Overview

The World Health Organization (WHO) estimates that 1 in 10 hospital inpatients are the victims of unintentional medical error. They calculate that 50% of these errors could be avoided if lessons from previous incidents were learned. Of course, errors and system failures also result in adverse incidents in social care settings, which is important given the integrated nature of our services in Health and Social Care.

An adverse incident has been defined as: **“any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation”**. (Safety First, March 2006)

Benefits

Systematically reporting, investigating and analysing adverse incidents can help identify potential hazards, quantify risks and provide information as to where the system is breaking down. This can help when targeting improvements and system changes to reduce the re-occurrence of adverse incidents and the likelihood of injury to patients and clients in the future.

Organisations or individuals benefit from reporting incidents if they receive back useful information and learning gained by generalising and analysing similar cases. There is also, of course, a cost associated with adverse incidents and, consequently, a financial benefit to be gained by maximising learning from those events, applying those lessons, and avoiding re-occurrence.

Determining a serious adverse incident (SAI)

The following criteria will determine whether or not an adverse incident constitutes a serious adverse incident (SAI):

- Serious injury to, or the unexpected/unexplained death (including suspected suicides and serious self-harm) of:
    - a service user;
    - a service user known to mental health services (including child and adolescent mental health services (CAMHS) or Learning Disability (LD)

within the last two years);
    - a staff member in the course of their work;
    - a member of the public while visiting a HSC facility.
- Unexpected serious risk to a service user and/or staff member and/or member of the public.
- Unexpected or significant threat to provide service and/or maintain business continuity.
- Serious assault (including homicide and sexual assault) by a service user:
    - on other service users;
    - on staff;
    - on members of the public occurring within a healthcare facility or in the community (where the service user is known to mental health services including CAMHS or LD within the last two years).
- Serious incidents of public interest or concern involving theft, fraud, information breaches or data loss.

Regional adverse incident learning (RAIL)

A new model of information management for adverse incidents was developed in consultation with around 200 HSC staff from a range of backgrounds. The Regional Adverse Incident Learning model (RAIL) has been approved by the departmental board of the DHSSPS and the Health Minister.

RAIL will aim to:

- maximise the reporting of adverse incidents and near misses;
- ensure that learning from all incidents and near misses, where relevant, is identified;
- provide a mechanism to share learning from adverse incidents in a meaningful way within the HSC;
- ensure that learning from adverse incidents is put into practice in a timely manner.

The project team and project board have been established and both have had their first meetings. Mrs Mary Hinds, Director of Nursing and Allied Health Professions, is the Project Team Director, and Dr Jim Livingstone, Director of Safety and Quality, DHSSPS, is the Senior Responsible Officer for the project. Membership includes representation from the DHSSPS, PHA, Health and Social Care Board (HSCB), Health

and Social Care Trusts (HSCTs), Business Support Organisation (BSO), RQIA and Patient and Client Council.

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