Belfast Health and Social Care Trust

Inquiry into Hyponatraemia-related Deaths

Additional Information Request April 2014

Question 4

Categorisation of Adverse Incidents

All HSC Trusts in Northern Ireland use a commercial risk management software system called Datix within which is a pre-installed three tier categorisation system called CCS (Common Classification System). The first two tiers of the CCS cannot be amended or added to, whilst the third tier can be amended by individual organisations in order to meet local need.

CCS codes can be interpreted as codes to either describe the incident or describe the cause or outcome of the incident, and the description of each code can influence which interpretation to use. This can contribute to inconsistencies in how incidents are coded, especially across different Trusts where reporting culture will have largely developed independent to one another.

There are also slightly different versions of the original CCS codes, so the Trusts in Northern Ireland may not be using the same version. This would appear to be the case as three of the four headings identified in the bullet points in question 4 are not recognised as CCS codes within the Belfast HSC Trust and do not appear in this pre-installed element of the Belfast HSC Trust's Datix system.

Organisations can also create their own unique categorisation codes within the Datix system which are separate from the CCS codes; however Belfast HSC Trust use only CCS codes.

Within the Belfast HSC Trust each incident is coded centrally by the Corporate Governance team, using all three tiers of the CCS. Central coding encourages greater consistency than if every staff member reporting incidents throughout the Trust coded individually. Local managers have access to their own incidents via Datixweb (web-based interface to the Datix system) and monthly listing reports of incidents are also sent out to Directorates via Quality & Governance Managers for review and checking for any coding inaccuracies.

It should be noted that the Belfast HSC Trust would consider CCS coding of incidents useful in high level trend analysis of incident data and to assist in extracting certain types of incidents for analysis by teams or individuals within the Trust. However for extraction of learning it is important to look at the detail of incidents below this.

In relation to Serious Adverse Incidents (SAIs) and before the revised SAI procedures in October 2013, the HSCB on receipt of an SAI would have allocated the CCS code. The revised SAI Procedures now include the requirement for the reporting Trust to allocate a CCS code when reporting the SAI. This will reflect any inconsistencies in CCS coding across the region compared with the previous procedure of central coding at HSCB.

SAI Procedures

The attached draft *BHSCT SAI Procedure* (as revised following the new October 2013 HSCB SAI Procedures) describes the system for identifying and reporting SAIs within the context of the Trust Incident Reporting and Management policy. This policy was approved by the Trust's Policy Committee on the 7 April 2014 and will be placed on the Trust's intranet. This procedure will be applied fully from April 2014.

The inclusion of different levels of investigation within the procedure recognises that a Root Cause Analysis type methodology is not suitable for every SAI. The need to complete such a potentially detailed analysis may not have been resource efficient in terms of producing the required learning. The introduction of Significant Event Audit (SEA) methodology has contributed to more efficient use of resources that are now tailored to suit the requirements of the incident complexity. This has had the effect of reducing the time it takes to complete many investigations.

That said, the timeframes for completing investigations are very challenging and the Trust does not always meet deadlines in this respect despite rigorous efforts. The challenges include; the availability constraints of investigation team members (including any relevant experts and independent members) and the time required for evidence gathering, service user / family/ carer involvement and the final approval process. To help tackle this problem the Trust has identified the need to increase the pool of trained investigators available for the more complex investigations. Therefore the Trust's internal SAI Group has begun to establish a sufficiently large resource of trained level 2/3 SAI investigators to help provide the required availability as well as ensure a high quality of investigation.

Review of the adverse incident reporting system in the context of managing SAIs has identified a need to support the identification of learning for sharing and trends related to this. Currently the Trust's Datixweb adverse incident reporting system is being developed to include codes for learning themes and contributory factors from SAIs to allow for better trend analysis to further support learning initiatives. The Trust has also introduced an additional means of sharing learning from SAIs and

other incidents through a Trust wide newsletter “Safety Matters” which was developed from a previous newsletter “Learning from SAIs”. The Trust SAI Group has also developed a system where learning templates are generated from SAI learning to be shared across directorates and this is controlled under a formal process. These initiatives support each directorate’s arrangements for sharing learning from incidents.

There are some difficulties associated with family involvement regarding the new SAI criteria to report all deaths of children under 18 years of age as such incidents may include deaths that were expected e.g. palliative care and where there is no indication that any adverse incident as per the Trust definition[1] has occurred. Two issues have arisen as a result. Firstly, it may not always be helpful to a grieving family be inappropriate to contact a family to notify them that such a death is now the subject of a Serious Adverse Incident report, in situations where there are no concerns regarding care management. The value of review is however recognised. Secondly, the 4 week timeframe for investigation using SEA methodology (which is the usual level for this type of SAI) is insufficient to involve family in the review at such a difficult and traumatic time and still meet the HSCB investigation report deadline. As such, currently the Trust advises the family that the child’s death, as with all deaths will be reviewed as per Trust policy and a report will be forwarded if any issues are identified. If care management issues are identified a higher level of family engagement is possible.

The administration requirements to support the SAI system are a significant challenge to the Trust and have increased significantly since the introduction of the revised HSCB guidance in October 2013. Often after DRO queries are responded to it may still take months or in some cases years for the HSCB to close the report. In the meantime the report may have been shared with external stakeholders e.g. family, Coroner, legal services etc where it is unclear if the report is final or remains in draft and subject to change. The Trust has a process to help manage this issue including the addition of an addendum referencing the changes, but there is no regional consistency in this regard.

Question 5

The attached draft BHSCT SAI Procedure (as revised following the new October 2013 HSCB SAI Procedures) describes the requirement for service user / family / carer involvement in SAIs. This reflects and supports those requirements as outlined in the HSCB SAI Procedures October 2013, BHSCT Incident reporting and Management Policy; and the Risk Management strategy 2013-16. This is also

[1] Trust definition of an incident from Incident reporting and management policy ***“Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation.”*** (*How to Classify Adverse Incidents and Risk, HPSS 2006*)

supported by the recent development of an *SAI information leaflet* for families and service users which explains what they need to know about SAIs including their involvement in the process. This leaflet is to be given to every service user / family / carer as applicable when it becomes clear that an SAI has occurred. This is enclosed for reference.

Extracts of relevant sections of Trust documents which refer to the requirement to notify and involve families in the SAI process are as follows:-

BHSCT SAI Procedure April 2014

Paragraph 1.5 Informing the service user / family / carer

The principles of the Being Open policy must be adhered to when communicating to service users, their families or carers regarding the reporting of a Serious Adverse Incident. Where it is clear or suspected that a SAI has resulted in unexpected serious harm or death to a service user rapid and open disclosure and emotional support should be given.

The Co-Director responsible for the SAI is also responsible for ensuring the service user / family / carer is communicated with appropriately regarding the SAI and subsequent investigation. They will nominate the appropriate person to speak with the service user / family / carer initially and also ensure the service user / family / carer has a link person to contact throughout the SAI process as required. An information leaflet covering "What do I need to know about Serious Adverse Incidents" should be given to the service user / family / carer to include contact details for the link person.

If the Service User/Family/Carer has been notified of the incident before completing the SAI notification form, the appropriate date of notification must be included in section 15 of the form. If notification is planned and not yet complete at the time of reporting, or not planned, the reason(s) should be explained in the "Others" free text field in section 15 of the form, or where relevant in any updated form the HSCB subsequently issues.

Paragraph 2.4 Service User/Family/Carer involvement

HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents October 2013 Paragraph 5.4 should be adhered to and states the requirement for service user / family / carer involvement in SAI investigations is as follows:-

"It is important that teams involved in investigations in any of the above three levels ensure sensitivity to the needs of the service user/relatives/carers involved in the incident and agree appropriate communication arrangements, where appropriate. The Investigation Team should provide an opportunity for the service user / relatives / carers to contribute to the investigation, as is felt necessary. The level of

involvement clearly depends on the nature of the incident and the service users/relatives/carers wishes to be involved."

The Co-Director responsible for the SAI should ensure the appropriate level of involvement of service user / family / carer throughout the investigation including discussion / sharing of the final report with the service user / family / carer and this should be agreed with the investigation team from the outset.

The Co-Director responsible for the SAI should ensure the completion of a SAI Investigation Report checklist when submitting Investigation reports to HSCB. This checklist will explicitly describe the involvement (and if not, the circumstances where it has not happened) of Service Users/Relatives/Carers in the Investigation and whether they received a final report.

Approved SAI final reports should be shared or talked through with the service user/relatives/Carer as appropriate and where this is not done, an explanation must be submitted within the SAI checklist and if pending, this should be included as an action in the subsequent Action Plan for that SAI.

In all cases the principles of consent and patient confidentiality must be upheld.

For guidance on how to involve families in the SAI investigations please refer to the RCA Guidance on the hub.

<u>Involvement specific to SEA reports</u>

Under the HSCB timeframe for completing SEAs it may not be possible to involve the service user / family / carer in the investigation process before the final report is submitted to the HSCB. In such cases, where family involvement is deemed appropriate, the approved report should be discussed / shared with the family at a date as soon as possible after submission of the report and any issues addressed and those requiring material changes to the SEA report should be added as an addendum and forwarded to Corporate Governance for sending to HSCB in a revised report.

<u>Where a SAI is also a Complaint</u>

Where a Serious Adverse Incident is also a Complaint, the investigation under the SAI process will take precedence and the Complaints investigation will be put on hold until the SAI investigation is complete. The Complainant must be notified of this as soon as possible. An information leaflet along with an explanation of the change in process should be given to the Complainant.

Note that communication through the complaints process with the Complainant should continue regarding timescales and any associated delays. The SAI investigation process as per above will also have a link person identified to

communicate with the service user / family / carer and will communicate through this process as appropriate. When complete the SAI final report will be shared with the Complainant and the complaints process remains open until the complaint is formally closed with all complaints issued addressed.

BHSCT Incident Reporting Policy

6.10 Line Managers *Line Managers have responsibility to:*

- *Communicate with the patient/client and their relatives/carers as appropriate following an adverse incident.*

4.1.11 *All Trust employees must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty of openness, transparency and candour.*

BHSCT Being Open Policy

Extract

Being open' involves:

- *acknowledging, apologising and explaining when things go wrong.*
- ***keeping patients and carers fully informed when an incident has occurred.***
- *conducting a thorough investigation into the incident and reassuring patients, their families and carers that lessons learned will help prevent the incident recurring.*
- *providing support for those involved to cope with the physical and psychological consequences of what happened.*

Objectives:
This policy defines the BHSCT"s commitment to „Being open' by establishing a culture where:

- *patients and carers receive* ***rapid and open disclosure*** *and emotional support when they experience* ***serious incidents which cause moderate, major or catastrophic harm****.*
- ***they receive the information they need*** *to enable them to understand what happened and the reassurance that everything possible will be done to ensure that a similar type of incident does not occur again.*
- *healthcare professionals, managers, patients & carers are appropriately supported when things go wrong.*
- ***Patients and carers receive timely information about the outcome of any investigation****.*

8.6 Support for the Patient

Patients and/or their carers can reasonably expect to be ***kept fully informed*** *of the issues surrounding a patient safety incident in a face-to-face meeting. They will be*

treated sympathetically with respect and consideration. They will be provided with support in a manner appropriate to their needs.

BHSCT Risk Management Strategy 2013-16

Paragraph 7.1.4 Incident reporting

The Trust relies upon the accurate reporting of incidents by its entire staff. The data analysis of this source of risk identification will continue to be a crucial part of monitoring progress and ensuring lessons are learned from adverse incidents. The use of evaluation, audit, service reviews, complaints and litigation must also be utilised as source data for the identification and reporting of risk.

Any media interest in reported incidents will be managed in a positive way, by reassuring the public that adverse incident reporting is essential to the prevention of serious incidents and a high level of incident reporting is a major step forward in improving the quality and safety of patient care. It will be important that staff, service users and carers are supported and receive feedback on all incidents reported within the Trust. The degree of feedback being dependent on the nature of the risk associated with the incident reported.

SAIs may relate to a range of issues or incidents, not all of which involve service users directly. They may also refer to near misses, for example call back exercises where no harm is identified. The level of engagement of service users or their families therefore depends on the circumstances. The Trust is clear that where material harm has occurred to a service user of a member of staff, that they should be informed and then subsequently be advised of the outcome of the investigation. We recognise that we now need to go further and ensure that in all cases the service user is offered the opportunity to be involved in the investigation. Where the service user has died, or been incapacitated or otherwise wishes their family to be involved then we will ensure this happens.