NIPEC

Northern Ireland Practice and Education Council for Nursing and Midwifery

Systematic Review of Northern Ireland Public Inquiries and Reports

INVESTOR IN PEOPLE

CONTENTS

FOREWORD

Public inquiries and reviews contain helpful information on the quality of the provision delivered by health and social care services. While inquiries and reviews cannot undo any of the consequences of failures in the services provided, they make available information that explains what happened, why it happened and the opportunity to learn from the experiences of those involved in order to minimize reoccurrence.

This systematic review of health and social care related public inquiries and reviews conducted in Northern Ireland over the past five years, highlights organisations which were not up to the task, of confusion as to where responsibility lay for ensuring the quality of care provided to patients was good enough and inadequate systems, processes and services. A range of common themes which require development within health and social care organisations emerged during the process of this review. These included issues that have broad relevance to health and social care organisations, such as, leadership and communication and those which affect specific aspects of health care, such as, record keeping and training and development.

It would be reassuring to believe that mistakes will not reoccur as a result of these public inquiries and reviews. Whilst no one can give such an assurance, the chances of such things happening again will be significantly reduced if lessons are learnt and recommendations are fully implemented.

For this reason we have sought to identify what the lessons are and, in light of doing so, to highlight how improvements might be identified and implemented to support the future development of nursing and midwifery practice in Northern Ireland. However we recognise that nurses and midwives do not work in isolation and so many of the identified issues will also have wider implications for multi-professional teams.

Ms Frances McMurray
Chief Executive
NIPEC

1.0 INTRODUCTION

1.1 The Northern Ireland Practice and Education Council for nursing and midwifery (NIPEC) was established by the Northern Ireland Assembly in 2002 to support the development of nurses and midwives by promoting high standards of practice, education and professional development.

1.2 NIPEC delivers its functions and works in accordance with a number of key values to:

- provide leadership that will have a positive impact on the nursing and midwifery professions
- promote a culture of equality and diversity
- work in partnership with stakeholders for the good of the public
- act at all times with complete integrity and transparency
- be accessible to individuals and interested organisations
- be accountable to the public and our stakeholders
- be open-minded and creative in our approach to our work.

1.3 NIPEC activities include providing advice and guidance across a range of professional areas in relation to the practice, education and professional development of nursing and midwifery. Often the strategic work of NIPEC encompasses strands of all three professional functions simultaneously. NIPEC also promotes safe and effective high-quality care through reviewing practice, disseminating and promoting best practice, and by focusing on organisational activities to improve nursing and midwifery.

1.4 In 2009, NIPEC's corporate mission statement set the organisation the task of undertaking a systematic review of relevant Northern Ireland Public Inquiries and Reviews, published within the last five years, to identify themes and issues arising pertinent to improving nursing and midwifery practice. This report presents the approach and main findings of the review along with suggested recommendations for the future development of practice for nursing and midwifery.

2.0 BACKGROUND

2.1 In Northern Ireland the Department of Health, Social Services and Public Safety's (DHSSPS) overriding purpose is to encourage improvement in the quality and safety of health and social care services provided to patients. The development of clinical and social care governance in health and social care (HSC) organisations is a key aspect of the quality and safety agenda arising out of the public consultation on Best Practice Best Care (DHSSPS, 2002). Clinical and Social Care Governance is the framework within which HSC organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care and treatment (DHSSPS, 2007).

2.2 To support this, a significant programme of work is currently underway in the HSC to improve quality and ensure patient and client safety. All HSC Trusts have a statutory duty to ensure that the principles of clinical and social care governance are embedded at all levels in the organisation and supported by clear reporting structures, good use of information, education and research, audit, risk management and complaints management. The Regulation and Quality Improvement Authority (RQIA), established under the '*The Health and Personal Social Services (Quality, Improvement and Regulation)(Northern Ireland) Order 2003',* is charged with bringing about the achievement of quality improvement in service provision through robust monitoring and reviewing against specified Quality Standards for Health and Social Care developed by the DHSSPS (2006).

2.3 However, despite considerable efforts being made to ensure that patients receive safe, good quality care, some errors still occur. Public inquires and reviews play a vital role in establishing why, despite the many systems designed to keep patients safe, these errors still happen.

2.4 A public inquiry is an official review of important public events or issues, ordered by government. Its purpose is to examine the events and circumstances surrounding a service failure or problem, find out what happened, understand why and learn from

the experiences of those involved (Bristol Royal Infirmary, 2001; Walshe & Higgins, 2002). Where necessary, recommendations are made to prevent errors from happening again. One of the most important benefits of this type of inquiry is its public and open nature. This transparency allows the general public to have information on important issues which they might not otherwise learn about, for example, through the media or elected representatives.

2.5 In contrast, although an HSC Trust can commission an independent panel to review an identified problem, failure or incident, the findings do not always end up in the public domain. Nevertheless, the public may request access to reports from these inquiries and public bodies may be called on to publish such documents under the Freedom of Information Act (2000). Public inquiries can also be an important means for reform, where, if acted upon, the final report of a public inquiry can lead to important changes in government attitudes and practices (Makarenko, 2009).

2.6 Several major failures in our health and social care services in Northern Ireland have been subjected to independent, public inquiries and reviews; the reports of which have had a wide ranging impact on health and social care policy (RQIA, 2005; EHSSB, 2006; EHSSB, 2007; DHSSPS, 2008). For instance, in March 2006 the then Minister for Health, Shaun Woodward, commissioned an independent review into the circumstances surrounding the death of an 18 year old man and the details of the treatment and care offered to him by the health and social care system. The teenager, who had a history of depression and self harm, died by suicide after his request to be admitted to hospital was turned down. The independent review panel confirmed serious failings in the care provided to him by the Health and Social Care Trust and made six recommendations, one of which included an apology to the family.

2.7 According to Walshe and Higgins (2002) many of the problems identified by public inquiries are cultural and demand changes in attitudes, values, beliefs and behaviours which are difficult to prescribe in any set of recommendations.

Nonetheless, it is important to consider that governments may not implement all the recommendations of an inquiry immediately as they are under no legal obligation to do so. In addition, many inquiries reveal similar organisational problems and make similar recommendations, suggesting that the lessons from previous inquiries are not being learnt (Walshe & Higgins, 2002).

3.0 AIM AND OBJECTIVES

Aim

3.1 To undertake a systematic review of relevant Northern Ireland public inquiries and reviews published between January 2004 and January 2009.

Objectives

3.2
- To identify themes arising and issues pertinent to improving nursing and midwifery practice;
- To identify areas for further development in relation to the evaluation and improvement of nursing and midwifery education and, practice;
- To raise and promote improvement in issues of professional significance with key stakeholders including the DHSSPS and the Health and Social Care sector.

4.0 DESIGN

4.1 The systematic review methods outlined in the NHS Centre for Reviews and Dissemination (2001) were used throughout the conduct of this review. Table 1 outlines the main stages of the review as follows:

Table 1: Stages of the systematic review

1. Identification of the need for the review
2. Background research and problem specification
3. Requirements for the review protocol
4. Literature searching and study retrieval
5. Assessment of studies for inclusion on the basis of relevance and design
6. Assessing the validity of the studies
7. Data extraction
8. Data synthesis
9. Structure of the report
10. Review of the report for scientific quality, content and relevance
11. Submission of the final report and plans for dissemination

5.0 METHODOLOGY

Locating the inquiries and reports

5.1 The starting point in identifying potential public inquiries and reviews for inclusion in this review involved pilot testing search terms to identify those most effective in yielding relevant reports. The search terms used included: public AND inquiry AND Northern Ireland; independent AND review AND Northern Ireland; review AND critical incident AND Northern Ireland and inquiry AND critical incident AND Northern Ireland. No comprehensive chronology of health and social care service

inquiries or reviews currently exists; therefore the authors conducted a rigorous search of online bibliographic databases to include *Ovid Online* (which incorporates the *British Nursing Index, Medline, AMED, CINAHL*), *SCIE* (Social Care Institute of Excellence), *Social Science Citation Index and* UKOP*(UK Official Publications).* Furthermore, relevant websites were searched including the Northern Ireland Executive, RQIA, DHSSPS, the four legacy Health and Social Services Boards and the eighteen legacy Health and Social Care Trusts. The search strategy covered the period January 2004 to January 2009.

Quality appraisal

5.2 Due in part to the paucity of systematic reviews in the area of health of social care and the interest in identifying available reports on this important topic, reports were not excluded based on methodology. However, the following pre-established inclusion and exclusion criteria were developed:

Inclusion criteria

5.3 Reports were included if they were:

- relevant to the definition of a public inquiry or review
- conducted and reported in Northern Ireland between 2004 -2009
- of relevance to the provision of health and social care services

Exclusion criteria

5.4 Reports were excluded if they:

- were not relevant to the definition of a public inquiry or review (e.g. protocols)
- were service development reviews (e.g. Bamford Review of Mental Health)
- did not evaluate the relative effectiveness of health and social care services
- lacked recommendations
- were outside the five year time frame

Two authors independently searched and screened the titles and abstracts/summaries of all the retrieved reports for duplication and relevancy. This led to the exclusion of irrelevant reports. The authors then performed a second stricter screen by examining full-text reports of the remaining records. Reasons for exclusion at all levels of screening were documented.

Data abstraction

5.5 The authors abstracted data from each of the 19 identified reports, the purpose or reason for the inquiry/review, context, design, methodology, findings and recommendations. Additional data extracted included sample size and characteristics of all health and social care personnel involved in the inquiry or review.

Data analysis

5.6 Because of the wide variance in the design and methodology of the identified reports, a thematic content analysis approach was used. Extracted data was therefore ordered, coded and categorised in an attempt to present any common and specific themes emerging from the reports.

6.0 FINDINGS AND DISCUSSION

Search outcome

6.1 After the first screening a total of 33 potentially relevant reports were identified. These were then re-screened according to the pre-established inclusion and exclusion criteria. A total of 19 reports which met the inclusion criteria were then agreed (Appendix 1). Of these, 8 (47%) were conducted by RQIA, 6 (32%) by the DHSSPS, 3 (16%) by two of the four legacy Health and Social Services Boards, 1 (5%) by a legacy Health and Social Care Trust and 1 (5%) by the National Confidential Enquiry into Maternal and Child Health organisation. A summary of an illustrative selection of the inquiries is presented in Table 2 below:

Table 2: A summary of an illustrative selection of the inquiries included in the review

References	Inquiry/review details	Findings and recommendations
RQIA, 2005	Independent review following the death of Mrs Murtagh after a routine laparoscopic examination resulted in peritonitis which led to her death in 2002	Opportunities existed for medical and nursing staff to take actions that could have led to a different outcome. Three key areas of concern included patient care, leadership and communication and protocols and procedures. A total of 11 recommendations were made.
EHSSB, 2006	Inquiry to examine the circumstances surrounding Mr McCleery's admission, treatment and discharge from a psychiatric unit after he went missing and fatally stabbed his girlfriend in 2003.	One of the defining elements of this inquiry was the Trust's failure to implement DHSSPS guidance on discharge from hospital and care in the community. A total of 48 recommendations were made.
DHSSPS (2008)	Independent review into the quality of the professional work of the various agencies involved with Mr Arthur McElhill, Ms Lorraine McGovern and their 5 children, particularly in the area of child protection prior to a house fire on 13th Nov 2008 in which they all died.	This review found deficits in communication and dissemination of information between all agencies in respect of the criminal offences committed by Mr McElhill and the assessment of potential risks he posed. A total of 63 recommendations were made.

Common themes

6.2 Several trends can be identified from this systematic review. Firstly, the findings demonstrate an increase in the number and scope of public inquiries and reviews undertaken in Northern Ireland within the last five years with relevance to health and social care. For instance, ten inquiries and reviews were conducted in 2008 compared to 3 in 2005, two in 2006 and two in 2007. Secondly, problems which may in the past have been dealt with internally are now more likely to be examined independently and externally, with the findings made public. For instance, the RQIA was formally requested to undertake the majority of the inquiries and reviews which were included in this report by the Minister for Health, Social Services and Public Safety. Thirdly, throughout the process of this review a range of similarities and common themes emerged from the identified reports. Some of the general themes that have broad relevance to health and social care organisations have been identified along with those affecting specific aspects of health and social care (Table 3).

Table 3: General and specific themes emerging from the inquiries and reviews

General themes	Specific themes
• Corporate & clinical governance • User/carer involvement • Leadership • Interagency /multidisciplinary working • Communication/information • Child protection/safeguarding vulnerable adults • Workforce/recruitment/retention	• Policies/guidelines/protocols • Mental health • Maternity services • Infection control • Recordkeeping • Admission/discharge/transfer • Training and development • Clinical supervision

General themes

Corporate and clinical governance

6.3 Clinical and Social Care Governance is a framework within which Health and Social Care organisations are accountable for continuously improving the quality of their services and taking corporate responsibility, for performance and providing the highest possible standard of clinical and social care (DHSSPS 2003).

6.4 However, throughout this review a lack of robust monitoring of clinical and social care governance arrangements was evident within some of the legacy Trusts. This included a lack of review, audit, monitoring and implementation of quality and professional standards and guidance, assessment and risk assessment procedures, care planning procedures, effectiveness of interventions, record keeping and patient identification to ensure their compliance with DHSSPS standards.

6.5 Similarly, a number of concerns and recommendations were presented with relevance to risk management and incident reporting. Risk management is an approach to help improve the quality and safe delivery of health and social care by placing emphasis on identifying circumstances that put patients at risk of harm, and acting to prevent or control those risks (National Audit Office, 2005). The reporting, monitoring and analysing of incidents are important to examine the systems in which any events occurred in order to redesign processes or develop improvement strategies for reducing or removing the potential for a similar event in the future (Shaw *et al.,* 2005; Walsh & Antony, 2007).

6.6 Nonetheless, within this review the systems for reporting, analysing and monitoring incidents within all organisations were seen to be inadequate as well as the written and verbal information provided to patients on how to minimise risks. The development of an appropriate systematic approach to best practice within

organisations and for sharing lessons learned between and across Trusts was highly recommended within the majority of reports.

6.7 Contemporary best practice for clinical and social care governance involves organisations setting clear programmes for the improvement of clinical services to support staff and patients through implementation and change (NHSCT, 2008). This process is particularly important in order to support the recent reconfiguration and amalgamation of HSC Trusts in Northern Ireland that has taken place as a direct result of the Review of Public Administration. It is important to acknowledge that this structural reorganisation has impeded the progress made on many of the broader organisational and governance issues. The findings should therefore be seen in the context of significant organisational change having taken place.

Users/carer involvement

6.8 Patients and their carers look to the HSC to provide safe, quality services on a wide range of health and social care problems. The clients have the right to be involved in decisions which affect them. According to NHS Scotland (2002) involvement can and should take place at a number of different levels: involvement of an individual patient (or carer) in their own care; involvement of patients in monitoring and improving the quality of care in an existing service; involvement of patients and the public at an organisational level and involvement of patients and the public in planning changes in service provision.

6.9 Patients and their carers also need to be welcomed, kept informed and cared for successfully and in a way that resolves these problems. Therefore, service users need to have confidence and trust in the nurses and midwives providing care. According to the Nursing and Midwifery Council (NMC; 2004) nurses and midwives must recognise and respect the role of patients and clients as partners in their care and the contribution they can make to it.

6.10 This review revealed the importance of obtaining the views of users and carers as part of the assessment, care planning and review processes which, in some situations, may require the use of independent advocates and/or alternative augmentative communication systems. In addition, a proactive approach to the involvement of service users in the prevention of adverse incidents was recommended. Similarly, organisations were advised to continue to seek new ways of engaging service users, carers and the public in shaping services to best meet their needs.

Leadership

6.11 Leadership is clearly important in setting the direction of an organisation, developing its culture, ensuring delivery and maintaining effective governance (Healthcare Commission, 2008). Similarly, effective leadership is the key factor in managing the change necessary to deliver world class health care (NHS Scotland, 2002). Leadership is also the key to excellence in nursing and midwifery care.

6.12 The public inquiries and reviews included in this review found recurring instances of poor leadership within the health and social care trusts investigated. It was evident that, with relevance to nursing and midwifery, significant developments in the area of effective leadership are required to improve systems and processes. Other areas for improvement include the need to create robust leadership structures and the right multi-professional environment with the emphasis on vision, leadership and management. Recommendations included ensuring that leadership is clearly established as part of a formally determined protocol and making leadership and management development opportunities available to staff at all levels.

Interagency/multidisciplinary working

6.13 Government guidance, and recent legislation across a range of services, emphasise the importance of interagency and multidisciplinary working. In addition, evidence indicates that these models provide effective ways of breaching barriers and promoting understanding, particularly of professional roles (Townsley *et al.,*

2004; Fitzgerald, 2008). Other perceived benefits range from patients having quicker access to services and better relationships with services to professionals experiencing higher job satisfaction (Bertram *et al.,* 2002; Sloper, 2004).

6.14 The findings from this review suggest that a review of multi-professional working, training and information sharing arrangements within organisations is required. In addition, the development of a systematic approach to multidisciplinary working and the sharing of best practice were recommended along with the creation of a multi-professional environment in which staff can work together as a coherent team. Other recommendations included the need for organisations to ensure that comprehensive multidisciplinary assessments, care plans and reviews are in place.

Communication/information

6.15 Every information exchange is a communication act, whether it is the exchange that occurs between two people or two machines (Toussaint, 2005). The role of effective communication in managing healthcare organisations and the healthcare business is especially crucial. Similarly, without good communication between health care professionals and their patients, mistakes may be made, proper care may not be administered, and trust may not be established (Halwani, 2004).

6.16 Throughout the process of this review a range of failures in communication were identified among the inquiries and reviews. Recommendations included the need for the development of regional guidance on effective communication between hospitals, primary care practitioners and care homes as well as good communication links and pathways between relevant hospitals and services, for example, dermatology and primary care. In addition, the need for systems whereby clinical staff including locum staff can communicate with a designated accountable senior manager at any time were highly recommended.

Child protection/safeguarding vulnerable adults

6.17 Every child and vulnerable adult needs to be protected from harm (Lord Laming, 2009). To support this, a heavy responsibility has rightly been placed on HSC organisations to ensure it happens. Policies, legislation, structures and procedures are, of course, of immense importance, but it is the robust and consistent implementation of these which keeps children and vulnerable adults safe. A great deal of progress has been made towards putting the required systems into practice. Nonetheless, recent events highlighted within the public inquiries included in this review have shown that much more needs to be done to ensure that the services are as effective as possible at working together to achieve positive outcomes for children and vulnerable adults.

6.18 One of the main themes arising from this review included the need for HSC Trusts to ensure that any work related to safeguarding children and vulnerable adults is structured, focused and informed by all relevant professionals and evidenced by the written record. In addition, policies and strategies to improve safeguarding practice should be effectively coordinated and put into practice. This action requires leaders of local services to effectively translate relevant policies, legislation and guidance into every day practice to guide frontline staff. Similarly, professional standards and statutory requirements relating to children and vulnerable adults should be regularly audited and monitored.

6.19 The public inquiries also acknowledged the demanding task faced by frontline staff in each of the key services related to this vitally important area which requires not only knowledge and skill but also determination, courage, and the ability to cope with sometimes intense conflict. To support staff in this important task of protecting children and vulnerable adults further recommendations included the need for HSC organisations to ensure that reviews of the relevant training and awareness of staff and the use of comprehensive multi-disciplinary assessments and care plans were undertaken regularly.

Workforce/recruitment/retention

6.20 Workforce development has a key role to play in the HSC to improve healthcare services for patients. It is about getting the right people with the right skills to be in the right places at the right time (NHS Scotland, 2002). Nurses and midwives form the largest group of staff working in the HSC. They are the members of staff that patients and the public are most likely to meet. They provide continuity of care twenty four hours a day, seven days a week and are a point of focus when others health care professionals have been and gone. Nurses and midwives are therefore the key to success, from a patient's perspective, from the public's perspective and success for the Trust in achieving the objectives of the business.

6.21 A number of important workforce issues have become apparent through this systematic review. These include the need to consider on-going staff shortages, within an agreed action plan based on the assessed risks and good governance, the development and implementation of workforce planning strategies with a range of skill mix options and a review of selection and recruitment processes. In addition, it was highly recommended that all relevant, multi-professional staff should have clearly defined roles and responsibilities with appropriate skills and knowledge for the role, supported by formalised competency assessment tools.

6.22 Many recruitment and retention problems are already being addressed by Trusts across Northern Ireland. Some Trusts however need more co-ordination and leadership. Opportunities may exist for new workforce co-ordinators roles which are designed to make sure workforce development moves forward in a way that integrates with service planning at Trust and regional level. Nurses and midwives are in an ideal position to apply for these positions, given their background, experience and understanding.

Specific themes

Policies/guidelines/protocols

6.23 Health and social care is a complex process involving a multitude of actions by many different people. Policies, guidelines and protocols aid in improving the quality of health care provision by articulating consistent approaches for best practice (An Bord Altranais, 2000). They indicate to staff working in organisations "what" needs to be done and "how" to do it. This can lead to fewer misunderstandings or debates about what to do in particular situations.

6.24 This review has highlighted a number of important issues including the lack of compliance or rigorous pursuit in relation to existing policies, guidelines and protocols. Recommendations included the need to regularly review existing policies, guidelines and protocols to ensure they are kept up to date with changing legislation and changes within individual HSC organisations. Other areas for development included the need for HSC organisations to establish a system for the development, approval and implementation of policies that include clear lines of accountability and specific timescales for review. In addition the need to provide clinical teams with formalised, 'user-friendly' protocols and guidance was strongly recommended.

6.25 Further recommendations included the need for effective systems within organisations to ensure the effective communication and dissemination of the content of policies, guidelines and protocols to all relevant staff. In addition, the evaluation of the effectiveness of systems for developing and implementing policies, guidelines and protocols, should be part of the organisation's quality improvement programme.

6.26 Nurses and midwives must be cognisant that their own professional judgement should not be compromised or ignored if deviation from policies, guidelines or protocols is appropriate (An Bord Altranais, 2000). It should also be recognised that

policies, guidelines and protocols represent a statement reflecting an expected standard of care and can be introduced in law as evidence of the standard of care expected of a 'reasonable nurse or midwife' (An Bord Altranais, 2000). Therefore, reasons for the deviation should always be well documented.

Mental health

6.27 A few of the inquiries included in this study had specific relevance to failures within mental health services. A common theme arising from these inquiries related to failures by HSC Trusts to learn from serious untoward events. Areas highlighted included the need for the development of policies, procedures and strategies that actively engage service users and their carers in the planning, delivery and evaluation of mental health services. The need to develop policies explicitly detailing the duties and responsibilities of the Primary and Associate Nursing roles was also recommended.

6.28 Similarly, a number of concerns were presented with relevance to a lack of patient information exchange between mental health nursing staff and the police or ambulance staff. In addition, recommendations were made regarding the need for community mental health staff to remain actively involved after their patient's admission and discharge planning was implemented.

6.29 Recommendations were also made to ensure HSC Trusts undertake an appropriate assessment of training needs to ensure that training provision is focused on an individual's continuous professional development and organisational needs and that a multi-disciplinary approach is facilitated where appropriate. In addition, the review and prioritisation of training and information for all levels of staff who encounter adolescents, young people and families seeking advice and assistance on mental health was recommended. Similarly, recommendations were made in relation to the need for HSC Trusts to ensure that all staff (clinical and non-clinical) and volunteers working in adult mental health services receive formal training in child and adult protection and the management of aggressive or challenging behaviour.

Maternity services

6.30 Similarly, a few inquiries included within this study made specific relevance to critical incidents and failures within maternity services. Areas highlighted for development with relevance to midwives include the need for the development of midwifery skills to enable midwife led services and the utilisation of midwives, including the use of support roles. Other areas included the need for HSC Trusts to strengthen the processes for the dissemination of action required and feedback from audits and, an increase in regular audits and reviews of record keeping standards.

6.31 Recommendations were also made to ensure that meetings of labour ward forums within HSC Trusts were conducted at least once every three months with risk management groups meeting at least once every six months and that these meetings should be formally recorded and minutes made available to all staff. In addition, the creation of the right multi-professional environment with emphases on vision, leadership and management was emphasised along with the provision of multi-professional continuous professional development and on-site training where appropriate.

Infection control

6.32 Hospital-acquired infections can cause significant morbidity and mortality among patients who receive health care. In Northern Ireland infection control teams operate within HSC Trusts to advise on measures to tackle hospital-acquired infections.

6.33 However, three separate inquiries included in this study highlighted concerns with specific relevance to infection control. These concerns included the need for a regional workforce plan and career structure for infection control, a review of the training and learning needs and the development of a regional training programme for infection control staff. In addition, the availability of staff with appropriate skills and dedicated time for surveillance functions was recommended along with the

need for arrangements to be put in place to ensure 24 hours per day, 7 days per week on-call cover for infection control.

6.34 The development of nurse consultant posts in infection control across the region was also recommended along with arrangements to ensure that the views of service users were used to inform infection control processes.

Recordkeeping

6.35 Good recordkeeping is at the heart of safe and effective patient care and an essential component of understanding what went wrong and why if things do go awry (Bridgelal & Carpenter, 2007). It is therefore vital all staff maintain up-to-date and accurate information relating to symptoms, diagnosis and treatment in patient health records for many reasons, particularly as inaccurate record keeping can result in delays and possible harm to the patient. Nonetheless, independent inquiries, health ombudsmen's reports and the courts have repeatedly criticised the quality of records and the resulting failings of care (Pullen & Loudon, 2006).

6.36 Similar poor practice related to recordkeeping has been identified by the inquiries included in this review. These includes the low priority given to the recording and management of records; the lack of awareness of the importance of good record-keeping; a lack of standardised approaches to documentation that would enable a continuous record of assessed needs; a lack of clarity in the recorded planning and coordination of care and inadequate recording of communication between key players, be they professionals, patients or carers.

6.37 The recommendations from this review suggest a range of areas that require development in relation to recordkeeping. These include the need for the development of effective documentation and clinical recording practices as part of clinical governance in all clinical settings**.** In addition, the need for a review of the implementation of assessment, risk assessment and care planning procedures by all professionals to ensure they comply with DHSSPS standards was identified.

This practice would also help to ensure recordkeeping contains clear records on opening and closing cases, a chronology of events, interagency communication, detailed care plans and transfer procedures and that all multi-disciplinary records are kept in one section of the in-patient file in continuous, chronological order. Similarly, to support good recordkeeping practices recommendations were made to ensure that all medical, midwifery and nursing staff within HSC Trusts have access to training and updates in relation to documentation and record keeping as and when required.

Admission/discharge/transfer

6.38 In recent years, numerous reports and documents have highlighted the need for improvements to the admission and discharge arrangements for patients within health and social care services (DH, 2000; DH, 2004a, b, c). Of equal importance is the need to ensure that the transition of patients from hospital to community care, or vice versa, is safe, timely, coordinated and well communicated. Errors arising at "handover points" within the healthcare system and the need for greater communication and co-operation between health and social care, and secondary and primary care sectors, are seen as key elements to effective transfer and discharge (Royal Pharmaceutical Society, 2009).

6.39 The findings from this review highlighted current variability across the HSC about the way in which admissions, discharges and transfers are handled. Although many elements of good practice exist, in many places more could be done to improve the effectiveness and efficiency of admissions, discharges and transfers as well as the patient's experience of these processes.

6.40 Recommendations from the inquiry reports included the need for HSC Trusts to ensure that procedures for admission and discharge are not viewed as separate actions. They should be as a single process that provides staff with a framework for structured and continuous care. In addition, mechanisms for effective communication between all health and social care professionals involved in the

care of a patient are important if planning for discharge or transfer is to start as early as possible. In order for this to happen risk assessments should be included in any admission and discharge policy. Also the multi-professional team must be aware of their role in discharge planning, have access to appropriate tools and guidance, implement in full all aspects of the discharge guidance and be supported by relevant education and training opportunities.

6.41 Other recommendations from the inquiries included the need for HSC Trusts to review admission and discharge protocols and procedures and develop a clear discharge pathway to include patient and carer involvement. Similarly, the need for Trusts to review inter-hospital transfer arrangements including the transfer arrangements of patients' records was strongly recommended.

Training and Development

6.42 Training and development is the keystone of clinical governance and assurance frameworks (NHSCT, 2008). To support this, every health care organisation needs to have a locally managed system of continuing professional development with the emphasis on learning in teams and work-based learning (Swage, 2004).

6.43 However, the findings from this review highlight a range of shortcomings in relation to training and development within HSC organisations. These include a lack of evidence with relevance to clear training and education strategies as well as systems to identify training needs, data systems to capture provision, uptake and audits of training and development.

6.44 Recommendations from the inquiries included the need for the education, development and training needs of staff to be assessed and linked to training plans with appropriate policies, procedures and training programmes in place to enable staff to meet the needs of the service. In addition, information systems that ensure details of attendance at training events, particularly mandatory training, are recorded and monitored where recommended.

6.45 Where relevant, the need for multi-professional team training and multidisciplinary education opportunities were also strongly recommended to assist health and social care professionals to build better working relationships, with knowledge and respect for one another's roles. Other areas highlighted for development included the need for continuous training opportunities for staff aimed at re-emphasising accountability and responsibility and, improving their skills in listening to and communicating with patients and families. Similarly, the need to provide access to life skills training, accredited programmes, core skills and continuous professional development in response to Trust and health service were identified. To support this process, the promotion of equality of access and a range of flexible learning interventions, recognising the 24/7 environment in which people work and the need for work/life balance was highlighted as an area for further development.

6.46 Recommendations also re-emphasised the need for annual staff appraisals which include a training needs assessment, linked to the trust training needs analysis and induction and, on-going training of staff to highlight Trust policies. The importance of HSC Trusts ensuring that the education and training provided to staff is continually quality assured and sources of funding are used effectively, efficiently and appropriately was also recommended.

Clinical supervision

6.47 Recommendations from the majority of the inquiries included in this review supported the need for the development, implementation and maintenance of robust supervision processes within HSC Trusts for safe and effective care delivery across all disciplines. A review of supervision policies within HSC Trusts was also recommended to include the maintenance of appropriate records in any supervision processes.

6.48 Clinical supervision is a term used to describe the formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance

patient/client protection and safety of care in complex clinical situations (National Public Health Service, 2005). While clinical supervision may be a new concept to many healthcare practitioners, supervision in practice is not, although there may well be differences in the emphases or functions of supervision depending on the professional background (Driscoll, 2009).

6.49 In relation to nursing and midwifery, recommendations were made to ensure that HSC Trust policies introduce and maintain sound arrangements for clinical supervision in accordance with the NMC's (2002) principles in 'Supporting nurses and midwives through lifelong learning'.

6.50 To further support these recommendations, and subsequent to a review of clinical supervision carried out by the Northern Ireland Practice and Education Council for nursing and midwifery (NIPEC, 2007), the Chief Nursing Officer (CNO) for Northern Ireland published two standard statements for supervision (CNO, 2007). The implementation and maintenance of supervision processes will be monitored against these standards via a report submitted annually to the DHSSPS by each Trust Executive Director of Nursing.

7.0 CONCLUSION

7.1 This systematic review identified an increase in the number and scope of public inquiries and reviews with relevance to health and social care in Northern Ireland in recent years. Public inquiries and reviews provide a unique and important opportunity to identify the lessons to be learned for all healthcare settings in order to increase patient safety and improve on the quality of care. Furthermore, the findings from these reports provide health and social care organisations in Northern Ireland with a baseline for the development of governance arrangements, systems and processes.

7.2 It is worrying that the consistency with which these inquiries and reviews highlight similar causes and concerns, suggest that their recommendations are not being fully implemented. Findings that emerge again and again include a lack of clarity in the planning and coordination of care, poor record-keeping, inadequate communication and poor implementation of local guidance and statutory obligations. Similar issues have also been reported in earlier public inquiries, independent reviews and health ombudsmen's reports conducted locally and nationally as well as within international patient safety research literature.

7.3 The recommendations include the need for HSC organisations to ensure that robust governance arrangements, visible and rigorous structures, systems, processes, roles and responsibilities are in place to plan for, deliver, monitor and promote safety and quality improvements in the provision of health and social care. Similarly, effective leadership and communication, workforce development, multi-disciplinary working and the implementation of statutory obligations and local guidance are key factors in managing the change necessary to improve healthcare services for patients.

7.4 It is imperative that the recommendations and lessons from public inquiries and reviews are adopted and applied, where relevant, by all HSC Trusts in Northern Ireland and that nurses and midwives within each Trust or practice area consider their own practice and service so that the risk of recurrence of failures is minimised.

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Appendix 1

Inquires and reviews which met inclusion criteria

RQIA commissioned reviews

Month/Year	Title
October 2005	Review of the Lessons Arising from the Death of Mrs Janine Murtagh
March 2006	Governance review of the Northern Ireland Breast Screening Programme
September 2007	Cherry Lodge Children's Home: Independent review into safe and effective respite care for children and young people with disabilities
April 2008	Reducing the risk of hyponatraemia when administering intravenous infusions to children
March 2008	Review of assessment and management of risk in adult mental health services in health and social care (HSC) trusts in Northern Ireland
May 2008	*Clostridium Difficile* RQIA Independent Review. Protecting patients – reducing risks
August 2008	Independent Review into the Outbreak of *Clostridium difficile* at the Northern Health and Social Care Trust
October 2008	Review of actions taken on recommendations from a critical incident review within maternity services, Altnagelvin Hospital, Western Health and Social Care Trust
February 2008	Review of Clinical and Social Care Governance Arrangements in HPSS Organisations in Northern Ireland, Overview Report

Health and Social CareTrust reviews

Month/Year	Title
July 2008	Independent review of maternity services in the Northern Health and Social Care Trust

Health and Social Care Board reviews

Month/Year	Title
May 2006	The report of the inquiry panel (McCleery) to the Eastern Health and Social Services Board
June 2007	Independent Review of Circumstances Surrounding Death of Danny McCartan. Report of an independent review panel of the Eastern Health and Social Services Board concerning the Mater Hospital Trust, N&W Belfast Trust and S&E Belfast Trust
March 2008	Report of the independent inquiry panel to the Western and Eastern Health and Social Services Boards re Madeleine and Lauren O'Neill

DHSSPS reviews

Month/Year	Title
August 2005	Department of Health Social Services and Public Safety Review of Children First Final Report
June 2008	Independent review report of agency involvement with Mr Arthur McElhill, Ms Lorraine McGovern and their children
March 2005	The report of an independent review of endoscope decontamination in Northern Ireland
May 2008	Independent review of autism services
June 2008	Independent Review Report Of Agency Involvement with Mr A.McElhill, Ms L.McGovern and their children

Other reviews

Month/Year	Title
December 2005	National Confidential Enquiry into Maternal and Child Health Organisation - Project 27/28: inquiry into quality of neonatal care and its effect on the survival of infants who were born at 27 and 28 weeks in England, Wales, and Northern Ireland

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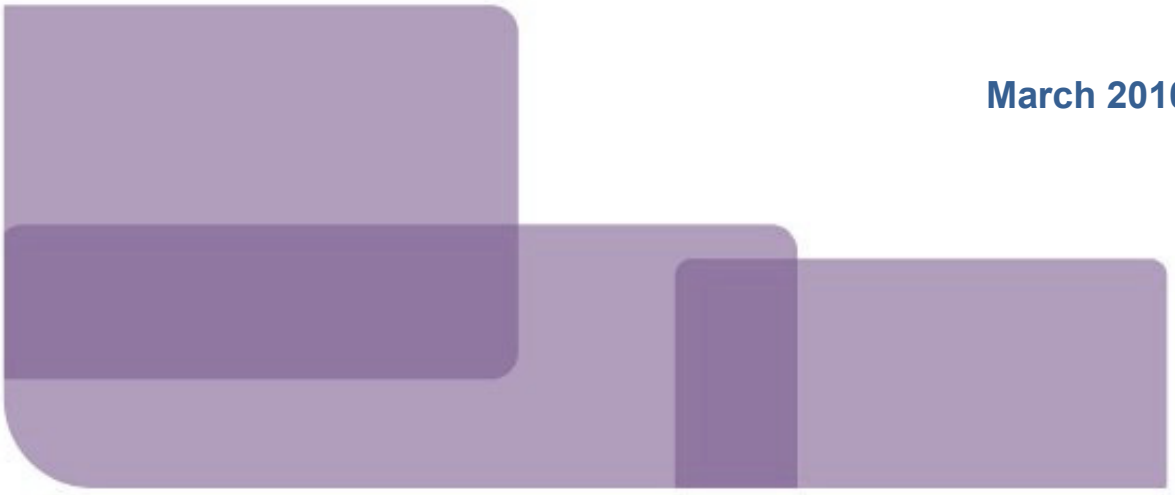

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