Health and Social Care Board

Public Health Agency

HSCB/PHA

2013-14

Mid-Year Report on Safety and Quality Alerts

1 April 2013 – 30 September 2013

Contents

Background

1. Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in its care. However, all health and social care comes with the risk of unintended harm, and on occasions, adverse events do occur.

2. A robust and comprehensive process for ensuring that care is safe and that adverse events and harm are minimised, involves identifying risks, managing those risks by responding appropriately, disseminating information effectively, and applying the learning from safety or quality related adverse events. As such, the Department of Health Social Services and Public Safety (DHSSPS) issues a variety of correspondence collectively referred to as Safety Alerts. These are issued to service providers to identify those actions which providers should undertake to assure patient and client safety and best practice.

HSCB/PHA Process for the Management of Safety and Quality Alerts

3. In July 2009, DHSSPS transferred responsibility for performance managing implementation of Safety Alerts to the HSCB. Since then, Safety and Quality Alerts issued by DHSSPS and accompanied by an assurance template, were logged and recorded on the HSCB/PHA Safety Alerts Database.

4. A multidisciplinary group led by PHA professional advisers and supported by PMSI, oversaw the process and appropriate closure of Alerts.

5. In April 2012, taking account of comments from HSCB/PHA and Trust staff, the process for managing Safety Alerts was refined and new arrangements introduced. Challenges with the process at that time, included managing the range of safety alerts and guidance issued, ensuring a proportionate response to substantive issues that require a high level of assurance, taking action as a region where appropriate, and managing the workload within finite staff resources.

6. The key changes included broadening the range of correspondence managed through this process, introducing a standard assessment of the assurance required taking account of complexity, likelihood, risks and other factors, and seeking more specific assurance from Trusts. The Medical Director/Director of Public Health was identified as the lead Director, and chair of the reconfigured Safety and Quality Alerts Team (SQA Team). The team includes representatives from the Health and Social Care Board (HSCB) and the Public Health Agency (PHA). A Central Coordinating Office (CCO) managed by the Governance Team within HSCB Corporate Services was established to manage and maintain a system to oversee the process, and track progress of safety and quality alerts.

7. During 2012/13, further refinements to the process were made which included enhancement of timely communication with DHSSPS and HSC Trusts to ensure specified timescales are met for implementation of alerts and circulars. The process was refined further under Task 1 of the Quality 2020 Strategy implementation arrangements to ensure liaison between DHSSPS and HSCB/PHA prior to issuing of Alerts that include assurance requirements. The HSCB/PHA Safety and Quality Alerts Protocol was subsequently endorsed by DHSSPS and formally adopted in August 2013.

8. The implementation of the Safety Quality Alerts Protocol is carried out by the Safety and Quality Alerts Team (SQAT) which meets fortnightly and is chaired by the Medical Director/Director of Public Health. Membership of the SQA Team is included within appendix 1. The Team 'closes' an Alert when it is assured that an Alert has been implemented, or there is an existing robust system in place to ensure implementation.

Legacy Alerts [pre July 2009]

9. In 2011/12 the DHSSPS asked the HSCB to follow-up on 11 legacy circulars. These were patient safety circulars which had been issued to Trusts prior to the transfer of responsibility to the HSCB in July 2009.

10. Each was reviewed by the SQA Team and information on the current status of implementation was requested from the Health and Social Care Trusts.

11. At the end of April 2013, it was reported that two of the 11 legacy circulars remained opened, but by end of September 2013, all 11 legacy circulars have been closed.

Update on Activity in 2011/12

12. During 2011/12 and up to 31 March 2013, 35 legacy Safety and Quality Alerts were reviewed by the SQA Team. These comprised of 29 outstanding alerts issued in previous years (July 2009-March 2011) and six alerts issued in the financial year 2011/12.

13. At March 2013, 10 of these alerts remained opened. Five of these have been closed and at 30 September 2013, the following five circulars remain open:

- HSC(SQSD) 17/10 - Preventing Fatalities from Medication Loading Doses (Issued in 2010/11)
- RQIA Follow Up Review Reducing the Risk of Hyponatraemia when Administrating Intravenous Infusions to Children (Issued 2010/11) – This alert was previously closed from SQAT on 10 May 2013 however reopened on 3 June 2013
- NCEPOD "Are we There Yet" (Issued 2011/12)
- NCEPOD "Knowing the Risk" (Issued 2011/12)

- HSC(SQSD) 3/2011 – The Adult Patient's Passport of Safer Use of Insulin

Update on Activity in 2012/13

14. From 1 April 2012 – 31 March 2013, 73 Category 1 Alerts or equivalent correspondence were reviewed by the SQA Team. At the end of 2012/13, it was reported that 12 of these alerts remained open with action plans in place. In the reporting period 1 April 2013 – 30 September 2013, six of these 12 alerts were closed leaving the following six alerts open:

- NECPOD Report "Time to Intervene";
- Learning Letter "Learning from recent adverse incidents in maternity services" - LL/SAI/2012/003(MCH);
- PEWS and the Management of the Deteriorating Patient - HSS(MD) 39/12;
- RQIA Review of Under 18s Accommodation in Adult Hospital Wards;
- Learning Letter - Patient Selection and Intrapartum Care in Maternity Units - LL/SAI/2012/013(MCH);
- MOU on Investigating Patient or Client Safety Incidents - HSS(MD) 8/2013.

15. In addition, eight Category 2 Safety Alerts Broadcasts (SABs) have been reviewed by the SQA Team. The one alert reported as open at the end of 2012/13 has since been closed in the reporting period 1 April to 30 September 2013.

Activity to date in 2013/14

16. Between 1 April 2013 – 30 September 2013, 52 Category 1 Alerts or equivalent correspondence have been reviewed by the SQA Team. A breakdown of the category 1 alerts has been summarised in table 1 below. As of September 2013, 39 of these alerts have been actioned and closed with the following 13 alerts remaining open:

- HSS(MD) 14/2013 – Guidance on health clearance for TB, Hep B, Hep C, HIV for new healthcare workers with direct clinical contact with patients – Locum and Recruitment Agencies and Service Commissioners;
- CBRN Preparedness for HSC Organisations – HSC(PHD) 01/2013;
- Oral Ketoconazole: Do not prescribe or use for fungal infections at risk of liver injury outweights benefits – HSS(MD) 31/2013;
- Regional Templates for CME/McKinley T34 Syringe Pump Prescription and Administration – HSC(SQSD) 1/13;
- Haemolysis during or after Haemodialysis – LL/SAI/2013/018;
- Know the Massive Haemorrhage Protocol – LL/SAI/2013/019(AS);
- Child Centred Decision Making – LL/SAI/2013/020(F&CC);
- Communication of Patients' Risk Status for CJD – LL/SAI/2013/021(AS) Revised;

- Care Planning for Adult Mental Health Patients - LL/SAI/2013/022(MH);
- Safe Use of Intravenous (IV) Magnesium Sulphate - LL/SAI/2013/023(AS);
- RQIA Report on their Review of Hospitals at Nights and Weekends;
- RQIA Review of the Management of Controlled Drug Use in Trust Hospitals;
- RQIA Review on Nice Guidance Implementation Process in HSC Organisations.

Table 1 - Summary of Category 1 Alerts 1 April 2013 – 30 September 2013

Category 1	Status of Alert		Total
	Closed	Open	
Safety and Quality Alerts / Circulars	30	4	**34**
Learning Letters	2	6	**8**
RQIA Reports	7	3	**10**
Medicines Safety Alerts	0	0	**0**
Total	**39**	**13**	**52**

17. During the reporting period 1 April 2013 – 30 September 2013, 53 Category 2 SABs have been received by the CCO, all of which have been closed at the end of September 2013.

RQIA Reports

18. A system has been introduced from 8 July 2013 whereby all RQIA reports are considered by the HSCB/PHA Safety and Quality Alerts Team (SQAT) to review the reports and confirm the relevant Director/Lead and any actions required through SQA Team, other existing structures, or bespoke Task and Finish Groups.

19. The CCO will produce a 6-monthly overview report for Governance Committee detailing progress on implementation of RQIA Reports. It will include a summary of progress, key issues/risks, and key next steps. The first report will give the position as of 1 November 2013.

Key Safety/Quality Improvements

20. As well as assuring implementation of Alerts, the SQA Team has also overseen a number of key safety/quality improvements during April 2013 – September 2013 including:

- Development and issue of a regional competency assessment framework to enable Trusts to adopt a standard approach to testing the competency of staff in the safe administration of intravenous fluids to reduce the risk of hyponatraemia;
- Preliminary work to develop an e-learning module on 4 case studies relating to fluid management and hyponatraemia;
- A regional approach to preventing fatalities from medication loading devices, through the Medicines Safety Subgroup;
- Development and issue of a regional passport and leaflets to support safer administration of insulin;
- Establishing a regional training programme to nurses regarding the "Safer Administration of Insulin";
- Work with Trusts to improve appropriate resuscitation practice for patients at end of life;
- Refinement of patient selection criteria for maternity units that do not fully meet the Maternity Strategy standards for resident anaesthetic, paediatric and obstetric medical staff; this is pending medium term review of service models across NI as part of the implementation of the Maternity Strategy;
- Work through the NI Critical Care Network to standardise pre-operative risk assessment in response to the NCEPOD Report 'Knowing the Risk';
- Full roll out of the new National Early Warning System (NEWS) in all Trusts;
- Work with Trusts to implement the recommendations of the RQIA report on Hospitals at Night;
- Development of a new regional learning newsletter "Learning Matters" to cover learning that does not warrant a Learning Letter, but staff need to be reminder or made aware of particular incidents;
- Joint PHA/HSCB action plan in response to the Memorandum of Understanding, Investigating patient or client safety incidents (Unexpected death or Serious Untoward Harm): Promoting Liaison and Effective Communications.

The processes used by the Safety Quality Alerts Team have been welcomed by Trusts and continue to be refined in collaboration with Trust and DHSSPS colleagues.

Conclusion

21. An end of year report on activity for 2013/14 will be provided by the CCO in April/May 2014 to the HSCB/PHA SQA Team, HSCB Senior Management Team, Local Commissioning Group (LCG) Chairs, HSCB Governance Committee, HSCB Board and others as required. The CCO will continue to provide an annual and Mid-Year Report each year.

Appendix 1

Safety and Quality Alerts Team Membership

Carolyn Harper [Chair]	Executive Medical Director/Director of Public Health
Brenda Bradley	Pharmacy Lead Medicines Governance and Public Health
Elaine Hamilton	Assistant Governance Manager
Margaret McNally*(seconded to cover maternity leave from 17/6/13)*	Assistant Governance Manager (A)
Gavin Lavery	Clinical Director Northern Ireland HSC Safety Forum
Jackie McCall	Consultant in Public Health
Janet Little	Assistant Director Service Development & Screening
Gill Murphy	Safety Quality and Patient Client Experience Lead
Michael Bloomfield	Director of Performance Management and Corporate Services
Oriel Brown	Senior Manager, Safety Quality Patient Experience
Zara Mayne*(until 12 August 2013)* Position currently vacant	Medical Advisor
Mareth Campbell	Governance Officer, Central Co-ordinating Office (CCO)