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Northern Ireland Breast Screening Programme
Learning Event/Incident Protocol

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Approved By:	**QA Director for Breast Screening**
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HSC Public Health Agency

NORTHERN IRELAND BREAST SCREENING PROGRAMME

LEARNING EVENT/ INCIDENT REPORTING PROTOCOL

July 2013

Quality Assurance Reference Centre

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NORTHERN IRELAND BREAST SCREENING PROGRAMME
LEARNING EVENT / INCIDENT REPORTING PROTOCOL

This protocol has been developed to assist in addressing risk management issues raised in EL(97)67 and reduce risks within the Northern Ireland Breast Screening Programme. This document was produced following the publication of 'Managing Serious Incidents in National Screening Programmes'[1] and 'Guidelines for Managing Incidents in the Breast Screening Programme'[2].(NHSBSP publication no 44) website address is given below.

http://www.cancerscreening.nhs.uk/breastscreen/publications/pm-09.html

The rationale for this protocol is to instigate a learning event/incident reporting agreement between all Northern Ireland Breast Screening Units and the Regional Quality Assurance Reference Centre (QARC), PHA. The aim is for Units to alert the QARC at the earliest opportunity of any potential or actual untoward incidents within the Northern Ireland Breast Screening Programme. The definition of an untoward incident is variable, but relates to potential clinical risk to the eligible population, risk to the service, adverse media attention and risk of litigation. If in any doubt, it is advisable to report the incident regardless.

The Breast Screening Service Screening Director/Lead for Breast Screening is responsible for adherence to this protocol. This protocol should be used concurrently with local clinical governance policies and early warning schemes and should be part of the breast screening service agreement at local level. This protocol should also be used in conjunction with national guidance, NHSBSP publication no 44, for adverse incidents.

Initial procedure for informing QARC

The process for reporting incidents is detailed in **Appendix 1**. Initially the Unit Screening Director (or nominated representative) should immediately inform, by telephone, either Colin McMullan or Joan McSorley at the QA Reference Centre (**QARC – see Appendix 2**) of any event which adversely impacts on breast screening service provision. The service concerned will also be asked to submit their internal Trust incident reporting form for information to the QARC within 5 days.

Quarterly Reporting

In addition to events and incidents being reported to QARC as they occur, all Directors/ Leads for Breast Screening are asked to complete the Northern Ireland Breast Screening Programme Quarterly Learning Event /Incident **(Appendix 3).**

What constitutes an incident?

It must be noted that many problems identified by screening services are isolated events and not systemic throughout the programme posing a serious risk to the eligible population. However, the QARC should be informed of "near misses" and other minor incidents/learning events whatever the perceived importance at the time.

The following are suggestions as to what may constitute an incident:

- Failure to invite women when due (e.g. GP practices/individuals left off call and recall system)
- Inadequate failsafe batching
- Failure to follow programming guidance (e.g. Right Results protocol, note clinical signs and symptoms IR(ME)R guidance)

- Quality control procedures not followed
- Inadequate screening/film reading
- Inadequate/incomplete assessment
- Recall to assessment not actioned
- Failure to invite back women on early recall
- Biopsy specimen mix-up
- Client identity mix-up
- Equipment failure (including PACS & digital integration)
- Inability to retrieve digital images
- Breach of confidentiality (e.g. loss of screening packets/screening samples)
- Any resignation or unexpected absence (for example due to ill health for more than 10 working days) of personnel *(usually lead personnel in each discipline and all Consultant staff)*.
- Any equipment failure that results in stopping screening/assessment for more than 5 working days.
- Postponing screening/assessment for more than 5 working days or a reduction in the usual screening or assessment workload equivalent to 5 working days.
- Any potential serious untoward incident or any concerns considered as significant by the local breast screening team.

These examples are taken from NHSBSP publication no 44[2] and the East Midlands Adverse Incident Reporting Protocol

Reporting to the QARC

The above is not an exhaustive list. The QA Director must be informed immediately of a suspected problem in any of the following circumstances:

- actual harm or risk of harm to women eligible for breast screening
- actual harm or risk of harm to staff
- concern about professional competence of an individual
- concern about the competence of the screening team
- failure or misuse of equipment
- failure or malfunction of the breast screening IT system (NBSS)
- breach of patient confidentiality or data security
- systematic failure to comply with national guidelines or local breast
- screening protocols.

The process of managing Learning Events / Incidents in the Breast Screening Programme is outlined in Appendix 1. This process will be applied in parallel to local protocols for managing incidents. Where appropriate incidents which are sufficiently serious will be managed as Serious Adverse Incidents.

The QARC and Unit Screening Director will discuss the likely impact of the reported situation. An assessment of the situation will be made with agreed actions between the Breast Screening Director/Lead for Breast Screening and Director of Quality Assurance (D Adrian Mairs). If the incident is deemed sufficiently serious, the QA director will advise the Chief Executive of the host organisation, the Director of Public health and the Assistant Director of Service Development and Screening that an incident should be declared. The National Cancer Screening office will also be informed of the incident.

The role of QARC is to work with the provider organization to investigate and to assist in resolving any issues and to identify and promote any shared learning. Learning events will be reviewed by the Breast Screening QA Committee and relevant QA Subgroups.

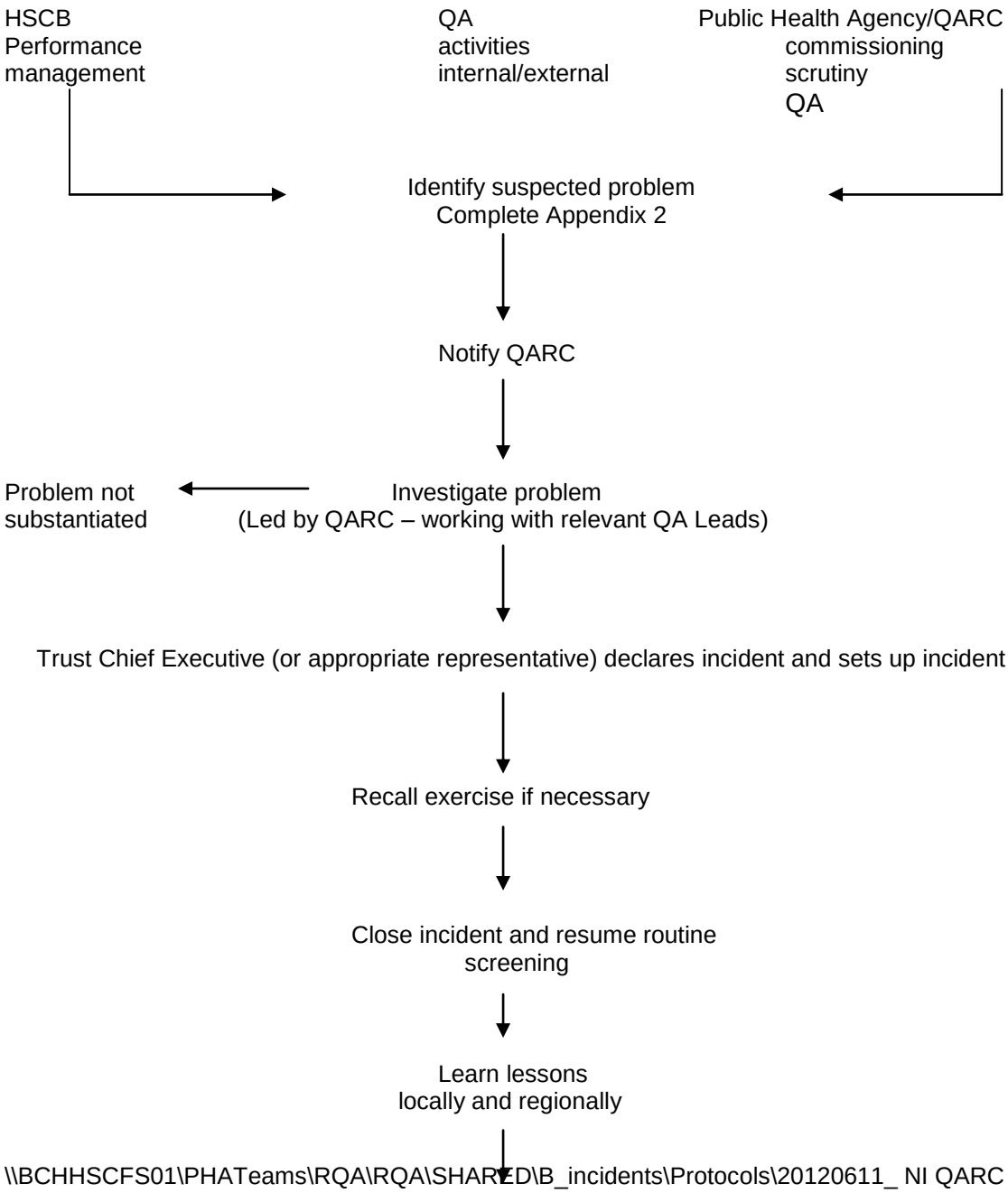
References
Note that if any of these documents are later revised, the most recent edition should be referred to.

1. *Managing Serious Incidents in National Screening Programmes* Guidance on behalf of UK National Screening Committee, NHS Cancer Screening programmes National Patient Safety Agency (April 2010)

2. *Guidelines for Managing Incidents in the Breast Screening Programme* NHSBSP Publication No. 44 (Third Edition January 2009)

Appendix 1

Guidelines for Managing Learning Events/Incidents in the Breast Screening Programme



Monitor actions

APPENDIX 2

Learning event / Incident reporting form – for screening service providers reporting to QARC, PHA

Organisation	Service concerned	Staff reporting incident to QARC (and designation)	Date and person reported to in QARC	Date of incident
Description of problem				
Action undertaken to date				
Other people/organisations informed				
Further actions planned				
QARC comments/actions				
Escalated to SAI?				

Appendix 3

NORTHERN IRELAND BREAST SCREENING PROGRAMME QUARTERLY LEARNING EVENT /INCIDENT REPORT

SERVICE NAME: ..... **SCREENING DIRECTOR: .....**

Quarter ……. No incidents to report ☐ **please tick**

Date of Event	Details	Involved Parties	Action Undertaken by Unit	QA previously advised? Y/N (with dates)	Any Further Action Required	How has the Learning been shared within the Unit?	Suitable for shared learning with other Units?	Is there potential for re-occurrence?

REPORTED BY: .....

Appendix 4
Northern Ireland QA Contacts

QA Reference Centre

Name	Title	Telephone No.	Email
Dr Adrian Mairs	QA Director	028 90279392	adrian.mairs@hscni.net
Mr Colin McMullan	Cancer Screening Programmes Manager	028 90279381	colin.mcmullan@hscni.net
Joan McSorley	Quality Assurance Co-ordinator	028 90279381	joan.mcsorley@hscni.net
Clare Hall	Breast Screening Support Officer	028 90279381	clare.hall@hscni.net
Claire Armstrong	Administrative Officer	028 90279381	claire.armstrong@hscni.net
Gemma Harper	Meetings Administrator	028 90279381	gemma.harper@hscni.net
Frances Redmond	Admin Assistant	028 90279381	frances.redmond@hscni.net

QA Professional Co-ordinators

Name	Title	Telephone No.	Email
Mrs Georgie O'Kane	Administration & Clerical Co-ordinator	028 90333700	georgie.o'kane@belfasttrust.hscni.net
Dr Adam Workman	Medical Physics Co-ordinator	028 90944385	adam.workman@belfasttrust.hscni.net
Ms Elaine Heaney	Nursing Co-ordinator	028 94424874	elaine.heaney@northerntrust.hscni.net
Dr Neil Anderson	Pathology Co-ordinator	028 90632676	neil.anderson@belfasttrust.hscni.net
Dr Gavin Briggs	Radiology Co-ordinator	028 38334444 x 3699/3754	gavin.briggs@southerntrust.hscni.net
Dorothy McFaul	Radiography Co-ordinator	028 7161 1443	Dorthy.mcfaul@westerntrust.hscni.net
Mr Robert Kennedy	Surgery Co-ordinator	028 90484511 X 3399	robert.kennedy@setrust.hscni.net