate or incorrect labelling, use of common liveries for different products and drug names that look and sound alike

7.5 Patients may also use prescribed medication incorrectly, thus contributing to the occurrence of adverse events.

7.6 The types of error indicated above are often associated with poor communication such as unclear or inadequate documentation or the transmission of information by telephone. .

7.7 Also the risk of such adverse events occurring may be higher in contexts where the potential for human error is increased, for example where there is inadequate staffing, time pressures to complete the task, environmental distractions and lack of training and support for additional checking.

7.8 Good medicines management practices are essential and practitioners who are trained and authorised to administer medication must know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, interactions, toxicity profile and precautions and contra-indications.

7.9 The practitioner must be certain of the identity of the patient to whom the medicine is to be administered, be clear about the dosage, and the time of administration. A clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, must be made, ensuring that any written entries and the signature of the practitioner are clear and legible.

7.10 Some drug administrations require complex calculations to ensure that the correct volume or quantity of medication is given. In these situations it may be necessary for a second practitioner to check the calculation in order to minimise the risk of error.

7.11 In respect of controlled drugs, a signed record should be made of all quantities of drug that have been disposed of.

**Learning arising**

7.12 The following learning points arising from incidents involving medicines management in this period have been identified by HSC organisations.

**Opioid Patches**

- Risks associated with the inappropriate use, storage or disposal of opioid patches should be considered before prescribing opioids via the transdermal route.
- Patients on opioid patches should be advised about safe storage and disposal as part of counselling on their discharge medicines, as detailed in the patient information leaflet.
- A patient information leaflet should be dispensed with all prescriptions.
- Staff are reminded of their responsibilities in relation to controlled drug usage.
- Consideration should be given to implementing a system of recording when a bolus dose of drugs is administered.
- Medical staff should ensure that buprenorphine patches are discontinued prior to prescribing a morphine infusion.
- Medical staff should ensure care is taken to ensure the correct concentration of drugs is recorded on the medicine kardex, to prevent potential errors in administration.
- Drugs that are prescribed should be administered. Any reason for not giving a prescribed drug must be recorded.

## Storage of Medicines

- Trusts are reminded that appropriate processes and safeguards must be in place to provide assurance on the security of medicines in HSC wards and departments.
- Trust Pharmacy departments should agree and implement procedures for dealing with telephone calls from suppliers regarding delivery of problematic orders, and for discrepancies in receipting.
- There should be direct communication between prescriber and pharmacist when a change occurs to the medication regimen of a patient receiving medicines by instalment dispensing.

## 8. CHILDREN'S SERVICES

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

- non-compliance with child protection policies and procedures;
- children absconding from residential care;
- perpetration of criminal damage/assault while in residential care;
- deaths of children - including suspected suicides of children and young people, some of whom had previous involvement with social services; and
- interfaces with the Juvenile Justice Centre.

### Child Protection

8.2 Case Management Reviews (CMRs)[8] are undertaken to determine the learning, if any, that can be identified and disseminated regionally. CMRs were progressed in relation to eight of the SAI reports received. In the same period an Independent Review was undertaken and a report submitted to the Department.

8.3 In view of the challenges presented by the increase in the number of potential CMRs and the emergence of some recurring themes, a review was undertaken and this identified a number of areas for improvement. This is an ongoing process and the Regional Child Protection Committee (RCPC) is working to improve the consistency and quality of CMRs, including training for those involved in the process. This drive toward continuous review and improvement of process will be further enhanced by the establishment of a statutory regional Safeguarding Board for Northern Ireland, which will replace the current RCPC administrative arrangements. Responsibility for CMRs will transfer to the SBNI once it becomes operational in 2012 and the circumstances for CMRs will be set out in Regulations along with a requirement to disseminate learning from such cases.

8.4 DHSSPS issued Standards for Child Protection Services in July 2008.[9] The standards are an important part of the overall framework to deliver continuous improvement in, and strengthening of, child protection services in Northern Ireland and their associated accountability arrangements. They should also help families and members of the public understand how services work to protect children and the important contribution they themselves can make to the safeguarding of children and young people. Among other matters, the Standards address the Interfaces and Joint Working Arrangements for

[8] The circumstances under which a CMR should be conducted or considered, its purpose and the framework for its completion are set out in Chapter 10 of *Co-operating to Safeguard Children* (May 2003). *Co-operating to Safeguard Children* can be accessed through: http://www.dhsspsni.gov.uk/show_publications?txtid=14022

[9] The Standards and reports related to the Inspection of Child Protection Services can be accessed through: http://www.dhsspsni.gov.uk/index/ssi/oss-child-protection.htm

Children in Need of Residential Care, across Fieldwork, Child and Adolescent Mental Health Services (CAMHS), Adult Mental Health and other Agencies. The RQIA has, subsequently, published a number of reports from the first phase of its Child Protection Review.[10]

8.5 The Reform Implementation Team (RIT) was established in 2007 to drive forward the comprehensive change agenda for child protection services in Northern Ireland, based on a Care Pathway approach. Subsequently, through the work of the RIT a number of developments have taken place to assist with regard to safeguarding all children generally, and, specifically, in addressing the needs of children in Residential Care.

8.6 Through the use of Understanding the Needs of Children in Northern Ireland (UNOCINI) assessment and planning documentation there is a system to ensure improved and consistent methods of referral and initial assessment of children who may be at some level of risk. This was then developed as more in-depth assessment using specific Pathways of Family Support, Child Protection and Looked after Children. These Pathways will also become available as Web Based tools.

8.7 To further enhance this work and ensure it is facilitated on a multi-agency basis, a protocol on Multi-agency Information Sharing is to be issued. The RIT Implementation Group and the Children's Services Programme Improvement Board, in conjunction with the Trust Change Co-ordinators and the Workstreams, are all mechanisms to ensure good practice with regard to children is discussed fully and agreed by all Trusts and with partner Agencies.

**Children Absconding from Residential Care and those with Challenging Behaviour**

8.8 The majority of SAI reports received related to the absconding of children from residential care. DHSSPS wrote to all Boards and Trusts 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.

8.9 From 1 April 2009, a joint protocol between HSC Trusts and the PSNI came into operation entitled *Regional Guidance – Police Involvement in Residential Units – Safeguarding of Children Missing from Home and Foster Care.* It provides guidance to carers, social workers and police officers in dealing with situations where children go missing and where police officers attend residential units. A number of other policies have been developed to ensure good/safe practice in relation to a range of issues related to preparing for and caring for children in a residential setting. These include guidance on:

[10] Reports from the RQIA Child Protection Review can be accessed through: http://www.rqia.org.uk/publications/rqia_review_reports.cfm

- Use of Children's Resource Panels (to ensure a safe and appropriate allocation of Residential Care/Foster Care to children);
- Admission Policy & Procedure, Record Keeping, Review and Monitoring arrangements;
- Child Protection Policies for Children's Homes;
- Misuse of Substances Policy for Children's Homes;
- Anti-bullying Policy for Children's Homes; and
- Protocol on the use of Physical Restraint.

8.10 DHSSPS has also funded the development of a range of therapeutic approaches within a number of children's homes across Northern Ireland. It is anticipated that this initiative will have consequential benefits for the management of challenging behaviours.

8.11 DHSSPS, in conjunction with other Government Departments and other voluntary sector partners, sought to develop a comprehensive strategy to better enable care-experienced young people to achieve their potential and deliver improvements in their health, educational, social and economic outcomes. The Department launched a consultation document entitled *Care Matters in Northern Ireland – a Bridge to a Better Future* in March 2007; *Care Matters in Northern Ireland* outlines a strategic vision for wide-ranging improvements in services to children and young people in, and on the edge of, care. *Care Matters in Northern Ireland* was fully endorsed by the Northern Ireland Executive in September 2009.[11] The *Care Matters in Northern Ireland* 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.

**Interface with the Juvenile Justice Centre**

8.12 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 11 September 2006 asking that all such placements be reported as serious adverse incidents. Work is being progressed in this arena, with guidance being developed to include

- Children in Residential Care who are in conflict with the law;
- Protocol between PSNI and Residential Child Care in relation to police involvement in Residential Child Care incidents;
- Protocol between PSNI and Residential Child care with regard to admissions to care and custody;
- Supporting Young people through Court processes; and
- Care Planning for Children admitted to the Juvenile Justice Centre.

[11] http://www.dhsspsni.gov.uk/index/hss/child_care/child_care-carematters.htm

## Process Issues

8.13 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 reporting form, which 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.

8.14 The establishment of a single HSC Board offers an opportunity to achieve greater consistency in the recording and analysis of child-related events, including those which, under the new RAIL system, require to be reported to DHSSPS.

## Learning arising

8.15 Learning with regional application for Children's Services provided by HSC organisations that has arisen in this SAI reporting period from SAIs, CMRs and Independent Review include:

- Training in the use of assessment frameworks, including risk assessment, interface with other models and the timely completion of assessments;
- Ensuring that awareness training on the arrangements established for the risk management of sexual and violent offenders (PPANI)[12] is an integral part of child protection training;
- Interventions that are structured, therapeutically sound and outcome focused, and informed by the skill, expertise and experience of all relevant professionals;
- Need for routine enquiry, priority referral, and follow-up of suspected domestic violence cases where there are children in the family;

[12] Public Protection Arrangements Northern Ireland (PPANI) – http://www.publicprotectionni.com - refers to the arrangements introduced in October 2008 for the risk management of sexual and violent offenders, and certain potentially dangerous persons whose assessed risks require multi agency input to the delivery of individual risk management plans. PPANI replaced and extended the previous Multi Agency Sex offender Risk Assessment and Management (MASRAM) arrangements.

- Improving communication, information sharing, analysis, decision-making and planning in safeguarding children across disciplines, between agencies, with primary care and other processes such as Multi Agency Risk Assessment Conferences and PPANI;
- Effective and timely record keeping;
- Clear guidance on data protection matters, consent with regard to information sharing and competent decision making with regard to young people;
- Ensuring continuity of service provision to vulnerable children and notifications of failure to keep planned appointments;
- Safe escort arrangements for young people who are at risk;
- Ensuring consistent application of thresholds for referral and intervention;
- Conflation of guidance and ensuring access for staff to up-to-date information on policy, practice and procedures;
- Effective interfaces between Adult Mental Health Services, Child and Adolescent Mental Health Services and Children's Services;
- Effective interfaces between General Practice and Children's Services;
- Responding to anonymous referrals;
- Effective systems to address unallocated cases and waiting lists;
- The recruitment and retention of skilled staff in child protection and adherence to NISCC Codes of Practice;
- Review of out-of-hours provision;
- Strengthened supervision and management; and
- Monitoring and audit by senior management of the implementation by staff of Regional Child Protection Committee and DHSSPS policies and standards for child protection.

## 9. CONCLUSION – THE WAY FORWARD

9.1 Safety, defined as "avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them", must continue to be a cornerstone of health and social care in Northern Ireland.

9.2 The Department will continue to promote safety as a key element of protecting and improving the quality of services. *"Quality 2020: A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland"* will be launched in the autumn of 2011 with a view to implementation beginning in 2012. It will set strategic goals for:

- Transforming the Culture;
- Strengthening the Workforce;
- Measuring the Improvement;
- Raising the Standards; and
- Integrating the Care.

9.3 The Public Health Agency is leading a project to devise a new Regional Adverse Incident and Learning System. It is hoped that phased implementation will begin later in 2012.

9.4 The HSC Board will continue to receive reports of serious adverse incidents and disseminate key learning widely.

9.5 The Regulation and Quality Improvement Authority is working on a new Review Programme to cover the period 2012 to 2015, which will help to inform and improve health and social care.

9.6 In these and other ways the HSC will continue to take appropriate action when things go wrong and provide appropriate assurance that learning has been taken account of and improvements made, where appropriate.