

Risk & Governance

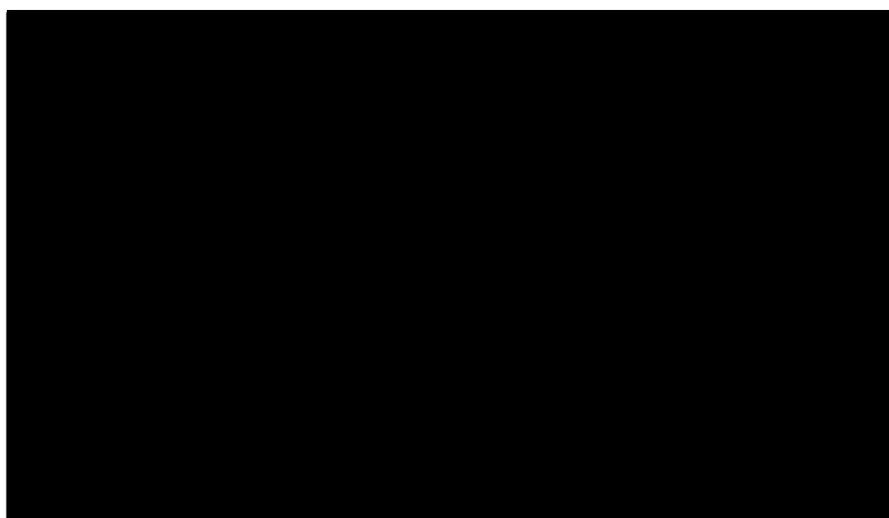
Amalgamated Assurance Report

May 2023

Incorporating:

[Trust Incident & SAI Quarterly Report:](#)

April 2022 – March 2023





TRUST ADVERSE INCIDENTS AND SERIOUS ADVERSE INCIDENTS REPORT

For reporting period 01 April 2022 to 31 March 2023 (as at 24
April 2023)

1 EXECUTIVE SUMMARY

Adverse Incidents



↑ 17%

Increase in Incidents from same period in the previous year (36,284 incidents).

When incident data is compared to 2017/2018 period there had been 30,083. (42% increase)

Note: This report does not include Incidents reported by Independent Sector Providers. (8,362 incidents)

Serious Adverse Incidents



2% ↓

Slight decrease in SAIs compared to the same period in the previous year which had 199 SAI Notifications.

When SAI data is compared to 2017/2018 period there had been 86 (128% increase)

Breakdown of level of review:

170 Level 1 SEA
26 Level 2 RCA

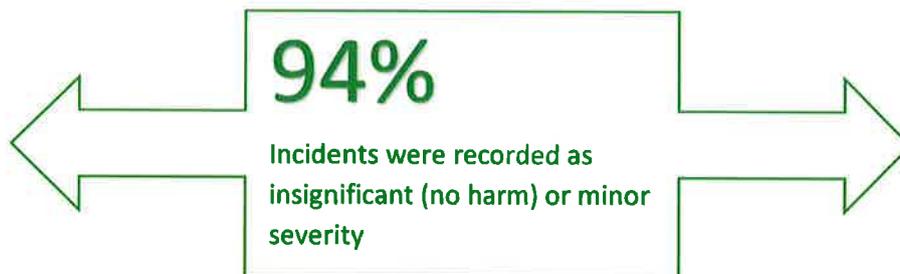
These 196 SAIs include:

5 Never Events
15 linked to Complaints
32 linked to Coroners
35 linked to Early Alerts

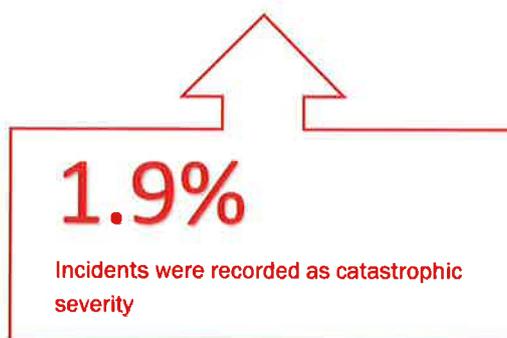
At 31st March 2023 there were 275 SAI reviews identified as being outstanding with SPPG. 168 SAI reports were submitted to SPPG during this reporting period.

Adverse Incidents by Severity

Trends in relation to severity remain largely unchanged for insignificant or minor severity incidents.

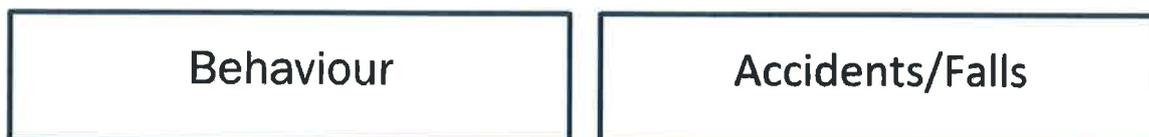


Catastrophic severity incidents have increased from 0.6% in the same period of the previous year. This is due mainly to the increased reporting of overcrowding/ ongoing pressures in the Emergency Departments (with a Catastrophic Severity)



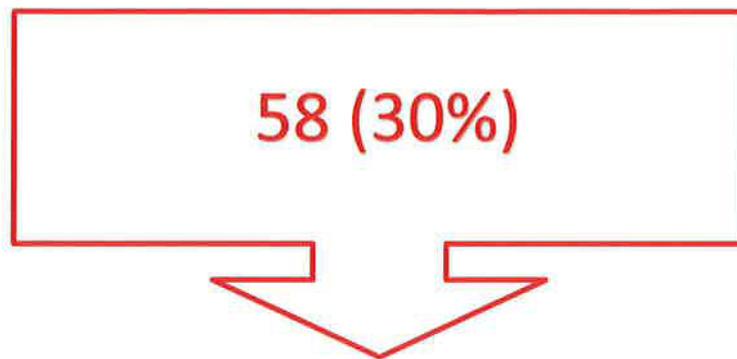
Adverse Incidents by Type

The most commonly reported types of incidents for this reporting period were:



Incident data is used to support a wide range of quality Improvement projects.

Serious Adverse Incidents with a Catastrophic Severity



| Type Tier One | Count |
|--|-----------|
| Administrative Processes (Excluding Documentation) | |
| Behaviour (Including Violence and Aggression) | 14 |
| Communication | |
| Diagnostic Processes/Procedures | |
| Infection Control Incident (Healthcare Associated Infection) | |
| Maternity Care | |
| Medical Gases/Oxygen | |
| Medication/Biologics/Fluids | |
| Other | |
| Patient Accidents/Falls | |
| Service Disruptions (environment, infrastructure, human resources) | |
| Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration) | |
| Unexpected Deaths or Severe Harm | 21 |
| Grand Total | 58 |

Serious Adverse Incidents by Type (Tier 1)

The most commonly reported types of incidents for this reporting period were:



| Breakdown by Type Tier 3 | Count |
|---|-----------|
| Abduction | |
| Absconded/left without informing staff | |
| Actual self harm | |
| Drugs | |
| Incorrect procedure | |
| Manipulation of device/equipment/supplies by unauthorized/unqualified persons | |
| Other self harming behaviour | |
| Physical | |
| Physical contact (actual assault) | 6 |
| Psychological abuse (bullying and harassment) | |
| Self harm attempt/gesture | |
| Sexual (including indecent exposure) | 13 |
| Suicide (actual) | 11 |
| Suicide attempt/gesture (not overdose) | |
| Suicide attempt/gesture (overdose) | |
| Therapeutic recommendations/interventions | |
| Grand Total | 53 |

| Breakdown by Type Tier 3 | Count |
|---|-----------|
| Requires investigation to be completed to establish if an incident occurred | 24 |
| Grand Total | 24 |

| Breakdown by Type Tier 3 | Count |
|---|-----------|
| Requires investigation to be completed to establish if an incident occurred | 24 |
| Grand Total | 24 |

1. INTRODUCTION

1.1. ALL ADVERSE INCIDENTS

During the period between 01 April 2022 and 31 March 2023 a total of 42,598¹ reported incidents occurred Trust-wide. In comparison, during the period from 01 April 2021 and 31 March 2022, a total of 36,284 reported incidents occurred. This represents a 17% increase.

In addition, there were 8,362 incidents reported by Independent Sector providers inputted onto Datix during this reporting period. These incidents are not included in the following graphs and statistics. They are separately monitored and reported on by the Trust's Quality & Support Team and/or Contracts office.

Fig. 1

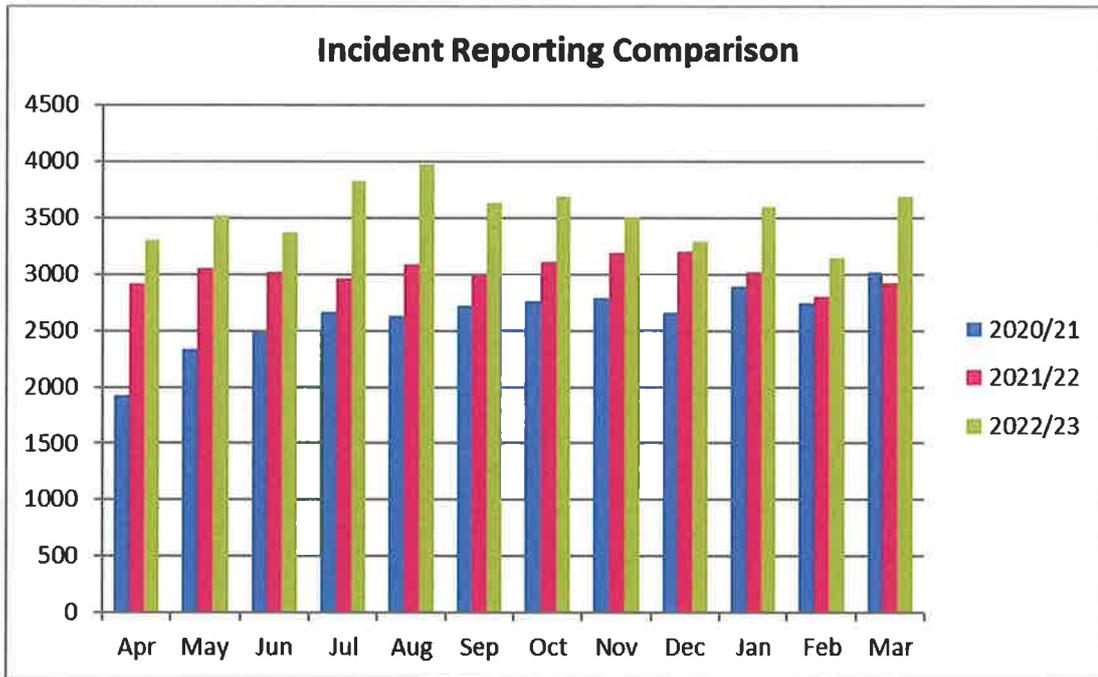


Figure 1 shows the monthly comparison of incident reporting figures in the last 3 years.

The 2020/21 period was during the height of the COVID-19 pandemic when there was a general downturn in incident reporting. Reporting levels have generally steadily increased since.

¹ It should be noted that quality assurance of data is ongoing, therefore statistics throughout this report are presented subject to alteration.

1.2. SERIOUS ADVERSE INCIDENTS (SAIS)

1.2.1 New SAI Notifications

During the period between 01 April 2022 and 31 March 2023 a total of 196 new SAI notifications were submitted to the Strategic Planning & Performance Group (SPPG).

Of these SAIs, 7 occurred in the Trust's Emergency Departments which was the same figure for the same period in the previous year.

Fig. 2

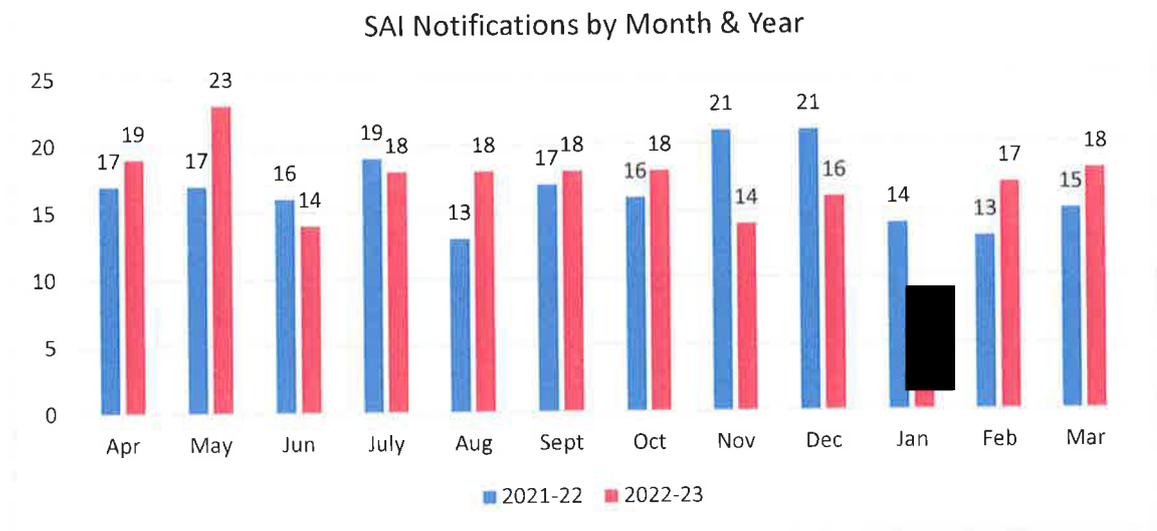


Figure 2 above shows the monthly comparison of new SAI notifications between the two periods in 01 April 2021 to 31 March 2022 and 01 April 2022 to 31 March 2023.

Fig.2a

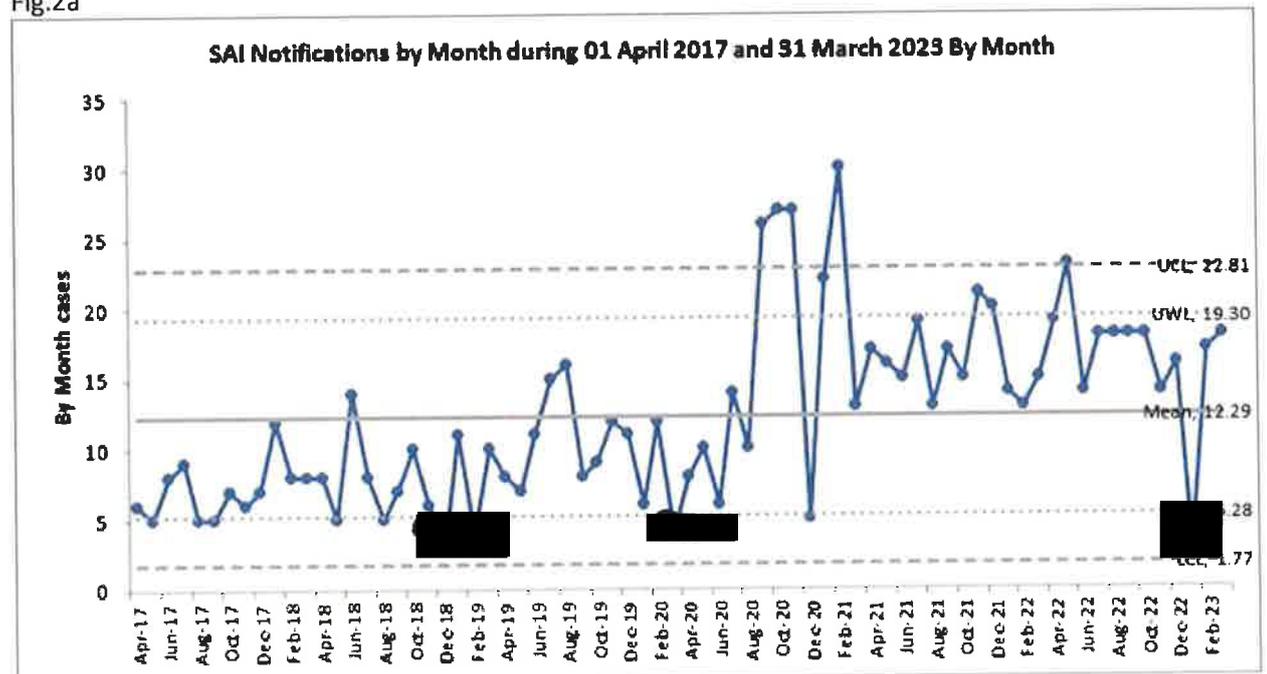


Figure 2a provides a breakdown of SAI notifications by month from 01 April 2017 to 31 March 2023. The SPC chart shows that there has been a general increase in SAI notifications especially over the last 3 years which has been more significant since September 2020 onwards

Fig. 2b

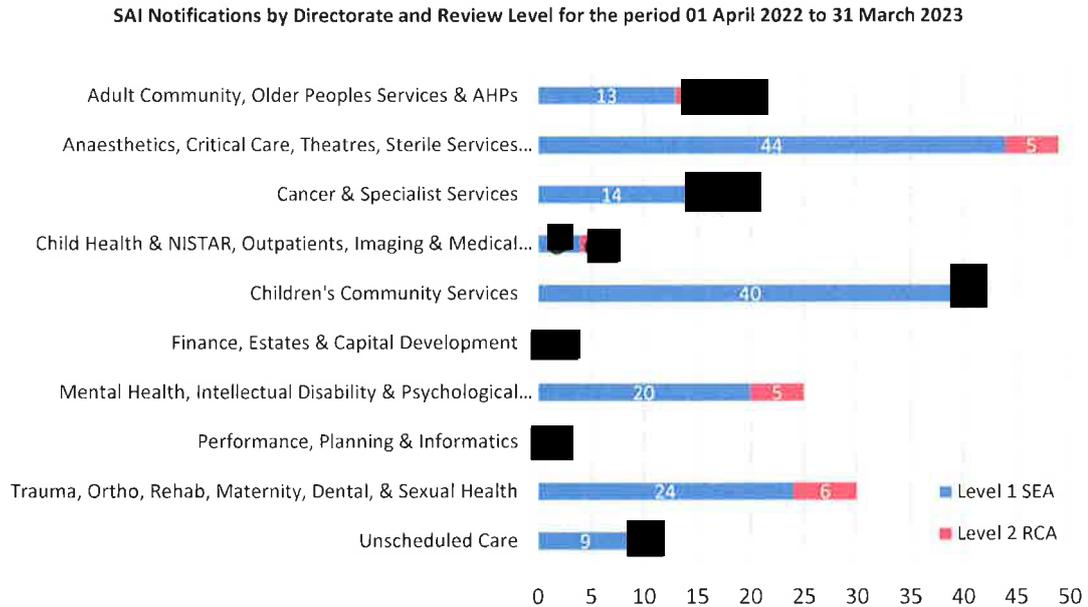


Figure 2b shows a breakdown of new SAI notifications for the period by Directorate and SAI Review Level.

170 (87%) new SAI notifications were for Level 1 SEA review while 26 (13%) were for Level 2 RCA. There were no Level 3 notifications for the reporting period.

[For the same period in previous year, 176 (88%) new SAI notifications were for Level 1 SEA review, 22 (11%) were Level 2 RCA reviews and there was 1 (1%) Level 3 review].

Level 3 SAIs are reviews that are considered particularly complex involving multiple organisations, have a degree of technical complexity that require independent expert advice; and/or are very high profile and attracting a high level of both public and media attention.

For level 2 and 3 reviews, terms of reference would be submitted to the SPPG for their review/approval, in advance of the review commencing.

1.2.2 SAI Reviews Activity

Fig.3

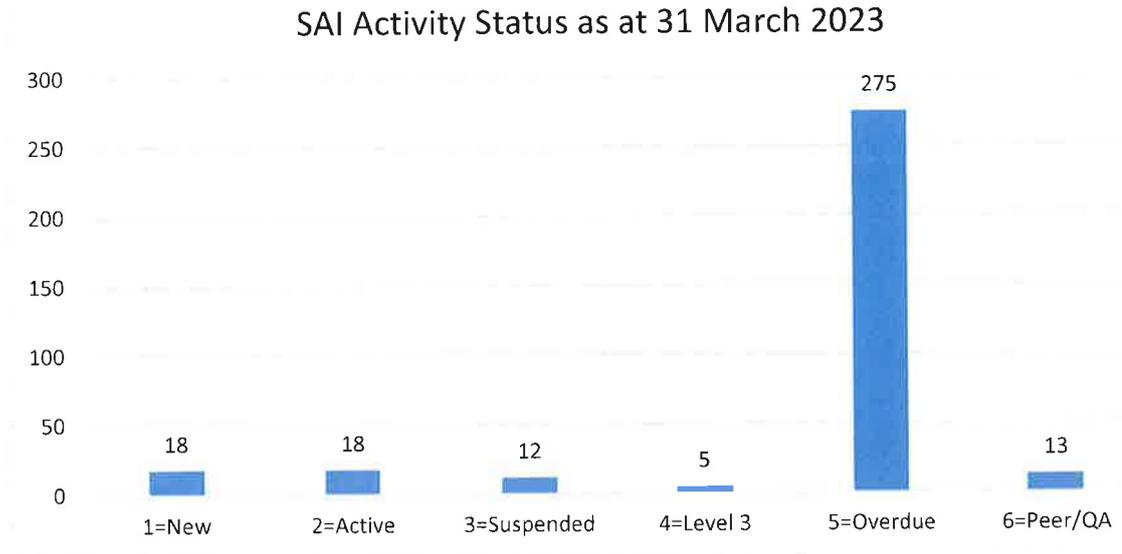


Figure 3 provides a breakdown of SAI activity as at 31 March 2023.

There are 36 SAI reviews underway (18 +18) that are still within SPPG timelines (i.e. have not yet reached their date of report due date to become overdue); 4 level 3 reviews ongoing; 12 SAI reviews suspended due to ongoing PSNI investigations; and 275 SAI reviews overdue (i.e. date report due has past SPPG timelines and the report has not yet been submitted to Corporate Governance for peer/QA review).

In addition, 13 SAI reviews have finalised reports submitted for Peer/QA review. (This includes 6 Level 1 SEA reviews, 6 Level 2 RCA reviews and 1 Level 3). This is a process to quality check reports for consistency, accuracy and completeness before submission to SPPG.

Fig.3a

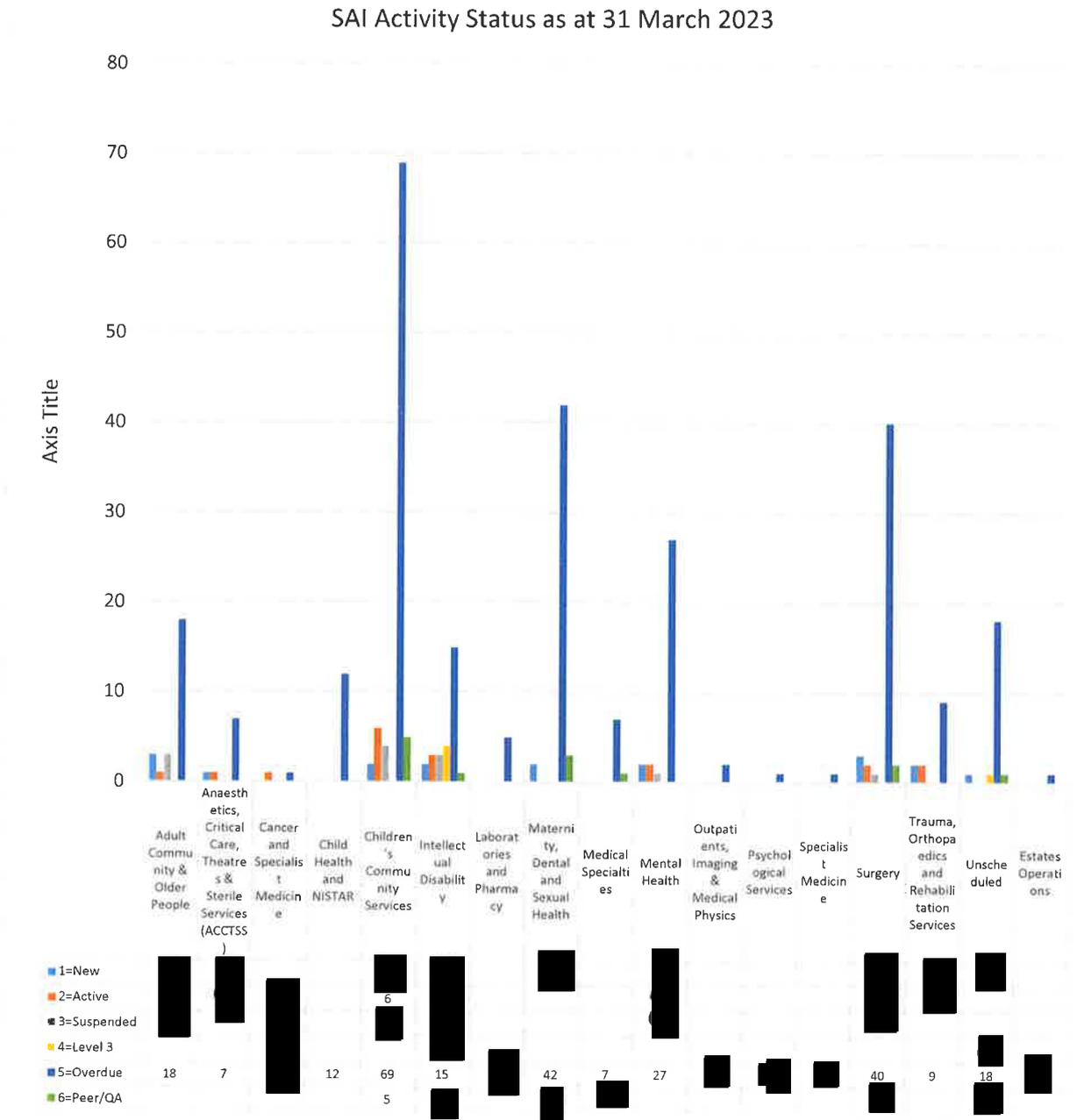


Figure 3a provides a breakdown of SAI activity by Directorate as at 31 March 2023.

Fig.3b

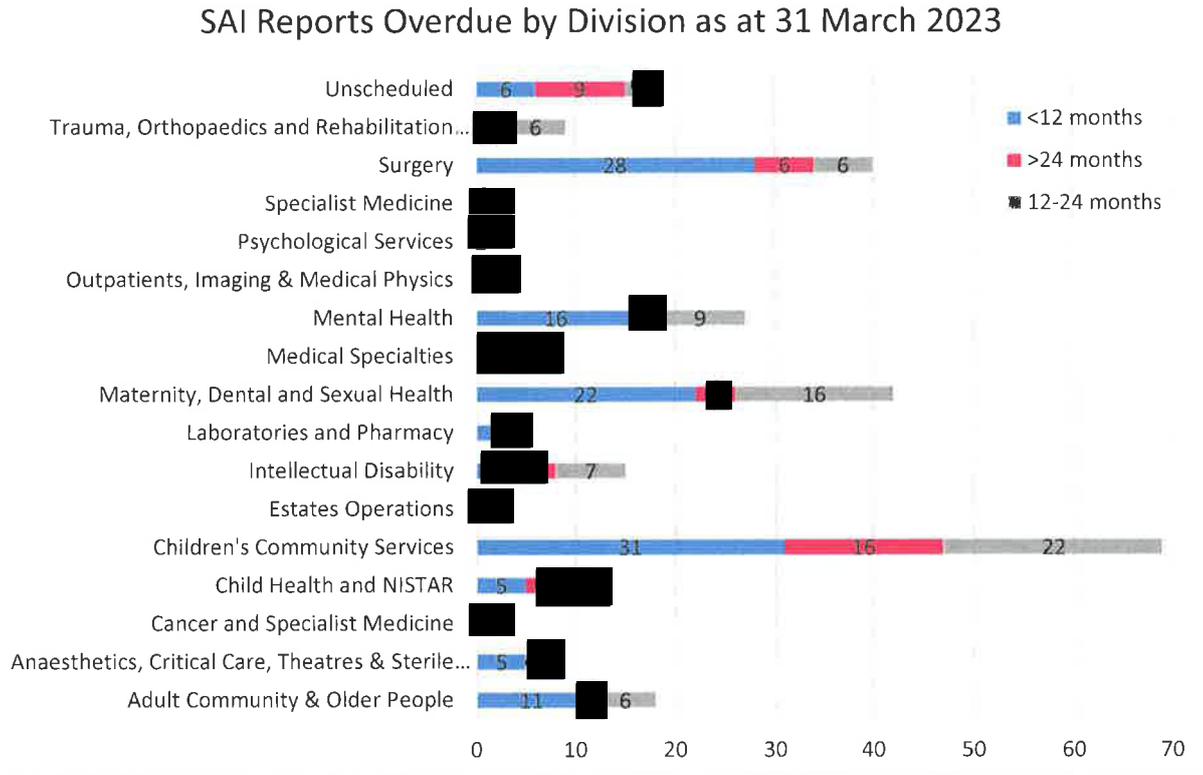


Figure 3b provides a breakdown of SAI reports overdue as at 31 March 2023 by Directorate and how long overdue (i.e. number of months past report due date)

1.2.3 SAI Reports Completed

A total of 168 SAI reports were submitted to SPPG during the period 01 April 2022 and 31 March 2023, compared to 121 reports submitted for the same period in the previous year.

Fig.4

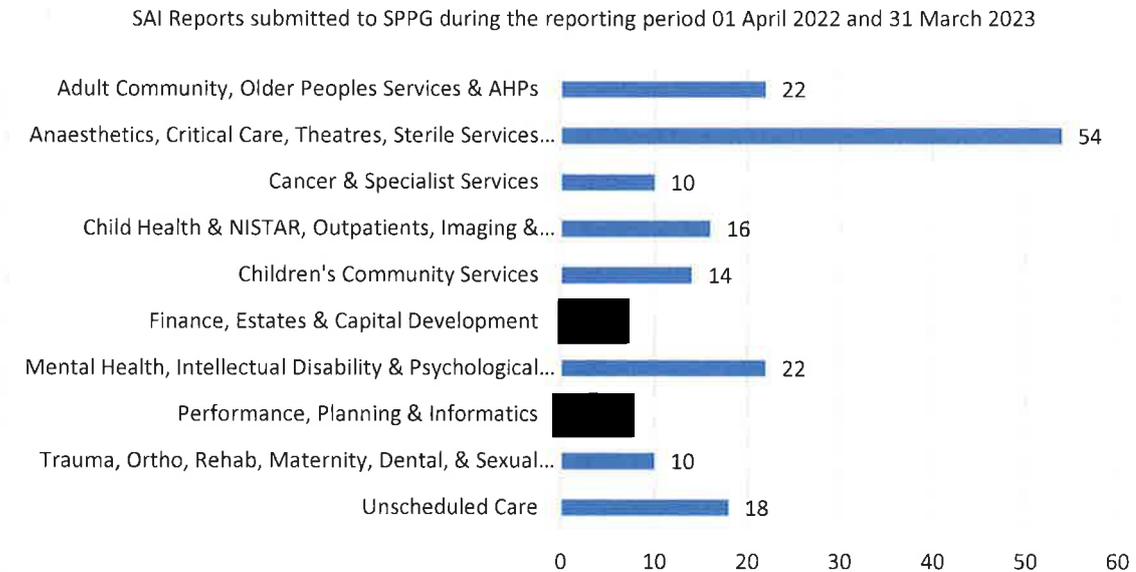


Figure 4 provides breakdown of these reports by Directorate. 153 (91%) were Level 1 SEA reviews, 11 (7%) were Level 2 RCA reviews and 2 (2%) were Level 3 RCA reviews.

There was one report submitted within the timeline expected by SPPG (Level 1 is 8 weeks and Level 2 is 12 weeks. Level 3 timelines vary and are agreed with the SPPG/PHA).

For the 153 Level 1 reports submitted the min timeline was 0 weeks** and the max timeline was 242 weeks, with an average of 73 weeks. (This was because the Incident had been previously reviewed and a SEA undertaken. The SAI notification was submitted at a later date and was able to be followed with the already completed report)

For the 11 Level 2 reports submitted the min timeline was 45 weeks and the max timeline was 191 weeks, with an average of 120 weeks.

Over the last year there have been regular performance meetings with SPPG and BHSC. On the 20th September 2022 concern had been flagged about the upward trend in outstanding SAI reviews. Following this meeting there was a specific focus on Level 1 SAI reviews outstanding and 101 SAIs were identified. At the 31st March 2023 80 of these had been processed, 6 identified as requiring additional work and 15 outstanding. This data along with all outstanding SAI review data is fed into the current Trust QMS arrangements via a monthly report. In addition to the monthly QMS report

there has been an update on Datix on the systems used by all HSC Trusts to ensure there is consistency in identifying the stage a SAI review is at. This has been helpful for both the Trust and also SPPG on the running of reports for the Performance meetings referenced above.

From January 2023 SPPG identified a third party who had extensive experience of undertaking service reviews of clinical care, patient safety, governance quality and risk to support NI HSC Organisations with outstanding SAI reviews. This work commenced in February and initially 38 BHSCCT SAI reviews were identified as those that may benefit from some additional external support.

From March 2023 individual meetings have been set up and commenced with Senior Leadership teams to discuss SAI data for each Division. This has included reviewing the number of SAI reviews outstanding, SAI Action Plans to be submitted for previously submitted SAIs and SAI Action Plans still to be closed.

Where there is a delay in completion of SAI reviews the main reasons given for not being able to meet the SPPG timeframes for submission of the final report include:

- Difficulties in securing a suitable team to support the SAI review primarily due to competing pressures on staff
- Difficulties in arranging Review Team meetings
- Delays associated with completing complex review
- For level 2 reviews, identifying an independent chair
- Completing Peer Review process and implementing any suggested changes

For a number of the more complex SAIs, review team availability during Covid-19 was also flagged as a major factor.

In addition, reporting timelines are impacted when an SAI review is put on hold while the PSNI complete their own investigation. During this reporting period there were ten reviews impacted.

Ongoing completion of SAI reports would be discussed as part of the monthly SAI Group chaired by the Deputy Medical Director. From Feb 2022 Terms of Reference for the SAI Group have been updated to enhance the information that is presented on SAI reviews still ongoing. This includes any early learning and new risks identified. This is to help ensure all relevant staff who need to be made aware are.

When a SAI occurs the service will consider if any urgent action is required to make the service safe and to identify any immediate learning. The Trust has established guidance for having a hot debrief following a SAI or an incident. The purpose of a hot debrief is to identify any urgent learning and changes required and to also remind staff of support available.

In addition to the above, all new SAI notifications are presented at a weekly Governance tele-con to allow further immediate discussion and to help identify if there is any immediate wider learning that needs to be actioned. This information is then provided as part of a weekly report to the Executive team at their Safety huddle the same week.

2. INCIDENTS BY DIRECTORATE AND DIVISION

2.1 All Adverse Incidents

Fig. 5

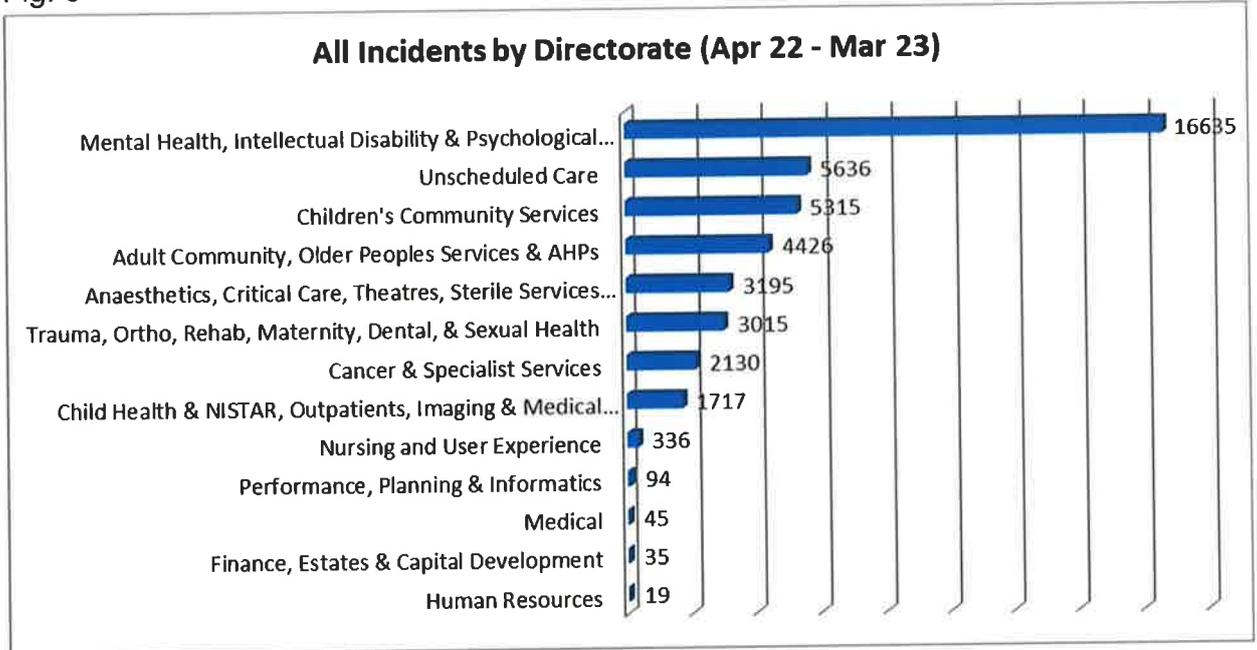
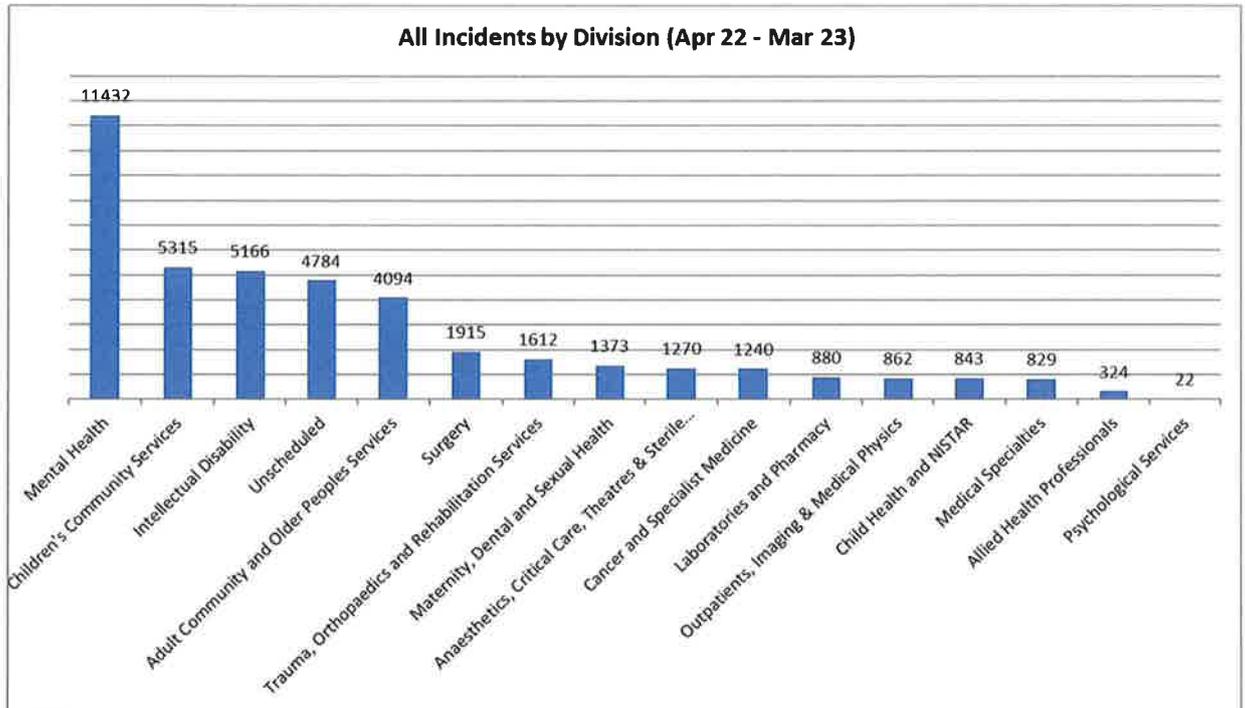


Figure 5 shows that the Directorate with the most reported incidents is Mental Health, Intellectual Disability & Psychological Services with 16,635 (39%) incidents. Unscheduled Care reported the second highest number of incidents with 5,636 (13%) incidents.

Figure 6 provides further illustration of incidents reported by Division.

Fig.6



2.2 Serious Adverse Incidents (SAIs)

Fig. 7

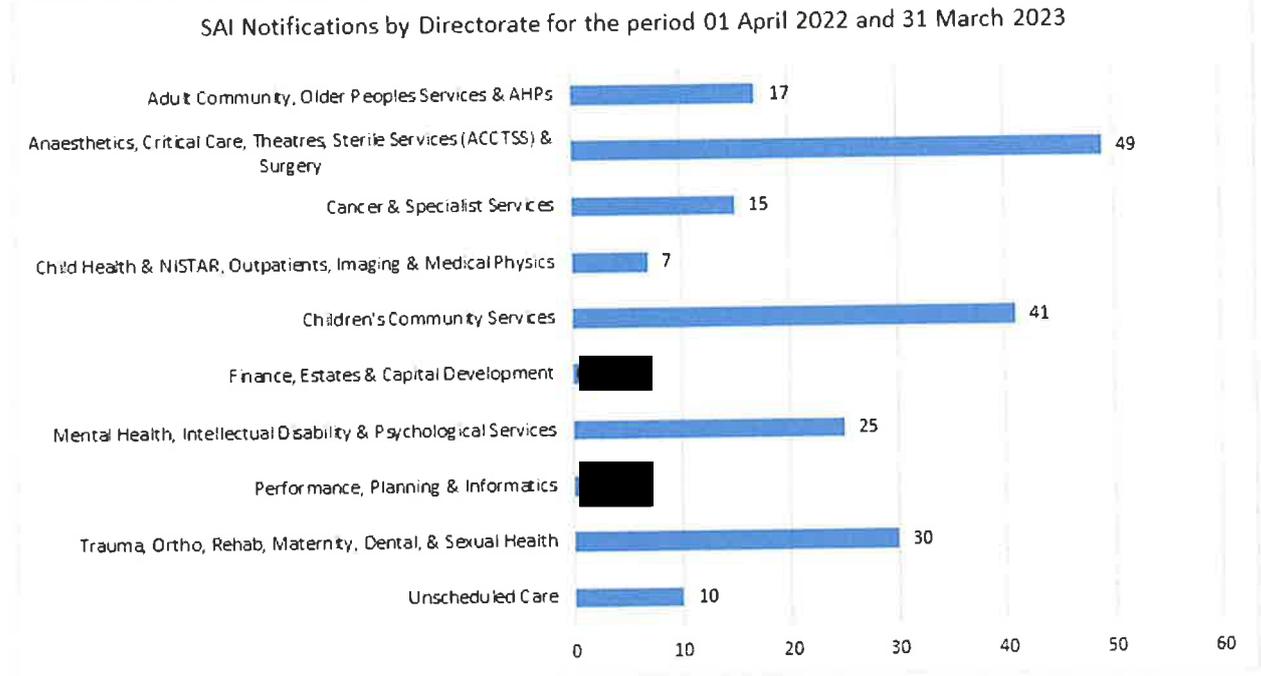
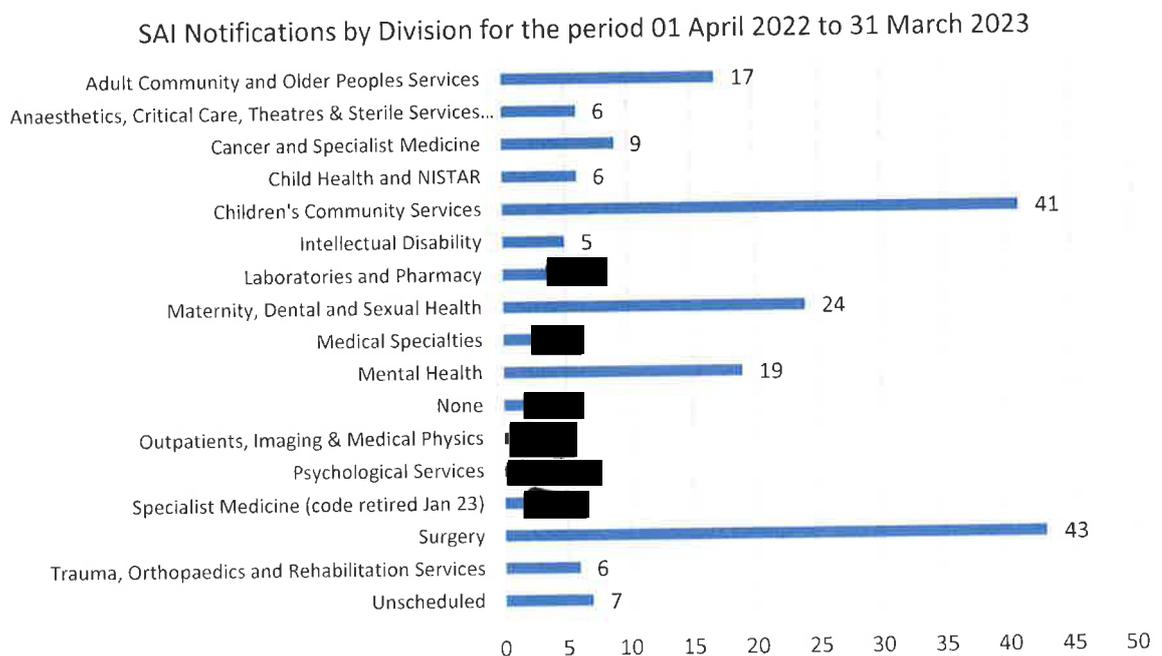


Figure 8 provides a further illustration of SAI Notification submitted by Division for the period.

Fig. 8



The 19 SAI Notifications raised by the Mental Health Division relate 15 suicides, 1 suicide attempt, 1 serious risk, and 2 physical assault.

3. INCIDENTS BY SEVERITY

3.1 ALL ADVERSE INCIDENTS

Fig. 9

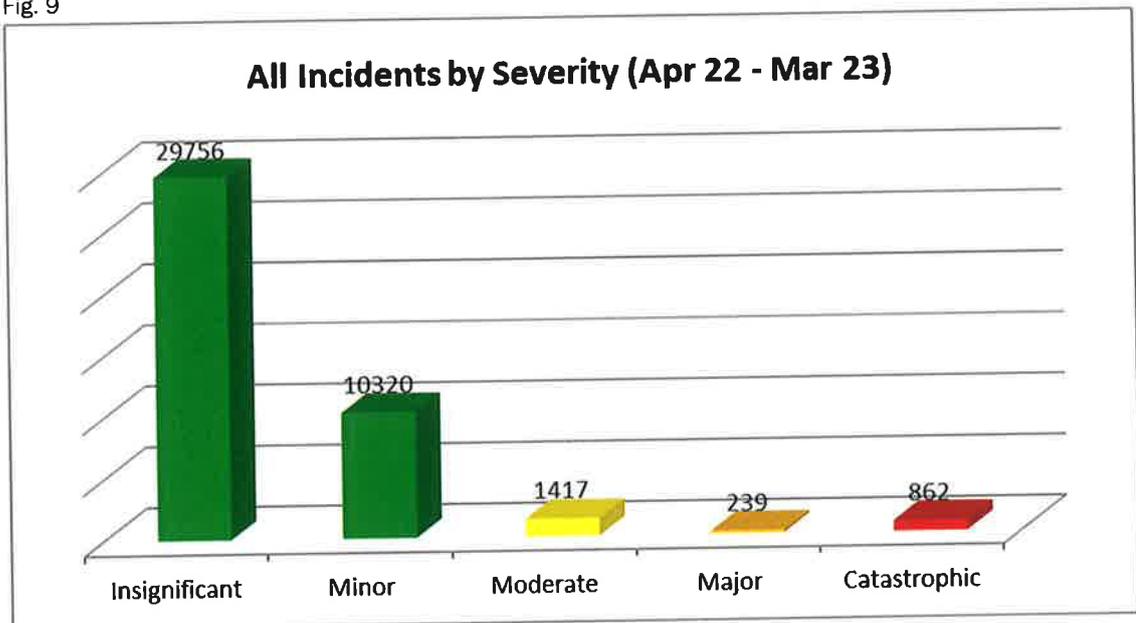


Figure 9 indicates that 40,076 (94%) of incidents were assessed as having a severity rating of insignificant or minor while 862 (2%) were rated as catastrophic. The severity rating indicates *actual** harm or damage as a result of the incident rather than potential risk. (*Ref Section 3.2.2 below for additional information on the catastrophic incidents reported by both the RVH and Mater Emergency Department)

Service Directorates regularly review major or catastrophic severity incidents to ensure appropriate grading and follow-up. All catastrophic severity and extreme risk incidents are also discussed at the weekly Governance teleconference.

3.1 FURTHER BREAKDOWN OF MAJOR / CATASTROPHIC SEVERITY INCIDENTS

3.2.1 Major Severity Incidents by Type Tier One and Division

Fig. 10

| | Adult Community and Older Peoples Services | Anaesthetics, Critical Care, Theatres & Sterile Services (ACCTSS) | Cancer and Specialist Medicine | Child Health and NISTAR | Children's Community Services | Intellectual Disability | Laboratories and Pharmacy | Maternity, Dental and Sexual Health | Medical Specialties | Mental Health | Outpatients, Imaging & Medical Physics | Surgery | Trauma, Orthopaedics and Rehabilitation Services | Unscheduled | None | Total |
|--|--|---|--------------------------------|-------------------------|-------------------------------|-------------------------|---------------------------|-------------------------------------|---------------------|---------------|--|---------|--|-------------|------|-------|
| Accidents/Falls | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 5 |
| Administrative Processes (Excluding Documentation) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Anaesthesia Care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Behaviour | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Communication | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Diagnostic Processes/Procedures | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Documentation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Exposure to Environmental Hazards | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Infection Control Incident (Healthcare Associated Infection) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Injury of unknown origin | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| IT Systems | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Medical Devices, Equipment, Supplies | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Medication/Biologics/Fluids | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Neonatal/Perinatal Care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Pressure Ulcers | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Service Disruptions (environment, infrastructure, human resources) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Unexpected Deaths or Severe Harm | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | | | 8 | 7 | 18 | 5 | 7 | | 6 | 10 | 5 | 6 | 21 | 14 | 123 | |

Of the 239 incidents with a severity of major:

- 22 of these were reported as SAIs (Serious Adverse Incidents) and are subject to full review under this process.
- 89 were categorised as **Service Disruptions** incidents. 78 of these were related to overcrowding/ ongoing pressures in the Emergency Departments, 54 in RVH, 17 in Mater and 7 in RBHSC. In relation to overcrowding/ ongoing pressures there is ongoing escalation to the Senior and Executive Teams on duty.

3.2.2 Catastrophic Severity Incidents by Type Tier One and Division

Fig. 11

| | Adult Community and Older Peoples Services | Anaesthetics, Critical Care, Theatres & Sterile Services (ACCTSS) | Cancer and Specialist Medicine | Child Health and NISTAR | Children's Community Services | Maternity, Dental and Sexual Health | Medical Specialties | Mental Health | Outpatients, Imaging & Medical Physics | Psychological Services | Surgery | Trauma, Orthopaedics and Rehabilitation Services | Unscheduled | Total |
|--|--|---|--------------------------------|-------------------------|-------------------------------|-------------------------------------|---------------------|---------------|--|------------------------|---------|--|-------------|-------|
| Accidents/Falls | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Administrative Processes (Excluding Documentation) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Behaviour | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 9 | 0 | 0 | 0 | 0 | 0 | 9 |
| Blood/Plasma Products | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Communication | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Diagnostic Processes/Procedures | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Documentation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Exposure to Environmental Hazards | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Infection Control Incident (Healthcare Associated Infection) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Maternity Care | 0 | 0 | 0 | 0 | 0 | 21 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 21 |
| Medical Devices, Equipment, Supplies | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Medication/Biologics/Fluids | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Neonatal/Perinatal Care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other | 0 | 9 | 0 | 0 | 0 | 0 | 18 | 0 | 0 | 0 | 10 | 5 | 0 | 42 |
| Service Disruptions (environment, infrastructure, human resources) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 9 | 0 | 0 | 0 | 0 | 0 | 9 |
| Unexpected Deaths or Severe Harm | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 6 | 9 | 0 | 0 | 13 | 0 | 28 |
| Total | 10 | 13 | 9 | 0 | 0 | 21 | 18 | 15 | 9 | 7 | 10 | 13 | 13 | 144 |
| No. of the above reported as SAIs | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 17 | 0 | 0 | 6 | 0 | 0 | 23 |

Of the 862 incidents with a severity of catastrophic:

- 48 were reported as SAIs (Serious Adverse Incidents) and are subject to full review under this process.
- 645 were categorised as **Service Disruptions** incidents. 641 of these were related to overcrowding/ ongoing pressures in the Emergency Departments, 450 in RVH and 191 in Mater. These did not involve patient deaths but were graded as catastrophic due to gross failure to meet professional standards.

3.3 SERIOUS ADVERSE INCIDENTS (SAIS) BY SEVERITY

Fig. 12

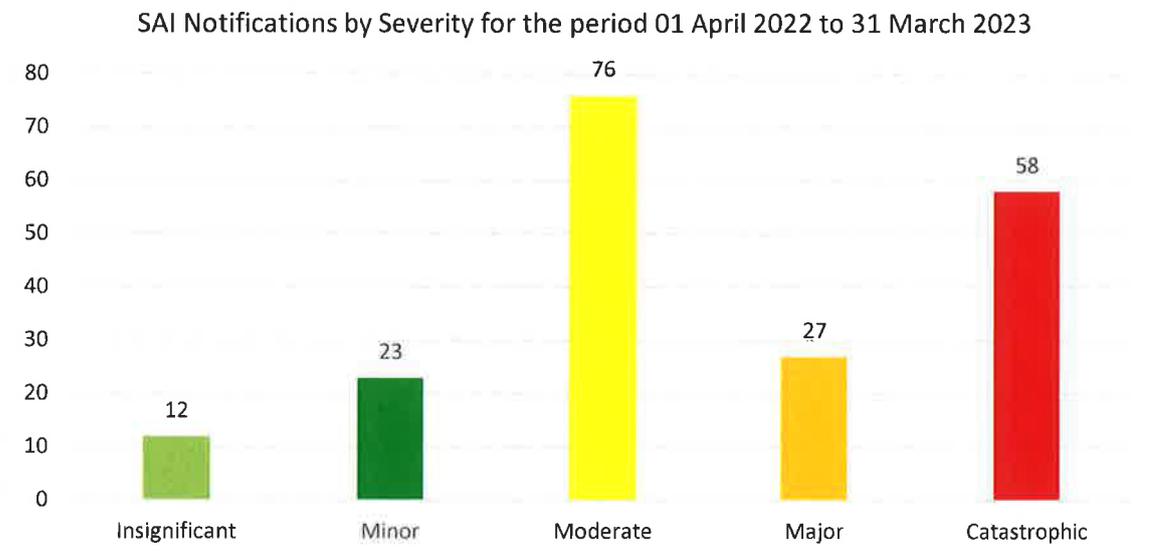


Figure 12 shows that, of the 196 SAI Notifications submitted to SPPG for the period, 58 (30%) had catastrophic severity, of which includes 16 suicides- actual (█ for Mental Health Division and █ for ACOPS) and █ attempted suicide* within Mental Health Division. █

4. INCIDENTS BY TYPE / CRITERIA

4.1 ALL ADVERSE INCIDENTS BY TYPE

Fig. 13

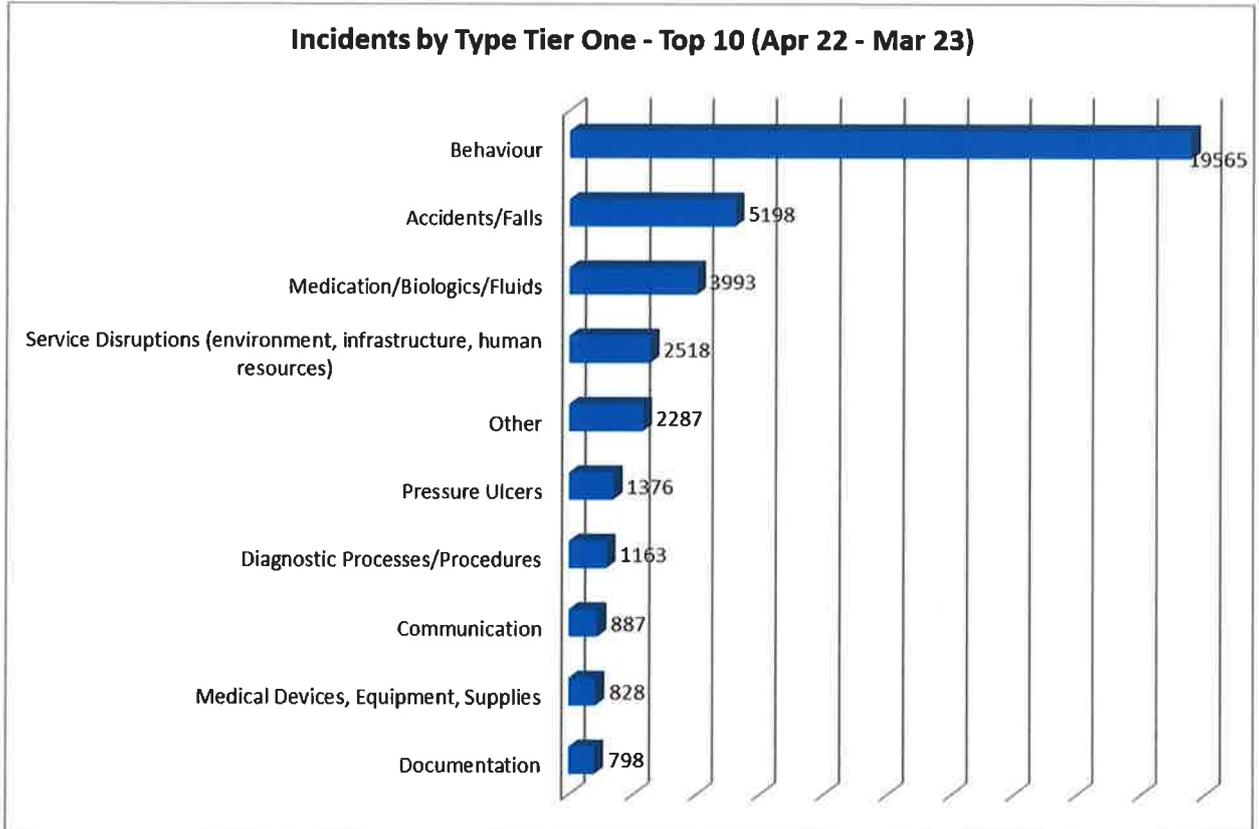


Figure 13 shows that the most commonly reported incident type is **Behaviour** with 19,565 (46%) incidents. The 2nd most commonly reported type is **Accidents/Falls** with 5,198 (12%) incidents. Within the Accidents/Falls Type, falls account for 83% of the incidents reported.

The top 2 types are displayed by Division in figures 14 and 15 below.

Fig. 14

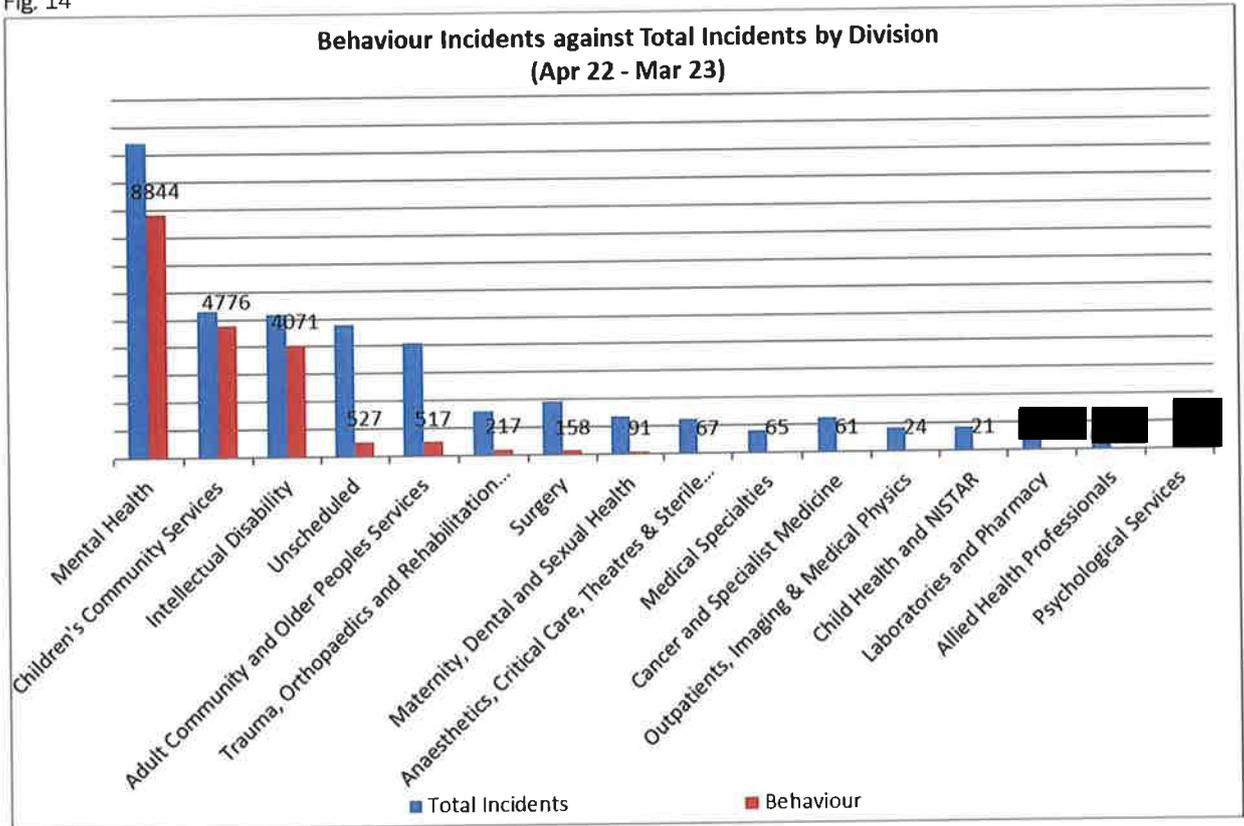
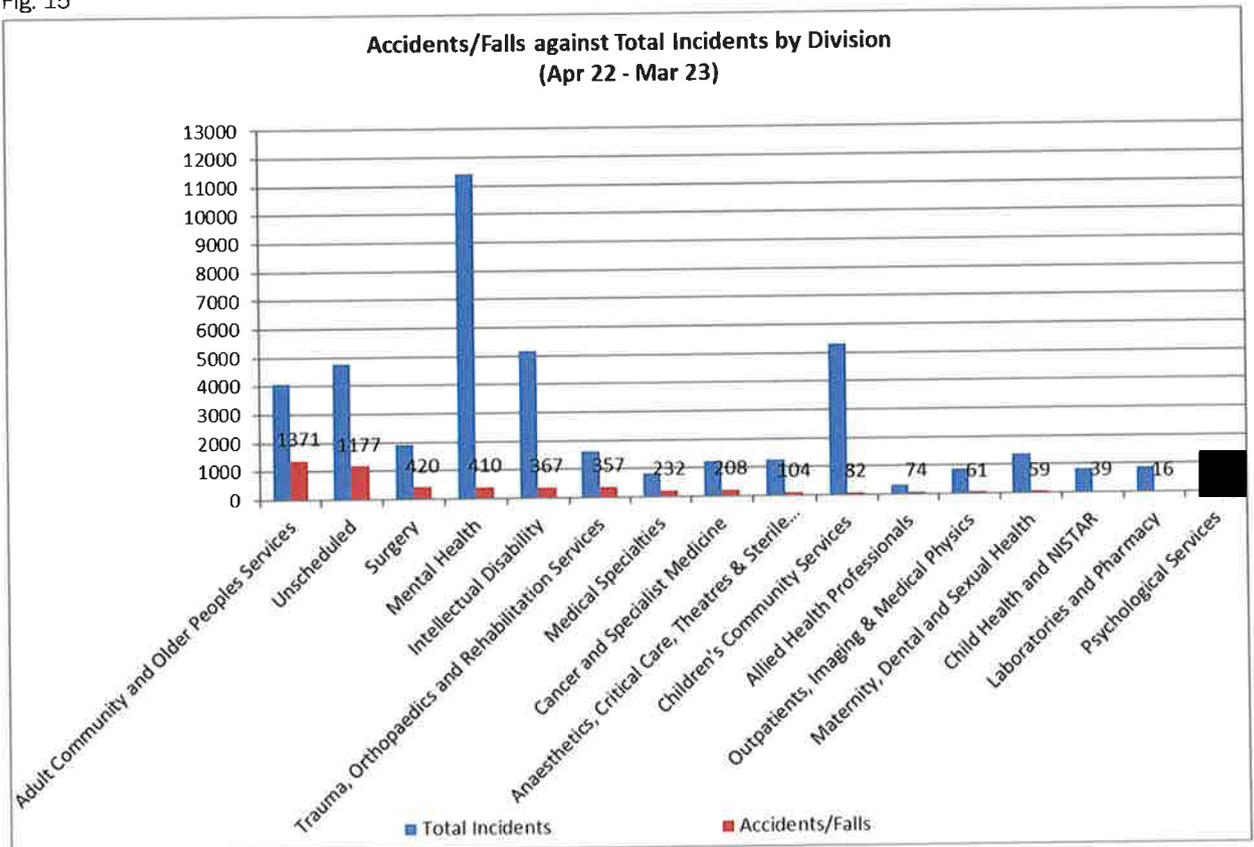


Fig. 15



Individual run charts for the top 2 incident types for the last 2 years are shown in figures 16 and 17 below:

Fig.16

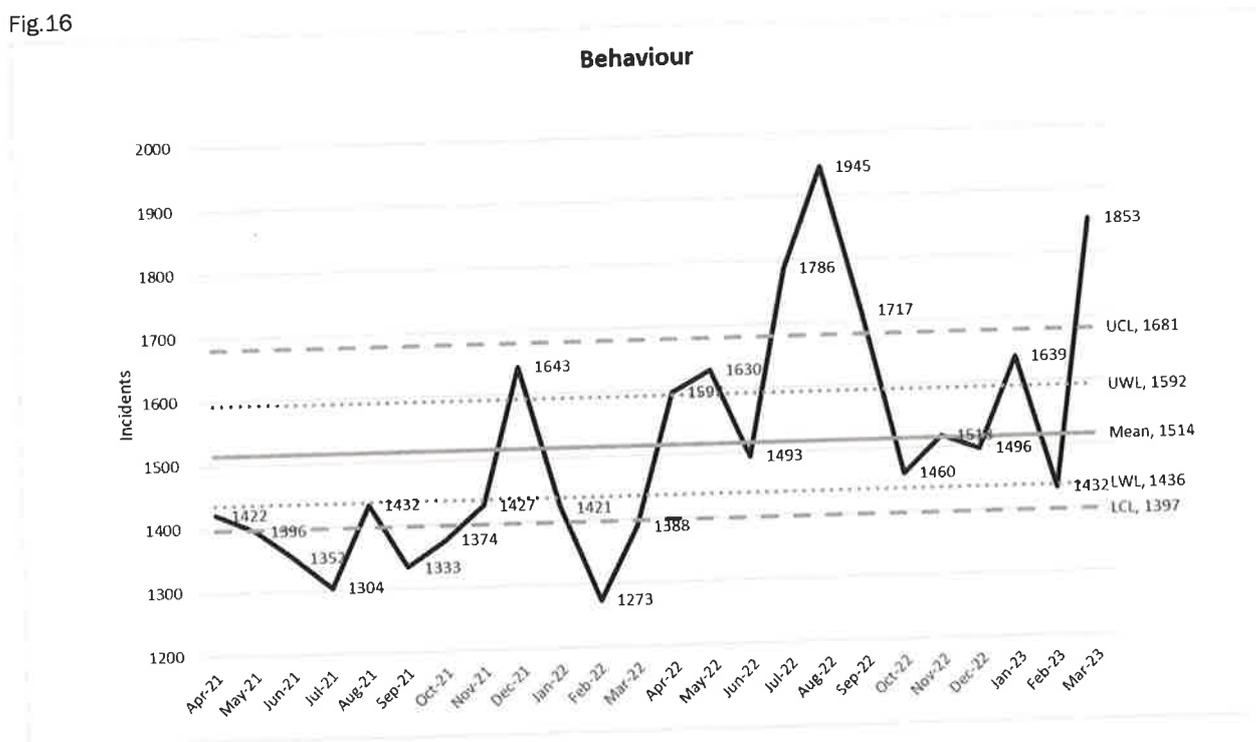
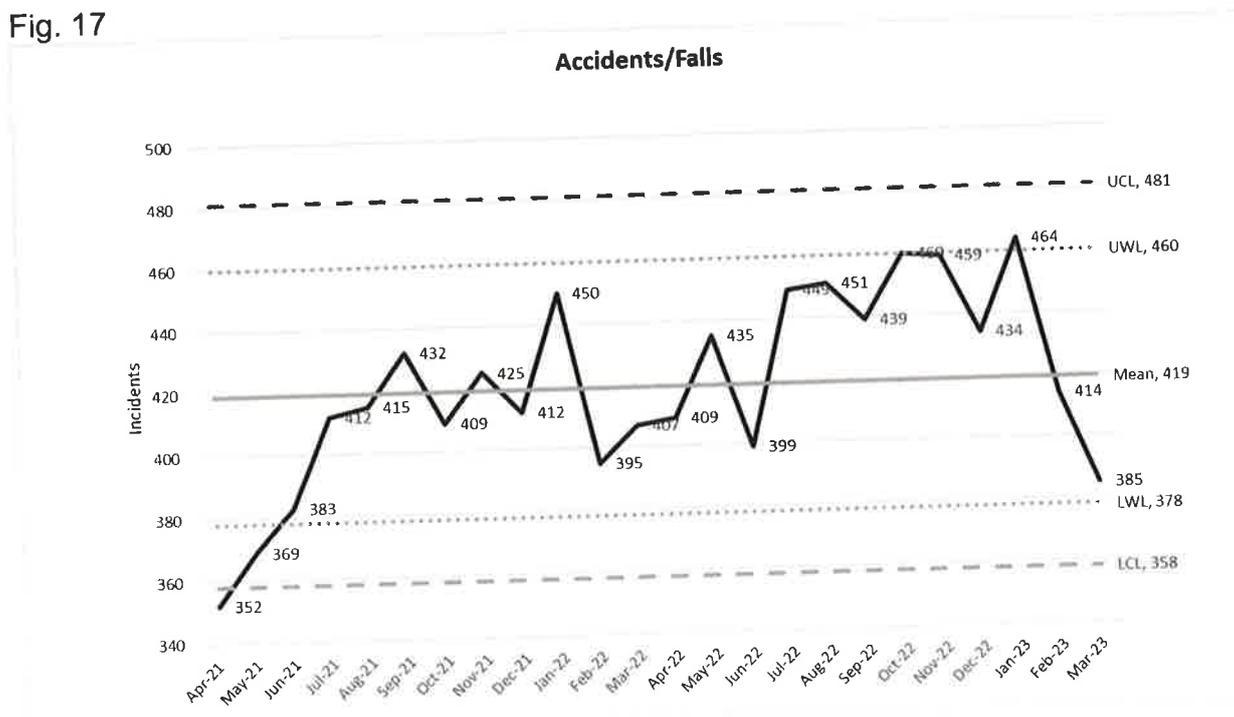


Fig. 17



4.2 FURTHER BREAKDOWN OF TOP 2 INCIDENT TYPES

4.2.1 'BEHAVIOUR' INCIDENTS BY DIVISION (TOP 3)

The data in figure 16 has been further broken down by the top 3 Divisions in figures 18 to 20 below. Figure 14 shows that, during this reporting period, the top 3 Divisions for Behaviour incidents were Mental Health, Children's Community Services and Intellectual Disability .

Fig. 18

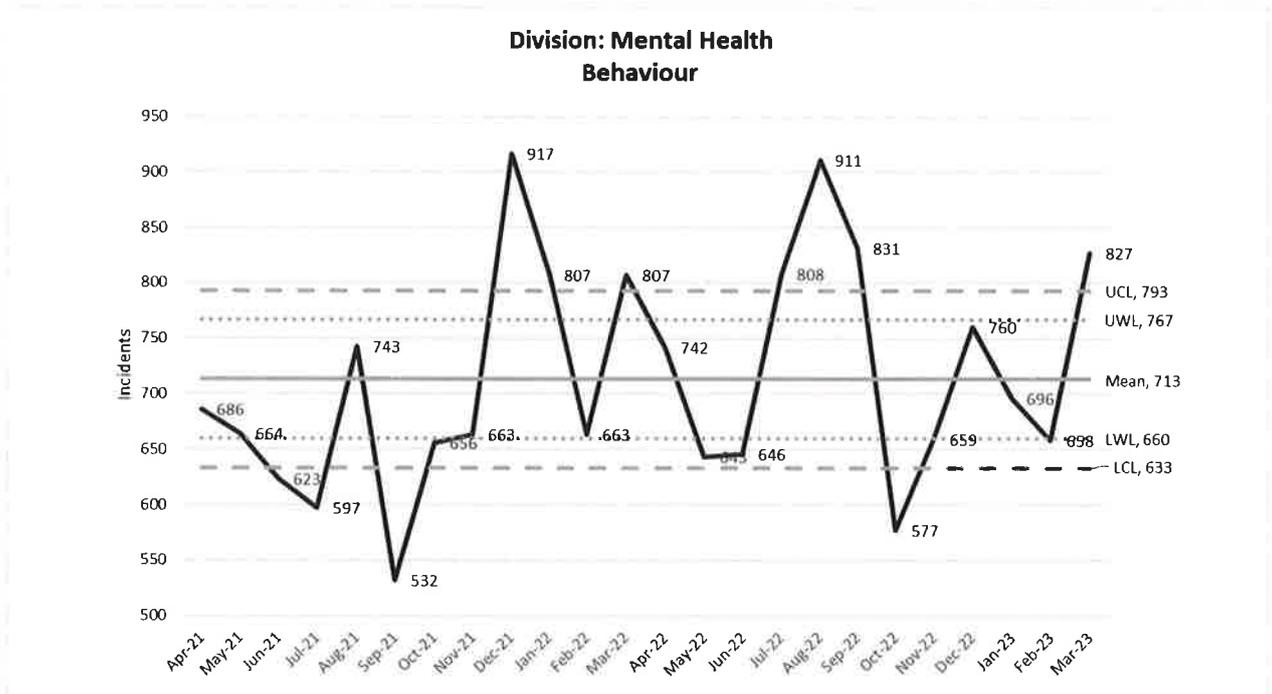


Fig. 19

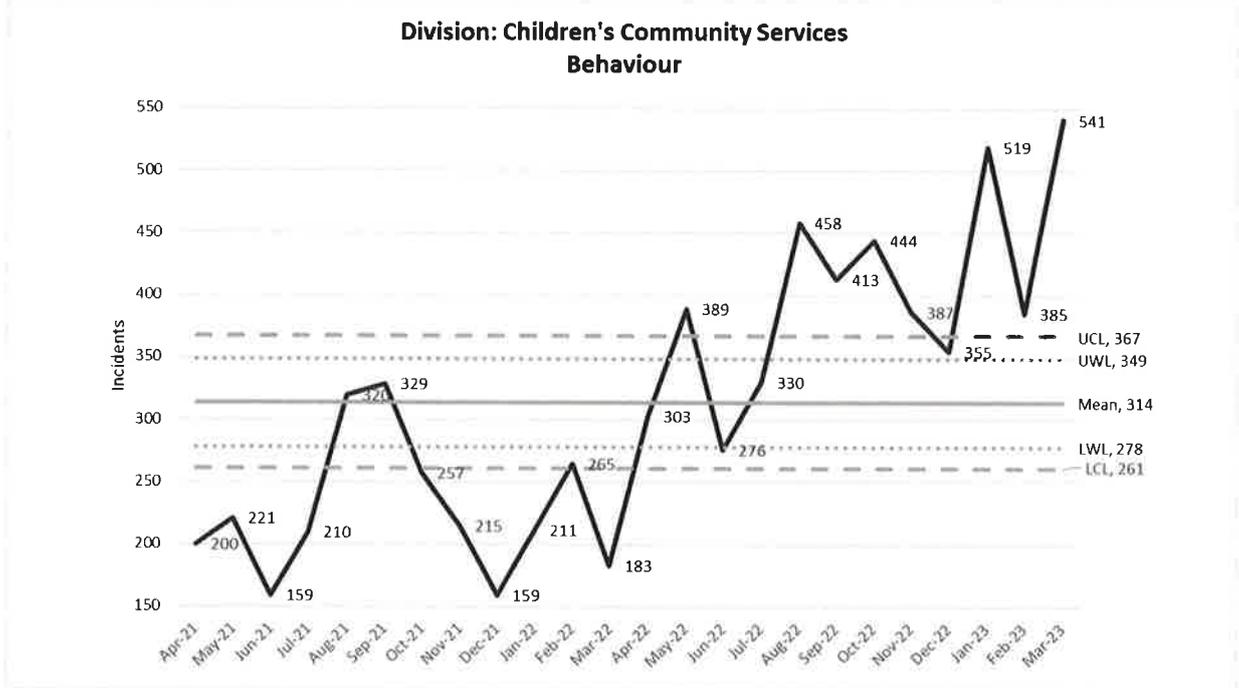
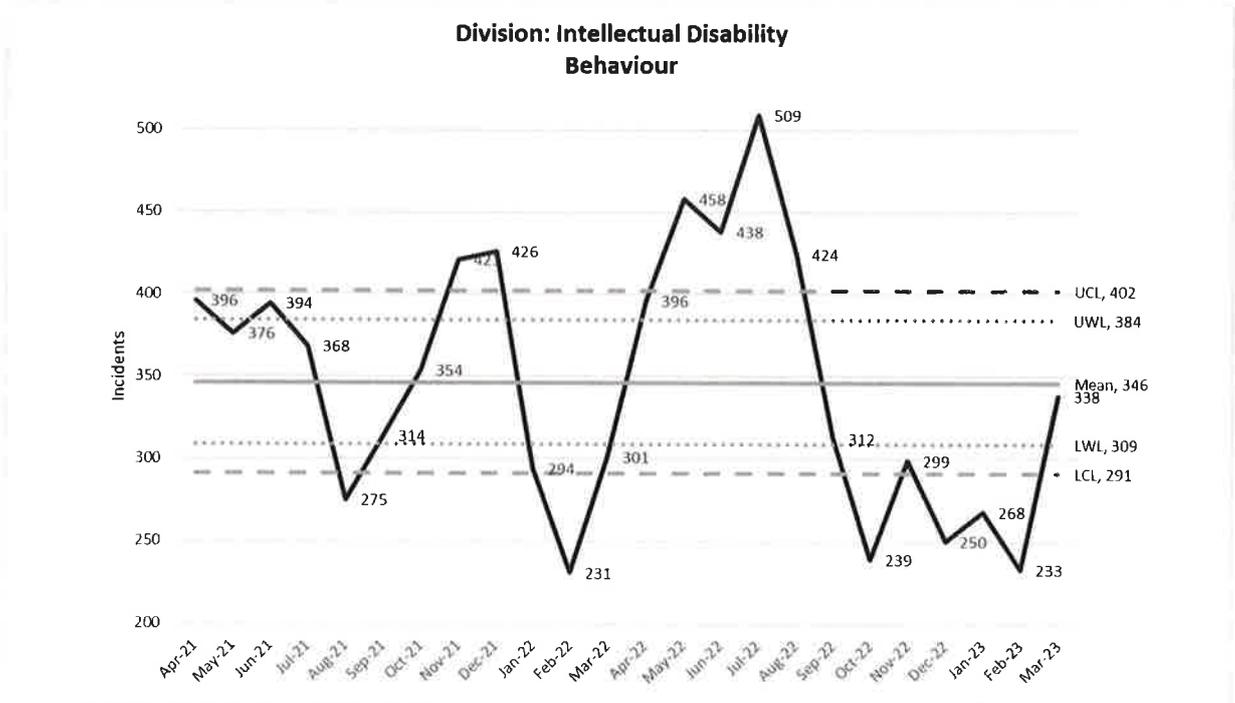


Fig. 20



There has been a marked decrease in behaviour incidents within Intellectual Disability over the last two quarters. This can be at least partly explained by Positive Behavioural Support (PBS) training that has been made available to all staff bolstering the ongoing work of the Positive Behavioural Support Therapists throughout the ID services. This enables staff to recognise, and understand, situations which may trigger challenging behaviours in our patients and service users and ultimately prevent it from becoming an adverse incident.

The service would hope that the number of incidents continues to consistently decrease, however is mindful that 1 service user or patient in crisis may increase this figure albeit temporarily. PBS training has raised the confidence of all the staff groups with the hope that the service users and patients feel more understood by the staff caring for them. The Division has confirmed this will be gauged through direct service user or patient feedback and continuing staff training and updates.

4.2.2 'BEHAVIOUR' INCIDENTS BY SEVERITY

Fig. 21

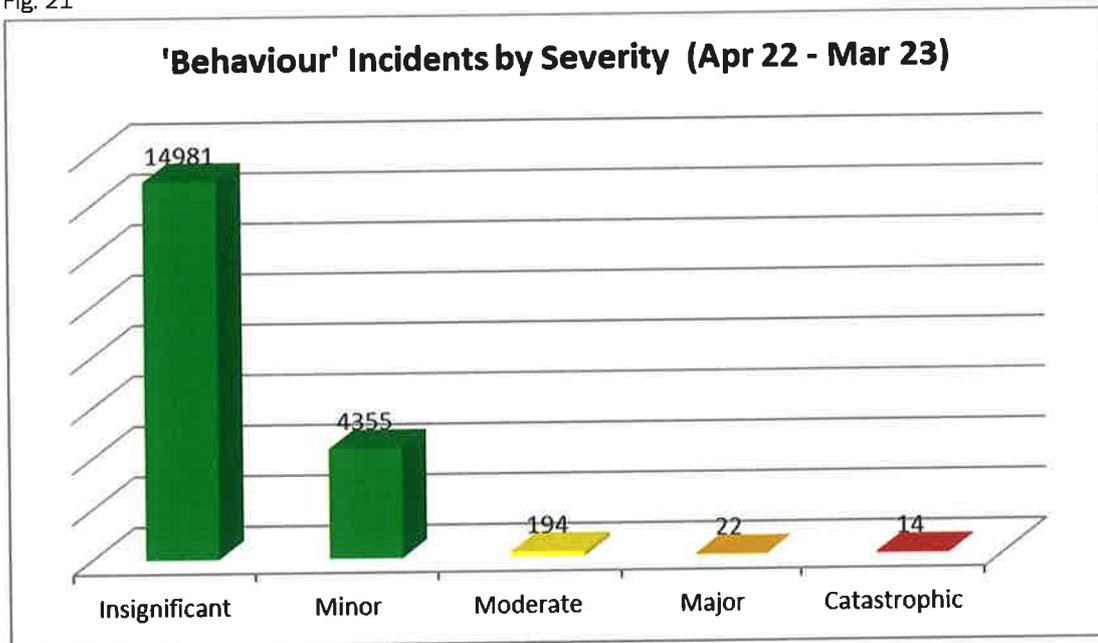
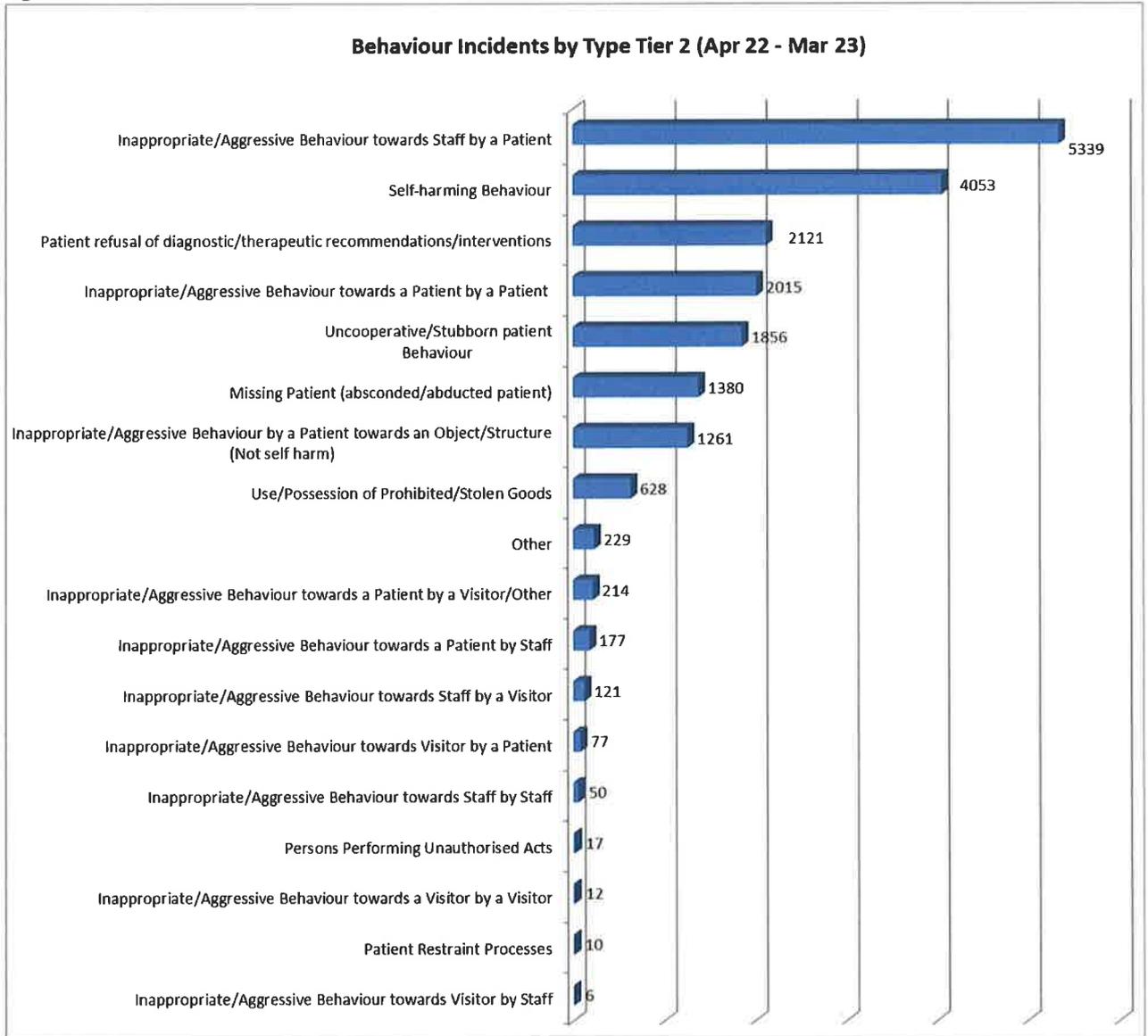


Figure 21 shows that the majority of incidents in this type (19,336 or 99%) were of insignificant or minor severity. There were 22 (0.1%) graded as major and 14 (0.1%) graded as catastrophic.

4.2.3 'BEHAVIOUR' INCIDENTS BY TYPE TIER TWO

Fig. 22



Incidents of 'Inappropriate/Aggressive Behaviour towards Staff by Staff' are shared with the HR Dept on a quarterly basis for them to triangulate on their own review processes.

Incidents of 'Inappropriate/Aggressive Behaviour towards a Patient by Staff', were the investigation is still ongoing at time of this report being generated are shared with Directorate teams for follow-up.

4.2.4 'Accidents/Falls' Incidents by Division (Top 3)

The data in figure 15 has been further broken down by the top 3 Divisions in figures 23 to 25 below. Figure 15 shows that, during this reporting period, the top 3 Divisions for accidents/falls were Adult Community & Older People Services, Unscheduled and Surgery.

Fig. 23

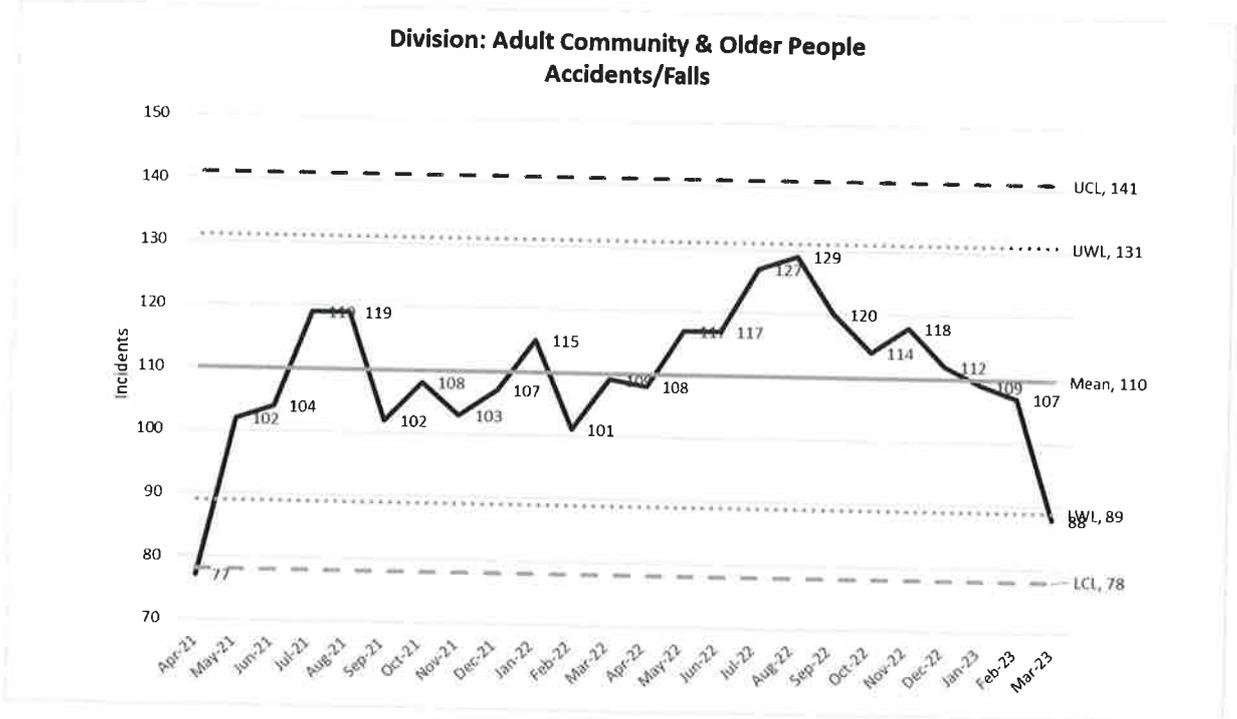


Fig. 24

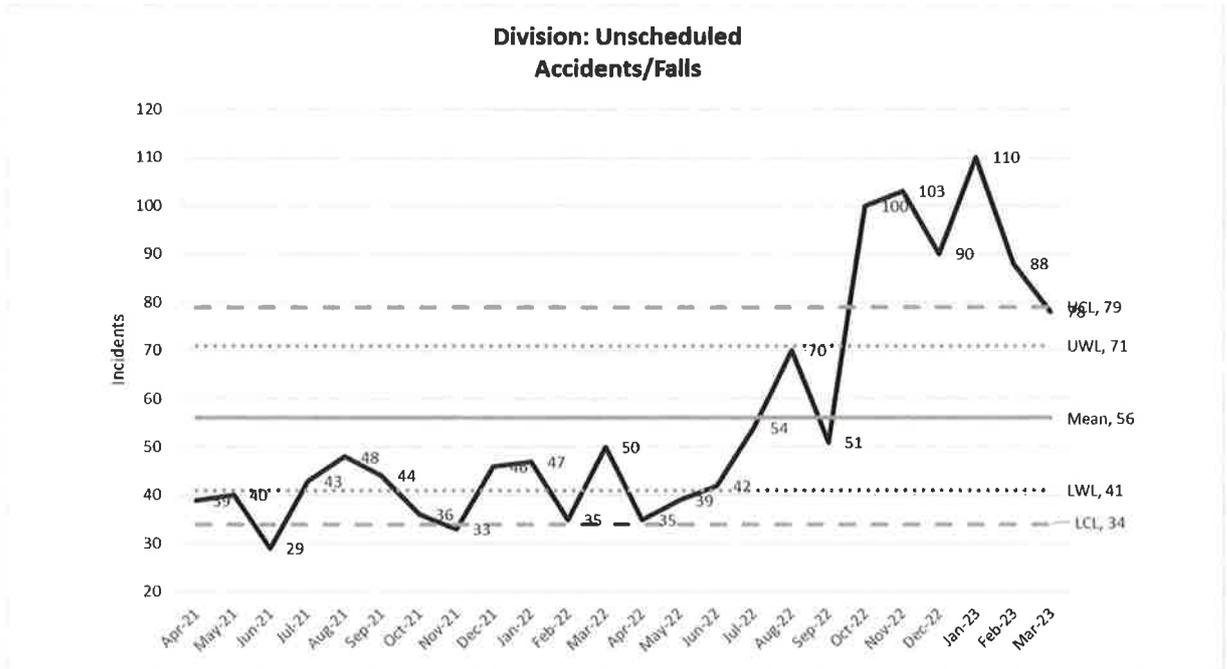
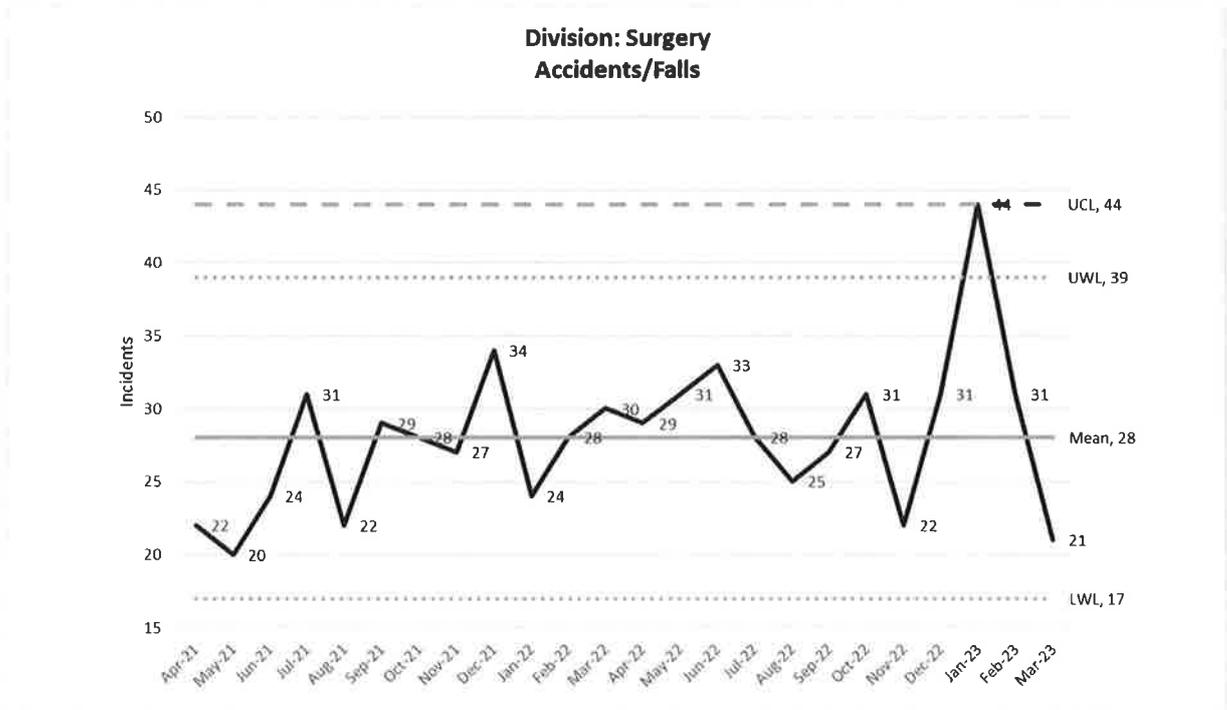


Fig. 25



4.2.5 'Accidents/Falls' Incidents by Severity

Fig. 26

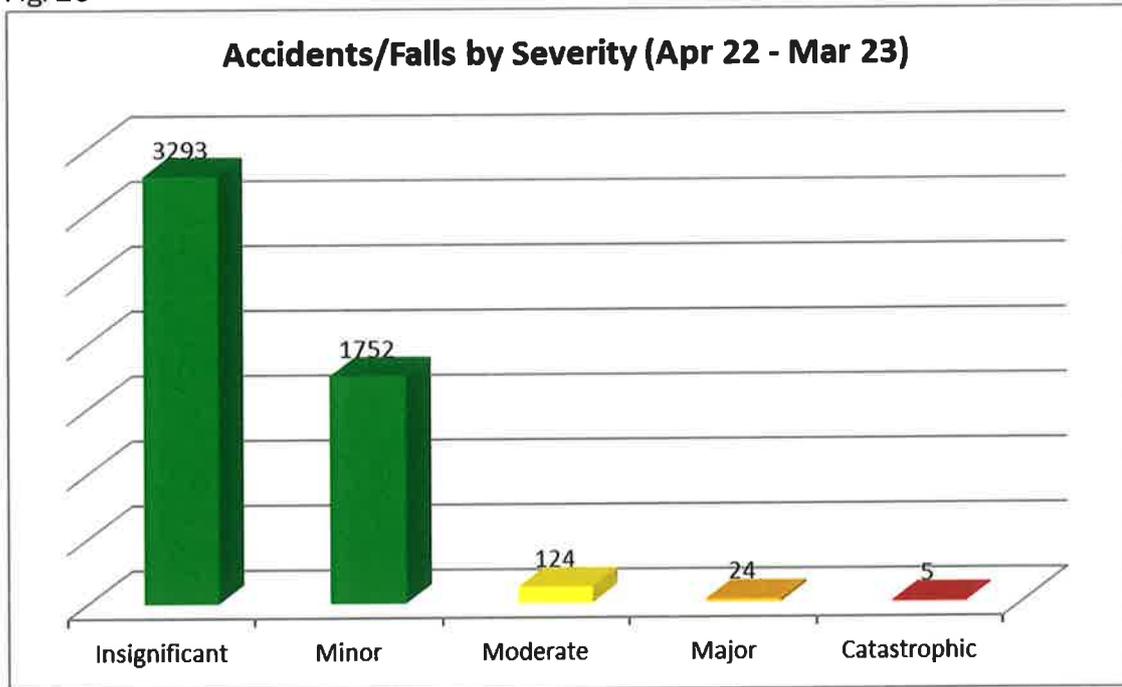
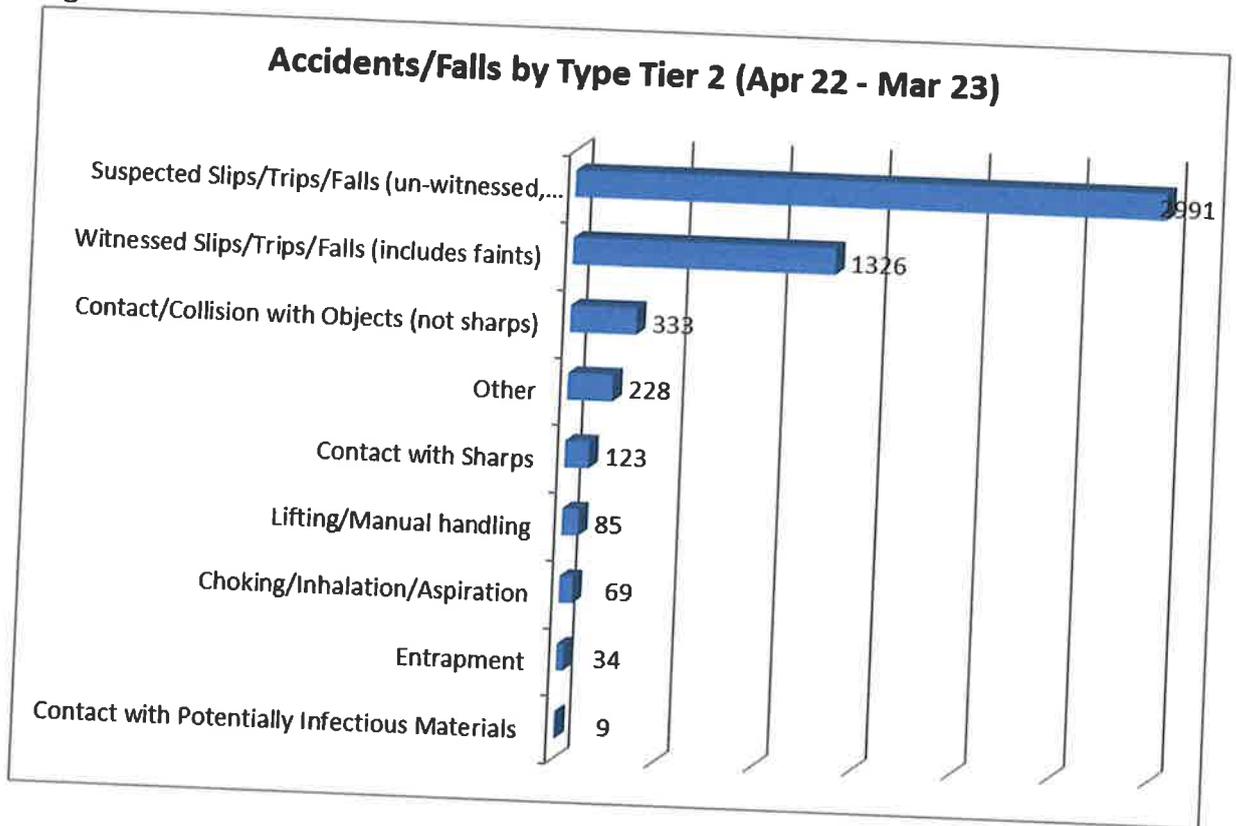


Figure 26 shows that the majority of incidents in this category (5,045 or 97%) were of insignificant or minor severity. There were 24 (0.5%) graded as major and 5 (0.1%) graded as catastrophic.

4.2.6 'Accidents/Falls' Incidents by Type Tier Two

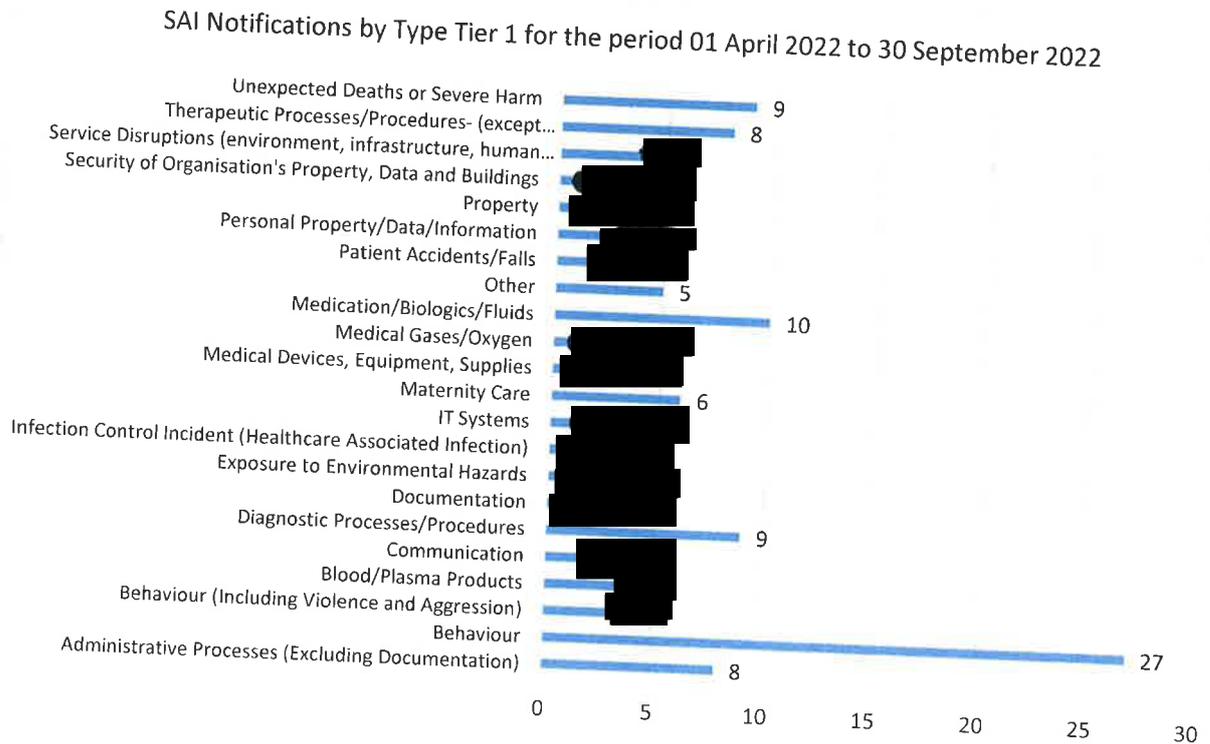
Fig 27



4.3 SERIOUS ADVERSE INCIDENTS BY INCIDENT TYPE / CRITERIA

4.3.1 SAIs by Type

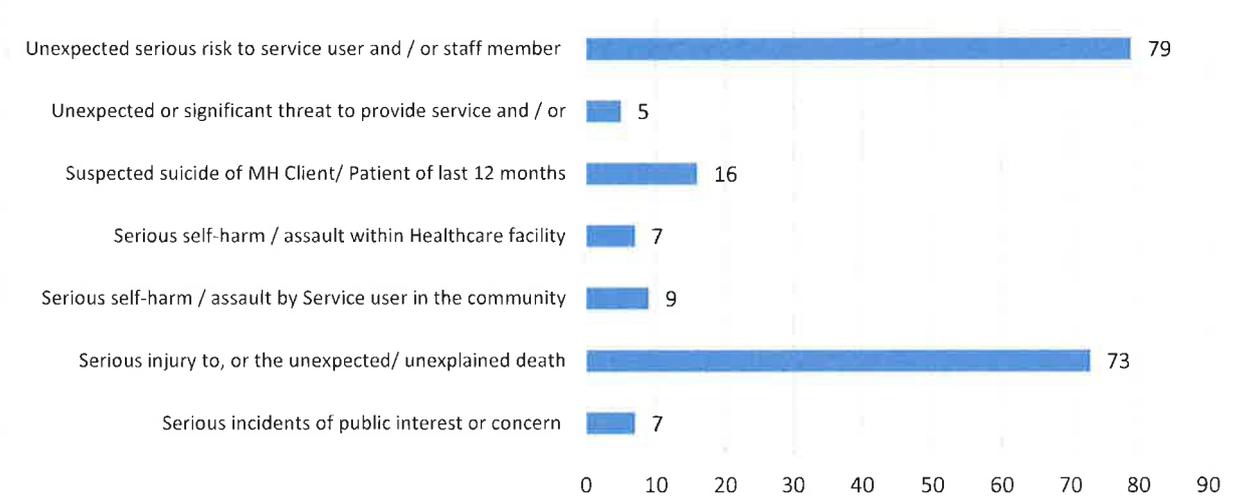
Fig.28



4.3.2 SAIs by Criteria

Fig. 29

SAI Notifications by Criteria for the period 01 April 2022 to 31 March 2022



Criteria: 'serious injury to, or unexpected/unexplained death' includes [redacted] child deaths for Child Health & NISTAR Division

Figure 29 shows a breakdown of SAIs by Criteria

Child deaths are reported to the Department of Health (DoH) using the Child Death Notification (CDN) process. This process includes a multidisciplinary review of all child deaths at local Patient Safety Clinical Governance meetings that incorporates Mortality and Morbidity meetings and all child deaths are reported to the Public Health Agency (PHA).

The Directorate confirmed for the [redacted] child deaths referenced above [redacted] of these have gone through CDN process. (Delay is usually because this reporting occurs after the M&M process, so often after the submission of the initial SAI notification).

5. SAIs REPORTED TO OTHER ORGANISATIONS

5.1 Regulation & Quality Improvement Authority

The Regulation & Quality Improvement Authority (RQIA) continues to require incidents to be reported to it in accordance with its statutory responsibilities. All mental health and learning disability SAIs are reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986 AND any SAI that occurs within the regulated sector (whether statutory or independent) for a service that has been commissioned/funded by a HSC organisation.

38 SAIs reported to SPPG were also reported to RQIA for the period 01 April 2022 to 31 March 2023 and this includes 15 suicides from Mental Health Division and 1 suicide from ACOPS.

5.2 Northern Ireland Adverse Incident Centre (NIAIC)

The Northern Ireland Adverse Incident Centre (NIAIC), part of Health Estates, exists to record and review reported adverse incidents involving medical devices, non-medical equipment, plant and building items used in HPSS and to issue warning notices and guidance to help prevent recurrence and avert patient, staff, client or user injury.

There was 1 SAI for the reporting period which was also reported also to NIAIC and this relates to 1 attempted inpatient suicide, 1 retained foreign object post procedure, 1 outbreak and 1 service user fall in the community.

5.3 Health & Safety Executive (HSE)

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1997 (RIDDOR) require employers and others to report accidents and some diseases that arise out of or in connection with work. These reports enable the enforcing authorities to identify where and how risks arise and to review serious accidents.

There was 1 SAI which met the requirement for reporting to Health & Safety Executive (HSE) under RIDDOR for this period. These related to 1 inpatient fall resulting in brain injury, 1 patient fall resulting in limb injury and 1 physical attack by patient to staff.

(In Oct 2022 HSE informed Trust they would be requesting a copy of a completed SAI review of a SAI reported in relation to choking submitted previously in August 2021)

5.4 Interface Incidents

Interface incidents are incidents that have occurred in another organisation, which may be reportable as SAIs.

There were 34 interface notifications submitted to SPPG from BHSCT during the period 01 April 2022 and 31 March 2023, compared to 32 interface notifications submitted for the same period in the previous year.

Of the 34 interface notifications, 28 have been closed by SPPG after receipt of an SAI Notification from another Trust and [redacted] was subsequently reported by BHSCT as an SAI. A further 5 remain open under review.

In addition there have been 9 interface notifications received by the Trust from SPPG (*these are managed under the External Interface process*).

Of these 9, [redacted] have been closed with no requirement for SAI notification; [redacted] has been responded to advising it does not meet SAI criteria but a local SEA review will be completed to identify learning; [redacted] are currently being reviewed by the Directorate; and [redacted] has been queried by the Directorate as the related patient death was [redacted] years ago.

Work is underway with counterparts (in 2023) with the other Trusts to improve the sharing of learning at the earliest opportunity when a SAI led by one Trust identifies learning for another specific Trust.

6 EARLY ALERTS

Since June 2010, the Trust is required to make the Department (and thus the Minister) aware of those events (which may include potential SAIs) that require urgent attention or possible action by the Department. The Department issued guidance outlining seven criteria which may trigger an “Early Alert” notification.

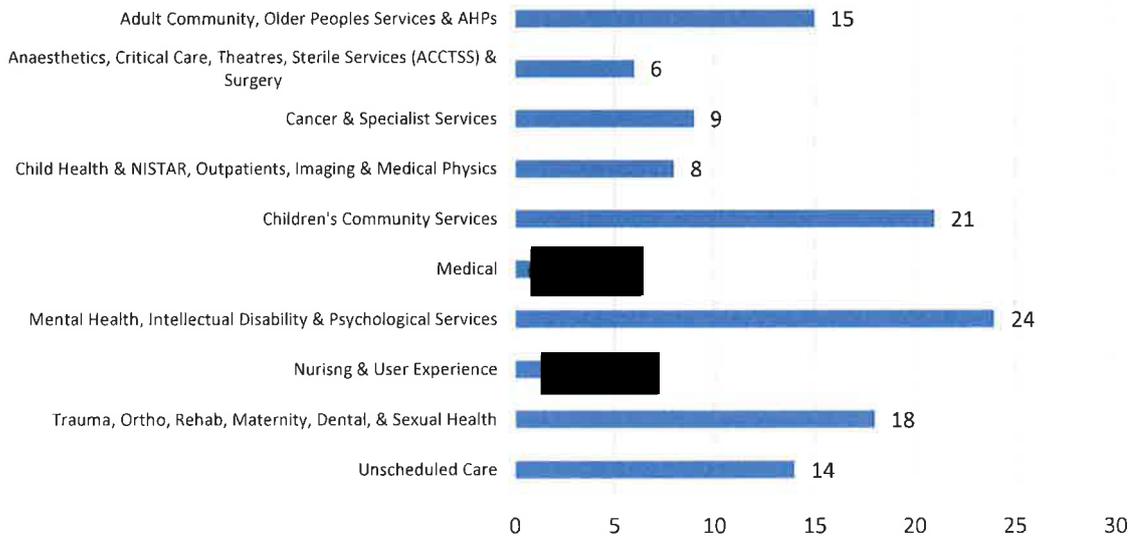
The SPPG have a process for requesting Early Alerts to be considered for reporting as SAIs. As a result the Trust Early Alert protocol was circulated to all Directors to provide clarification in facilitating prompt notification and follow up where required.

During this reporting period the Trust submitted 118 Early Alerts; 12 of these were also reported as SAIs. During the same period in the previous year 155 Early Alerts have been submitted. This is a reduction compared to recent years where there has been a trending increase in (new) Early Alerts. The 2021 reporting period was the first time when there had been more Early Alerts than SAIs. To outline the significant increase in Early Alert activity- In 2017 there was a total of 48 Early Alerts sent.

Figure 30a below shows the breakdown by Directorate for the reporting period.

Fig30a

New Early Alerts by Division for the period 01 April 2022 and 31 March 2023



7 NEVER EVENTS

Never events are included as part of the Serious Adverse Incident (SAI) Notification process following the issuing of Department of Health (DoH) Circular HSC (SQSD) 56/16 in October 2016.

During this reporting period there were 5 SAI notifications submitted to SPPG relating to Never Events.

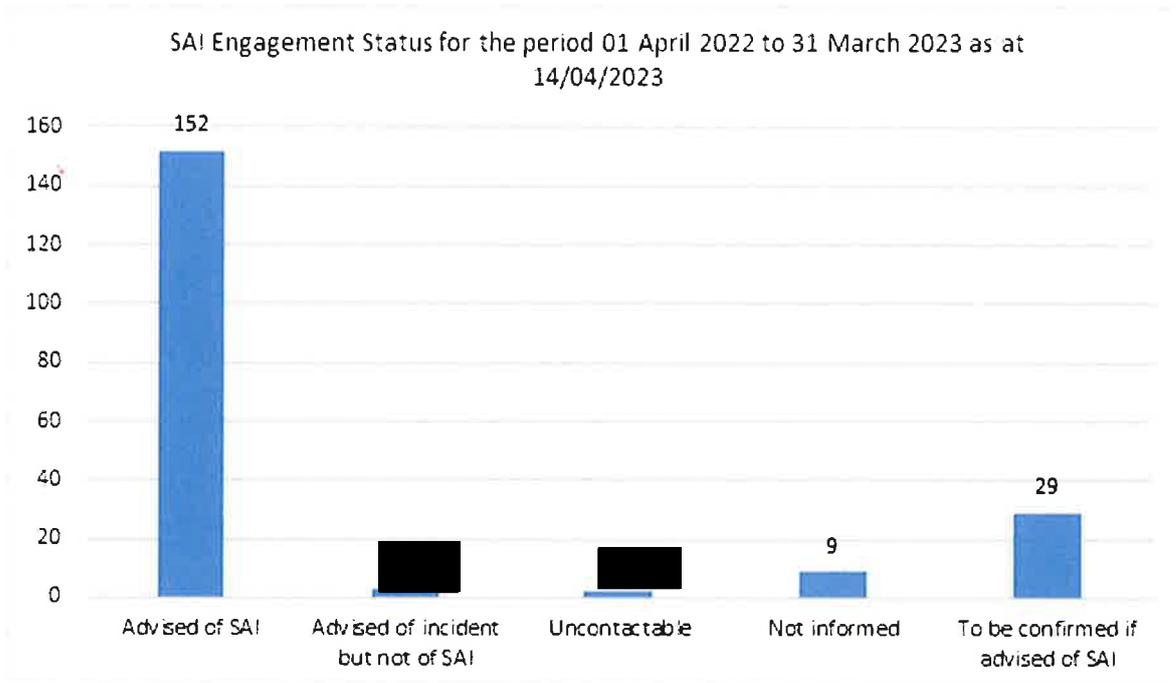
| Division | Review Level / Status | Never Event Criteria |
|---|----------------------------|----------------------|
| Maternity, Dental and Sexual Health Services | Level 1 SEA Report Overdue | |
| Anaesthetics, Critical Care, Theatres & Sterile Services (ACCTSS) | Level 1 SEA Report Overdue | |
| Surgery | Level 1 SAI Report Overdue | |
| Cancer & Specialist Medicine | Level 1 SEA Report Overdue | |
| Maternity, Dental and Sexual Health Services | Level 1 SEA Report Overdue | |

8 SERVICE USER / FAMILY ENGAGEMENT

As part of the procedure for reporting and follow-up of Serious Adverse Incidents (SAIs) the Trust service users, families and/or carers should be made aware of an incident that has been reported as an SAI.

Fig 31a shows a breakdown of engagement status for the period 01 April 2022 and 31 March 2023, as per Datix.

Fig. 31a



The figures for 'TBC if advised of SAI' in figure 31a above are displayed by Division in figure 31b below.

Fig. 31b

| Division | Count |
|---|-----------|
| Adult Community and Older Peoples Services | |
| Anaesthetics, Critical Care, Theatres & Sterile Services (ACCTSS) | |
| Child Health and NISTAR | |
| Children's Community Services | 9 |
| Maternity, Dental and Sexual Health | |
| Medical Specialties | |
| Mental Health | 5 |
| Surgery | |
| Trauma, Orthopaedics and Rehabilitation Services | |
| Unscheduled | |
| Grand Total | 29 |

Support team. They explain to staff the importance and function of “behaviours that challenge” for our inpatients, and ultimately what staff can learn from this.

The Adult Safeguarding Team (ASG) also participate explaining staff roles and responsibilities during SI. Clarification and clear guidance given on what may constitute a Safeguarding referral with the purpose of increasing staff confidence.

The service also introduced a “Lived Experience of Restrictive Practice” element to the SI training, delivered to staff by a past inpatient. This Unique perspective is invaluable, aiding staff’s understanding of the impact restraint can have on an individual.

The service intention is for a holistic approach to restraint practices and a reduction in behavioural incidents. The service wish to increase staff confidence in dealing with behaviours that challenge and reduce patient anxiety potentially reducing escalation to restraint practices by staff. The overarching intention being increasing service safety, improving quality and experience for Inpatients and Staff alike.

Separate interventions contributing to a reduction in behavioural incidents for some inpatients is the clear increase in PBS staffing onsite, and the stabilisation of their medication regime.

The Service is aiming to reduce reactive behaviours, which may manifest as self-injurious/suicidal behaviours through a QI project currently in progress.

Accidents/Falls

The Trust continues to implement actions for falls incidents as follows:

- Learning from fall incidents when a contributing factor to a fall incident relates to the assessment of enhanced care and the lack of assessment tools to aid staff with this assessment within the BHSCT. The development of an **Enhanced Patient Care and Observation (EPCO)** by a Regional Working Group provides staff with an assessment tool which should be commenced for any adult in-patient, who requires assessment and monitoring of distressed behaviours, which may increase the risk of harm to themselves and /or others. EPCO is not designed to be used in isolation and should be part of a person centred management plan, to promote safety, while identify the cause of and reducing distress. This assessment tool is currently being piloted within a number of ward areas within the BHSCT.
- Regional Shared Learning from SAI. The Regional Inpatient Falls Prevention Group have developed an amended version of the *Falls Assistive Technologies* guideline for inpatient settings that was issued on the 19th August 2022. The purpose of this document is to provide key information on Falls Assistive Technologies, which will support staff in ensuring safe and effective use of falls prevention equipment, which may be available in the inpatient setting. The amendment to this document was as a result of learning

identified from a Serious Adverse Incident, and highlights the importance of daily monitoring of any assistive technology that is in use.

- The Falls Forum resumed their monthly meetings in September 2022. The steering group is a multidisciplinary environment to ensure that a reduction in harm from falls is represented as an integral part of the Trusts quality improvement plan. A report giving an overview of the monthly moderate and above falls is discussed, focusing on themes and trends with a view to addressing arising issues.
- A recent initiative from the Falls Forum group was developing a 'Delirium, Learning from falls' review. This provides ward staff with invaluable learning from the Delirium Lead Nurses on serious falls where delirium has been noted as a contributory factor.
- Learning from moderate and above falls (across acute in-patient wards)- all falls coded moderate and above continue to have a Minimum Data Set for Post Fall Review completed within 10 days of the incident. It is the Ward Managers responsibility to complete an action plan to reflect the learning from the incident reviewed and share this effectively with the MDT. The learning from these incidents are reported quarterly to the Public Health Agency.
- A report of all moderate and above falls is presented to the Senior Nursing and Midwifery monthly team meeting. The themes and trends of the fall incidents reviewed are highlighted within this report.
- The FallSafe Coordinator continues to support ward areas with falls quality improvement work and FallSafe Awareness sessions. Staff from Ward E, MIH where nominated to participate in the e-Safety Quality Belfast. The project aim is to: *'Improve Compliance with FallSafe Care Bundle A&B on Ward E by 50% by May 2023'*

The Ward has introduced a number of new change ideas one of which was the introduction of a urinalysis trolley. In October 2022 the FallSafe audit identified only 50% of patients audited had a urinalysis completed. Initially this was highlighted at the ward safety huddles by senior nursing staff and in November the audit showed that 70% of patient had a urinalysis completed. In November '22 the 'Urinalysis Trolley' was implemented and in December 2022 the FallSafe audit identified that 90% of patients had a urinalysis performed.

To date 90% of Ward E staff have received FallSafe training and the ward is experiencing a consistent reduction in the number of patient falls.

- During March to Safety 2023 there was a focus on 'The role of the FallSafe Champion' with bespoke training sessions on their role and responsibilities. There was also a number of MST FallSafe awareness sessions included within the 'March to Safety Calendar'

9.2 Learning from Adverse Incidents

Incidents are reviewed locally and learning is shared with teams and across the Trust if applicable. Service areas can run their own incident reports or can be provided by Corporate Governance to specialist teams upon request. Quarterly and monthly reports are also provided routinely to Directorates to enable identification of trends and to inform improvement work.

Datixweb Incident Dashboards are well established and provide easy access to local trend information.

A dataset is available for adult in-patient wards and will be issued each month via Qlik software. Ward/unit level datasets are produced manually for ICU, Children's Community Services and Mental Health. Work continues to have datasets provided for all services electronically. Divisional datasets are provided each month to every Division. Specialty level datasets are being developed at present. Datasets triangulate safety and quality data with activity information and nurse staffing levels. Patient feedback is included for those 48 wards where real time feedback is collected every two weeks. Reports also include governance information on incidents, SAIs and complaints.

A number of quality improvement projects have made use of incident data to inform their work.

Introduction of Type Tier (CCS2) coding from April 2019 and new Category codes from April 2020 has provided a more comprehensive set of detailed codes however there have been some challenges for staff applying them accurately and consistently. Corporate Governance and the Directorates continue to work together to improve the accuracy and consistency of coding. Note: Directorate structures on Datix were updated 30th September 2022.

9.3 Learning from Serious Adverse Incidents (SAIs)

Over the last three years there have been a number of additional steps introduced within the Trust to help improve the SAI Review process. This has included training additional staff in Root Cause Analysis Methodology and using these staff to chair the review of new level 2 SAIs. If a level 2 review, SAI chairs have the opportunity of bringing their final report to a Peer Review Group prior to final approval to help improve both the consistency of SAI reports and helping identify additional learning opportunities and recommendations.

On SAI report completion Commissioning Directorate will also confirm the theme or themes identified as part of the SAI review.

During the period 01 April 2022 and 31 March 2023 a total of 168 SAI Reports were completed and submitted to SPPG. A summary of Learning Themes identified is outlined in Figure 32a.

Fig32a

SAI Learning Themes for the period 01 April 2022 to 31 March 2023

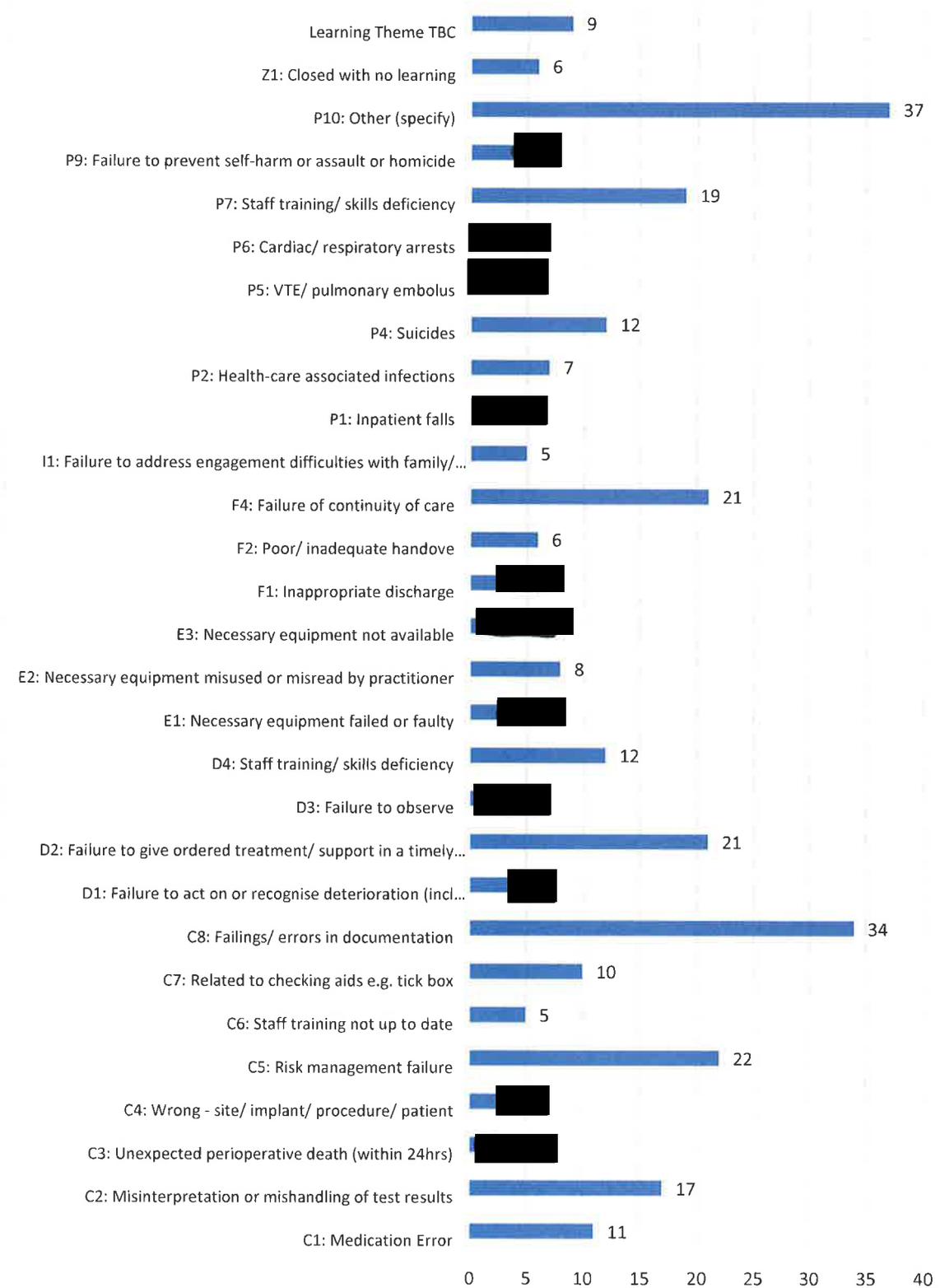


Table below (Fig 32b) shows the Top theme by Directorate

Fig 32b

| Total SAI Learning Themes by Directorate for the reporting period and Top reported theme | Count |
|--|------------|
| Unscheduled Care | 46 |
| C2: Misinterpretation or mishandling of test results | 5 |
| Trauma, Ortho, Rehab, Maternity, Dental, & Sexual Health*** | 12 |
| P10: Other (specify) | [REDACTED] |
| C8: Failings/ errors in documentation | [REDACTED] |
| C5: Risk management failure | [REDACTED] |
| C8: Failings/ errors in documentation | [REDACTED] |
| Mental Health, Intellectual Disability & Psychological Services | 38 |
| P4: Suicides | 6 |
| Children's Community Services | 14 |
| C8: Failings/ errors in documentation | [REDACTED] |
| Child Health & NISTAR, Outpatients, Imaging & Medical Physics | 31 |
| C2: Misinterpretation or mishandling of test results | 5 |
| Cancer & Specialist Services | 11 |
| D2: Failure to give ordered treatment/ support in a timely way | [REDACTED] |
| Anaesthetics, Critical Care, Theatres, Sterile Services (ACCTSS) & Surgery | 84 |
| P10: Other (specify) | 16 |
| Adult Community, Older Peoples Services & AHPs | 47 |
| C5: Risk management failure | 9 |

*** TOR & MDS had 4 top themes with a count of [REDACTED] each

9.4 Shared Learning

The Trust Procedure for sharing learning governs how learning from Adverse Incidents and SAIs should be shared throughout the organisation and beyond. In support of this process Learning Templates are produced where learning has been identified from AIs and SAI reviews. These are initially reviewed as part of the Shared Learning Review Group prior to being passed to the appropriate group within the Assurance Framework to discuss and approve. For learning that has originated from Incidents and SAIs the relevant group is the SAI Group. After approval at SAI Group these are shared to Directors for cascading as appropriate and a copy placed on the Trust Loop.

The Trust Policy applies to learning from any source including:

- An incident or Serious Adverse Incident (SAI)
- A complaint or compliment
- A morbidity / mortality review case (including Cardiac Arrest reviews)
- A litigation case,
- An audit,
- Some events in other Trusts that learning has been shared

Figure 32c shows a breakdown of shared learning issued from Adverse Incidents/SAIs for the period 01 April 2022 to 31 March 2023.

Shared Learning is discussed also at relevant speciality Patient Safety Clinical Governance meetings that incorporates Morbidity & Mortality. Shared learning is available on the Trust's Loop via the following link:

<https://bhsct.sharepoint.com/sites/medical/SitePages/Shared-Learning.aspx>

Fig. 32c

| Shared Learning | | |
|------------------------------|---|--------------|
| 01 April 2022 to 31 Mar 2023 | | |
| Ref No. | Detail: | Date Shared: |
| | Confirmation Bias | May 2022 |
| | Restricted areas must be kept secure at all times | May 2022 |
| | Risks associated with not following manufacturer's instructions on medical devices | May 2022 |
| | Patients at higher risk of developing cancer whilst on planned waiting lists must be booked within a clinically indicated timeframe | May 2022 |

| Ref No. | Detail: | Date Shared: |
|---------|--|--------------|
| | PEG Device | May 2022 |
| | Insulin Pen Administration | May 2022 |
| | Inventory of Chemicals | May 2022 |
| | Age of Freezers | May 2022 |
| | PEG Device (Update by PHA) | June 2022 |
| | Anticoagulant infusions in critical care require extra caution and attention. | June 2022 |
| | A "Pause and Stop" check must be implemented before the commencement of any imaging guided injection procedure. | Sept 2022 |
| | A Controlled Drug (CD) may be transferred only when the patient is receiving this medicine by means of eg PCA infusion, epidural, transdermal patch. Otherwise, CDs MUST NOT be transferred between wards or locations. | Sept 2022 |
| | Discharging Patient's on Warfarin | Sept 2022 |
| | Heparin infusions | Sept 2022 |
| | All blood grouping and antibody screen samples must have the correct patient details and staff signature to allow issue of blood components, thus preventing unnecessary delays in provision of blood and further sampling of the patient. | Sept 2022 |
| | A full vetting process must be undertaken before offering and engaging with individual from employment agencies. | Sept 2022 |
| | Risk of fracture in patients with prolonged high dose bisphosphonates in patients with metastatic cancer | Oct 2022 |
| | Outpatient clinic outcome forms must be completed at time of clinic | Oct 2022 |

| Ref No. | Detail: | Date Shared: |
|------------|---|--------------|
| [REDACTED] | When a patient is required to undergo emergency surgery, staff must ensure the patient's next of kin is informed. | Oct 2022 |
| [REDACTED] | Patient identity verification prior to the administration of a specialised treatment | Oct 2022 |
| [REDACTED] | Staff involved in distributing meals to patients must ensure patients receive the correct diet. | Oct 2022 |
| [REDACTED] | [REDACTED] | Nov 2022 |
| [REDACTED] | Review of radiology reports | Nov 2022 |
| [REDACTED] | Nursing staff: When preparing medications for a syringe pump | Nov 2022 |
| [REDACTED] | Inappropriate access to electronic service user records is a data breach. | Nov 2022 |
| [REDACTED] | Bedside pre transfusion checks must be adhered to at all times. | Nov 2022 |
| [REDACTED] | Outpatient appointments booked via Waiting list "Shared Mailboxes" must have a check and audit process. | Nov 2022 |
| [REDACTED] | Myasthenia Gravis | Nov 2022 |
| [REDACTED] | Access NI Check to be completed by Recruitment Agency | Nov 2022 |
| [REDACTED] | [REDACTED] | Nov 2022 |
| [REDACTED] | Staff must be remember to check all medications prior to administration as per the BHSCT Medicines Code Policy | Nov 2022 |

| Ref No. | Detail: | Date Shared: |
|------------|--|--------------|
| [REDACTED] | When prescribing or administering opioid medications, all staff should confirm any recent opioid dose, formulation, frequency of administration and any other analgesic medication prescribed for the patient. | Nov 2022 |
| [REDACTED] | Communication with carers re safeguarding concerns | Nov 2022 |
| [REDACTED] | Ankylosing Spondylitis | Nov 2022 |
| [REDACTED] | [REDACTED] | Jan 2023 |
| [REDACTED] | When performing subdermal contraceptive implant procedures it is essential to confirm with the patient whether it is a removal, an insertion or a replacement and to carry out the correct procedure. | Jan 2023 |
| [REDACTED] | Sensitive and/or personal information pertaining to staff attending a group meeting should not be disclosed within a group invite | Jan 2023 |
| [REDACTED] | Awareness around care of the dying | March 2023 |
| [REDACTED] | Staff assigned one to one role | March 2023 |
| [REDACTED] | Viewing Live Images (Ophthalmology) | March 2023 |
| [REDACTED] | Point of Care Testing (PoCT) | March 2023 |

In addition to this the Trust would continue to receive external learning from the SPPG that has arisen from SAI reviews completed across HSC Trusts. Any learning relating to SAIs would be formally shared and noted at the next SAI Group.

Shared learning outside the SAI process is also considered for reporting through as per regional procedure for raising important learning through to PHA / SPPG for their consideration.

9.5 Other sources for sharing learning in the Trust

Safety Message of the week is also considered as part of the established governance arrangements, such as the weekly governance call or the Shared Learning Review Group, in addition to any learning to be presented in a learning template.