

**THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY (RQIA)**

**IMPROVEMENT NOTICE PURSUANT TO ARTICLE 39 OF THE HEALTH AND PERSONAL SOCIAL SERVICES (QUALITY IMPROVEMENT and REGULATION) (NORTHERN IRELAND) ORDER 2003**

<b>IN Ref:</b> IN000002(E)	<b>Issue Date:</b> 22 July 2019
<b>Health and Social Care Trust:</b> Western Health and Social Care Trust (RQIA ID: 020643)	<b>Address of Trust:</b> Western Health and Social Care Trust Headquarters, MDEC Building Altnagelvin Area Hospital Site Glenshane Road Londonderry BT47 6SB
<b>Responsible Person:</b> Dr Anne Kilgallen, Chief Executive	
<b>STATEMENT OF MINIMUM STANDARDS</b>	
<b>The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (March 2006).</b>	
<b>Standard 5.1</b>	
<b>Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.</b>	
<b>Failure to Comply</b>	
<b>5.3 Criteria</b>	
5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk	
The organisation:	
<i>(b) acknowledges and promotes the central place that patients, service users and carers have in the prevention and detection of adverse incidents and near misses;</i>	
<i>(f) has properly maintained systems, policies and procedures in place, which are subject to regular audit and review to ensure: awareness raising and staff knowledge of reporting arrangements for adverse incidents and near misses, and whistleblowing arrangements when poor performance and/or unsafe practice in examination, treatment or care comes to light.</i>	

### 5.3.2 Preventing, Detecting, Communicating and Learning from Adverse Incidents and Near Misses

The organisation:

- (a) has systems and processes in place to prevent, identify, assess and manage and review adverse incidents and near misses across the spectrum of care and support provided;*
- (b) promotes an open and fair culture, rather than one of blame and shame, to encourage the timely reporting and learning from adverse incidents and near misses;*
- (c) has reporting systems in place to collate, analyse and learn from all adverse incidents, and near misses, share knowledge and prevent reoccurrence of adverse incident or near miss; and*
- (d) has systems in place that promote ongoing communication with service users and carers when treatment or care goes wrong, and puts in place an individual care plan to minimise injury or harm.*

#### **Specific failings to comply with the statement of minimum standard:**

An Improvement Notice was issued to the Western Health and Social Care Trust (the Trust) on 22 July 2019. The Improvement Notice was issued as a result of the Trust failing to ensure that it has a robust system in place for recognition and management of adverse incidents and near misses across the Directorate of Adult Mental Health & Disability Services, as evidenced during unannounced inspections of Evish and Carrick Ward in Grangewood Hospital on 13 March 2019 and the Trust's Acute Mental Health Inpatient wards from 3 to 5 June 2019 (inclusive).

RQIA met with representatives from the Trust on 2 September 2019 to receive an update regarding progress towards compliance with the actions outlined in the Improvement Notice issued on 22 July 2019. The information shared with RQIA during this meeting, together with that contained in the Trust's action plan (submitted to RQIA on 9 October 2019), provided assurances that the Trust understood its responsibilities, with respect to the recognition and management of adverse incidents and near misses across the Directorate of Adult Mental Health & Disability Services. In addition, the Trust's Action Plan confirmed that it had a programme of work in place to address the requirements as set out in the Improvement Notice.

RQIA undertook an unannounced inspection of Acute Mental Health Inpatient Wards in the Tyrone and Fermanagh Hospital and Grangewood Hospital from 13 to 14 November 2019 (inclusive). Our multidisciplinary inspection team evidenced improvements in the numbers of staff trained to be Datix handlers across the Directorate of Adult Mental Health & Disability Services. We were informed of the ongoing work to assure the Directorate's Governance Group in respect of the recognition and management of adverse incidents and near misses, including that Trust staff acting as Datix handlers would review incidents in a more timely manner.

The Improvement Notice issued on 22 July 2019 required the Trust to undertake an urgent review of information recorded in the Trust's Datix system, to ensure that it understood the nature and extent of risks captured in the system as it operates across the Directorate of Adult Mental Health & Disability Services. At the time of our inspection in November 2019 we determined that the pace and progress of this work was slow and limited. During our meeting with senior Trust representatives on 20 December 2019 and on analysis of the Trust's updated action plan received following this meeting, we were assured that the pace and progress of this work had improved significantly with clear timescales for completion being detailed.

During the November 2019 inspection, our multi-disciplinary inspection team sought assurances at ward level that staff across the Directorate of Adult Mental Health & Disability Services had sufficient knowledge, awareness and understanding of adverse incidents and near misses and were able to recognise and accurately record these in the Trust's Datix system. Staff of all grades confirmed that work in this area has commenced, with Datix handlers working to ensure that all incidents are reviewed in a timely manner and any learning identified through the Datix handler's review of incidents is shared with relevant staff. We acknowledged that work in this area has commenced, however our review of a sample of recorded incidents identified inaccuracies in the recording and the grading of some incidents. We evidenced incidents being incorrectly categorised in the Datix system leading to a potential risk that these incidents may not be appropriately escalated. We remained concerned about the appropriate grading of incidents and the identification and timely dissemination of learning. The planned audit of incidents had not commenced.

At our meeting with senior Trust representatives on 20 December 2019 we determined that senior Trust staff have a clear understanding of their responsibilities and a clear commitment to improve Trust systems in relation to preventing, detecting, communicating and learning from adverse incidents and near misses. We acknowledged the work the Directorate of Adult Mental Health & Disability Services has undertaken to date and the Trust's plans to continue towards compliance with the actions outlined in the Improvement Notice issued on 22 July 2020.

In recognition of the improvements made to date, of work currently in progress and planned by the Trust and of confirmed plans to strengthen the governance and assurance systems and processes across the Directorate of Adult Mental Health & Disability Services we determined that a further period of time is required for the Trust to fully address and embed all improvements required under Improvement Notice IN000002. RQIA determined to extend the deadline for achievement of all aspects of this Improvement Notice to 22 June 2020.

**Improvements necessary to achieve compliance:**

The Chief Executive, Executive Team and Director of Adult Mental Health and Disability Services must:

1. Undertake an urgent review of information recorded in the Trust's Datix system, to ensure that they understand the nature and extent of risks captured in the system as it operates across the Trust's Directorate of Adult Mental Health and Disability Services.

2. Take action to address and mitigate specific patient safety risks (individual, themes and/or trends) identified as part of the above review and ensure these risks are appropriately addressed in a timely manner.
3. Assure themselves that staff across the Directorate of Adult Mental Health and Disability Services have sufficient knowledge, awareness and understanding of adverse incidents and near misses, so that they (incidents and/or near misses) are appropriately recognised and accurately recorded in the Trust's Datix system. The grading of adverse incidents and near misses must be based on the risk inherent in each event and not on the outcome reported for the event in question.
4. Ensure that there are appropriate structures in place to review, approve and escalate all incidents, adverse incidents and near misses captured in the Trust's Datix system as it operates across the Directorate of Adult Mental Health and Disability Services and demonstrate that mechanisms for assuring this dynamic process are sufficiently robust.
5. Design and implement processes to ensure that i) they are regularly updated on the spectrum of adverse incidents and near misses occurring across the Directorate of Adult Mental Health and Disability Services, ii) all incidents and near misses are graded on inherent risk, iii) appropriate mitigating actions have been identified and progressed in relation to risks identified, iv) learning arising from incidents and near misses has been identified and shared with all relevant staff, and v) they and Trust Board receive appropriate assurance(s) regarding the operation of these processes.

**Date by which compliance must be achieved: 22 June 2020**

Signed..........  
**Director of Improvement and Medical Director**

**This notice is served under Article 38 and 39 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Department of Health, Social Services and Public Safety, Quality Standards for Health and Social Care (March 2006).**

**It should be noted that failure to comply with the measures identified in this Improvement Notice may result in further enforcement action by RQIA.**