Health and Social Care Board

Public Health Agency

Learning Report

Serious Adverse Incidents

April 2012 – September 2012

November 2012

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SECTION 1

1.0 INTRODUCTION

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,[1] arising during the course of the business of an HSC organisation / Special Agency or commissioned service. Appendix A of this report sets out the criteria of a Serious Adverse Incident (SAI).

These incidents occur in all health systems and can be the result of system failures, human error, intentional damaging act, rare complications or other causes.

An organisation with a culture of safety will not only report these incidents but will have a process in place by which learning from these incidents is shared both locally and regionally.

This report identifies key regional learning, action taken and proposed arising from SAI's reported during the period 1 April 2012 to 30 September 2012.

The aim is to improve the care and treatment of patients and clients, to improve safety and ensure effective management of the incident.

2.0 BACKGROUND

Responsibility for management of SAI reporting transferred from the DHSSPS (Department) to the Health and Social Care Board (HSCB) working in partnership with the Public Health Agency (PHA), with effect from 1 May 2010.

In April 2010, following consultation with key stakeholders, the HSCB issued the procedure for the 'Reporting and Follow up of Serious Adverse Incidents' for full implementation on 1 May 2010. The procedure sets out the arrangements for reporting, managing, investigating and reviewing of all SAIs occurring during the course of business of an HSC organisation, Special Agency or commissioned service. It also sets out the arrangements of how SAIs are managed within Primary Care Services in conjunction with the adverse incident system in place within the HSCB Integrated Care Directorate.

The procedure details arrangements for internal management of SAIs by HSCB and PHA staff, supported by an additional internal protocol in relation to the nomination and role of a HSCB/PHA Designated Review Officer (DRO).

[1] Source: DHSSPS How to classify adverse incidents and risk guidance 2006
www.dhsspsni.gov.uk/ph_how_to_classify_adverse_incidents_and_risk_-_guidance.pdf

3.0 MANAGING SERIOUS ADVERSE INCIDENTS REPORTED

The arrangements for managing SAIs reported to the HSCB/PHA include:

- Regional reporting system to the HSCB for all SAIs.
- The nomination of a DRO to review and scrutinise reports.
- Regional SAI Group meeting held on a bi-monthly basis to consider reports, identify learning and agree actions.
- Escalation if required in respect of:
  -timescales for receipt of SAI and Investigation reports
  -assurances for action being taken forward by reporting organisations following the investigation.

In addition, the HSCB Senior Management Team receives and considers all SAI's on a weekly basis.

4.0 SAIS REPORTED DURING PERIOD APRIL 2012 – SEPTEMBER 2012

During the period 1 April 2012 to 30 September 2012, the HSCB received 141 SAI notifications. This is largely unchanged from the previous six months (October 2011-March 2012) when 144 SAIs were reported to HSCB. A breakdown of these SAIs by reporting organisation and programme of care is detailed at Appendix B.

4.1. PROGRAMMES OF CARE

SAIs are categorised by Programmes of Care as follows:

- Mental Health
- Acute Services
- Family and Child Care
- Learning Disability
- Corporate Business / other
- Maternity and Child Health
- Primary Health and Adult Community (Including General Practice)
- Elderly
- Physical Disability and Sensory Impairment
- Health Promotion and Disease Prevention

5.0 DE-ESCALATION OF A SAI

HSC organisations/Special Agencies or Commissioned Service Providers are encouraged to report SAIs, however, it is recognised that SAI reports can be based on limited information at the time of reporting and on further investigation the situation may change.

This can result in the incident no longer meeting the criteria of an SAI. In such instances a request can be submitted by the reporting organisation to de-escalate the

SAI. The decision to approve de-Escalation of a SAI is made by the HSCB/PHA Designated Review Officer

During the reporting period six (6) SAI notifications received were de-escalated.

SECTION 2

1.0 LEARNING FROM SERIOUS ADVERSE INCIDENTS

The purpose of any adverse incident reporting system is to improve patient safety. A key aim of the SAI reporting and learning process is to reduce the risk of recurrence, both within the reporting organisation and across the HSC as a whole. The dissemination of learning following a SAI is core to achieving this and to ensure these lessons are embedded in practice and the quality of care provided.

The Regional SAI Group has a role in meaningful analysis, identifying learning across organisations, making recommendations for change and informing the development of solutions.

Learning opportunities can be identified in a number of ways:

- Through individual investigations and Root Cause Analysis (RCA)
- Aggregation of similar incidents over time identifying common themes and trends.
- Systematic reviews of areas of concern.

When learning is identified, both providers and the Regional SAI Group have a role in identifying actions which will make changes to practice through, for example, prioritisation, training or dissemination of information and in implementing and sustaining these changes in practice.

The Regional Group may also decide to commission specific thematic reviews of Serious Incidents to identify trends and patterns across commissioned provider organisations and ensure wider implications and key learning points are disseminated across the HSC.

In taking forward this work, the Regional SAI Group recognises that there are many barriers to learning as identified in 'An Organisation with a Memory'.[2]

- An undue focus on the immediate event rather than on the root cause of problems
- A tendency towards scapegoating and finding individuals to blame rather than acknowledging and addressing deep rooted organisational problems
- Lack of corporate responsibility
- Organisational culture

In meeting its objectives the Regional SAI Group will be exploring new methods of learning to maximise the impact on patient safety.

[2] An Organisation with a memory (2000) Department of Health England.

2.0 DISSEMINATION OF LEARNING INITIATIVES

These current initiatives were identified as part of the SAI review process and relate to both learning from trends, reviews and individuals cases. Some of these initiatives may relate to learning identified and reported in the previous report as part of ongoing work.

2.1. PHYSIOLOGICAL EARLY WARNING SCORES

Further to the Regional Learning Event, to disseminate understanding of sharing learning in relation to Physiological Early Warning Scores (PEWS) in health care, on the 28 March 2012 a request was made by the Senior Management Team (SMT) to review and identify the numbers and types of SAIs relating to identification and response to deteriorating patients in the clinical setting to decide whether any further action was required to be taken through the Regional SAI Review Group.

This review provided a detailed analysis of SAIs relating to the deteriorating patient reported to the HSCB from within HSC acute services, for the period 1 May 2010 to 19 July 2012.

The findings indicate that the majority of these incidents can be attributed to the following themes:

THEME 1: No observations made for a prolonged period

THEME 2: No recognition of the importance of the deterioration and/or no action taken other than recording of observations

THEME 3: Delays in the patients receiving medical attention, even when deterioration had been detected and recognised.

THEME 4: Poor recording/absence of recording of observation rates.

The findings of this review indicate that consistently and effectively detecting and acting upon patient deterioration is a multifaceted issue. The findings of this review mirror the results presented by the Regional GAIN Audit, in that there are variations in PEWS practice between sites. There were many complex cases most of which highlight deficits in communication, ownership and handover. A number of points where the process did not work effectively were identified, including not taking observations, not recognising the early signs of deterioration, not communicating observations causing concern and not responding to these appropriately. Lack of clear and comprehensive documentation was evident in many of these cases which raised the issue of lack of awareness of professional responsibility and associated accountability, in relation to the need for accurate record keeping.

A wide range of contributing factors were also identified, including workforce issues, lack of effective teamwork and leadership, poor communication and clinical handover, problems with dual diagnosis and a lack of successful implementation of relevant policies and procedures. Whilst the focus of this report was on PEWS, a number of SAIs related to deficits in recording, reporting and escalation of abnormal neurological observations, which contributed to the incident. A number of recommendations have been made within the report including the recommendation

that HSC Trusts should continue ongoing work on PEWS as set out in HSS (MD)17/2010 and confirm their commitment to a regional approach to the use of PEWS in the identification and management of the deteriorating patient.

This PHA/HSCB report will be circulated to all HSC Trust Chief Executives for further learning. It will also be shared with pre and post graduate learning institutions. As a result a regional approach will be developed to ensure recognition and response to the deteriorating patient is included in regional core training for foundation and common training for doctors and general nursing.

2.2. HEPARIN SODIUM

A regional learning letter was circulated to HSC Trusts, General Practice and community pharmacists, following a serious adverse incident (SAI) involving flushing of a central line with the incorrect strength of heparin sodium injection. The review of this particular SAI identified important lessons to be learnt and the following action to be taken:

- Discharge planning includes timely communication with all who will contribute to the patient's ongoing care;
- Compliance with discharge medication supplies;
- Removal of brand names from policies and guidelines;
- Clear dosing information to be provided regarding dose, volume and frequency;
- Care to be taken by GPs and community pharmacists, when selecting products for prescribing, dispensing and ensuring correct dose of product selected.

HSC Trusts have been requested to provide an assurance regarding actioning these recommendations.

2.3. OBSTETRIC ANAESTHETIC INCIDENT

Following a number of obstetric anaesthetic incidents occurring in Northern Ireland involving 'Thiopentone' being accidentally administered instead of an intravenous antibiotic (which is administered prophylactically for caesarean sections), a learning letter was issued to HSC Trusts recommending a number of good practice points to eliminate similar incidents. The following recommendations were made to promote safer clinical practice:

- All anaesthetic drugs should be clearly labelled
- Within each Trust, a named individual should be identified and be responsible for ensuring the choice of drugs, dosage and labelling are appropriate

- Measures outlined for the safe preparation, labelling, storage, administration and discarding of 'Thiopentone' should be adhered to.

2.4. GP MENTAL HEALTH REFERRAL FORMS TO SECONDARY CARE

The SAI process has identified an issue regarding risk information on the GP mental health referral forms to secondary care. These forms do not have a 'don't know' option in the section regarding forensic history. As a result, a scoping exercise was completed in Mental Health Services in HSC Trusts, requesting clarification on this issue. The outcome of this exercise has indicated that there is a variation in practice not only across HSC Trusts, but also by teams within HSC Trusts. It is planned to standardise these forms regionally. This should be completed by April 2013, and an update will be available in the next SAI Learning Report.

2.5. INDUCTION OF LABOUR

As part of an ongoing SAI review relating to the death of a neonate, a learning letter was distributed to all Heads of Midwifery in Northern Ireland, reinforcing the importance of regular assessment of both the woman and fetus during induction of labour in all clinical settings. This letter also reminded HSC Trusts that local guidelines must comply with NICE guidance CG70 (2008): Induction of Labour and the linked NICE Guidance: Intrapartum Care CG55 (2007), and that they are fully implemented, regularly reviewed, adhered to and audited.

2.6. RARE CASE OF FATAL SCALP HAEMORRHAGE

Following an SAI report where an elderly patient suffered a fatal haemorrhage due to a laceration of scalp (head injury), a learning alert letter was issued to all Trusts, Integrated Care and RQIA, setting out the following learning actions:

- Ambulance crews should advise ED staff of significant blood loss, if known;
- Clinical staff assessing patients with head injury should enquire about possible significant blood loss after minor head injury, with ambulance crews, patients or eye witnesses;
- Clinicians should explore scalp wounds fully if there is a history of significant blood loss, or if the patient presents with a large haematoma;
- Patients with a bleeding minor head injury should be screened for ischaemic heart disease or liver disease as a potential risk factor for fatal bleeding;
- Patients who have required extra measures to secure scalp haemostasis including application of a pressure dressing should normally have an additional period of observations before discharge home.

2.7. NEWBORN HEARING SCREENING INCIDENT

An SAI investigation in a newborn hearing screening service has identified a number of regional recommendations including the following:

- To ensure that when redeploying staff to a screening programme, or other key clinical posts, a mechanism should be in place to provide assurance to the new line manager that the staff member meets all the essential criteria for the post. Where an element of essential criteria is not met, the training and support required to meet the essential criteria should be identified prior to redeployment.

A learning letter, highlighting this issue was issued to all HSC Trust Chief Executives, requesting that this be disseminated to all appropriate staff and that evidence of completions of the actions be maintained by HSC Trusts in the event it is required in the future.

2.8. PSEUDOMONAS OUTBREAK

A final report regarding the 'Independent Review of Incidents of *Pseudomonas aeruginosa* Infection in Neonatal Units in Northern Ireland' was published on 31 May 2012. This report brings together the findings of phase one and two of this review.

The interim report made 15 recommendations and HSCB/PHA have a joint process in place to implement the recommendations relevant to HSCB/PHA. The second phase of the review includes a particular emphasis on the experiences of the families and communication between organisations. The report indicates that the reviewers have met with senior teams from all of the organisations involved and they have been advised that this review has been used as an opportunity to reflect on and strengthen their systems.

The final report has made a number of further recommendations, particularly in relation to communication, with regards to making these more systematic, relying less on informal networks and ensuring that information is shared and reaches those that need it.

2.9. INFORMATION GOVERNANCE

The number of Information Governance related SAIs has increased steadily over the last three years. In response to this increase and at the request of the SAI Review Group the Information Governance Team carried out an analysis of Information related incidents for the period May 2010 to September 2012 seeking to identify any emerging themes and learning which could be shared across the service. When presented to the October meeting of the SAI Review Group the report not only highlighted the increase in incidents but also showed that more than half of the incidents reported in 2012 arose as a result of transferring sensitive personal information. The report identified an example of good practice to help address this emerging trend.

Learning from this exercise will communicated across the service via the HSCB Information Governance Manager who has shared it with the regional Information Governance Advisory Group (IGAG). Regular updates of the analysis will also be conducted to ensure any future emerging themes and learning can be shared via the IGAG in a quick and timely manner.

SECTION 3

NEXT STEPS

1.0 REVIEW OF COMPLAINTS AND SAIS REPORTED IN RELATION TO CARE AND TREATMENT OF OLDER PEOPLE

Following discussions at the Regional SAI Group and subsequently with the chair of the Regional Complaints Group, it has been agreed to conduct an analysis of SAIs and complaints relating to care and treatment of older people. *(An Older Person is defined as someone 65 years and over).*

A group has been established within the PHA/HSCB to examine SAIs and Complaints reported within the period April 2011 – March 2012, to identify themes, patterns and trends and roll out any learning arising from this in depth analysis.

The methodology for this thematic review will be:

- A review of Older People complaints identifying themes;
- A review of Older People SAIs identifying themes;
- Focus group to elicit first-hand experience of health and social care by older people;
- A cross-reference of the information gathered above with patient experience reports.

In parallel with this thematic review the Regulation Quality Improvement Authority (RQIA) are also undertaking a review of the care of older people in acute hospital wards. As both organisations' work is related consideration is to be given to PHA / Board hosting a joint learning event early next year.

An independent reviewer has been asked to complete a regional analysis in respect of:

- reviewing all complaints within the Acute, Older Peoples and Mental health programmes of care and in Family Practitioner Services from April 2011 to March 2012 that pertain to older people including complaints made personally and those submitted on behalf of an older person and highlight any themes identified;

- reviewing all SAIs within the Acute and Older Peoples programmes of care and in Family Practitioner Services April 2011 to March 2012 that pertain to older people and highlight any themes identified;

- reviewing the HSCB overview report on the HSC Trusts discharge of delegated statutory functions;

- meeting with key stakeholders to help inform this work;

- linking with the HSC Trusts to identify good practice pertaining to delivery of services to older people that could be shared with other organisations;

- compiling a report by 31 January 2013, capturing this information and present information in relation to SAI and complaints at a future learning event.

2.0 REVIEW OF THE PROCEDURE FOR REPORTING AND FOLLOW UP OF SAIS

As part of the review of 2010 Procedure for Reporting and Follow up of SAIs a series of events and meetings have been held. These have included meetings with HSC Trusts, in order to identify and resolve issues which have proved problematic in relation to the current procedure.

A group of HSCB/PHA staff involved in the SAI process are currently taking forward the outcome of these events and meetings. This has resulted in a number of sub groups being established to review particular aspects of the procedure e.g. guidance on review team composition, criteria for SAIs, guidance on joint investigations etc. A draft procedure will be circulated to the HSC for consultation early 2013; with formal issue and implementation anticipated in April 2013.

3.0 REGIONAL ADVERSE INCIDENT AND LEARNING (RAIL) SYSTEM

The PHA working closely with the HSCB and all other HSC Organisations has a responsibility to ensure the Regional Adverse Incident Learning System is successfully designed, implemented and evaluated. The aim of the project is to implement agreed proposals for an integrated system that will support a culture of learning from adverse incidents and the effective implementation of that learning across the HSC and Primary Care services.

The RAIL Outline Business Case (OBC) was completed in July 2012 and sent to DHSSPS. This OBC recommends a phased approach to the implementation of the RAIL system, with the first phase being a 12-month pilot to test and refine the system in practice, and determine the staffing, processes and system infrastructure required for RAIL to operate effectively in the longer term. It is intended that the RAIL system will be fully operational by April 2014, subject to positive evaluation of the pilot phase, and approval of a future separate business case for the recurrent long term staffing and infrastructure.

4.0 SAFETY ALERTS TEAM ESTABLISHED –STANDARDS AND GUIDELINES

The HSCB/PHA has established a Safety Quality Alerts Team who are responsible for the implementation and assurance of regional Safety and Quality Alerts/Letters/Guidance issued by DHSSPS and HSCB/PHA.

The work of this group is closely aligned to the regional SAI Review Group and Regional Complaints Group to ensure there is a fully integrated approach in relation to dissemination of learning.

5.0 PROGRESS WITH IMPLEMENTING MENTAL HEALTH REVIEW RECOMMENDATIONS

Following a commissioned review of all SAIs relating to suicide, a workshop was held in October 2011 to agree actions in response to regional learning identified. This workshop was attended by lead clinicians and managers of mental health services across Northern Ireland. Expert speakers from across the UK as well as other agencies interfacing with mental health services led the discussions and action planning.

The outcome of this workshop is an action plan for improvements to services. A number of key areas of work were identified to improve systems, and processes and the quality of service to clients and their families. The action plan continues to be taken forward by representatives from HSCB, PHA in conjunction with representatives from HSC Trusts, voluntary and community sectors and other agencies. These include:

A Place of Safety: Identification and Clarification

The interagency working group established to ensure an agreed definition of a place of safety has produced a draft joint working protocol. This is currently with all relevant agencies (HSCB, PHA, HSC Trusts, NIAS, PSNU and RQIA). It is intended that this work will be completed by November 2012.

Consideration is also being given to appropriate provision of safe, quiet places for mental health services users attending ED's. The Belfast LCG has provided some financial support to the BHSCT to complete a scoping exercise to consider the current provision of support and services which are safe places in the community.

An unscheduled care pilot was initiated in the last quarter of 2011-12 and has since been extended to run to the end of March 2013. This pilot is currently being evaluated and an interim report will be available by November 2012

Review of Mental health IEAP and application of DNA practice standards.

The issue of people who do not attend appointments with mental health services was identified as an area for improvement and it was decided to review the clinical and management practices associated with patients who DNA their appointments. A report has recently been produced which makes a number of recommendations. The findings have been shared with HSC Trusts whose Service Improvement Managers are developing service improvement plans and increasing general awareness amongst staff of the the DNA guidance in the mental health IEAP. Consideration is also being given to obtaining the views of service users as to the reason they DNA appointments and HSC Trusts are looking at ways of providing more flexible appointments.

Telephone access for individuals who are in a crisis

The audit to assess the use of telephone answering services and response to messages left by mental health services users has been completed and a report is currently being drafted. Key issues identified include:

- The need for all HSC Trust to have a policy in place for the management of telephone answering services

- The need for all telephones including mobiles phones, that may be accessed by service users, to have an answer message which should contain the following information:
    - Name of service
    - Hours of operation
    - How to leave a message
    - Timeframe for responding to client
    - Lifeline number (for 24/7 access in case of in emergency)
    - Out of Hours GP contact (for use in emergency)

Single point referral for mental ill health patients

HSC Trusts have developed single point of access for crisis resolution home treatment services.

It is intended that a workshop will be held in 2013 to highlight and disseminate the learning outcomes from the various work streams within the action plan and from the review of SAIs. It is intended that user and carers will be participate in this event.

SECTION 4

CONCLUSION

Within this reporting period, a number of learning letters were issued. The six HSC Trusts are positively responding to the interim arrangements for disseminating and implementing change as a result of learning from SAIs. Until agreement is reached on a Regional learning system, the current arrangements enable and support regional learning arising from SAI investigations. Furthermore the arrangements facilitate engagement with HSC Trusts on SAI data analysis, and provide opportunities to collectively agree solutions to improve reporting and dissemination of lessons learned.

Over the next six months action will be taken forward to implement and develop reporting systems to further enhance safety and quality processes. Learning outcomes as a result of specific reviews will be disseminated locally, regionally and where appropriate nationally, in order to improve both safety and quality and ultimately the care and treatment of patients and clients.

APPENDIX A

DEFINITION OF AN ADVERSE INCIDENT AND SAI CRITERIA

'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation, [3] arising during the course of the business of an HSC organisation / Special Agency or commissioned service.

The following criteria will determine whether or not an adverse incident constitutes a SAI.

SAI CRITERIA

- serious injury to, or the unexpected/unexplained death (*including suspected suicides and serious self harm*) of :
  - A service user
  - A service user known to Mental Health services (including Child and Adolescent Mental Health Services (CAMHS) or Learning Disability (LD) within the last two [4] years)
  - A staff member in the course of their work
  - A member of the public whilst visiting an HSC facility.

- Unexpected serious risk to a service user and/or staff member and/or
  - member of the public

- Unexpected or significant threat to provide service and/or maintain business
  - continuity

- Serious assault (*including homicide and sexual assaults*) by a service user
  - on other service users,
  - on staff or
  - on members of the public

  Occurring within a healthcare facility or in the community (where the service user is known to mental health services including CAMHS or LD within the last two years).

- Serious incidents of public interest or concern involving theft, fraud, information breaches or data losses.

[3] Source: DHSSPS How to classify adverse incidents and risk guidance 2006
www.dhsspsni.gov.uk/ph_how_to_classify_adverse_incidents_and_risk_-_guidance.pdf

[4] Mental Health Commission 2007 UTEC Committee Guidance

ANALYSIS OF SAI ACTIVITY APRIL 2012 – SEPTEMBER 2012

The HSCB has **received 141 SAI Notifications** from across Health and Social Care (HSC) for the above period. The information[5] below has been aggregated into summary tables with commentary to prevent the identification of individuals.

Table 1 below provides an overview of all SAIs reported by organisation and includes **year on year comparison** of activity for the same **reporting period 1 April to 30 September.**

TOTAL SAI ACTIVITY	April – Sept 2011	April – Sept 2012
BHSCT	50	45
HSCB	1	1
NHSCT	27	29
NIAS	0	3
PCARE	1	5
PHA	0	1
SEHSCT	29	23
SHSCT	28	15
VOL	0	1
WHSCT	14	18
TOTALS	150	141

SAI DE-ESCALATION

SAI reports submitted can be based on limited information at the time of reporting. If on further investigation the incident does not meet the criteria of an SAI, a request can be submitted by the reporting organisation to de-escalate.

In line with the HSCB Procedure for the reporting and follow up of SAIs the reporting organisation provides information on why the incident does not warrant further investigation under the SAI process. This information is considered by the HSCB/PHA Designated Review Officer prior to approving any de-escalation. During the reporting period **6 SAI notifications** received were subsequently **de-escalated.**

TOTAL DE-ESCALATED	April – Sept 2011	April – Sept 2012
BHSCT	4	3
NHSCT	2	0
SEHSCT	3	1
SHSCT	5	0
WHSCT	3	1
P Care	0	1
TOTALS	17	6

[5] Source- HSCB DATIX Information System

SAI ANALYSIS BY PROGRAMME OF CARE

De-escalated SAI notifications have been **excluded** from the analysis in the remainder of this report.

ACUTE SERVICES

ORGANISATION	April – Sept 2011	April – Sept 2012
BHSCT	20	19
NHSCT	2	7
NIAS	0	3
SEHSCT	0	3
SHSCT	3	1
WHSCT	1	1
Totals	26	34

Current period: Thirty four (34) incidents were reported relating to the following classifications, with less than 6 incidents being reported in any one category.

- **Classification:**

  - Administration of assessment
  - Administration or supply of a medicine from a clinical area
  - Abuse by the staff to the patient
  - Cancer - Dx failed or delayed
  - Discharge
  - Slips, trips, falls and collisions
  - Images for diagnosis (scan / x-ray)
  - Infection control
  - Medical device/equipment
  - Possible delay or failure to Monitor
  - Diagnosis - other
  - Medication error during the prescription process
  - Connected with the management of operations / treatment
  - Test results / reports
  - Transfer

There were no major themes emerging from the SAIs. The largest group (n=5) associated with the category was 'Administration of assessment'

MATERNITY & CHILD HEALTH

ORGANISATION	April – Sept 2011	April – Sept 2012
BHSCT	0	1
NHSCT	1	1
SEHSCT	1	1
SHSCT	2	1
WHSCT	0	4
Totals	4	8

Current period: Eight (8) SAIs relating to maternity and child health were reported.

FAMILY & CHILD CARE

	April – Sept 2011	April – Sept 2012
BHSCT	6	1
NHSCT	3	7
SEHSCT	1	1
SHSCT	7	3
Totals	17	12

Current period: Twelve (12) SAIs were reported relating to the following classifications, with less than four incidents being reported in any one category.

- **Classification:**
  - Abuse by the staff to the patient
  - Discharge
  - Abuse etc of Staff by patients
  - Abuse - other
  - Accident caused by some other means
  - Security - other
  - Self harm in primary care, or not during 24-hour care

OLDER PEOPLE SERVICES

ORGANISATION	April – Sept 2011	April – Sept 2012
BHSCT	1	2
NHSCT	1	2
SEHSCT	2	3
SHSCT	2	1
WHSCT	1	1
Total	7	9

Current period: Nine (9) SAIs were reported relating to the following classifications, with less than five incidents being reported in any one category.

- **Classification:**
  - Administration of assessment
  - Abuse by the staff to the patient
  - Slips, trips, falls and collisions
  - Fires, fire alarms and fire risks
  - Abuse etc of patient by patient
  - Injury caused by physical or mental strain

There were no major themes emerging from the SAIs. The largest group (n=4) associated with these categories was 'Slips, trips, falls and collisions'

MENTAL HEALTH

ORGANISATION	April – Sept 2011	April – Sept 2012
BHSCT	14	13
NHSCT	18	5
SEHSCT	20	14
SHSCT	8	9
VOL	0	1
WHSCT	8	10
Totals	68	52

Current period: Fifty two (52) SAIs relating to adult mental health services were reported.

- 49 related to suspected/attempted suicides* or unexpected deaths

The remaining three (3) reported related to the following classifications.

- **Classification:**
  - Abuse - other
  - Sexual
  - Assault etc with a weapon

**Suspected suicide – suicide (completed) whether suspected or proven. 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.*

LEARNING DISABILITY SERVICES

ORGANISATION	April – Sept 2011	April – Sept 2012
BHSCT	1	0
NHSCT	0	1
SEHSCT	2	0
SHSCT	1	0
WHSCT	1	1
Total	5	2

Current period: Two (2) SAIs relating to learning disability services were reported.

PHYSICAL DISABILITY AND SENSORY IMPAIRMENT

ORGANISATION	April – Sept 2011	April – Sept 2012
BHSCT	1	0
Totals:	1	0

Current period: No reported incidents

PRIMARY HEALTH AND ADULT COMMUNITY (INCLUDING GENERAL PRACTICE)

ORGANISATION	April – Sept 2011	April – Sept 2012
BHSCT	0	1
NHSCT	0	1
PCARE	1	4
Total	1	6

Current period: Six (6) SAIs relating to Primary Health and Adult Community were reported relating to the following classifications.

- **Classification:**
  - Administration or supply of a medicine from a clinical area
  - Confidentiality of information
  - Patient's case notes or records
  - Electronic Patient Record
  - Problem with the referral from primary to secondary care

CORPORATE BUSINESS

ORGANISATION	April – Sept 2011	April – Sept 2012
BHSCT	3	5
HSCB	1	1
NHSCT	0	5
PHA	0	1
Totals:	4	12

Current period: Twelve (12) SAIs were reported relating to the following classifications, with less than five incidents being reported in any one category.

- **Classification:**
  - Confidentiality of information
  - Patient's case notes or records
  - Environmental matters
  - Information Technology
  - Infrastructure or resources - other
  - Security incident related to Premises, Land or Real Estate

HEALTH PROMOTION AND DISEASE PREVENTION

No reported incidents