Northern Ireland NIAIC Alert

Action

Ref: NIA/2015/002 Issued 16 Feb 2015 at 14:00

Reporting of Estates and Facilities Adverse Incidents & Near Misses and disseminating Alerts

Information

The purpose of this document is to act as a reminder that:

- In the interests of patients, staff and visitor safety **all** regulated healthcare providers, Dental practices and GP surgeries have a requirement to report Adverse Incidents (AIs) involving engineering plant, infrastructure and non-medical devices to the Department via the Northern Ireland Adverse Incident Centre (NIAIC). The aim of this reporting and any subsequent investigation is to identify learning that will be shared across all healthcare service providers and work towards reducing the chances of the incident reoccurring thereby improving safety for all.

- Defects and Failures must be reported to the NIAIC via the appropriate Adverse Incident reporting form (copy attached in Appendix) as per section 4 below.

- All Estates and Facilities Alerts issued via the Safety Alert Broadcast System (SABS) need to be disseminated to the key relevant people in your organisation, to ensure senior stakeholders are engaged and involved.

This document provides guidance on:

1) What constitutes an Estates and Facilities Adverse Incident and when they be must reported.
2) The categories Adverse Incident and near misses that should be reported.
3) Actions required by all providers of healthcare services.
4) How reporting should be carried out.
5) Other actions and responsibilities.
6) What should happen to an item involved in an Adverse Incident.
7) What actions the NIAIC will take.

1. What constitutes an Estates and Facilities Adverse Incident

An Estates and Facilities Adverse Incident can be classed as:

a) Any adverse event involving the safety of patients, staff or others, arising from the defect or failure of equipment. These events may range from causing no actual harm (near miss) to serious harm and may include:

- fatal accident or serious injury.

- reportable RIDDOR 2013 incident relating to equipment that contributed to an accident.
- an explosion or sudden fracture of any pressure vessel, pressurised system or steam / high pressure water main.
- a major electrical discharge or explosion (e.g. transformers or switchgear or failure of cable joints).
- a runaway lift or a lift crash.

b) Incidents which result in the defect or failure of equipment that arise through:

- incorrect use of equipment,
- inappropriate modifications or adjustments,
- inadequate servicing and / or maintenance.
- design or manufacturing flaw

c) Deficiencies in the technical or economical performance of equipment.

d) Failure of equipment designed to avoid patient harm (e.g. a person overcoming anti-ligature device).

e) Any defects in a product, or inadequate instructions for use (including decontamination details).

f) Any utility or infrastructure failure in critical services (electricity, water, steam, gas, communications systems etc.), including the receipt of an enforcement order from the authorising authority.

g) Serious failure of building infrastructure, i.e. collapsed ceilings/walls, falls from windows etc.

h) Structural integrity of the building or associated structure is at risk. No actual failure has occurred, but there is a significant/material risk (damaged or rotting chimney, etc.)

2. The categories for which the Adverse Incident Report Form should be used.

The Northern Ireland Adverse Incident Centre (NIAIC) deals with Adverse Incidents relating to non-medical devices, engineering plant and infrastructure in the following categories:

a) Building and building components (e.g. general structural integrity, windows, flooring, doors, ceilings, curtain rails and tracking, showers, baths, toilets, thermostatic mixing valves etc.)

b) Engineering plant and services of all types e.g. lifts, boilers, pressure systems, generators, heating and ventilation systems, specialised ventilation systems (e.g. theatres and isolation rooms), hot and cold water systems (including water disinfection systems), drainage systems, electrical installations, and any other fixed plant equipment, but not medical devices.

c) Demolitions and construction carried out under CDM regulations, including plant. (e.g. failures of protocols, such as hosing down to prevent spread of Aspergillus etc.).

d) Fire detection, protection installations (including fire stopping, smoke dampers and fire extinguishing systems) and portable fire-fighting equipment.

e) Permanently installed sterilizers, bedpan washers and disposal units.

f) Equipment in laundries, catering departments, workshops and any other plant or equipment used for maintenance or cleaning.

g) Piped medical gas and vacuum systems, cryogenic liquid systems (CLS) including vacuum insulated evaporators (VIE's) and anaesthetic gas scavenging systems.

h) Fixed luminaries including theatre, examination, and emergency lamps, and their associated support systems.

i) IT systems used for monitoring and controlling the site / infrastructure. Pendants and Communications equipment (e.g. telephone and bed head services, nurse call systems, paging systems, alarm and video / audio equipment).

j) Lightning protection and electrostatic discharge systems.

k) Incinerators and other clinical waste management / treatment equipment.

l) Environmental aspects (buildings) covered by the Control of Substances Hazardous to Health (COSHH) Regulations.

m) Installation aspects of fume cupboards and microbiological safety cabinets, including protection ductwork and their interaction with ventilation systems.

n) Ambulances and similar patient transport vehicles, tugs etc. excluding vehicles for disabled persons, leased vehicles and goods vehicles.

o) Fuel supply and storage systems.

3. Actions required by all providers' of healthcare services.

The provider organisations Chief Executive / Board Member / nominated person with special responsibility for adverse incident safety must ensure that, in accordance with local procedures, this alert is brought to the attention of appropriate staff within their organisation(s) (this includes PFI and any external contractors as appropriate) for information purposes.

The following arrangements should already be in place:

a) Ensure a designated person is responsible for receiving and disseminating Estates and Facilities related alerts from the Safety Alert Broadcast System (SABS).

b) Regular review of monitoring procedures to ensure there is a person in place, with backup arrangements, that has responsibility for promptly reporting appropriate estates and facilities adverse incidents at all times.

c) Communication arrangements to ensure personnel are aware of the reporting system available.

d) Ensure relevant personnel are familiar with the SABS website where alerts are posted http://sabs.dhsspsni.gov.uk/

e) Advising the NIAIC Office on Tel 028 9052 3868 or email niaic@dhsspsni.gov.uk of changes to SABS liaison officer or point of contact.

4. How reporting should be carried out.

Estates and Facilities adverse incidents can be reported by an individual or centrally by the organisation. All HSC Trusts will have their own protocols for reporting of adverse incidents and this should be followed by their employees. If in doubt - report directly, using the appropriate adverse incident form.

Forms for reporting incidents may be downloaded from the NIAIC website and when completed can be electronically emailed as a .doc or .pdf file to niaic@dhsspsni.gov.uk . They may also be printed and sent by post or fax. Copies of forms are also available from:

Northern Ireland Adverse Incident Centre
Department of Health and Social Service & Public Safety
CMO Group
Room 17, Annex 6
Castle Buildings
Stormont Estate
Dundonald
BT4 3SQ

Tel: 028 90523868
Fax: 028 90523900

Web: www.dhsspsni.gov.uk/niaic
Email: niaic@dhsspsni.gov.uk

In the event of any incident resulting in death or serious injury an urgent report may be submitited by telephone.

Telephone reports must always be followed up by a written (post, email or fax) confirmation. In urgent cases outside of normal office hours an answering machine at the NIAIC carries a message giving the contact telephone number for the duty officer. The duty officer is able to contact senior NIAIC staff.

Alternatively, telephone messages may be left on the answering machine for the next working day.

5. Other actions and responsibilities.

This reporting system does not affect the duty of local staff to take actions as required by legislation and / or by line management, because of an adverse incident. Additional actions may be required as follows:

a) Prevent further use of equipment that may be defective.

b) Reporting of incidents to the most appropriate officer within the organisation (e.g. radiation hazards to the Radiation Protection Advisor, infection issues to Infection Control).

c) Reporting to the Health and Safety Executive (HSENI) “Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR 2013)”.

d) Reporting under “Ionising Radiation Regulations 1999”.

e) The manufacturer / supplier should also be contacted by the originator of the report and supplied with a copy of the incident report, in order that the two parties can establish the reason for the Adverse Incident.

f) The outcome of any investigation, either by the healthcare provider or jointly with the manufacturer, should be added forwarded to the NIAIC quoting the incident reference number supplied following the initial report.

g) When an incident occurs it must be reported to all relevant bodies. It is important to ensure that the use of local reporting and risk management systems does not result in the reporting of relevant adverse incidents being overlooked. If a relevant incident report is submitted to another body (for example the Health & Safety Executive Northern Ireland), an entry must also be made to NIAIC ass detailed above.

h) In addition, all patient safety incidents that meet the criteria of a Serious Adverse Incident should be reported .to the HSCB via the SAI arrangements.

6. What should happen to an item involved in an Adverse Incident.

a) All defective equipment is potential legal evidence and should be treated as such by the most senior person on site at the time. It should not be modified, cleaned or dismantled, unless immediate repair is the only possible option.

b) All material evidence shall be identified and kept secure under the charge of a named responsible officer.

c) If possible photographs (ideally digital and dated and timed) should be taken of the incident scene and / or the damage.

d) Defective / failed items should not be interfered with in any way except for safety reasons or to prevent injury, damage or loss.

e) Where appropriate a record, which should be signed and dated, should be kept of all readings, settings and position of switches, valves, dials, gauges and indicators etc.

f) A detailed incident report shall be compiled and if necessary timed and signed. Eyewitness reports should also be obtained as soon as reasonably possible. In serious cases, these reports should be signed and dated in front of witnesses.

g) The manufacturer/supplier should be promptly notified directly by the healthcare provider and shall be allowed accompanied access with a responsible officer, to inspect the equipment. Care must be taken to ensure the manufacturer does not exchange, interfere or remove any part, as this could prejudice any subsequent investigations by other official bodies.

h) The equipment should not be handed over to the supplier, repaired or discarded before there has been an opportunity to investigate and a course of action agreed.

i) Where there is a clinical need for the equipment to be kept in use, any defective parts must be clearly identified. They can be removed, secured and identified for later inspection and the equipment can be repaired (and where necessary inspected and re-certified) for re-use after due consultation with a named responsible officer.

j) If equipment is contaminated and constitutes a bio hazard, advice contained in Device Bulletin, DB(NI)-2014-02 “Managing Medical Devices” – Section 9, should be followed.

NB:

1) It is illegal to send contaminated items through the post.
2) Health and Safety Inspectors have legal powers under the Health and Safety at Work Order 1978 ,to enter property at a reasonable time, and take possession or samples of any equipment, material or article, make examinations, take measurements, photographs, order dismantling, question personnel and take copies of documents.
3) Health and Safety Inspectors may also act or investigate on behalf of HM Coroner.

7. What actions the NIAIC will take.

When the NIAIC receives an Adverse Incident report, the following action(s) are taken:

a) If the NIAIC is notified of an adverse incident via a different route the originator will be prompted to complete the appropriate AI form for inclusion on the Adverse Incident Register. (See section 4)

b) An acknowledgement will be sent by the NIAIC to the originator and the appropriate Liaison Officer with a unique reference number that should be quoted in all correspondence.

c) The NIAIC or their representative may contact the originator, to discuss the incident and then may liaise with the manufacturer and other bodies as appropriate.

d) The report is evaluated by NIAIC Officer to identify any appropriate action required.

e) Based on historical data within the Adverse Incident Register system, the nature of the incident, the manufacturer's report and the originator's own investigations, the NIAIC may discuss the need to publish an Estates and Facilities Alert with the other devolved administration of the UK. Where there is no national interest the NIAIC may still consider a Northern Ireland Alert or Early warning notice.

Suggested onward Distribution

- Chief Executives
- Liaison Officer
- Directors of Estates & Facilities
- Risk Management Leads
- Health & Safety Manager's
- PFI/PPP staff
- Others as deemed appropriate

Additional information for Northern Ireland

This Alert was compiled by the NIAIC for circulation in Northern Ireland only.

Action required by this alert should be **underway by: 1st March 2015**
Action required by this alert should be **completed by: 31st March 2015**

Enquires should quote reference number NIA-2015-002 and be addressed to:
niaic@dhsspsni.gov.uk

A copy of this Alert can be found on http://sabs.dhsspsni.gov.uk

NIAIC ADVERSE INCIDENT REPORT FORM

Details of the report:	**Location of the incident:**
Reporting Body: Address : Post Code : Reporter : Position : Tel No : Email : Your or Hospital IR1 Reference:	As Reporter : ☐ Facility/Building: Ward/Dept : Local Contact : Position : Tel No : Email :

Details of device:

Product		Catalogue No	
Model		Serial No	
Manufacturer			
Supplier			
Batch No		Expiry date	
Date of mfr		Quantity defective	
	Location of device now		

Is there a CE-mark? Yes ☐ No ☐ Don't Know ☐ If YES, was the manufacturer or supplier contacted? Yes ☐ No ☐

Incident Details :

Date of Incident

Nature of Injury : Fatality ☐ Serious ☐ Revision ☐ Distress ☐ Minor ☐ None ☐

Injury details:

Nature of defect / details of incident:

Action taken by staff :

PLEASE NOTE IT IS ILLEGAL TO SEND CONTAMINATED ITEMS THROUGH THE POST.
If you still have the incident device please retain it and await further instructions from the NIAIC.

Signed Date

Please send completed form to: **Northern Ireland Adverse Incident Centre, CMO Group, DHSSPSNI, Annex 6, Castle Buildings, Stormont Estate, Dundonald, BT4 3SQ, Tel 028 90523868 Fax 028 90523900**

Preferred method e-mail : niaic@dhsspsni.gov.uk

Version 2015/01