FOI2300 - Concerning "near misses"

We can confirm that Southern Health NHS Foundation Trust can advise as follows in response to your Freedom of Information request.

Please can you confirm how you deal with near misses for patient safety issues?

Near misses incidents are managed in line with the NHS National Reporting and Learning Systems (NRLS).

These are defined as:
"An incident resulting in No Harm (impact prevented) has a degree of harm of 'no harm' but was an incident that was prevented from occurring or the where the impact was prevented from occurring. For example, a patient is nearly given someone else's medication; however, the nurse double checking the patient's identification realises the mistake and does not given the patient the medication. This may be termed locally as a near miss".

All incidents are imported into our data analysis tool to allow for identification of themes, trends, and emerging risks.

Do you have a policy on this subject?

The Trust has a procedure in place for this, a copy of which is attached:

Policy Number SH NCP 17 - Procedure for Reporting and Managing Incidents.

How do you define near misses?

Please see response to Q1 above.

How do you involve patients and carers in assessing near misses and learning to be gained from it?

Low harm, no harm, and near misses themes and trends data, and associated learning, is reported monthly to the Trust wide Serious Incident & Mortality Forum, which has representation from a patient partner – a patient and service user representative.

In addition, our Trust incident framework operates in line with Regulation 20: Duty of Candour.

Our staff are open and transparent with service users and families in relation to their treatment and when things go wrong.

How is learning from near misses put into practice across the Trust?

Thematic reviews and trend analyses are reported to the Trust wide quality groups; the Clinical Effectiveness Group, the Patient Safety Group, and the Caring & Patient Experience Group.

These groups include clinical representation from every division of the Trust and are tasked with taking learning back to their areas.

Further, the Central Alert System and internal communications are utilised to share learning across the Trust.

How many near misses have you recorded in the last 3 years?

9,486 incidents reported as near misses for the past three years.

Do you collect data on reoccurring themes for near misses?

The Trust uses a Business Objects Tool to collect and analyse data from the Trust's Risk Management system.

The data is viewed using Statistical Control Process charts alerting the Trust to areas of concern and those requiring action.

The data can be viewed in monthly, quarterly or yearly time frames, incident type (assault/ medicine management), team, if this incident is RIDDOR Reportable, was the patient on an end of life pathway, safeguarding concerns or any combination of these data sets.

Bespoke reports can be generated to provide data for specific queries.

This data forms part of weekly and monthly team meetings - where teams review the data at a local level for themes and trends to be addressed. Each business unit has a Performance Meeting, where the collated team data is reviewed.

Incident data, trends and themes are reported monthly to the Trust Wide Patient Safety group, and reported quarterly to the Quality and Safety Committee, which is a sub meeting of the Board.

Please can you provide details of those themes?

The Quality & Safety Committee Serious Incident, Incident, & Mortality Report for September 2018 identified; an increase in medicines management incidents, overtaking self-injurious and disruptive behaviour as the second most numerous. Assault, abuse, and threats to staff remain the most frequent incident type. Increases were partially attributed to staff training on incident management for specific sites. Key actions taken to address medicines management incident themes were:

1. Where temperature excursion has occurred, medication with an expiry date in 2018 to be destroyed.
2. Medicines Management staff to record medicines that have been destroyed.
3. Post heat wave; to reduce the expiry date of all other remaining medicines by 6 months.