

Risk & Governance

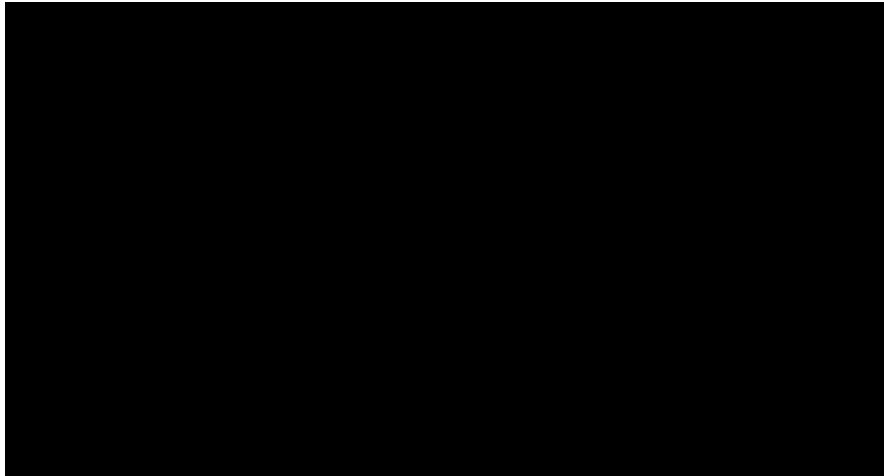
Amalgamated Assurance Report

November
July 2023

Incorporating:

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

Q1&Q2: 01 April 2023 to 30 September 2023



Trust Adverse Incidents and Serious Adverse Incidents Report

For reporting period 01 April 2023 to 30 September 2023 (as at
12 October 2023)

EXECUTIVE SUMMARY

Adverse Incidents

23,034¹

Incidents were reported across the Trust for the period

¹Approved incidents as at date of report completion. This report does not include incidents reported by Independent Sector Providers (ISP). For this reporting period there were 5,120 ISP Incidents. Analysis is provided separately.

Serious Adverse Incidents (SAIs)

94*

SAI Notifications were submitted for the period

*Excludes 1 SAI Notification that has since been withdrawn

↑ 6.3%

Increase in incidents from the same period in the previous year (21,671 incidents)

↓ 5%

Slight decrease in SAIs compared to same period in previous year (99*)

*Excludes 12 SAI Notifications that were subsequently withdrawn following further consideration.

When incident data is compared to 2017/18 period there had been 15,005 (53.5% increase)

When SAI data is compared to 2017/18 period there had been 38* (147% increase)

*Excludes 1 SAI Notification that was later withdrawn

Trust Adverse Incident definition:

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

Summary SAI Review Level:

Level 1 SEA = 88
Level 2 RCA = 6

Summary Linked Events:

SAI Never Events = [REDACTED]
SAI linked to Complaints = 10
SAI linked to Coroner's = 22
SAI linked to Early Alerts = 8

Summary SAI Reports:

As at 30 September 2023 there were 291 SAI reports outstanding with SPPG.

80 SAI reports were submitted to SPPG during this reporting period.

INCIDENT SEVERITY

Adverse Incidents

Serious Adverse Incidents (SAIs)

INSIGNIFICANT OR MINOR

95%¹
 Incidents recorded as insignificant (no harm) or minor severity

¹Trends in relation to severity remain largely unchanged for insignificant or minor severity incidents.

CATASTROPHIC

1.7%¹
 Incidents were recorded as Catastrophic severity

31* (33%)
 SAI Notifications were recorded as Catastrophic severity

¹Catastrophic severity incidents have increased from 117 (0.6%) to 401 (1.7%) since the same reporting period in 2021/22. This is due mainly to the increased reporting of overcrowding / ongoing pressures in the Emergency Departments (graded as Catastrophic Severity under the domain quality & professional standards/guidelines).

Breakdown by Type Tier 1:

Type Tier 1	Count
Admin Processes (excluding Documentation)	
Behaviour (Including Violence and Aggression)	10
Diagnostic Processes/Procedures	
Medication/Biologics/Fluids	
Patient Accidents/Falls	6
Unexpected Deaths or Severe Harm	8
Other	

INCIDENT TYPE TIER

Adverse Incidents

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

11,145 (48%)
Behaviour

Serious Adverse Incidents (SAIs)

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

22 (23%)
Behaviour

Breakdown by Type Tier 3 below:

Type Tier 3	Count
Actual Self-Harm	
Other	
Physical Contact (actual assault)	5
Sexual (including indecent exposure)	5
Suicide (actual)	10

2,617 (11%)
Accidents/Falls

19 (20%)
Diagnostic Processes/
Procedures

Breakdown by Type Tier 3 below:

Type Tier 3	Count
Delayed	
Delayed diagnosis	
Failure/insufficient response to significant change in patient status	
Failure/insufficient/incomplete monitoring	
Incorrect/insufficient triage in emergency situations	
Insufficient/incomplete / incorrectly performed	
Interpretation of investigation insufficient / incorrect / incomplete	
Interpretation of investigation not performed	
Investigation delayed	
Investigation not performed	
Missed diagnosis/failure to diagnose	
Specimen insufficient/incorrect/incomplete	
Specimen missing	

SECTION 1: INTRODUCTION

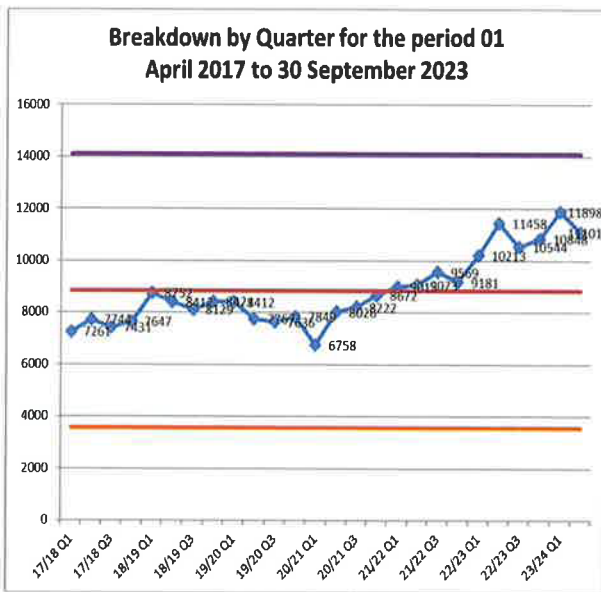
Trust Adverse Incident definition:

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

1.1 Incident Breakdown by Quarter

Adverse Incidents

Fig 1



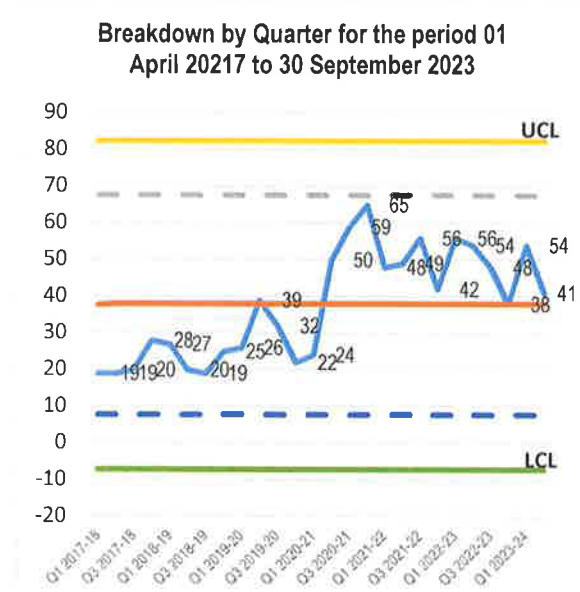
During this reporting period a total of 23,034 were reported and approved Trust-wide. In comparison, during the same period in the previous year, there were 21,671 incidents. This represents a 6.3% increase.

In addition, there were 5,120 incidents reported by Independent Sector providers inputted onto Datix during this reporting period. These incidents are not included in this report. They are separately monitored and reported on by the Trust's Quality & Support Team and/or Contracts office.

At 12 Oct there were 762 incidents (excluding Independent Sector) awaiting approval for this reporting period. There is an established escalation protocol to notify services of incidents overdue for approval.

Serious Adverse Incidents (SAIs)

Fig 2



During this reporting period a total of 94 new SAI notifications were submitted to the Strategic Planning & Performance Group (SPPG).

Of these SAIs, 5 occurred in the Trust's Emergency Departments compared to 5 for the same period in the previous year.

Figure 2 shows the shift in the volume of SAI Notifications over the last 6 years. The average number of SAI notifications raised during the period Q1 2021-22 to Q1 2023-24 was 51, while the average number of notifications for the period Q1 2017-18 to Q1 2020-21 was 24.

1.2 Incident Breakdown by Method of Review / Investigation

Adverse Incidents

Fig 3

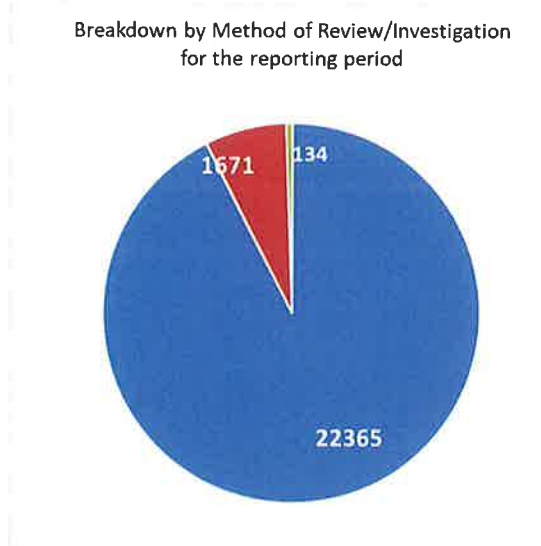


Figure 3 shows the breakdown of the 'Method of Review/Investigation' for incidents within the reporting period as follows:

- Local Informal Review - 22,365
- Other Methodologies - 1,671
- Review Methodology still to be agreed - 134

Other Methodologies include:

- Significant Event Audit (SEA)
- Root Cause Analysis (RCA)
- Patient Safety & Clinical Governance Meeting (incorporating M&M)
- Structured Judgement Review (SJR)
- Post Fall Review
- Post Pressure Ulcer Review
- Adult Safeguarding Review (ASR)
- Child Safeguarding Review (CSR)
- Perinatal Mortality Review Tool (PMRT formerly SCOR)
- Case Management Review (CMR)
- Joint Protocol Investigation
- Covid Death Review
- Independent External Review (e.g. Royal College)

Serious Adverse Incidents (SAIs)

Fig 4



Figure 4 shows a breakdown of Level of Review with

- 94% of SAI Notifications for the period 01 April 2023 to 30 September 2023 as Level 1 reviews (using SEA methodology) and
- 6% Level 2 reviews (using RCA methodology).
- There were no Level 3 notifications for the reporting period.

For the same period in the previous year, 89 (90%) SAI Notifications were Level 1 reviews and 10 (10%) were Level 2 reviews. There were no Level 3 notifications.

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.

1.3 Incident Breakdown by Directorate / Division

Adverse Incidents

Fig 5a

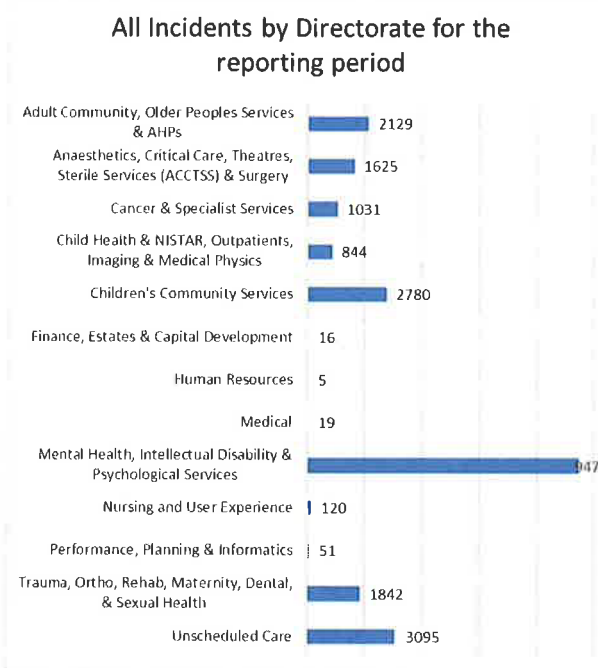


Fig 5b

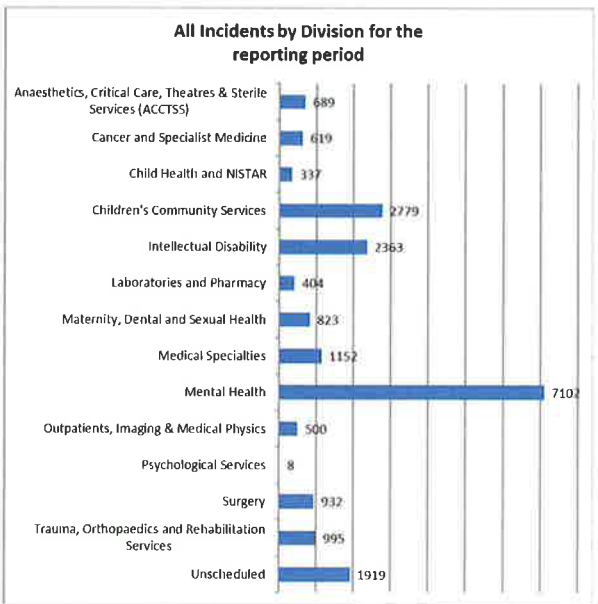


Figure 5b shows that the Division with the most reported incidents is Mental Health with 7,102 (31.22%) incidents. Children's Community Services reported the second highest number of incidents with 2,779 (12.21%) incidents.

Serious Adverse Incidents (SAIs)

Fig 6a

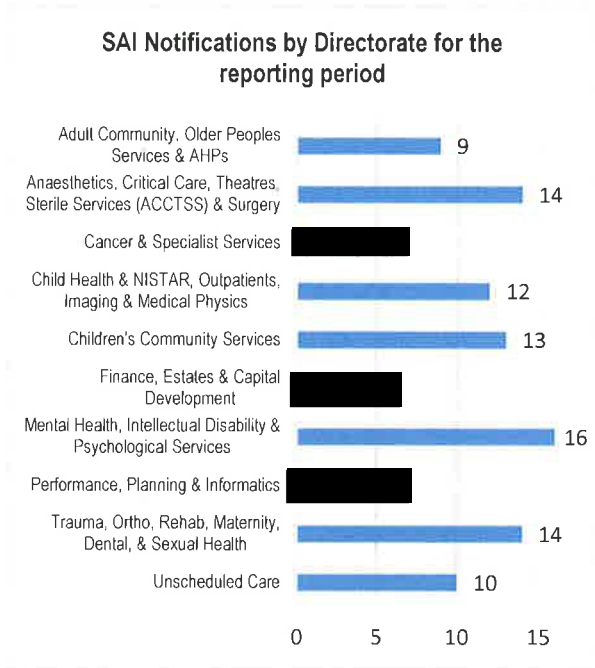


Fig 6b

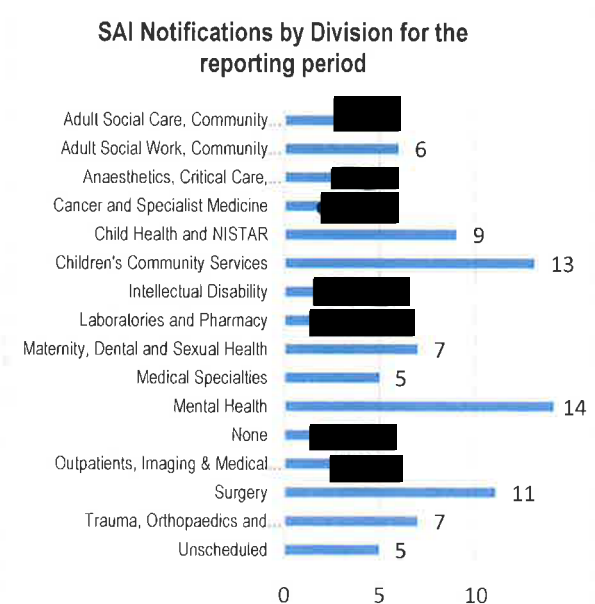


Figure 6b provides a further illustration of SAI Notification submitted by Division for the period. The 14 SAI Notifications raised by the Mental Health Division relate to suicides and resulting in patient death.

1.4 Incident Breakdown by Severity

Adverse Incidents

Fig 7

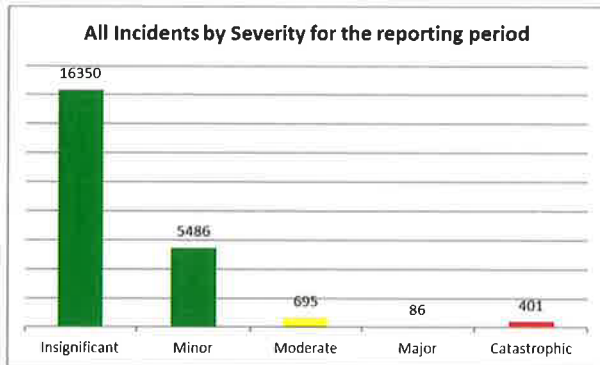


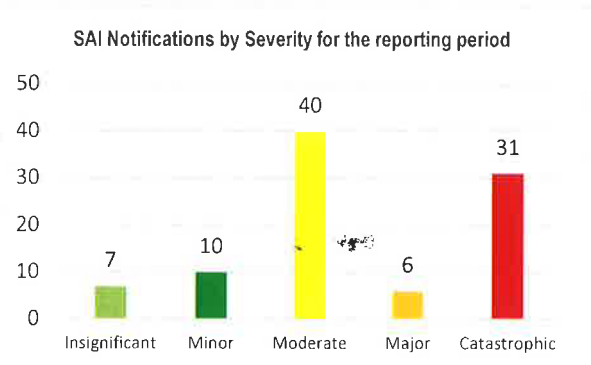
Figure 7 indicates that 21,836 (95%) of incidents were assessed as having a severity rating of insignificant or minor while 401 (1.7%) were rated as catastrophic. The severity rating indicates actual harm or damage as a result of the incident rather than potential risk.

Service Directorates 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.

For this reporting period, 319 out of the 401 Catastrophic incidents were reported under Adult Emergency Departments. Of these, 306 were coded as Type Tier One 'Service Disruptions (environment, infrastructure, human resources)'.

Serious Adverse Incidents (SAIs)

Fig 8

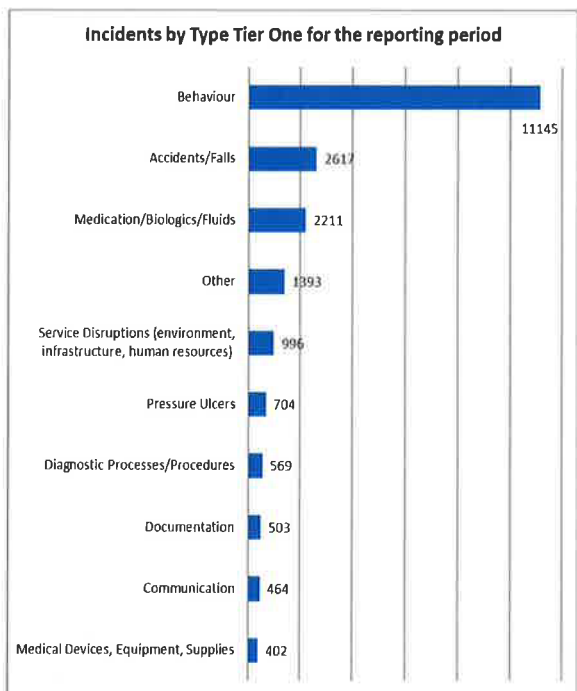


Catastrophic Severity by Division & Descriptor	Count
Adult SC, Community MH for OPS and P&DS	
Unexpected death of nursing home resident	
Adult SW, Community Services & ICS	
Unexpected death of service user (suspected suicide)	
Unexpected death of nursing home resident	
Unexpected death of service user who had fallen at home	
Child Health & NISTAR	
Unexpected child death	
Children's Community Services	
Unexpected child death	
Medical Specialities	
Delayed follow-up	
Unexpected inpatient death	
Mental Health	14
Choking incident resulting in patient death	
Death of a patient known to MHS (Suicide)	13
Outpatients, Imaging and Medical Physics	
Delayed Diagnosis	
Surgery	
Medication Error (Incorrect Medication/fluid)	
TOR and MDS	
Unexpected patient death	
Unscheduled	5
Unexpected death of patient who attended ED from a nursing home with a history of falls and head injury.	
Inpatient death following unwitnessed fall	
Unexpected death of service user at home following discharge	
Unexpected death of patient (missed diagnosis)	

1.5 Incident Breakdown by Type Tier One

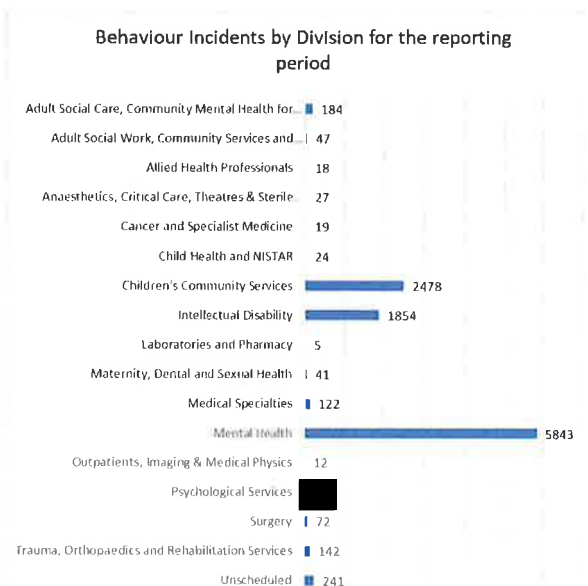
Adverse Incidents

Fig 9a



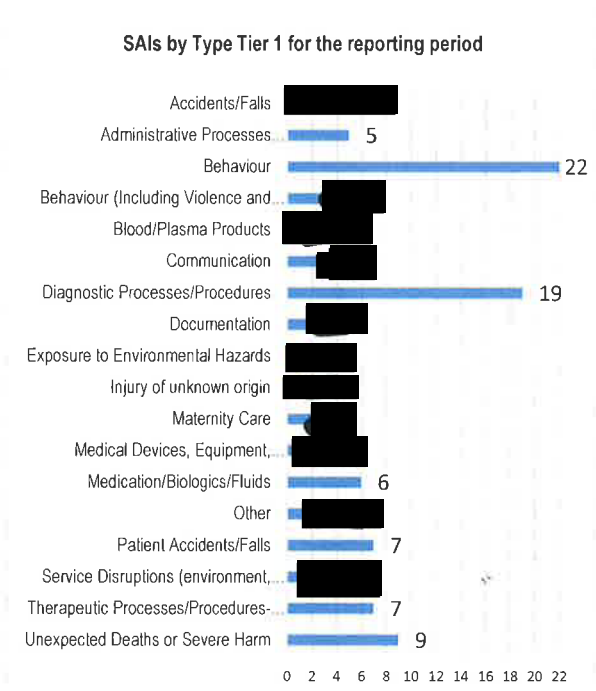
The top 2 types are displayed by Division in figures 9b and 9c below.

Fig 9b



Serious Adverse Incidents (SAIs)

Fig 10a



The top 2 types are displayed by Division in figures 10b and 10c below:

Fig 10b

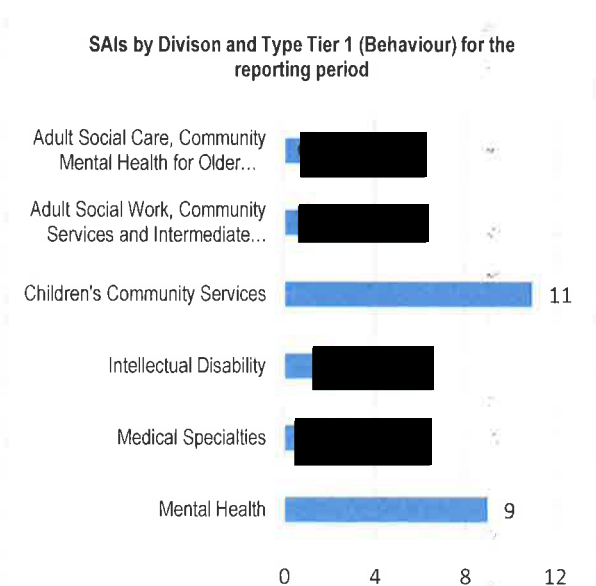


Figure 10b. SAIs include 9 suicides for Mental Health and 11 assaults (5 sexual and 6 physical) for Children's Community Services.

Fig 9c

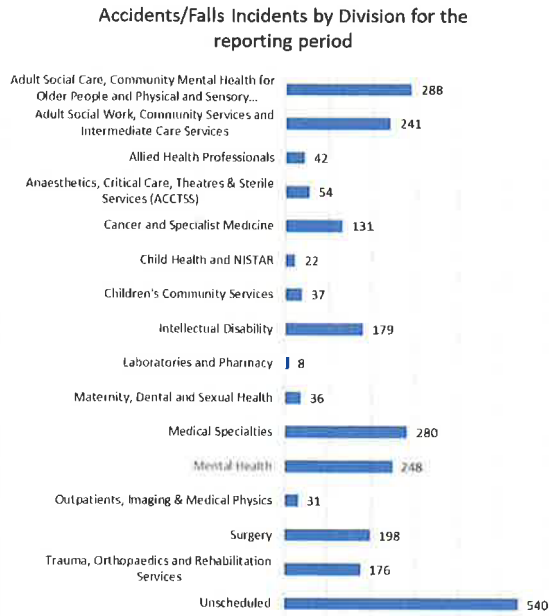
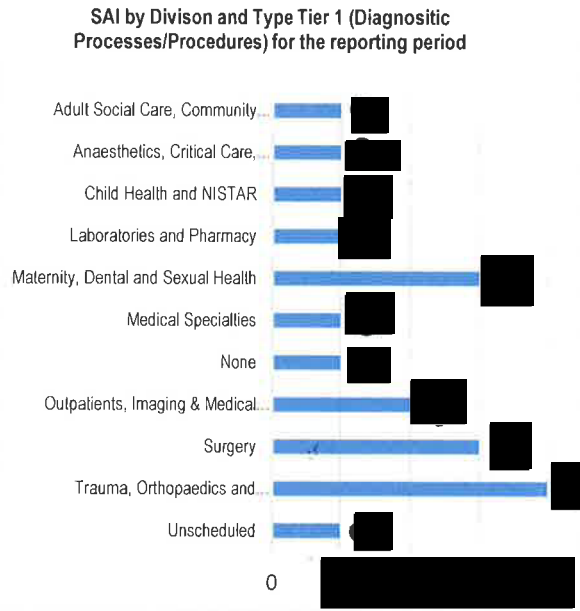


Fig10c



Individual run charts for the top 2 incident types for the last 12 months are shown in figures 9d and 9e below:

Fig 9d

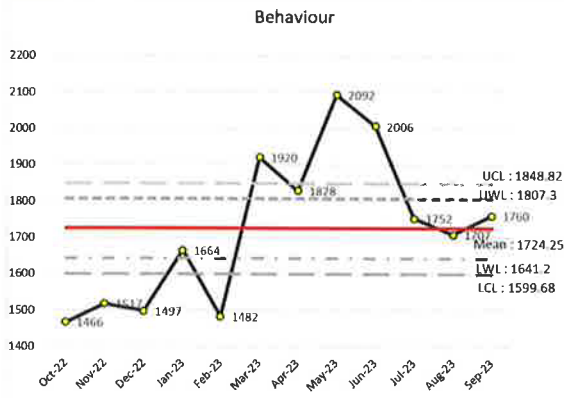
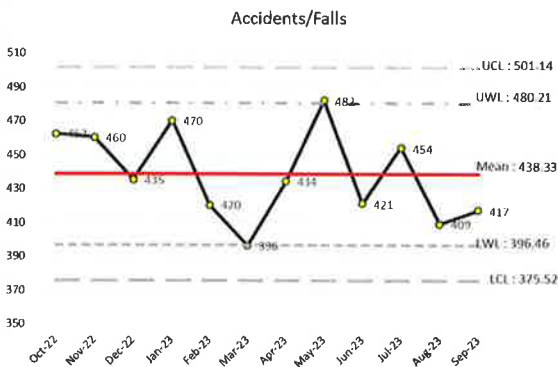


Fig 9e



SECTION 2: INCIDENT BREAKDOWN OF TOP 2 TYPES

2.1 'Behaviour' Incidents by Division (Top 3)

Adverse Incidents

Fig 11

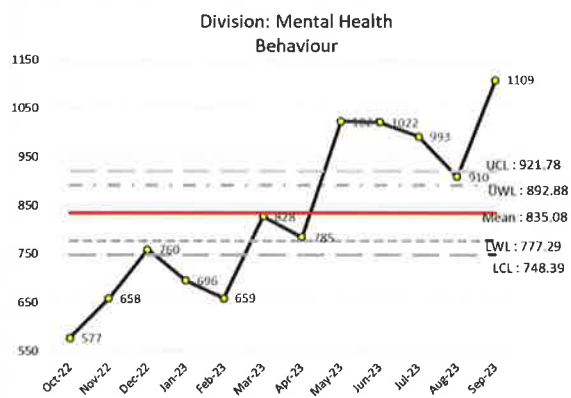
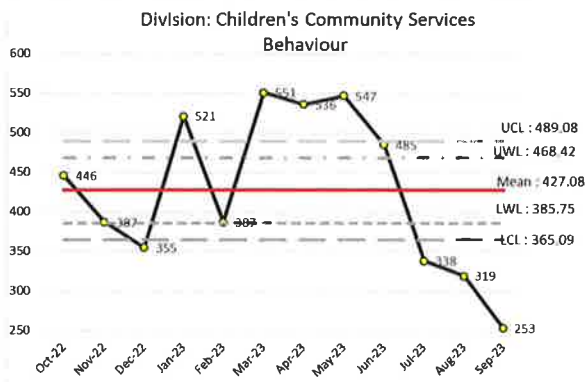


Figure 9b shows that, during this reporting period, the top 3 Divisions for Behaviour incidents were Mental Health, Children's Community Services and Intellectual Disability. Run charts for the last 12 months are shown in figures 11 to 13.

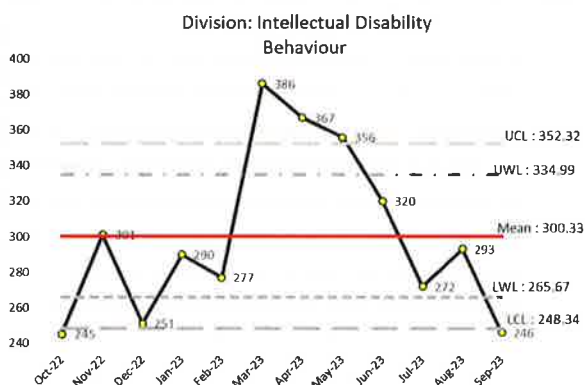
There has been a marked decrease in behaviour incidents within Intellectual Disability over the last two quarters. This can be at least partly explained by Positive Behavioural Support (PBS) training that has been made available to all staff bolstering the ongoing work of the Positive Behavioural Support 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.

Fig 12



The service would hope that the number of incidents continues to consistently decrease, however is mindful that one 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.

Fig 13



2.2 'Behaviour' Incidents by Severity

Adverse Incidents

Fig 14

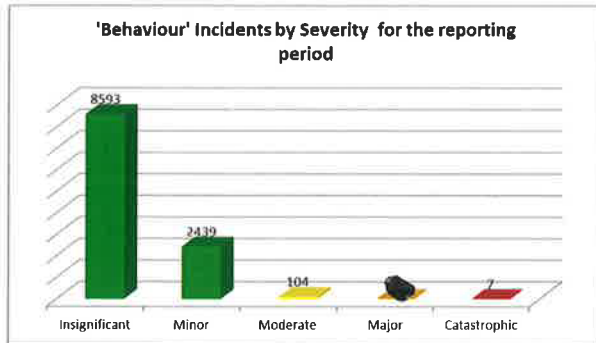


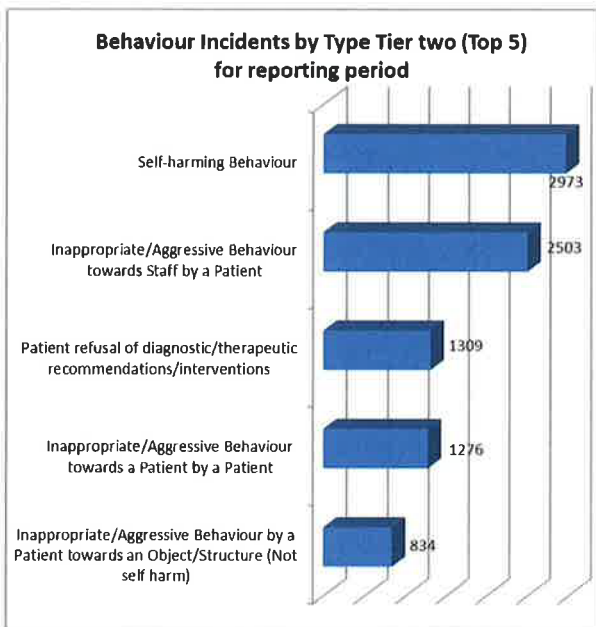
Figure 14 shows that the majority of incidents in this type (11,032 or 99%) were of insignificant or minor severity. There were [REDACTED] (0.02%) graded as major and 7 (0.06%) graded as catastrophic.

Of the total number of behavioural incidents, 277 had Safeguarding Review recorded as the Method of Review/Investigation.

2.3 'Behaviour' Incidents by Type Tier Two

Adverse Incidents

Fig 15



In addition to the top 5, there were 76 incidents of 'Inappropriate/Aggressive Behaviour towards a Patient by Staff'. Where the investigation is still ongoing at time of this report being generated, these incidents are shared with Directorate teams for follow-up.

There were also 30 incidents of 'Inappropriate/Aggressive Behaviour towards Staff by Staff'. These are shared with the HR Dept on a quarterly basis for them to triangulate with their own review processes.

2.4 'Accidents/Falls' Incidents by Division

Adverse Incidents

Fig 16

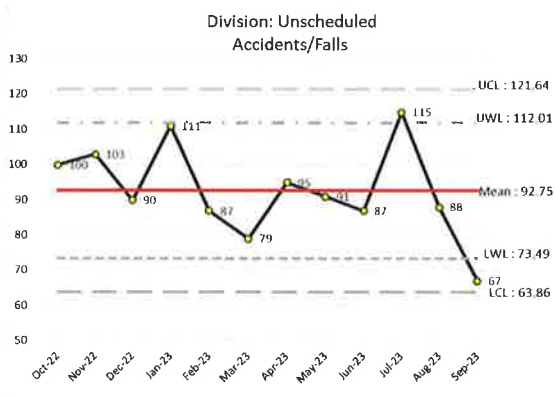


Figure 9c shows that, during this reporting period, the top 3 Divisions for accidents/falls were Unscheduled, Adult Social Care, Community Health for Older People and Physical and Sensory Disability Services, and Medical Specialties. Run charts for the last 12 months are shown in figures 16 to 18.

Fig 17

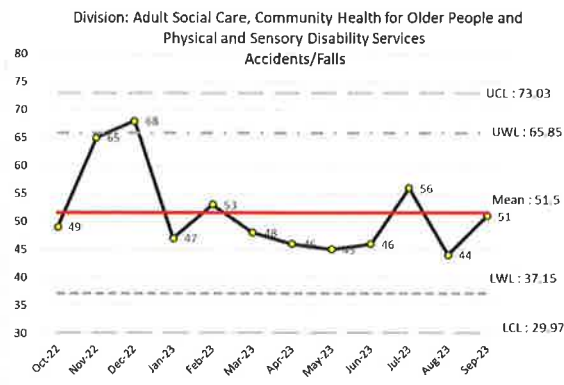
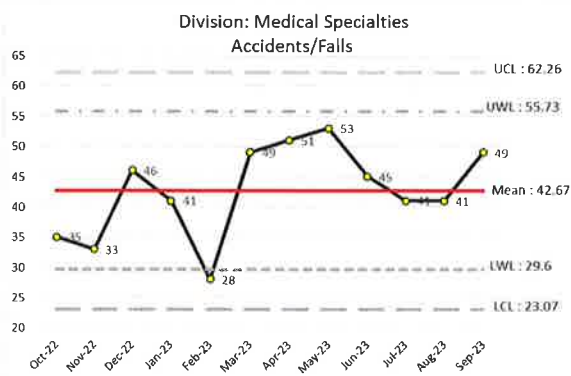


Fig 18



2.5 'Accidents/Falls' Incidents by Severity

Adverse Incidents

Fig 19

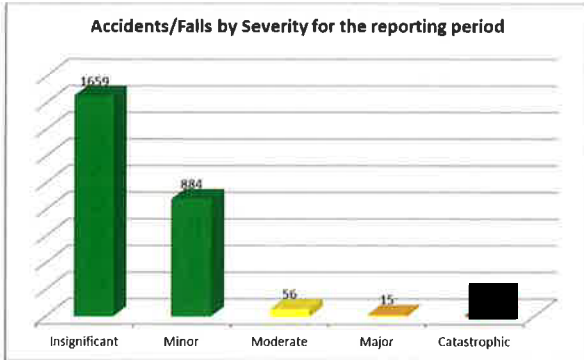
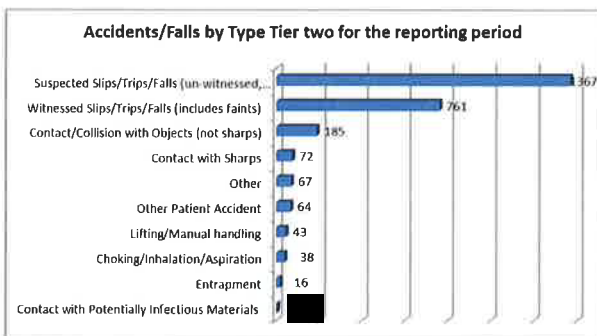


Figure 19 shows that the majority of incidents in this category (2,543 or 97%) were of insignificant or minor severity. There were 15 (0.6%) graded as major and 1 (0.2%) graded as catastrophic.

2.6 'Accidents/Falls' Incidents by Type Tier Two

Adverse Incidents

Fig 20



SECTION 3: SUMMARY OF SAI ACTIVITY

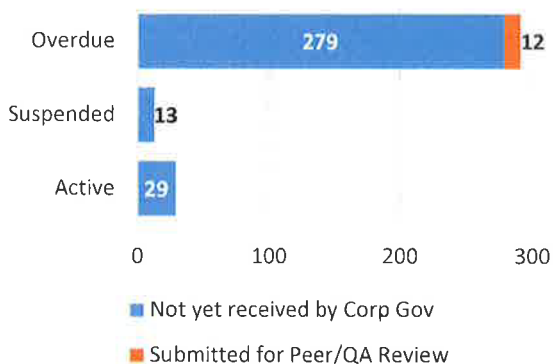
3.1 Breakdown of SAI Current Status

Serious Adverse Incidents (SAIs)

Fig 21

Figure 21 shows activity status of open SAI reviews as at 30 September 2023. 29 SAIs have not yet reached their report due date; 13 SAIs are suspended due to ongoing PSNI investigations; and 291 SAIs have reports overdue, with 12 of these having been submitted to Corporate Governance for Peer/QA Review (a process to quality check reports for consistency, accuracy and completeness prior to submission to SPPG). Monthly updates of SAI status is fed into the Trust QMS system

SAI Current Status as at 30 September 2023



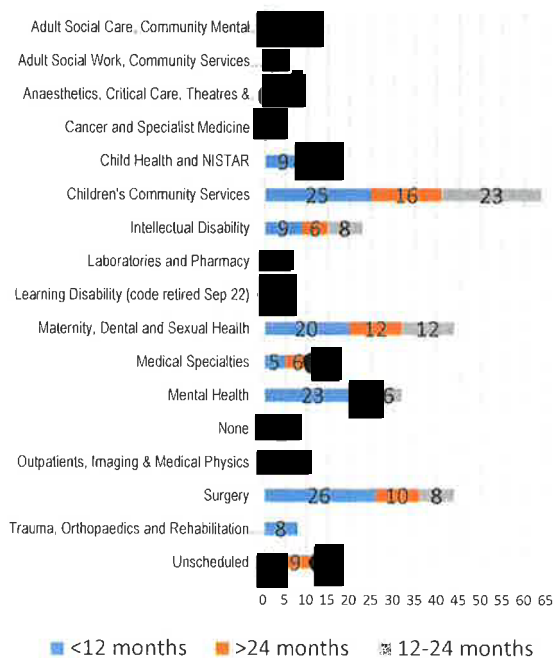
3.2 Breakdown of SAI Reports Overdue

Serious Adverse Incidents (SAIs)

Fig 22

Figure 22 provides a breakdown of SAI reports overdue as at 30 September 2023 by Division and how long overdue i.e. number of months past report due date.

SAI Reports Overdue by Division as at 30 September 2023



3.3 Breakdown of SAI Report Submitted

Serious Adverse Incidents (SAIs)

Fig 23

A total of 80 SAI reports were submitted to SPPG during the period 01 April 2023 to 30 September 2023, compared to 58 reports submitted for the same period in the previous year.

Over the last year there have been regular performance meetings with SPPG and BHSCT, with the most recent meeting occurring on the 28th June 2023. Concerns continue to be raised regarding high number of SAI reviews still not concluded and learning shared with SPPG.

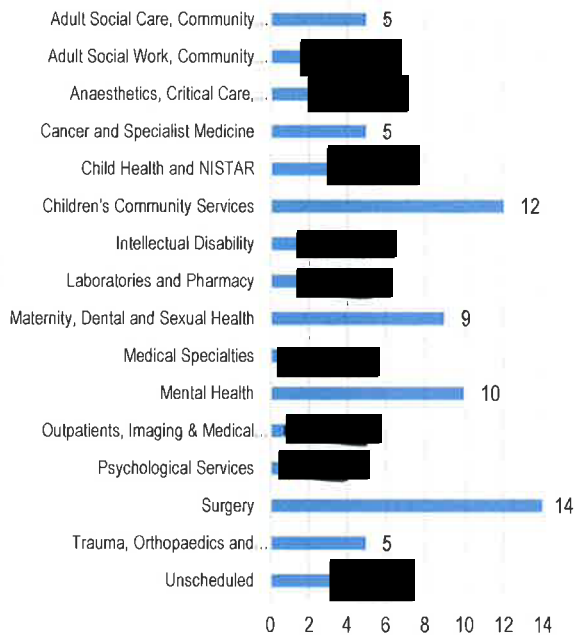
From Feb 2023 52 BHSCT SAI reviews were also identified for external support from an organisation identified by SPPG

From March 2023 individual meetings have been set up 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.

Further escalation emails have been issued on behalf of the Medical Director to Director colleagues highlighting outstanding SAI reviews. This will be monitored closely by Risk & Governance and the Medical Director updated at regular intervals.

In addition monthly monitoring of SAI review completion is considered at the Executive team Safety Huddle.

SAI Reports submitted to SPPG during the reporting period



3.4 Breakdown of SAI Never Events

Serious Adverse Incidents (SAIs)

Fig 24

Never Events are SAIs that are wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are already available at a national level and should have been implemented by all health care providers.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.

Division	Review Level	Never Event Criteria
Surgery	Level 1	[REDACTED]
Medical Specialties	Level 1	[REDACTED]
Outpatients, Imaging & Medical Physics	Level 1	[REDACTED]

During this reporting period there were [REDACTED] SAI notifications submitted to SPPG relating to Never Events.

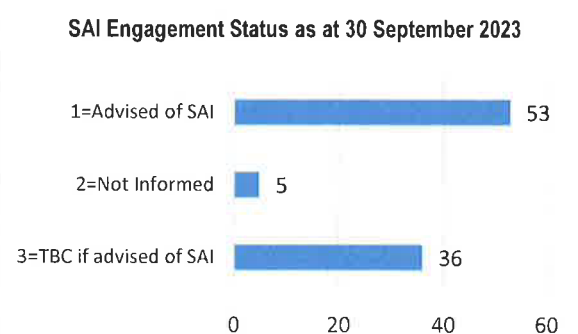
3.5 Breakdown of SAI Service User / Family Engagement

Serious Adverse Incidents (SAIs)

Fig 25

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

Figure 25 shows a breakdown of engagement status for the period 01 April 2023 and 30 September 2023.



The table provides a further breakdown by Division of SAIs where engagement is TBC (as at 30 September 2023).

Division	Count
Adult SW, Community Services and ICS	[REDACTED]
ACCTSS	[REDACTED]
Child Health and NISTAR	7
Children's Community Services	5
Laboratories and Pharmacy	[REDACTED]
Maternity, Dental and Sexual Health	[REDACTED]
Medical Specialties	5
Mental Health	9
Outpatients, Imaging & Medical Physics	[REDACTED]
Surgery	[REDACTED]
Unscheduled	[REDACTED]

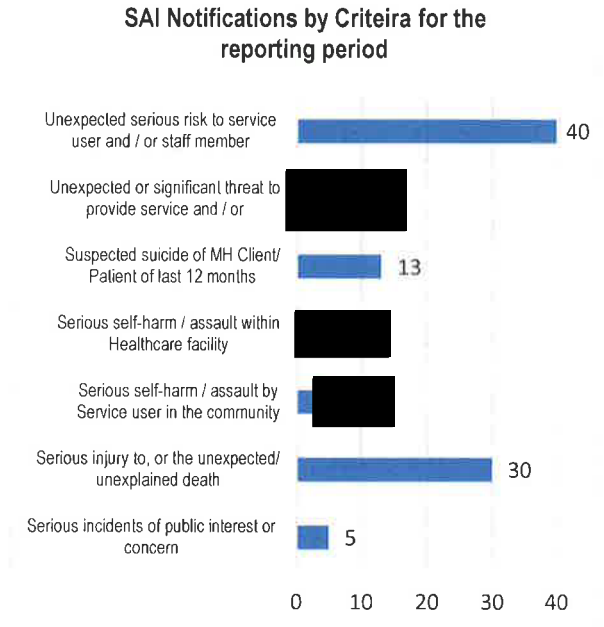
3.6 Breakdown of SAI Notifications by Criteria

Serious Adverse Incidents (SAIs)

Fig 26

Figure 26 shows a breakdown of SAI notifications for the reporting period by SAI Criteria.

40 (43%) were reported under Unexpected Serious Risk and 30 (32%) were reported under Serious Injury or Unexplained/Unexpected Death.



SECTION 4: EXTERNAL REPORTING

4.1 Regulation & Quality Improvement Authority (RQIA)

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 intellectual 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.

Serious Adverse Incidents (SAIs)

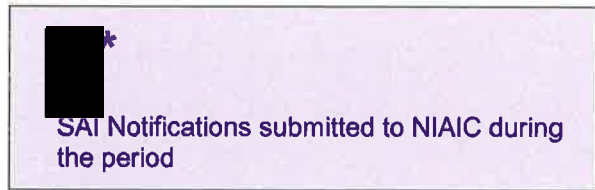


*Data includes [redacted] suicides and [redacted] from Mental Health Division; [redacted] IAH incidents from Intellectually Disability [redacted] assault from Children's Community Services; and [redacted] suicide [redacted] unexpected deaths resident in nursing home [redacted] nursing home falls and [redacted] incident failure to observe deterioration of nursing home resident from ACOPS Division

4.2 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.

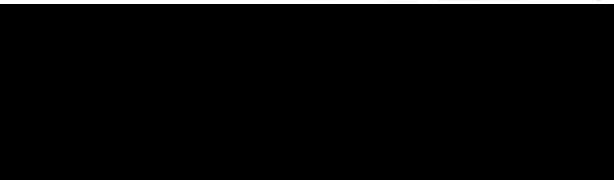
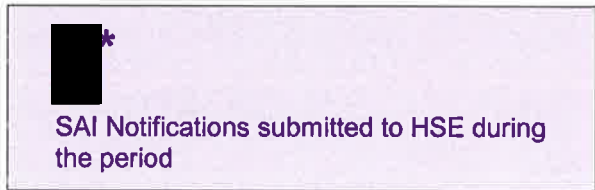
Serious Adverse Incidents (SAIs)



4.3 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.

Serious Adverse Incidents (SAIs)



4.4 Interface Incidents

Interface incidents are incidents that have occurred in another organisation, which may be reportable as SAIs. These Interface Incidents have been raised by BHSCT indicating an incidents believed to have occurred in other organisations.

The table provides a breakdown of the current status of each of the 18 interface incidents as at 30 September 2023.

Raised by BHSCT

18
Interface Incidents raised by BHSCT and submitted to SPPG during the period

Current Status	Count
Closed by SPPG	7
SAI Notification Submitted	
SAI Notification not required (as per SPPG)	
SAI Notification not required rationale submitted	
Open & Under Review	11

These Interface Incidents have been raised by other organisations indicating an incident in BHSCT and require review to determine if an SAI notification is required.

The table provides a breakdown of the current status of each of the 6 interface incidents as at 30 September 2023.

Received by BHSCT

6
Interface Incidents received by BHSCT from SPPG during the period

Current Status	Count
Closed by SPPG	
SAI Notification Submitted by BHSCT	
Open & Under Review	5

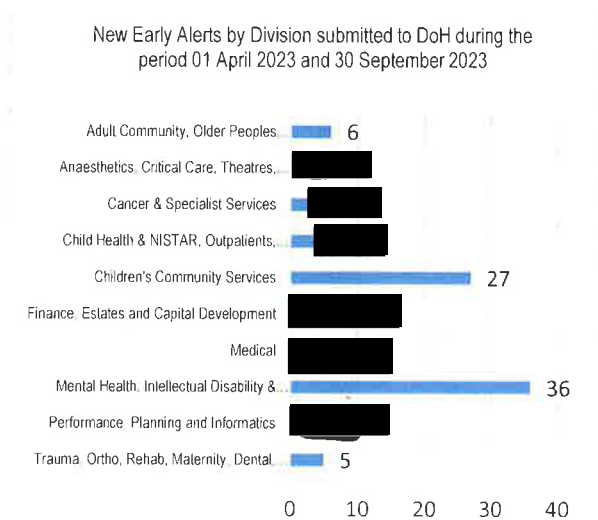
4.5 DoH Early Alerts

Figure 27 provides a breakdown by Division of Early Alerts (EAs) submitted during the reporting period. There was a total of 94 new Early Alerts; 7 of these were also reported as SAIs.

During the same period in the previous year 87 Early Alerts have been submitted. This is an increase of 8%.

This data does not include the many updates that can be submitted also for EAs.

Fig 27



SECTION 5: LEARNING FROM INCIDENTS

5.1 Examples of Actions from Incident /trend Data

Top Two Categories

BEHAVIOUR

The highest level of Behaviour (including self-harming) incidents are most commonly reported by Acute Mental Health units, Beechcroft Child and Adolescent Unit, and Intellectual Disability inpatient wards.

Mental Health:

Behaviour incidents continue to remain one of the highest for reporting of Adverse Incidents within Mental Health Services – particularly within the Acute Mental Health Inpatient Centre (AMHIC) and Beechcroft Child and Adolescent Unit. Within Acute MH this tends to be in the early stages of admission to acute settings for adults. Within AMHIC, there are a growing number of patients (Intellectual Disability) who have been placed there, as there is no other inpatient facility for them at this time (due to MAH being closed to admissions). AMHIC is a mental health unit and not an appropriate setting for such patients. Overall, this has an impact on bed pressures and increases the number of out of Trust transfers. There are a number of projects ongoing within AMHIC to reduce incidents of violence and aggression. As part of the weekly governance call arrangements, the Mental Health team have confirmed a risk is in place within their risk register in relation to demand for beds exceeding capacity within AMHIC.

Incidents continue to be monitored on a regular basis on the wards, in team meetings, and at Operational/ Patient Safety Meetings. Collective Leadership Team (CLT) have oversight of all incidents recorded (once approved) as Moderate or above severity and incidents graded as Moderate or above consequence. CLT also review the weekly Physical Interventions report which outlines the occurrence of Intermuscular (IM) / Prone/ Supine restraints on inpatients. If there is a particular area of concern, further investigation will be requested.

Within Beechcroft Child and Adolescent Unit, the majority of self-harming incidents are down to a small number of patients. CLT have been meeting with the senior management team in Beechcroft on a weekly basis to review the current situation for both assurances and support. This work remains ongoing.

Mental Health provide a trend analysis report for monthly governance meetings which also assists with local governance meetings.

Intellectual Disability:

Live Governance Meetings (which cover both Inpatient and Community ID services) are held weekly and attended by all Senior Management or their Deputies. Each service speaks to their incidents, in particular, those categorised as Behavioural focusing on Physical Intervention and all associated actions and learning for the service. If there is specific learning for staff in Intellectual Disability, a Local Learning Letter is shared at all service huddles.

When there are particular issues e.g. an increase in incidents with an individual patient or service user, this instigates a review of treatment and medication. Immediately post-significant incident a Hot Debrief takes place, formulated to support staff and extrapolate immediate learning and action. There may be a review using SEA methodology required.

Intellectual Disability services are currently working with both children and adults who are delayed discharge: these individuals are being supported in facilities which do not adequately fit their support

needs. There has been extensive work carried out in MAH around resettlement for all remaining patients as they are all in an unsuitable environment. There is a focus on resettlement.

Self-injurious behaviours may be a maladaptive means of communicating needs; treatment aims to provide the patient with a means of communicating needs in a safer way. However, it is likely these behaviours are chronic in nature, developed over many years, and as such may never be eradicated. Psychology and TSS are supporting the services to sustain the service user. The aim being a reduction of instances of self-injurious/suicidal behaviours, and reduction in the frequency and intensity of these behaviours.

A change in routine or circumstance increases patient and staff anxiety. The Resettlement program has resulted in an increased impact in both. Prompted by this, Safety Intervention (SI) training has evolved to provide greater support to both staff and patients. This training is inclusive of the Positive Behavioural 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. 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.
- 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.

5.2 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. Quarterly and monthly reports are also provided routinely to Directorates to enable identification of trends and to inform improvement work.

Every week all new approved incidents with a Catastrophic severity or Extreme risk grade are presented at the Trust Weekly Governance call. Any immediate learning identified by the relevant Directorate would be discussed as part of this call.

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.

5.3 Learning from Serious Adverse Incidents (SAIs)

Serious Adverse Incidents (SAIs)

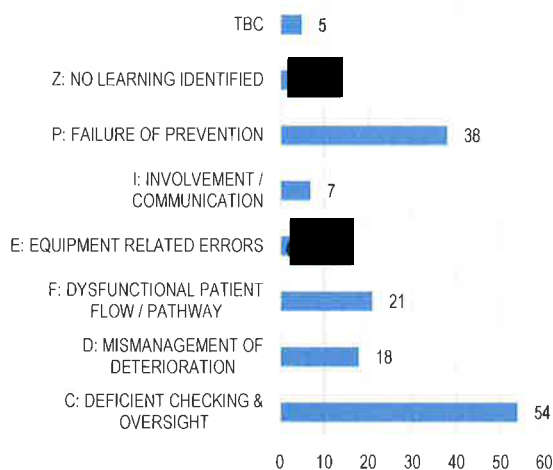
Fig 28

During the period 01 April 2023 and 30 September 2023 a total of 80 SAI reports were completed and submitted to SPPG.

Figure 28 provides a breakdown of learning themes from these SAI reports.

Of the 80 reports submitted, 75 had learning themes confirmed as at 30 September 2023 with a total of 144 learning themes across the 75 reports.

SAI Learning Themes (Group) for SAI Reports submitted during the period 01 April 2023 to 30 September 2023



The table provides a breakdown of sub-group learning themes for the top 2 groups, i.e. C: Deficient Checking & Oversight (54) and P: Failure of Prevention (38).

Work is underway to potentially add some additional learning themes to the current list to assist some services accurately capturing their key themes, for example Social Work.

Learning Theme	Count
C: Deficient Checking & Oversight	54
C1: Medication error	0
C2: Misinterpretation/mishandling of test results	0
C3 Unexpected perioperative death (within 24hrs)	0
C4: Wrong - site/implant/procedure/patient	6
C5: Risk management failure	11
C6: Staff Training not up to date	0
C7: Related to checking aids e.g. tick box	0
C8: Failings/errors in documentation	22
P: Failure of Prevention	38
P1: Inpatient falls	0
P2: Healthcare-associated infections	0
P3: Pressure sores/decubitus ulcers	0
P4: Suicides	0
P5: VTE/pulmonary embolus	0
P6: Cardiac / respiratory arrests	0
P7: Staff Training/ skills deficiency	10
P8: Infant/Child Death	0
P9: Failure to prevent self-harm/assault/homicide	0
P10: Other (specify)	19

SECTION 6: SHARING LEARNING

6.1 Shared Learning Letters

Adverse Incidents

Fig 29

Ref	Details	Date Issued
	Steroid induced Hyperglycaemia	31 May 2023
	Staff must not email patient related data to their unsecure personal emails or use non-Trust approved devices when dealing with patient data	27 July 2023
	Skin bundle commencement and use of interpreting service to communicate with patients at risk of pressure damage	28 July 2023
	NISCC Registration Checks	08 August 2023
	Temporary Storage for Filing Cabinets containing Documentation	08 August 2023

Access to Shared Learning Letters issued is available on the Trust's LOOP Learning Library via the following link:

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

Serious Adverse Incidents (SAIs)

Fig 30

Ref	Details	Date Issued
		04 May 2023
	For the attention of all SACT prescribers	09 May 2023
	Infection status must be completed at time of admission to ward	11 May 2023
	Post procedural instructions should be clearly documented and recorded for relevant patients	30 June 2023
	Incidental Findings	21 July 2023
	Transfer Directive Order (TDO) from Prison Services	24 July 2023
	DVT D-Dimer and further investigations	07 August 2023
	Communication and documentation of Patient Journey	08 August 2023
	Retinal Imaging Suspected Wet Age Related Macular Degeneration (AMD)	08 August 2023
	MRI Brain Reporting to include Vasculature Changes	30 August 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.

6.2 Safety Message of the Week (SMOTW)

Adverse Incidents

Fig 31

Ref	Details	Date Issued
[REDACTED]	POD System must not be used for TB specimens	06 July 2023
Multiple Incidents	Data Breaches	13 September 2023

Safety Message of the Week (SMOTW) 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.