Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
T: 02890 251005 | E: info@usi.org.uk | W: www.urologyservicesinquiry.org.uk

Mary Burke
Assistant Director of Acute Services; Medicine and Unscheduled care
Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

29 April 2022

Dear Madam,

Re: The Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust

Provision of a Section 21 Notice requiring the provision of evidence in the form of a written statement

I am writing to you in my capacity as Solicitor to the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust (the Urology Services Inquiry) which has been set up under the Inquiries Act 2005 ('the Act').

I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

You will be aware that the Inquiry has commenced its investigations into the matters set out in its Terms of Reference. The Inquiry is continuing with the process of gathering all of the relevant documentation from relevant departments, organisations and individuals. In addition, the Inquiry has also now begun the process of requiring individuals who have been, or may have been, involved in the range of matters which come within the Inquiry's Terms of Reference to provide written evidence to the Inquiry panel.

The Urology Services Inquiry is now issuing to you a Statutory Notice (known as a Section 21 Notice) pursuant to its powers to compel the provision of evidence in the form of a written statement in relation to the matters falling within its Terms of Reference.

The Inquiry is aware that you have held posts relevant to the Inquiry's Terms of Reference. The Inquiry understands that you will have access to all of the relevant information required to provide the witness statement required now or at any stage

throughout the duration of this Inquiry. Should you consider that not to be the case, please advise us of that as soon as possible.

The Schedule to the enclosed Section 21 Notice provides full details as to the matters which should be covered in the written evidence which is required from you. As the text of the Section 21 Notice explains, you are required by law to comply with it.

Please bear in mind the fact that the witness statement required by the enclosed Notice is likely (in common with many other statements we will request) to be published by the Inquiry in due course. It should therefore ideally be written in a manner which is as accessible as possible in terms of public understanding.

You will note that certain questions raise issues regarding documentation. As you are aware the Trust has already responded to our earlier Section 21 Notice requesting documentation from the Trust as an organisation. However if you in your personal capacity hold any additional documentation which you consider is of relevance to our work and is not within the custody or power of the Trust and has not been provided to us to date, then we would ask that this is also provided with this response.

If it would assist you, I am happy to meet with you and/or the Trust's legal representative(s) to discuss what documents you have and whether they are covered by the Section 21 Notice.

You will also find attached to the Section 21 Notice a Guidance Note explaining the nature of a Section 21 Notice and the procedures that the Inquiry has adopted in relation to such a notice. In particular, you are asked to provide your evidence in the form of the template witness statement which is also enclosed with this correspondence. In addition, as referred to above, you will also find enclosed a copy of the Inquiry's Terms of Reference to assist you in understanding the scope of the Inquiry's work and therefore the ambit of the Section 21 Notice.

Given the tight time-frame within which the Inquiry must operate, the Chair of the Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance in the Notice itself.

If there is any difficulty in complying with this time limit you must make application to the Chair for an extension of time before the expiry of the time limit, and that application must provide full reasons in explanation of any difficulty.

Finally, I would be grateful if you could acknowledge receipt of this correspondence and the enclosed Notice by email to Personal Information redacted by the USI.

Please do not hesitate to contact me to discuss any matter arising.

Yours faithfully

Personal Information redacted by the USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

Tel: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

Issued by Urology Services Inquiry on 29 April 2022. Annotated by the Urology Services Inquiry.

THE INDEPENDENT PUBLIC INQUIRY INTO
UROLOGY SERVICES IN THE
SOUTHERN HEALTH AND SOCIAL CARE TRUST

Chair's Notice

[No 19 of 2022]

pursuant to Section 21(2) of the Inquiries Act 2005

WARNING

If, without reasonable excuse, you fail to comply with the requirements of this Notice you will be committing an offence under section 35 of the Inquiries Act 2005 and may be liable on conviction to a term of imprisonment and/or a fine.

Further, if you fail to comply with the requirements of this Notice, the Chair may certify the matter to the High Court of Justice in Northern Ireland under section 36 of the Inquiries Act 2005, where you may be held in contempt of court and may be imprisoned, fined or have your assets seized.

TO:

Mary Burke
Assistant Director of Acute Services; Medicine and Unscheduled care
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.

2. The Notice requires you to do the acts set out in the body of the Notice.

3. You should read this Notice carefully and consult a solicitor as soon as possible about it.

4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.

5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by **noon on 10th June 2022.**

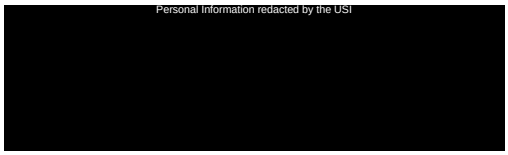
APPLICATION TO VARY OR REVOKE THE NOTICE

AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **noon on 3rd June 2022**.

Upon receipt of such a claim the Chair will then determine whether the Notice should be revoked or varied, including having regard to her obligations under section 21(5) of the Act, and you will be notified of her determination.

Dated this day 29th April 2022

Signed: 

Christine Smith QC

Chair of Urology Services Inquiry

Urology Services Inquiry

SCHEDULE

[No 19 of 2022]

General

1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"), except where those documents have been previously provided to the USI by the SHSCT. Please also provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. If you are in any doubt about the documents previously provided by the SHSCT you may wish to discuss this with the Trust's legal advisors, or, if you prefer, you may contact the Inquiry.

Your position(s) within the SHSCT

4. Please summarise your qualifications and your occupational history prior to commencing employment with the SHSCT.

5. Please set out all posts you have held since commencing employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

6. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for.

7. With specific reference to *the operation and governance of urology services*, please set out your roles and responsibility and lines of management.

8. It would be helpful for the Inquiry for you to explain how those aspects of your role and responsibilities which were *relevant to the operation and governance of urology services*, differed from and/or overlapped with, for example, the roles of the Medical Director, Clinical Director, Associate Medical Director and Head of Urology Service or with any other role which had governance responsibility.

Urology services/Urology unit - staffing

9. The Inquiry understands that a regional review of urology service was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. This review was completed in March 2009 and recommended three urology centres, with one based at the Southern Trust - to treat those from the Southern catchment area and the lower third of the western area. As relevant, set out

your involvement, if any, in the establishment of the urology unit in the Southern Trust area.

10. What, if any, performance indicators were used within the urology unit at its inception?

11. Was the *'Integrated Elective Access Protocol'* published by DOH in April 2008, provided to or disseminated in any way by you or anyone else to urology consultants in the SHSCT? If yes, how and by whom was this done? If not, why not?

12. How, if at all, did the *'Integrated Elective Access Protocol'* (and time limits within it) impact on the management, oversight and governance of urology services? How, if at all, were the time limits for urology services monitored as against the requirements of the protocol? What action, if any, was taken (and by whom) if time limits were not met?

13. The implementation plan, *Regional Review of Urology Services, Team South Implementation Plan*, published on 14 June 2010, notes that there was a substantial backlog of patients awaiting review at consultant led clinics at that stage and included the Trust's plan to deal with this backlog.

    I. What is your knowledge of and what was your involvement with this plan?
    II. How was it implemented, reviewed and its effectiveness assessed?
    III. What was your role in that process?
    IV. Did the plan achieve its aims in your view? OR Please advise whether or not it is your view that the plan achieved its aims? If so, please expand stating in what way you consider these aims were achieved.

14. Were the issues raised by the *Implementation Plan* reflected in any Trust governance documents or minutes of meetings, and/or the Risk Register? Whose role was to ensure this happened? If the issues were not so reflected, can you explain why? Please provide any documents referred to in your answer.

15. To your knowledge, were the issues noted in the *Regional Review of Urology Services, Team South Implementation Plan* resolved satisfactorily or did problems persist following the setting up of the urology unit?

16. Do you think the unit was adequately staffed and properly resourced from its inception? If that is not your view, can you please expand noting the deficiencies as you saw them?

17. Were you aware of any staffing problems within the unit since its inception? If so, please set out the times when you were made aware of such problems, how and by whom.

18. Were there periods of time when any posts within the unit remained vacant for a period of time? If yes, please identify the post(s) and provide your opinion of how this impacted on the unit. How were staffing challenges and vacancies within the unit managed and remedied?

19. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of urology services?

20. Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why?

21. Has your role changed in terms of governance during your tenure? If so, explain how it has changed with particular reference to urology services, as relevant?

22. Explain your understanding as to how the urology unit and urology services were supported by non-medical staff. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff. If you not have sufficient understanding to address this question, please identify those individuals you say would know.

23. Do you know if there was an expectation that administration staff would work collectively within the unit or were particular administration staff allocated to particular consultants? How was the administrative workload monitored?

24. Were the concerns of administrative support staff, if any, ever raised with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, you did in response.

25. Who was in overall charge of the day to day running of the urology unit? To whom did that person answer, if not you? Give the names and job titles for each of the persons in charge of the overall day to day running of the unit and to whom that person answered throughout your tenure.

26. What, if any role did you have in staff performance reviews?

27. Was your role subject to a performance review or appraisal? If so, please explain how and by whom and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

Engagement with unit staff

28. Describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.

29. Please set out the details of any weekly, monthly or daily scheduled meetings with any urology unit/services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

30. During your tenure did medical and professional managers in urology work well together? Whether your answer is yes or no, please explain by way of examples regarding urology.

Governance – generally

31. What was your role regarding the consultants and other clinicians in the unit, including in matters of clinical governance?

32. Who oversaw the clinical governance arrangements of the unit and how was this done? As relevant to your role, how did you assure yourself that this was being done appropriately?

33. How did you oversee the quality of services in urology? If not you, who was responsible for this and how did they provide you with assurances regarding the quality of services?

34. How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for this overseeing performance metrics?

35. How did you assure yourself regarding patient risk and safety in urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

36. How could issues of concern relating to urology services be brought to your attention? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the unit, such as from patients. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

37. Did those systems or processes change over time? If so, how, by whom and why?

38. How did you ensure that you were appraised of any concerns generally within the unit?

39. How did you ensure that governance systems, including clinical governance, within the unit were adequate? Did you have any concerns that governance issues were not being identified, addressed and escalated as necessary?

40. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as Governance meeting minutes or notes, or in the Risk Register? Please provide any documents referred to.

41. What systems were in place for collecting patient data in the unit? How did those systems help identify concerns, if at all?

42. What is your view of the efficacy of those systems? Did those systems change over time and, if so, what were the changes?

43. During your tenure, how well do you think performance objectives were set for consultant medical staff and for specialty teams? Please explain your answer by reference to any performance objectives relevant to urology during your time, providing documentation or sign-posting the Inquiry to any relevant documentation.

44. How well did you think the cycle of job planning and appraisal worked and explain why you hold that view?

45. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns having the potential to impact on patient care and safety arose. Please provide an explanation of that process during your tenure, including the name(s) and role of those involved, how things were escalated and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your tenure.

46. Did you feel supported in your role by the medical line management hierarchy? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.

Concerns regarding the urology unit

47. The Inquiry is keen to understand how, if at all, you, as Assistant Director, liaised with, involved and had meetings with the following staff (please name the individual/s who held each role during your tenure):

    (i) The Chief Executive(s);
    (ii) the Medical Director(s);
    (iii) the Director(s) of Acute Services;
    (iv) the other Assistant Director (s);
    (v) the Associate Medical Directors;
    (vi) the Clinical Director(s);
    (vii) the Head of Service;
    (viii) the consultant urologists.

    When answering this question, the Inquiry is interested to understand how you liaised with these individuals in matters of concern regarding urology governance generally, and in particular those governance concerns with the potential to impact on patient care and safety. In providing your answer, please set out in detail the precise nature of how your roles interacted on matters (i) of governance generally, and (ii) specifically with reference to the concerns raised regarding urology services. Where not previously provided, you should include all relevant documentation, dates of meetings, actions taken, etc.

48. Following the inception of the urology unit, please describe the main problems you encountered or were brought to your attention in respect of urology services? Without prejudice to the generality of this request, please address the following specific matters: -

    (a) What were the concerns raised with you, who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those concerns? Please provide details of all meetings, including dates, notes, records etc., and attendees, and

detail what was discussed and what was planned as a result of these concerns.

(b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?

(c) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If not, why not.

(d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements?

(e) How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?

(f) If you were given assurances by others, how did you test those assurances?

(g) Were the systems and agreements put in place to rectify the problems within urology services successful?

(h) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.

49. Having regard to the issues of concern within urology services which were raised with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether you consider that these issues of concern were -

(a) properly identified,
(b) their extent and impact assessed,
(c) and the potential risk to patients properly considered?

50. What, if any, support was provided to urology staff (other than Mr O'Brien) by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q64 will ask about any support provided to Mr O'Brien).

51. Was the urology department offered any support for quality improvement initiatives during your tenure?

Mr. O'Brien

52. Please set out your role and responsibilities in relation to Mr. O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?

53. What was your role and involvement, if any, in the formulation and agreement of Mr. O'Brien's job plan(s)? If you engaged with him and his job plan(s) please set out those details in full.

54. When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant documents. Do you now know how long these issues were in existence before coming to your or anyone else's attention? Please provide full details in your answer.

55. Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr. O'Brien, whether with Mr. O'Brien or with others (please name). You should set out in detail the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.

56. What actions did you or others take or direct to be taken as a result of these concerns? If actions were taken, please provide the rationale for them. You

should include details of any discussions with named others regarding concerns and proposed actions. Please provide dates and details of any discussions, including details of any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.

57. Did you consider that any concerns raised regarding Mr O'Brien may have impacted on patient care and safety? If so:

    (i) what risk assessment did you undertake, and
    (ii) what steps did you take to mitigate against this? If none, please explain. If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person.

58. If applicable, please detail your knowledge of any agreed way forward which was reached between you and Mr. O'Brien, or between you and others in relation to Mr. O'Brien, or between Mr O'Brien and others, given the concerns identified.

59. What, if any, metrics were used in monitoring and assessing the effectiveness of the agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before?

60. How did you assure yourself that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and comprehensive and were working as anticipated? What methods of review were used? Against what standards were methods assessed?

61. Did any such agreements and systems which were put in place operate to remedy the concerns? If yes, please explain. If not, why do you think that was the case? What in your view could have been done differently?

62. Did Mr O'Brien raise any concerns regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which

might impact on those issues? If yes, what concerns did he raise and with whom, and when and in what context did he raise them? How, if at all, were those concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something?

63. Did you raise any concerns about the conduct/performance of Mr O'Brien. If yes:
    (a) outline the nature of concerns you raised, and why it was raised
    (b) who did you raise it with and when?
    (c) what action was taken by you and others, if any, after the issue was raised
    (d) what was the outcome of raising the issue?
    If you did not raise any concerns about the conduct/performance of Mr O'Brien, why did you not?

64. What support was provided by you and the Trust specifically to Mr. O'Brien given the concerns identified by him and others? Did you engage with other Trust staff to discuss support option, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

65. How, if at all, were the concerns raised by Mr. O'Brien and others reflected in Trust governance documents, such as the Risk Register? Please provide any documents referred to. If the concerns raise were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.

Learning

66. Are you now aware of governance concerns arising out of the provision of urology services, which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why.

67. Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?

68. What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and the unit, and regarding the concerns involving Mr. O'Brien in particular?

69. Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

70. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

71. Do you think, overall, the governance arrangements were fit for purpose? Did you have concerns about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?

72. Given the Inquiry's terms of reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 19 of 2022

Date of Notice: 29th April 2022

Witness Statement of: Mary Burke

I, Mary Burke, Interim Assistance Director for Unscheduled Care, will say as follows:-

General

Q1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.

1. Having reviewed the terms of reference, and having considered my interim role as AD of Medicine and Unscheduled Care from 26th April 2012 -31st January 2013 when I covered for Mr Barry Conway, who was seconded out of this role and having considered my interim role of Medicine and Unscheduled Care 18th March 2020- 31st August 2020 when I covered for Mrs Anne McVey who was seconded out of this role, I can confirm that I was not involved in any meetings in relation to Urology services or Mr. Aidan O'Brien. I can confirm I had no knowledge or any concerns in relation to the Urology Service or Mr. O'Brien.

2. However, in my current role as interim AD for Unscheduled Care (1st September 2020 to present day), I can confirm that I attended the monthly Clinical Governance meetings which were chaired by the Director of Acute Services, Mrs Melanie McClements. I can confirm that at the meeting on 9th April 2021 which I attended, Mrs McClements advised under Chair's business that there were two matters arising, of which one was in relation to the Urology SAIs. Dr Maria O'Kane shared the learning from the 9 urology SAI's. The 9 SAIs were not shared at this meeting. This was the first time that I had knowledge of the concerns in relation to the Urology Service. *See 1. 202109041.1ClinicalGovernanceMinutes*

and 2.-35. 202109041.2ClinicalGovernanceAgenda located in S21 19 of 2022 Attachments

3. At a further Clinical Governance meeting on the 14th May 2021, which I attended, there was a paper shared in relation to the lessons learned and the recommendations in response to the findings from the nine patients, where a doctor did not adhere to agreed recommendations, varied from best practice guidance, and did not involve other specialists appropriately in care. This paper did not have an author and there was no further detail given on the SAIs. The Admin Review Process V13, was shared at the meeting. Mr Ronan Carroll (Assistant Director for Acute Services, Anaesthetics and Surgery) provided a summary of the review process and actions required to address ongoing risks/ flaws which were to be implemented.

   See located in S21 19 of 2022 Attachments, 36.-41. 202109041.3Admin Review, 42. 202109041.16LearningfromSAIs and 43.-82.20210514.1.17Acute Clinical Governance Agenda

4. My involvement included a further ten emails, which were emailed in June 2020, August 2021, October 2021, December 2021 and January 2022–

   a) 1 was a global email retirement announcement for Mr Aidan O'Brian on 08/06/2020
   See located in S21 19 of 2022 Attachments, 83. 202008061.8Retirement of Mr Aidan O'Brien,Consultant Urologist

   b) 4 emails were from three of the Assistant Directors regarding evidence which was being gathered regarding the inquiry received on the 14th October 2021. (Mr Barry Conway, Mr Ronan Carroll and Ms Anita Carroll)
   See located in S21 19 of 2022 Attachments, 84. 202114101.4Evidence Gathering 85.-86. 202114101.5Evidence Gathering, 87. 202114101.6Evidence Gathering, 88. 202114101.7Evidence Gathering

   c) 1 was on 31/08/21 and was a news article which was circulated by the communications team which I forwarded to my team on the same date –
   See located in S21 19 of 2022 Attachments, 89. 202131081.13NEDS - Inquiry into urology consultant to begin next week and 90. 20213108 NEDS1.12-Inquiry into urology consultant to begin next week forward

   d) 1 was a news article from Irish News regarding the inquiry on 02/12/2021 See appendix
   91.-92. 202102121.11NEDS update - Irish news - Urology inquiry located in S21 19 of 2022 Attachments

   e) 1 1 was a global email with an update from Heather Trouton for all staff regarding the inquiry which was sent on 09/12/2021 93. *202109121.9Public Inquiry Urology Services Global located in S21 19 of 2022 Attachments*

f) 1 was an expression of interest for Programme Director for Public Inquiry and Trust Liaison (for the Urology Inquiry) which was sent on the 07/01/2022 from global and forwarded onto my team by myself.
See located in S21 19 of 2022 Attachments 94. 202207011.10EOI Opportunity - Programme Director for Public Inquiry and Trust Liaison – Urology Services Inquiry

Roles Responsibilities -

Interim AD for Medicine and Unscheduled Care (24/04/2012-31/01/2013)

5. As the AD for Medicine and Unscheduled Care I was responsible for the operational/governance and financial management of all specialties in the Medical division. This incorporated the following specialties across all three sites (Craigavon Area Hospital, Daisy Hill Hospital, South Tyrone Hospital) - older people's medicine, endocrinology, rheumatology, neurology, gastroenterology, dermatology, cardiology, the emergency department, renal services, rehabilitation, discharge team, hospital social services, Minor Injuries, the emergency dental clinic and bed management. I collaborated closely with senior clinicians and other disciplines to implement the objectives of the Trust's Delivery Plan and ensure effective multidisciplinary working. I provided clear leadership to all staff in the division, as well as being responsible for effective financial management and the efficient use of all resources. I supported the Director of Acute Services with long term planning and service reform initiatives. My role did not include the Urology Service.

Interim AD for Medicine and Unscheduled Care (18/03/2020-31/08/2020)

6. As the AD for Medicine and Unscheduled Care I was responsible for the operational/governance and financial management of all specialties in the Medical division. This incorporated the following specialties across all three sites (Craigavon Area Hospital, Daisy Hill Hospital, South Tyrone Hospital) - older people's medicine, endocrinology, rheumatology, neurology, gastroenterology, dermatology, cardiology, the emergency department, renal services, rehabilitation, discharge team, hospital social services, Minor Injuries, the emergency dental clinic and bed management. I collaborated closely with senior clinicians and other disciplines to implement the objectives of the Trust's Delivery Plan and ensure effective multidisciplinary working. I provided clear leadership to all staff in the division, as well as being responsible for effective financial management and the efficient use of all resources. I supported the Director of Acute Services with long term planning and service reform initiatives. My role did not include the Urology Service.

Interim AD for Unscheduled Care (01/09/2020- Present)

7. As the AD for Medicine and Unscheduled Care I was responsible for the operational/governance and financial management of all specialties in the division. This incorporated Acute Medicine, Ambulatory Units, Minor Injuries unit, Emergency Departments and the Emergency Dental Clinic, as well as hospital at night and patient flow at Craigavon Area Hospital, Daisy Hill Hospital, and other settings as appropriate. I collaborated closely with senior clinicians and other

disciplines to implement the objectives of the Trust's Delivery Plan and ensure effective multidisciplinary working. I provided clear leadership to all staff in the division, as well as being responsible for effective financial management and the efficient use of all resources. My role does not include the Urology Service.

See located in S21 19 of 2022 Attachments, 95. 201102.1.14JDADMUSC and 96. 20190816.1.15JDADUC

Q2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"), except where those documents have been previously provided to the USI by the SHSCT. Please also provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below.

8. Please find attached all documents within my custody and control in relation to the Urology Service Inquiry, however, most of these documents are not specifically relevant to the Terms of Reference, with the exception of the Clinical Governance meetings on 9th April 2021, and the 14th May 2021.

   See S21 19 of 2022 Attachments for all documents

Q3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. If you are in any doubt about the documents previously provided by the SHSCT you may wish to discuss this with the Trust's legal advisors, or, if you prefer, you may contact the Inquiry.

Your position(s) within the SHSCT

Q4. Please summarise your qualifications and your occupational history prior to commencing employment with the SHSCT.

9. **Qualifications** –
   a) Pupil Nurse June 1983 to June 1984
   b) Registered Nurse June 1990-July 1991 (NMC Pin Personal Information redacted by the USI)
   c) BSc (Honours) in Nursing with a Management Pathway, Queens University Belfast obtained 2002

d) Postgraduate Certificate in Life Long Learning & Facilitation University of Ulster obtained 2004
e) Postgraduate Masters in Strategic Workforce Planning, University of Ulster – obtained June 2020

10. **Occupational History prior to SHSCT**
    a) Pupil Nurse, Craigavon Area Hospital, June 1982-1984.
    b) State Enrolled Nurse, Acute Medical Wards, Whittington Hospital, July 1984 – December 1986
    c) State Enrolled Nurse, British Nursing Association (Agency Nurse), January 1987-Feburary 1988.
    d) State Enrolled Nurse, General Surgical Ward University College Hospital London March 1988 – May 1990
    e) Student Nurse Bloomsbury Health Authority – June 1990 - July 1991
    f) Staff Nurse, Theatre Recovery, Craigavon Area Hospital, August 1991-Janurary 1993
    g) Staff Nurse, 2 North Surgical Ward, Urology/Gynaecology Craigavon Area Hospital, 1st February/ 1993- 2nd May 1999
    h) Night Sister/Bed Manager Craigavon Area Hospital, 3rd May 1999 1st October 2000
    i) Seconded to post of Clinical Educator for International Nurses/ Pre-reg and Newly Qualified Nurses/Nurse Bank Manager, 2nd October 2000 – 23rd September 2003
    j) Senior Nurse Manger South Tyrone Hospital and Nurse Bank, 24th September 2003-16th September 2007

Q5. Please set out all posts you have held since commencing employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

11.

- **Head of Non-Acute Hospitals - South Tyrone Hospital, Mullinure Hospital, Lurgan Hospital 17th September 2007-30th April 2010**

Areas of duties and responsibilities will include:

a) Elderly Care Wards/ Stroke Ward Day hospital, Lurgan Hospital, South Tyrone Hospital and Mullinure Hospital

b) I had overall responsibility for the operational management of Elderly Care and Stroke services in Non-Acute Hospital, ensuring programmes of care were identified and managed to improve the service provided to the older

person through improved performance, improved quality and an improved patient experience.

c) I was responsible for budget and for delivering financial balance within their area of responsibility and the management of cost improvement programmes to support the achievement of a balanced budget. I was also responsible for identifying and implementing service improvement initiatives within my area of responsibility.

d) I was responsible to ensure that staff were fully engaged in the process of change management and in particular, that clinicians and multi-disciplinary professionals were fully involved at the forefront of service improvement initiatives.

e) I provided managerial leadership for the staff within Non-Acute Hospitals in order to support the delivery of high quality clinical services for patients.

f) I worked in collaboration with Clinical Directors/Lead Clinician(s) to develop a team approach to the clinical services for which they were accountable

g) My role or responsibilities did not include the Urology services.

- **Head of Service for DHH Medicine and Unscheduled Care Daisy Hill Hospital 1st May 2010-30th November 2010**

Areas of Duties and Responsibilities –

a) As HOS I would have had responsibility for the Emergency Department, Female Medical, Male Medical, Level 4 Stroke and Elderly Care, and renal services on the DHH site.
b) I had overall responsibility for the operational management of these services, to ensure that programmes were identified and managed to improve the service provided to patients through improved performance, improved quality and an improved patient experience.
c) My role included effectively managing the budget and delivering financial balance within my area of responsibility and the management of cost improvement programmes to support the achievement of balanced budget. I was responsible for identifying and implementing service improvement initiatives within my area of responsibility.
d) I was responsible for ensuring that staff were fully engaged in the process of change management and in particular, that clinicians and multi-disciplinary professionals were fully involved at the forefront of service improvement initiatives.
e) The role involved providing managerial leadership for the staff within the relevant speciality(s) in order to support the delivery of high-quality clinical services for patients.

f) I worked in collaboration with Clinical Directors/Lead Clinician(s) to develop a team approach to the clinical services for which they were accountable ensuring good governance arrangements were in place
g) I worked in collaboration with other Heads of Services to ensure a consistent management approach across sites for efficient management of safe, high quality, Unscheduled and Elective Services to ensure delivery of all access standards.
h) My role did not include Urology Services

- **Head of Service/General Manager, Acute Medicine/ED/EDC, Craigavon Area Hospital, 1st December 2010-23rd April 2012**

Areas of duties and responsibilities-

a) Emergency Departments (EDs), Craigavon Area Hospital
b) Minor Injuries Unit (MIU), South Tyrone Hospital
c) Emergency Dental Clinic (EDC), Craigavon Area Hospital
d) Acute Medical Unit
e) Medical Wards and Specialty Craigavon Area Hospital site

a) I had overall responsibility for the operational management of the services, to ensure that programmes were identified and managed to improve the service provided to patients through improved performance, improved quality and an improved patient experience.

b) The role involved having responsibility for budget and for delivering financial balance within my area of responsibility and the management of cost improvement programmes to support the achievement of balanced budget. I was also responsible for identifying and implementing service improvement initiatives within my area of responsibility

c) I was responsible for ensuring that staff were fully engaged in the process of change management and in particular, that clinicians and multi-disciplinary professionals were fully involved at the forefront of service improvement initiatives.

d) I provided managerial leadership for the staff within the relevant speciality(s) that I was responsible for, in order to support the delivery of high-quality clinical services for patients.

e) My role involved working in collaboration with Clinical Directors/Lead Clinician(s) to develop a team approach to the clinical services for which they were accountable.

f) I was responsible for overseeing and ensuring good governance processes were in place for my areas of responsibility.

g) I worked in collaboration with other Heads of Services to ensure a consistent management approach across sites for efficient management of safe, high quality, Unscheduled and Elective Services to ensure delivery of all access standards.

h) My role did not include Urology services

- **Acting Assistant Director for Medicine and Unscheduled Care Craigavon Area Hospital - 24th April 2012-31st January 2013**

Duties and Responsibilities -

a) I was responsible to the Director of Acute Services for the delivery of high-quality care to patients in the Trust's Medicine and Unscheduled Care Division.

b) I was responsible for the operational management of all specialities in the division. This incorporated Older People's Medicine, Endocrinology, Rheumatology, Neurology, Gastroenterology, Dermatology, Cardiology, ED Department, Renal Services, Rehabilitation, Discharge team and Hospital Social Services and bed management in Craigavon Area Hospital and Daisy Hill Hospital.

c) My role involved working in close collaboration with senior clinicians and other disciplines to implement the objectives of the Trust's Corporate Plan and to ensure effective multidisciplinary working in the spirit of collective leadership.

d) I provided clear leadership to all staff in the division and was responsible for effective financial management and the efficient use of all resources. I also supported the Director of Acute Services with long term planning and transformation/service reform initiatives.

e) As an Assistant Director of Medicine & Unscheduled care I was a member of the Directorate's Senior Management team and contributed to policy development in the directorate and the achievement of its overall objectives.

f) My role did not include Urology Services.

- **Head of Service, Acute Medicine and Unscheduled Care, Craigavon Area Hospital, 1st February 2013-17th March 2020**

- **Duties and Responsibilities**

a) In this role I was responsible for the general medicine and medical specialties CAH, Medical Wards CAH, Emergency Department CAH, Minor Injuries Unit STH and the Emergency Dental Clinic.

b) I was responsible for budget and for delivering financial balance within my area of responsibility as well as the management of cost improvement programmes to support the achievement of balanced budget.

c) I was responsible for ensuring that staff were fully engaged in the process of change management and in particular, that clinicians and multi-disciplinary professionals were fully involved at the forefront of the service improvement initiatives.

d) I was responsible for providing managerial leadership for the staff within my area in order to support the delivery of high-quality clinical services for patients.

e) My Role did not include Urology Services.

- **Acting Assistant Director Medicine and Unscheduled Care, Craigavon Area Hospital, 18th March 2020-31st August 2020**

Duties and Responsibilities -

a) As the AD for Medicine and unscheduled care responsible to the Director of Acute Services for the delivery of high-quality care to patients in the Trust's Medicine and Unscheduled Care Division.

b) I am responsible for the operational management of all specialities in the division. This incorporates Older People's Medicine, Endocrinology, Rheumatology, Neurology, Gastroenterology, Dermatology, Cardiology, ED Department, Renal Services, Rehabilitation, Discharge team and Hospital Social Services and bed management in Craigavon Area Hospital and Daisy Hill Hospital.

c) I am responsible for working in close collaboration with senior clinicians and other disciplines to implement the objectives of the Trust's Corporate Plan and to ensure effective multidisciplinary working in the spirit of collective leadership.

d) My role and responsibilities were to provide clear leadership to all staff in the division and I was responsible for effective financial management and the efficient use of all resources.

e) I supported the Director of Acute Services with long term planning and transformation/service reform initiatives.

f) As an Assistant Director, I was a member of the Directorate's Senior Management team and contributed to policy development in the directorate and the achievement of its overall objectives.

g) I had no responsibility for the Urology Service.

- **Acting Assistant Director Unscheduled Care Craigavon Area Hospital 1st September 2020-Present**

Areas of duties and responsibilities -

a) As the AD of Unscheduled care, I am responsible to the Director of Acute Services for the delivery of high quality care to patients in the Trust's Unscheduled Care Division.

b) I am responsible for the operational management of all specialities in the division. This incorporates the Emergency Departments, Ambulatory care units, patient flow and hospital at night across both CAH & DHH sites. I am also responsible for Minor Injuries Unit STH, Emergency Dental Clinic Armagh Community Hospital and Acute Medicine Unit CAH site.

c) I am responsible for working closely using a collaborate approach with senior clinicians and other disciplines to implement the objectives of the Trust's Corporate Plan and ensure effective multidisciplinary working in the spirit of collective leadership.

d) I am responsible for ensuring there are good governance arrangements in place for unscheduled care.

e) I provide clear leadership to all staff in the division and am responsible for effective financial management and the efficient use of all resources. I also support the Director of Acute Services with long term planning and transformation/service reform initiatives.

f) As an Assistant Director, I am a member of the Directorate's Senior Management team and therefore contribute to policy development in the directorate and the achievement of its overall objectives.

g) I have no responsibilities for the Urology Service.

All Job Descriptions are an accurate reflection of my duties. *See Appendix 95. 201102.1.14JDADMUSC 96. 20190816.1.15JDADUC and 97. 2.1HOSMUSC located in S21 19 of 2022 Attachments*

Q6. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for.

12. As Head of Non-Acute Hospitals I reported directly to Mrs Angela McVey Assistant Director for Enhanced Services, Older People and Primary Care directorate from 17th September 2007- 30th April 2010.

Team who reported to me –

a) Sister Personal Information redacted by the USI
b) Sister Personal Information redacted by the USI
c) Sister Personal Information redacted by the USI
d) Sister Personal Information redacted by the USI
e) Sister Personal Information redacted by the USI
f) Sister Personal Information redacted by the USI
g) Charge Nurse Personal Information redacted by the USI

13. As Head of Service for DHH Medicine and Unscheduled I reported directly to the Assistant Director of Medicine and Unscheduled Care, Lynsey Stead from 1st May 2010 to 30th November 2010.

Team who reported to me –

- Lead Nurse for Medicine, Personal Information redacted by the USI

14. As Head of Service/General Manager, Acute Medicine/ED/EDC, I reported directly to Mr Barry Conway Assistant Director of Medicine and Unscheduled Care 1st December 2010 to 23rd April 2012.

Team who reported to me –

a) Personal Information redacted by the USI, Lead Nurse
b) Personal Information redacted by the USI, Lead Nurse

15. Acting Assistant Director for Medicine and Unscheduled Care (Covering for Mr. Barry Conway) I reported to Dr. Jillian Rankin Director of Acute Services from 24th April 2012 to 31st January 2013.

Team who reported to me -

a) Operational Support Lead - Personal Information redacted by the USI

b) HOS Acute Geriatric & Stroke - [redacted]
c) HOS Gastro Rheum & Diabetes - [redacted]
d) HOS Medicine and Unscheduled Care CAH – [redacted]

16. Craigavon Area Hospital, Head of Service Acute Medicine/ED/EDC

From 1st February 2013 until August 2015, I reported directly to Mr Barry Conway, Assistant Director for Medicine and Unscheduled Care. Then from 17th August 2015 to 17th March 2020 I reported to Mrs Anne McVey, Assistant Director for Medicine and Unscheduled Care.

Team who reported to me –

a) CAH Emergency Nursing - [redacted]
b) DHH Emergency Nursing - [redacted]
c) CAH Ward 1 Medical Ramone - [redacted]
d) DHH Direct Assessment Unit - [redacted]
e) CAH Acute Med Admission Unit - [redacted]
f) CAH Emergency Dental - [redacted]
g) STH Emergency Minor Injuries Unit - [redacted]
h) Lead Nurse EM - [redacted]

17. Southern Trust, based in Craigavon Area Hospital Acting Assistant Director Medicine and Unscheduled Care

From 18th of March 2020 to the 31st of August 2020 I reported directly to the acting Director for Acute Services Mrs Melanie McClements

Team who reported to me –

a) HOS Multi Services Nurse Manager (8B) - [redacted]
b) HOS Acute Hosp Social Work - [redacted]
c) HOS Multi Services Nurse Manager (8B) - [redacted]
d) Operational Support Lead - [redacted]
e) HOS Acute Geriatric & Stroke - [redacted]
f) HOS Gastro Rheum & Diabetes - [redacted]
g) HOS Medicine Dermatology & Haematology - [redacted]
h) DHH Nursing - Lead Nurse - [redacted]

18. Southern Trust, based in Craigavon Area Hospital Acting Assistant Director Unscheduled Care (Current Role)

From 1st of September 2020 to present I report directly to the acting Director for Acute Services Mrs Melanie McClements

Team who report to me –

a) HOS Multi Services Nurse Manager - Personal Information redacted by the USI
b) HOS Acute Medicine Patient Flow & Ambulatory - Personal Information redacted by the USI
c) HOS Quality & Safety Manager - Personal Information redacted by the USI
d) Patient Flow Manager - Personal Information redacted by the USI
e) Lead Nurse – Personal Information redacted by the USI

For all Job Descriptions please see 95. 201102.1.14JDADMUSC, 96. 20190816.1.15JDADUC, 97. 2.1HOSMUSC, 98. 2.2JDLNDHH, 99. 2.3JDLNSMN, 100. 2.4JDHOSW, 101. 2.5JDHOCHDRDN, 102. 2.6JDPF, 103. 2.7JDLN, 104. 2.8HOSDGNR, 105. 2.9HOSS, 106. 2.10HOSDHH, 107. 2.11JDLNM, 108. 2.12JDHOSUC located in S21 19 of 2022 Attachments

Q7. With specific reference to *the operation and governance of urology services*, please set out your roles and responsibility and lines of management.

19. Please see all of my roles from September 2007 until present day. After considering each role, I can confirm that I had no operational or governance roles and responsibilities in relation to the Urology Service

a) Head of Non-Acute Hospitals South Tyrone Hospital, Mullinure Hospital, Lurgan Hospital 17th September 2007-30th April 2010

b) Head of Service for DHH Medicine and Unscheduled Care Daisy Hill Hospital 1st May 2010-30th November 2010

c) Head of Service/General Manager, Acute Medicine/ED/EDC, Craigavon Area Hospital, 1st December 2010-23rd April 2012

d) Acting Assistant Director for Medicine and Unscheduled Care Craigavon Area Hospital , - 24th April 2012-31st January 2013

e) Head of Service, Acute Medicine and Unscheduled Care Craigavon Area Hospital, , 1st February 2013-17th March 2020

f) Acting Assistant Director Medicine and Unscheduled Care, Craigavon Area Hospital, 18th March 2020-31st August 2020

g) Acting Assistant Director Unscheduled Care Craigavon Area Hospital 1st September 2020-Present

For all Job Descriptions please see 95. 201102.1.14JDADMUSC 96. 20190816.1.15JDADUC and 97. 2.1HOSMUSC located in S21 19 of 2022 Attachments

Q8. It would be helpful for the Inquiry for you to explain how those aspects of your role and responsibilities which were *relevant to the operation and governance of urology services*, differed from and/or overlapped with, for example, the roles of the Medical Director, Clinical Director, Associate Medical Director and Head of Urology Service or with any other role which had governance responsibility.

20. Having considered all of my roles from 2007, I can confirm that there were no aspects of my roles or my responsibilities that were relevant to the operation and governance of urology services nor did they overlap with the Medical Director, Clinical Director, Associate Medical Director and Head of Urology Service or with any other role which had governance responsibility relevant to urology.

Urology services/Urology unit - staffing

Q9. The Inquiry understands that a regional review of urology service was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. This review was completed in March 2009 and recommended three urology centres, with one based at the Southern Trust - to treat those from the Southern catchment area and the lower third of the western area. As relevant, set out your involvement, if any, in the establishment of the urology unit in the Southern Trust area.

21. I had no involvement in the establishment of the urology unit in the Southern Trust area.

Q10. What, if any, performance indicators were used within the urology unit at its inception?

22. I have no knowledge of any performance indicators that were used within the urology unit at its inception.

Q11.Was the *'Integrated Elective Access Protocol'* published by DOH in April 2008, provided to or disseminated in any way by you or anyone else to urology consultants in the SHSCT? If yes, how and by whom was this done? If not, why not?

23. The integrated Elective access protocol was not shared with me to disseminate to Urology Consultants as I had no role or responsibilities for Urology Services. In April 2008 I worked as the Head of Non-Acute Hospitals and had responsibility

for Care of the Elderly Service in South Tyrone Hospital, Lurgan Hospital and Mullinure Hospital. After searching my email Archive from 2007 to present I can confirm that this was never provided to me.

Q12.1 How, if at all, did the *'Integrated Elective Access Protocol'* (and time limits within it) impact on the management, oversight and governance of urology services?

24. I have had no involvement with the management, oversight and governance of urology services hence I cannot comment on the impact of the Integrated Elective Access Protocol to the service.

Q12.2. How, if at all, were the time limits for urology services monitored as against the requirements of the protocol? What action, if any, was taken (and by whom) if time limits were not met?

25. I have had no involvement with the monitoring of the time limits that were detailed in the protocol, hence I cannot comment on what actions were taken if time limits were not met. In my work as AD for Unscheduled care services breaches are monitored using EEMS and there is an ongoing focus/initiatives taken forward to reduce the length of time patients wait in the ED on a bed becoming available at ward level. The Head of Service for Urology Martina Corrigan and the Assistant Director with responsibility for the Urology Services in 2008 Mrs Heather Trouton, and from April 2012 to January 2013, Assistant Director with responsibility for Urology Services Mrs Trudy Reid, and Current Assistant Director Mr Ronan Carroll would be able to best placed to answer this question.

Q13. The implementation plan, *Regional Review of Urology Services, Team South Implementation Plan*, published on 14 June 2010, notes that there was a substantial backlog of patients awaiting review at consultant led clinics at that stage and included the Trust's plan to deal with this backlog.

I. What is your knowledge of and what was your involvement with this plan?

I was aware that there was a Regional Review of Urology Services, however, I had no involvement with the Team South Implementation Plan which was published on the 14th June 2010

II. How was it implemented, reviewed and its effectiveness assessed?

I have no knowledge of how the implementation plan was implemented, reviewed or how the effectiveness was assessed.

III. What was your role in that process?

I had no role in the process

IV. Did the plan achieve its aims in your view? OR Please advise whether or not it is your view that the plan achieved its aims? If so, please expand stating in what way you consider these aims were achieved.

I am not in the position to answer this question as I had no involvement in the implementation plan nor the Urology Services.

Q14. Were the issues raised by the *Implementation Plan* reflected in any Trust governance documents or minutes of meetings, and/or the Risk Register? Whose role was to ensure this happened? If the issues were not so reflected, can you explain why? Please provide any documents referred to in your answer.

26. I had no knowledge nor was I privy to how issues raised by the implementation plan were reflected in Trust Governance documents, nor did I subsequently gain any knowledge regarding the implementation plan. The Risk Register for the Urology Service would sit with the Head of Service and Assistant Director for that Service.

Q15. To your knowledge, were the issues noted in the *Regional Review of Urology Services, Team South Implementation Plan* resolved satisfactorily or did problems persist following the setting up of the urology unit?

27. I have no knowledge of the issues noted in the regional review of Urology Services team South Implementation plan were resolved satisfactorily or if problems persisted following the setting up of the urology unit. I have no knowledge of this plan nor have I had responsibilities in the Urology Service. I do not recall attending any meetings in my role as Assistant Director for Medicine and Unscheduled Care where the Implementation Plan was discussed.

Q16. Do you think the unit was adequately staffed and properly resourced from its inception? If that is not your view, can you please expand noting the deficiencies as you saw them?

28. I had no operation responsibilities for the urology unit and was not aware of the workforce for this unit, therefore I am unable to comment.

Q17. Were you aware of any staffing problems within the unit since its inception? If so, please set out the times when you were made aware of such problems, how and by whom.

29. I was not aware of any staffing problems. When I was in my Head of Service role and was on call for Acute services/ Non-Acute Hospitals if there were staffing gaps on the Urology ward (like any other ward) this would have been escalated to me and actions would have been taken to secure cover for the shifts for example staff offered additional hours/overtime, bank/agency or redeployment from another ward. I would have had no knowledge of any other staffing problems within the Urology service.

Q18. Were there periods of time when any posts within the unit remained vacant for a period of time? If yes, please identify the post(s) and provide your opinion of how this impacted on the unit. How were staffing challenges and vacancies within the unit managed and remedied?

30. I was not aware of any vacancies on this ward as I had no operational management responsibilities for it.

Q19. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of urology services?

31. I am not in the position to comment, as I had no operational responsibilities for the urology service in any of my roles.

Q20. Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why?

32. I am not in the position to comment, as I had no operational responsibilities for the urology service in any of my roles

Q21. Has your role changed in terms of governance during your tenure? If so, explain how it has changed with particular reference to urology services, as relevant?

33. I have had no role or responsibilities in relation to Urology services, however in my role as Interim Assistant Director, I would have attended Clinical Governance Meetings. The only meetings which I attended where the Urology Service was discussed were the meetings on the 26th of April 2021 and 14th of May 2021.

See located in S21 19 of 2022 Attachments
109. 20210514.1.18.AcuteClinicalGovMinutes
2.-35. 202109041.2Acute Clinical Governance Agenda
43.-82. 20210514.1.17Acute Clinical Governance Agenda
1. 202109041.1Clinical Governance Minutes

Q22. Explain your understanding as to how the urology unit and urology services were supported by non-medical staff. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff. If you not have sufficient understanding to address this question, please identify those individuals you say would know.

34. I have no knowledge of how the urology unit and urology service was supported by non-medical staff as I had no operational management or governance responsibilities for this area.

Q23. Do you know if there was an expectation that administration staff would work collectively within the unit or were particular administration staff allocated to particular consultants? How was the administrative workload monitored?

35. I have no knowledge of the expectation of administration staff for the urology service, nor am I aware of how the administrative workload was monitored as I had no operational management or governance responsibility for the urology service.

Q24. Were the concerns of administrative support staff, if any, ever raised with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, you did in response.

36. I have no knowledge of any concerns from the administration staff and no issues were raised with me as I had no operational/ governance responsibilities for this unit

Q25. Who was in overall charge of the day to day running of the urology unit? To whom did that person answer, if not you? Give the names and job titles for each of the persons in charge of the overall day to day running of the unit and to whom that person answered throughout your tenure.

37. The Head of Service for the Urology Service was Martina Corrigan up until Wendy Clayton took over in October 2020 as HOS and still holds this position. The HOS reports into the Assistant Director for Acute Services, Anaesthetics and Surgery who was responsible for the Urology Service.

a) Heather Trouton was the Assistant Director for Surgery and Elective Care and had responsibility for the Urology service up until April 2012.
b) Trudi Reid was the Assistant Director for Surgery and Elective Care who had responsibility for the Urology Service from April 2012 to January 2013.
c) From February 2013 to April 2016, Heather Trouton was Assistant Director for Surgery and Elective Care responsible for the Urology Service.
d) Ronan Carroll, Assistant Director for Acute Services, Anaesthetics and Surgery, April 2016 to present is currently responsible for the Urology Service.

Q26. What, if any role did you have in staff performance reviews?

38. I had no role in staff performance reviews for any member of staff that worked within the Urology Service, as I had no responsibilities for this service during my time as Interim Assistant Director for Medicine and Unscheduled Care. However, in my current position as Interim AD for Unscheduled care it is my role and responsibility to carry out staff performance reviews for the HOS who report directly to me and work within Medicine and Unscheduled care. None of the staff who report directly to me have any role or responsibility for the Urology Services.

Q27. Was your role subject to a performance review or appraisal? If so, please explain how and by whom and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

39. My role is subject to a performance review by both myself and my manager Mrs Melanie McClements completing a KSF Personal Development Review Form.

See located in S21 19 of 2022 Attachments 110. 202107.5.0PerformanceReview for an example of this.

Engagement with unit staff

Q28. Describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.

40. Although I would have had no direct involvement with all staff within the urology service on a day-to-day basis, the Sister/senior nurse from the ward (Sister Laura White, Sister Gale McGill and Sister Caroline Caddell) would attend the daily bed meetings, which I chair approximately one day a week. I would have engaged with them when on call. As Head of Service the patient flow manager would contact me if there were any staffing gaps on any ward, and this would have included the Urology Ward. I would not have contacted the staff directly on the ward but would have advised the patient flow manager on the actions to take to ensure the ward was covered safely.

41. In my current role as interim AD for Unscheduled Care, I would attend meetings, i.e., huddles twice per week with other ADs where we would have discussions ranging from bed pressures, updates from our areas, updates from SMT, IPC issues etc. As AD I would be on call with the Heads of Services that work in acute, which includes the HOS for Urology. The HOS will always give the AD on Call an update on the hospital early warning score and contact them for advice if required.

Q29. Please set out the details of any weekly, monthly or daily scheduled meetings with any urology unit/services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

42. The Sister/Senior Nurse (Sister Laura White, Sister Gale McGill and Sister Caroline Caddell) from the urology ward attend the daily flow huddles approx. 3 times a day and once a day on Saturday and Sundays. These meetings last approximately 15 minutes. An example of what information is gathered at these meetings can be seen in appendix 3.1DFH

43. I have had no scheduled weekly, monthly or daily meetings with any Urology unit/Services staff. However, I would attend meetings with all AD's including the AD responsible for the Urology Service. These meetings include and are chaired by the Director of Acute Services and last approx. 60-90 minutes. These include:

a) Twice weekly huddle meetings lasting approximately one hour,
b) Monthly clinical governance meetings,
c) Monthly finance/HR meeting,
d) Monthly performance meetings.
e) Monthly Standards and Guidelines meetings

Q30. During your tenure did medical and professional managers in urology work well together? Whether your answer is yes or no, please explain by way of examples regarding urology.

44. I have no knowledge of how medical and professional managers worked together in the urology service and no issues were ever brought to me. I would have had no operational management/governance roles for this area.

Governance – generally

Q31. What was your role regarding the consultants and other clinicians in the unit, including in matters of clinical governance?

45. I had no role regarding the consultants and other clinicians in the unit in my Interim HOS role and my Interim AD roles. However, in my present role, and when I was previously AD of Medicine and Unscheduled Care, I take part in monthly Clinical governance meetings which the Director of Acute services Mrs Melanie McClements chairs, and all acute Assistant Directors and clinical directors attend. During these meetings, issues were not raised in relation to the Urology Consultants and other clinicians that worked in the Urology unit until the clinical governance meetings which took place in April and May of 2021.

See located in S21 19 of 2022 Attachments
109. 20210514.1.18.AcuteClinicalGovMinutes
2.-35. 202109041.2Acute Clinical Governance Agenda

Q.32 Who oversaw the clinical governance arrangements of the unit and how was this done? As relevant to your role, how did you assure yourself that this was being done appropriately?

46. I would have had no knowledge into how the clinical governance arrangements of the unit were managed by the operational managers. Mrs Heather Trouton until April 2016, Mrs Martina Corrigan HOS up until October 2020, Mrs Trudi Reid Interim AD until January 2013 and Mr Ronan Carrol from April 2016 until Present would have overseen the clinical governance arrangements for the unit. The operational/clinical governance arrangements for the unit, was not part of my roles or responsibilities. I would have presumed that the governance arrangement in place was reflected in each division within the Acute Service.

Q33. How did you oversee the quality of services in urology? If not you, who was responsible for this and how did they provide you with assurances regarding the quality of services?

47. I had no operational/governance responsibilities for the urology service. I am aware in my time working in acute (May 2010 to present), that the following AD's would have responsibility for the Urology service – Simon Gibson, Heather Trouton, Trudy Reid and Ronan Carroll. The Head of Service for this service was Martina Corrigan, up until October 2020 when Wendy Clayton took over and she still remains in this position.

Q34. How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for this overseeing performance metrics?

48. I had no operational/governance responsibilities for the urology service. I am aware in my time working in acute (May 2010 to present), that the following AD's would have responsibility for the Urology service – Simon Gibson, Heather Trouton, Trudy Reid and Ronan Carroll. The Head of Service for this service was Martina Corrigan, up until 2020 when Wendy Clayton took over as Head of Service, and she still remains in this position.

Q35. How did you assure yourself regarding patient risk and safety in urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

49. I had no operational/governance management responsibilities for the urology service, therefore I had no knowledge of what systems were in place.

Q36. How could issues of concern relating to urology services be brought to your attention? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the unit, such as from patients. What

systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

50. I had no operational/governance responsibilities in relation to the Urology Service. I have never had any issues of concern regarding the urology service which were brought to my attention by either internal sources or from outside the unit such as from patients. I have no knowledge of what systems or processes were in place for dealing with any concerns raised nor of the efficacy of such systems. Any issues of concern would have been brought to the attention of the HOS and the AD with responsibility for this service

Q37. Did those systems or processes change over time? If so, how, by whom and why?

51. I have no knowledge of these systems or whether or not they changed overtime, as I had no operational or governance responsibilities for the urology service.

Q38. How did you ensure that you were appraised of any concerns generally within the unit?

52. I had no operational/governance responsibilities for the Urology Service therefore I was never appraised of any concerns generally within the unit, until I attended the Acute Clinical Governance meeting on the 9th of April 2021, and 4th May 2021.

See located in S21 19 of 2022 Attachments
109. 20210514.1.18.AcuteClinicalGovMinutes
2.-35.202109041.2Acute Clinical Governance Agenda
43.-82. 20210514.1.17Acute Clinical Governance Agenda
1. 202109041.1Clinical Governance Minutes

Q39. How did you ensure that governance systems, including clinical governance, within the unit were adequate? Did you have any concerns that governance issues were not being identified, addressed and escalated as necessary?

53. I had no operational/governance responsibilities for the Urology Service, therefore I was not involved with ensuring that governance systems were adequate within the unit, nor did I have any concerns that governance issues were not being identified, addressed and escalated as necessary.

Q40. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as Governance meeting minutes or notes, or in the Risk Register? Please provide any documents referred to.

54. There were no concerns raised or identified by me or others reflected in Trust Governance documents when I was Interim Assistant Director for Medicine and Unscheduled Care from April 2012 – 2013. However as Interim Assistant Director for Unscheduled Care the learning from the 9 SAI's were shared at an Acute Clinical governance meeting in April 2021 and in the acute clinical Governance meeting in May 2021.

See located in S21 19 of 2022 Attachments
109. 20210514.1.18.AcuteClinicalGovMinutes
2.-35. 202109041.2Acute Clinical Governance Agenda
36.-41. 202109041.3AdminReview
42. 202109041.1.16LearningfromSAIs
43.-82. 20210514.1.17Acute Clinical Governance Agenda
1. 202109041.1Clinical Governance Minutes

Q41. What systems were in place for collecting patient data in the unit? How did those systems help identify concerns, if at all?

55. I would not have been aware within my role as HOS or Interim AD of the systems in place for the unit in regards to collecting data within the Urology Unit. However, I am aware that we have the following electronic systems–

a) NICER (Northern Ireland Electronic Record)
b) PAS (Patient Administration System)
c) Lab Centre
d) eEMS (Electronic Emergency Management System)
e) Picture Archiving and Communication systems

Q42. What is your view of the efficacy of those systems? Did those systems change over time and, if so, what were the changes?

56. In my role as HOS and Interim AD, I would use the systems stated above for information and to collate data, which I have found to be efficient. I am aware that there have been software updates to eEMS and NICER, but I have no knowledge of any other updates or changes.

Q43. During your tenure, how well do you think performance objectives were set for consultant medical staff and for specialty teams? Please explain your answer by reference to any performance objectives relevant to urology during your time, providing documentation or sign-posting the Inquiry to any relevant documentation.

57. I am unable to comment on this as I have no governance or operational responsibilities for this service

Q44. How well did you think the cycle of job planning and appraisal worked and explain why you hold that view?

58. I am unable to comment on this as I have no governance or operational responsibilities for this service

Q45. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns having the potential to impact on patient care and safety arose. Please provide an explanation of that process during your tenure, including the name(s) and role of those involved, how things were escalated and how concerns were recorded, dealt with and monitored. Please

identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your tenure.

59. During my tenure I was not involved with governance concerns in relation to the Urology Service, which would have impacted on patient care and safety. Any governance concerns would have been escalated to the HOS and AD for the Urology Service.

The documentation the inquiry may wish to refer to is located in S21 19 of 2022 Attachments:
109. 20210514.1.18.AcuteClinicalGovMinutes
2.-35. 202109041.2Acute Clinical Governance Agenda
36.-41. 202109041.3AdminReview
42. 202109041.1.16LearningfromSAIs
43.-82. 20210514.1.17Acute Clinical Governance Agenda
1. 202109041.1Clinical Governance Minutes

Q46. Did you feel supported in your role by the medical line management hierarchy? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.

60. I did feel supported by medical line management hierarchy when I was acting interim AD for Medicine and Unscheduled Care (24/04/2012-31/01/2013 and 18/03/2020-31/08/2020) and in my current role as Interim director for unscheduled care. For example, I have direct access to Clinical Directors and divisional Medical Directors on a daily basis. We currently meet formally on a weekly basis, have monthly specialty meetings and Governance meetings and I attend the ED M&M. Most recently, there was a medical and Dental Oversight Committee set up in 2019 which is chaired by the medical director, which the Director of Acute Services, the DMD, and AD attends to discuss any issues or competencies with medical staff. The Medical Director chairs this meeting. As I have not had no operational or governance responsibilities, I would not be meeting with the medical line hierarchy for the urology service. However, if I was required to discuss anything, I would have had no hesitation in contacting the DMD for urology, who is Mr Hayes.

Concerns regarding the urology unit

Q47. The Inquiry is keen to understand how, if at all, you, as Assistant Director, liaised with, involved and had meetings with the following staff (please name the individual/s who held each role during your tenure):

61. The Chief Executive(s); I had no meetings with the Chief Executive (Shane Devlin) regarding the Urology Unit in my role as HOS or Interim AD for Medicine and Unscheduled Care or Interim AD for Unscheduled Care.

62. The Medical Director(s); I attended one meeting where the medical director (Maria O'Kane) shared the main points of the learning from the 9 SAI's. The

details of the SAI's or the SAI's were not circulated. This meeting was on the 9th April 2021.

63. The Director(s) of Acute Services; I attended two clinical governance meetings with the Director of Acute Services (Melanie McClements), one of which the Director of Medicine shared the learning from the SAI's on 9th April 2021 and the second meeting was on the 14th May 2021 which I was in attendance. There was an update given in April 9th 2021 clinical governance meeting from Dr Maria O'Kane to share the learning from the 9 urology SAI's. The detail and actual SAI's were not shared, just the learning. On the 14th May 2021 there was a paper shared in relation to the learning and recommendations in response to the findings from nine patients, where a doctor did not adhere to agreed recommendations, varied from best practice guidance, and did not involve other specialists appropriately in care Lessons learned Urology. In addition an Admin Review Process was discussed.

See located in S21 19 of 2022 Attachments
109. 20210514.1.18.AcuteClinicalGovMinutes
2.-35. 202109041.2Acute Clinical Governance Agenda
36.-41. 202109041.3AdminReview
42. 202109041.1.16LearningfromSAIs
43.-82. 20210514.1.17Acute Clinical Governance Agenda
1. 202109041.1Clinical Governance Minutes

64. The other Assistant Director (s); I had no meetings with the Assistant directors regarding the Urology Services – with the exception of the Acute Governance Meeting which I attended in April 2021 and May 2021 – Ronan Carroll, Anita Carroll, Barry Conway, Tracy Boyce, Anne McVey

65. The Associate Medical Directors; I had no meetings with the Associate Medical Directors (Mark Haynes, Damien Scullion, Shahid Tariq, Philip Murphy, Damien Gormley, Gareth Hampton) regarding the Urology Unit – with the exception of the Acute Governance Meeting which I attended in April 2021 and May 2021

66. The Clinical Director(s); I had no meetings with the Clinical Directors (Seamus Murphy, Ted McNaboe, Aoife Currie, Pat McAffery, Una Bradley, Erskine Holmes, Neville Rutherford Jones) regarding the Urology Unit – with the exception of the Acute Governance Meeting which I attended in April 2021 and May 2021

67. The Head of Service; I had no meetings with the Head of service regarding the Urology Unit – with the exception of Patricia Kingnorth Head of Acute Governance who attended the Acute Governance Meetings which I attended in April 2021 and May 2021

68. The consultant urologists. I had no meetings with the Consultant urologist regarding the Urology Unit.

When answering this question, the Inquiry is interested to understand how you liaised with these individuals in matters of concern regarding urology governance generally, and in particular those governance concerns with the potential to impact on patient care and safety. In providing your answer, please set out in detail the precise nature of how your roles interacted on matters (i) of governance generally, and (ii) specifically with reference to the concerns raised regarding urology services. Where not previously provided, you should include all relevant documentation, dates of meetings, actions taken, etc.

69. I did not liaise with these individuals in matters of concern regarding urology governance generally nor any concerns regarding the potential impact on patient care.

Q48. Following the inception of the urology unit, please describe the main problems you encountered or were brought to your attention in respect of urology services? Without prejudice to the generality of this request, please address the following specific matters: -

a.) What were the concerns raised with you, who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those concerns? Please provide details of all meetings, including dates, notes, records etc., and attendees, and detail what was discussed and what was planned as a result of these concerns.

70. From the inception of the Urology unit, the only problems I would have encountered would have been when I was on call and if the ward was short staffed. This would have been raised to me by the patient flow manager who was on duty. This is no different from any other ward or department and to resolve staffing issues we would have authorised shifts to go out to bank/ agency or offer overtime to staff. If the shift was still let unfilled, we would ask the patient flow manager to review staffing on all wards/departments to establish if we could move a member of staff to the ward that required cover to ensure safe staffing levels.

b.) What steps were taken (if any) to risk assess the potential impact of the concerns once known?

71. The following steps would have been taken –

- Permanent staff would have been offered additional hours
- Gaps in staffing would have gone out to bank
- Out to agency
- Review the staffing across all wards and departments to ascertain if any extra staff could be redeployed. I.e., Staff member moved from one ward to another

to provide safe staffing levels. This would have been the same actions taken if any ward was short staff, not just Urology

c.) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If not, why not.

72. If any ward does not have its full complement of staff, we would consider capping the bed complement if there were patient safety concerns. All efforts were made to cover any nursing gaps in all wards.

d.) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements?

73. The Lead Nurse and Head of Service are responsible for ensuring all the nursing gaps are covered. When there are any gaps on the rota the following process is in place –
    - Permanent staff would have been offered additional hours
    - Unfilled shifts would go to bank, then out to agency
    - Review the staffing across all wards and departments
    - Consider Redeployment from other wards

e.) How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?

74. The above would have been put in place and the Lead nurse for the unit was responsible for advising the patient flow team and the head of service on call prior to going off duty if there were shifts outstanding for their areas in the out of hours period and the actions were taken to try and cover the shifts.

f.) If you were given assurances by others, how did you test those assurances?

75. In relation to the shifts being covered this would have provided assurance. In the event any ward had to work down a nurse the clinical coordinator would be asked to provide additional help and support to this ward overnight.

g.) Were the systems and agreements put in place to rectify the problems within urology services successful?

76. I have no knowledge of the systems and agreements put in place to rectify the problems within the urology service as I had no managerial or governance roles for this service.

h.) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.

77. N/A. See above.

Q49. Having regard to the issues of concern within urology services which were raised with you or which you were aware of, including deficiencies in practice,

explain (giving reasons for your answer) whether you consider that these issues of concern were -

78. **Properly identified** - The only issues of concern that would have been identified to me would have been when I was on call and if the ward was short staffed. All nursing gaps that existed on any wards or departments would have been handed over to the on-call teams. Where last minute nursing gaps occurred in the out of hours period these would have been telephoned out through to the HOS/AD on call by the bed manager.

79. **Their extent and impact assessed** - The extent and impact of nursing gaps would have been assessed and actions taken to provide help to the ward.

80. **The potential risk to patients properly considered** – In the event we could not get cover from bank or agency, staff would have been redeployed to cover gaps and ensure patient safety.

Q50. What, if any, support was provided to urology staff (other than Mr O'Brien) by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q64 will ask about any support provided to Mr O'Brien).

81. I have never been on call specifically for Urology. As the HOS or AD on call, if there were nursing gaps in the urology ward, I would have supported the staff by ensuring they got help on the ward to cover the gaps. When on call, the HOS and AD provide on call to give advice and support to all wards and departments on Craigavon Area Hospital/ Daisy Hill Hospital/ Non-Acute Hospitals for all wards and services.

Q51. Was the urology department offered any support for quality improvement initiatives during your tenure?

82. As I had no operational/governance responsibilities for urology I am unaware of any support for quality improvement initiatives.

Mr. O'Brien

Q52. Please set out your role and responsibilities in relation to Mr. O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?

83. I would have had no roles or responsibilities in relation to Mr O'Brien. I occasionally would have met him in the corridor approximately once every two months and would have just greeted him.

Q53. What was your role and involvement, if any, in the formulation and agreement of Mr. O'Brien's job plan(s)? If you engaged with him and his job plan(s) please set out those details in full.

84. I had no role or involvement in the formulation or agreement of Mr O'Brien's Job plan.

Q54. When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant documents. Do you now know how long these issues were in existence before coming to your or anyone else's attention? Please provide full details in your answer.

85. I was not in attendance at any meetings specifically regarding Mr. O'Brien. I was not aware of the issues of concern regarding Mr O'Brien until I attended the clinical governance meetings in April 2021 and May 2021. I have no insight into how long these issues were in existence before they came to anyone else's attention.

Q55. Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr. O'Brien, whether with Mr. O'Brien or with others (please name). You should set out in detail the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.

86. In my interim role as AD of Medicine and unscheduled Care (26th May 2021 -12th January 2013) and (18th March 2020 - 31st May 2020) I can confirm that I was not involved in any meetings in relation to Urology services and Aidan O'Brien. However, from May 2020, in my role as interim AD for unscheduled care, I can confirm that at the Clinical Governance meeting on 9th April 2021 of which I was in attendance, there was an update given from Dr Maria O'Kane which shared learning from the 9 urology SAI's. The actual SAI's were not shared, just the learning. On the 14th May 2021 there was another Clinical Governance Meeting which I attended at which a paper was shared in relation to the lessons learned and recommendations in response to the findings from the nine SAIs, where a doctor did not adhere to agreed recommendations, varied from best practice guidance, and did not involve other specialists appropriately in care Lessons learned Urology. In addition, an Admin Review Process was circulated and discussed. – See located in S21 19 of 2022 Attachments:

109. 20210514.1.18.AcuteClinicalGovMinutes
2.-35. 202109041.2Acute Clinical Governance Agenda
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43.-82. 20210514.1.17Acute Clinical Governance Agenda
1. 202109041.1Clinical Governance Minutes

Q56. What actions did you or others take or direct to be taken as a result of these concerns? If actions were taken, please provide the rationale for them. You should include details of any discussions with named others regarding concerns and proposed actions. Please provide dates and details of any discussions, including details of any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.

87. I shared the learning from the nine urology SAIs with my team.

See located in S21 19 of 2022 Attachments
111. 202104134.1TeamMeetingAgendaActions

Q57. Did you consider that any concerns raised regarding Mr O'Brien may have impacted on patient care and safety? If so:

- **what risk assessment did you undertake, and**
- **what steps did you take to mitigate against this? If none, please explain. If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person.**

88. I was not aware of any specific concerns raised regarding Mr O'Brien which may have impacted patient care and safety until the shared learning from the SAIs on the 9th April 2021*(42. 202109041.1.16LearningfromSAIs located in S21 19 of 2022 Attachments)* where I then would have been aware that the concerns raised would have impacted on the patient care and safety of patients under his care. However, I did not undertake a risk assessment or take steps to mitigate against this as I have no role or responsibilities for the Urology Service.

Q58. If applicable, please detail your knowledge of any agreed way forward which was reached between you and Mr. O'Brien, or between you and others in relation to Mr. O'Brien, or between Mr O'Brien and others, given the concerns identified.

89. I was not aware of any agreed way forward which was reached between anyone and Mr O'Brien in relation to any concerns raised about him as I had no operational or governance responsibilities for the urology service.

Q59. What, if any, metrics were used in monitoring and assessing the effectiveness of the agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before?

90. I was not aware of any metrics used in monitoring and assessing the effectiveness of the agreed way forward nor any measures introduced to address concerns as I had no operational or governance responsibilities for the urology service.

Q60. How did you assure yourself that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and

comprehensive and were working as anticipated? What methods of review were used? Against what standards were methods assessed?

91. I am not aware of any systems and agreements in place to address concerns nor any standards such methods would be assessed against as I had no operational or governance responsibilities for the urology service.

Q61. Did any such agreements and systems which were put in place operate to remedy the concerns? If yes, please explain. If not, why do you think that was the case? What in your view could have been done differently?

92. I am unaware of agreements or systems which were put in place to remedy concerns nor how they operated as I had no operational or governance responsibilities for the urology service.

Q62. Did Mr O'Brien raise any concerns regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which might impact on those issues? If yes, what concerns did he raise and with whom, and when and in what context did he raise them? How, if at all, were those concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something?

93. Mr O'Brien did not raise any concerns with me regarding patient care and safety, risk, clinical governance or administration or any other matters and I am unaware if he ever raised such concerns with any others nor what would have been done about them as I had no operational or governance responsibilities for the urology service.

Q63. Did you raise any concerns about the conduct/performance of Mr O'Brien? If yes:

- **outline the nature of concerns you raised, and why it was raised**
- **who did you raise it with and when?**
- **what action was taken by you and others, if any, after the issue was raised**
- **what was the outcome of raising the issue?**

If you did not raise any concerns about the conduct/performance of Mr O'Brien, why did you not?

94. In my role as interim assistant director 24/04/2012-31/01/2013 and 18/03/2020-31/08/2020 and in my current role, I have had no operational or governance responsibilities for the urology service nor was anything brought to my attention surrounding Mr O'Brien's conduct/performance. Furthermore, no one raised any concerns with me.

Q64. What support was provided by you and the Trust specifically to Mr. O'Brien given the concerns identified by him and others? Did you engage with other Trust staff to discuss support option, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

95. I did not provide, nor am I aware of any support which was provided to Mr O'Brien, nor of any concerns which had been identified by him or others.

Q65. How, if at all, were the concerns raised by Mr. O'Brien and others reflected in Trust governance documents, such as the Risk Register? Please provide any documents referred to. If the concerns raise were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.

96. The only meetings I attended in relation to Urology Service were on the 9th April 2021 and the 14th May 2021. As AD, at the Acute Clinical Governance meetings, the Risk Register for cancer services (*Appendix 112. 202006086.1CCSRR located in S21 19 of 2022 Attachments)* highlighted 62 Day Cancer risks relating to the 62-day target. The Risk was in relation to safe high quality and effective care due to the Trust failing to meet the 62-day cancer performance standard due to increasing red flag referrals demand outstripping capacity and other regional issues for tumour sites including Urology. The Surgical Elective Care Risk Register *(Appendix 113. 202006086.2SECRR located in S21 19 of 2022 Attachments*) recognises the inability to meet access times performance standards in urology.

See also located in S21 19 of 2022 Attachments -

109. 20210514.1.18.AcuteClinicalGovMinutes
43.-82. 202109041.2Acute Clinical Governance Agenda
36.-41. 202109041.3AdminReview
42. 202109041.1.16LearningfromSAIs
43.-82. 20210514.1.17Acute Clinical Governance Agenda
1. 202109041.1Clinical Governance Minutes

Learning

Q66. Are you now aware of governance concerns arising out of the provision of urology services, which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why.

97. I am now aware of the governance concerns which have arisen out of the Urology services which I was not aware of until April of 2021.

98. Where there are governance concerns escalated, these would be on the risk register and controls are in place to monitor and minimise the risks. Other governance issues can be brought to the attention of staff and management through Datix's, complaints, patient feedback and staff raising issues. Any concerns raised regarding the Urology Services are escalated to the HOS, AD, Clinical Director, and DMD for Urology services. As I had no role or responsibility for the Urology Service, it is my view that concerns should be reviewed and addressed by the AD for Urology Services, HOS for Urology Services, the clinical Director of Urology services and the DMD of the Urology services and this should be supported by the Medical Director.

Q67. Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?

99. Having had the opportunity to reflect and due to my limited awareness, it is difficult to give a clear explanation of what went wrong within the Urology Service and why. This question would be best answered by those who directly managed the Urology service.

Q68. What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and the unit, and regarding the concerns involving Mr. O'Brien in particular?

100. In my view, where clinical concerns are raised in relation to a clinicians practice, this should be escalated and addressed immediately.

Q69. Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

101. I cannot comment on this due to my limited awareness surrounding the issues in the urology service. The AD and AMD for the Urology Service would be those in the best position to respond to this.

Q70. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

102. I cannot comment on this due to my limited awareness surrounding the issues in the urology service and feel this answer would be best responded by the line managers for Urology.

Q71. Do you think, overall, the governance arrangements were fit for purpose? Did you have concerns about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?

103. As the Interim AD I have found the governance arrangements were fit for purpose and I have had no concerns about these arrangements.

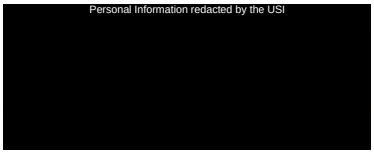
Q72.Given the Inquiry's terms of reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?

104. I have nothing further to add.

Urology Services Inquiry

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: 

Date: 01/07/2022

Section 21 Notice Number 19 of 2022

Witness Statement: Mary Burke

Attachments

Attachment	Document Name
1	202109041.1ClinicalGovernanceMinutes
2-35	202109041.2ClinicalGovernanceAgenda
36-41	202109041.3Admin Review
42	202109041.16LearningfromSAIs
43-82	20210514.1.17Acute Clinical Governance Agenda
83	202008061.8Retirement of Mr Aidan O'Brien,Consultant Urologist
84	202114101.4Evidence Gathering
85-86	202114101.5Evidence Gathering,
87	202114101.6Evidence Gathering
88	202114101.7Evidence Gathering
89	202131081.13NEDS - Inquiry into urology consultant to begin next week
90	20213108 NEDS1.12-Inquiry into urology consultant to begin next week forward
91-92	202102121.11NEDS update - Irish news - Urology inquiry
93	202109121.9Public Inquiry Urology Services Global
94	202207011.10EOI Opportunity - Programme Director for Public Inquiry and Trust Liaison – Urology Services Inquiry
95	201102.1.14JDADMUSC
96	20190816.1.15JDADUC
97	2.1HOSMUSC
98	2.2JDLNDHH
99	2.3JDLNSMN
100	2.4JDHOSW
101	2.5JDHOCHDRDN
102	2.6JDPF
103	2.7JDLN
104	2.8HOSDGNR
105	2.9HOSS
106	2.10HOSDHH
107	2.11JDLNM,
108	2.12JDHOSUC
109	20210514.1.18.AcuteClinicalGovMinutes
110	202107.5.0PerformanceReview
111	202104134.1TeamMeetingAgendaActions
112	202006086.1CCSRR
113	202006086.2SECRR

Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES

Director: Mrs Melanie McClement

Tel: Personal Information redacted by the USI

ACUTE CLINICAL GOVERNANCE

Date: Friday 9 April 2021

8am Melanie's meeting space. Personal Information redacted by the USI

1.0	Apologies: Clare McGahlie, Barry Conway Attendance Melanie McClements, Patricia Kingsnorth, Damian Scullion, Shahid Tariq, Patricia McCaffery, Ronan Carroll, Philip Murphy, Damian Gormley, Maria OKane, Tracey Boyce, Mary Burke , Anne McVey, Seamus Murphy Erskine Holmes, Gareth Hampton, Aoife Currie, Ted McNaboe, Neville Rutherford Jones, Una Bradley	
2.0	Notes from last meeting Notes from last meeting approved for factual accuracy	
3.0	Chairs business Melanie advised there were two matters arising, one was electronic sign off and one was in relation to the urology SAI. She handed over to Damian Gormley to address electronic sign off Dr OKane – to share the learning from urology SAI Maria to set the scene regarding the learning from the SAI. Important that early learning is out as quickly as can, in particular medical staff working in multidisciplinary teams in a meaningful way. In particular to the management of cancers and the role of the specialist nurse practitioners. Taking it back to ensure there is practical working. To provide safety to the patient and also to provide safety to the practitioner, that staff are aware of the sickest patient. Where there are concerns where clinical staff who don't seem to work within the system that we look at how they can be challenged. There may be some staff who are seen as too important to be challenged. There is a tradition to keep a target of 31 / 62 day targets rather than the quality of care for patients. There is a look back excerise to look at the patients with the DOH/ HSCB to improve patients safety. There are 20 staff trained in SMR and any learning in those cases will be disseminated as soon as possible. If there any concerns about isolation or stress- we need to be sign posting for support.	Dr OKane

Plan will use urology as a test bed for improvement. How can we realign nursing and medical to do this. Have been in contact with the staff in Belfast regarding the neurology enquiring to get learning. She apologised that she can't provide the details.
Dr TS said this was a good opportunity to look at our processes. This is the opportunity to get the resources and we are looking forward to improving our services. This is a great opportunity and we will take it.
Pat – this was review was very surprising about this colleague and how can we assure ourselves that this is not happening in our system. We would need a system of assurance particularly in outpatients to avoid it happening again.
Maria acknowledged this as it is difficult to know, one of the approached from Belfast – they are peer reviewing each other work. A system developed in Social work- monthly take a sample of cases load and discuss it, if there were concerns then they instigate a case review which may not be particularly useful. Randomly take 20 charts and review it. she said she is open to any suggestions to improve this.

Maria advised that she has been in contact with Birmingham about the Patterson's enquiry. Separating out 3 different strands – governance/ revalidation and peer review.
Ted- the key around the MDT- but we need to look at the validity of the MDT as some struggle to get the proper representation on the team – radiology/ oncology and pathology. The regional groups have the proper representation. Local groups have difficulty to look at the proper range of specialities are available for all occasions.
Anne said there is a fine line between clinicians and using evidence based practice. She recalled a meeting from a staff member is working with staff and did we have a proper process on how we can listen to staff were raised concerns and were listened it. she cautioned that we need to manage those concerns and we need to support that challenge when things go wrong.
The audit used in NICAN was not strong enough and we need to develop our own tool to ensure it is robust. To ensure follow advice given to keep the patient safe. The process to quality assure the work.
Ronan made a point- medical working in teams – in NI patients put under the care of one doctor, he offered a suggestion that we would need team job plans to ensure the work is checked by a second consultant to provide checks and balances.
Maria - Recognised there is a importance of continuity of care and how that is shared within the team. she wanted to know how do medical staff get to the point of being comfortable to work within a team.
Seamus liked the point about measuring time standards but less good to measure quality cancer. He referred to rectal cancers and how the services have changed. We are not good at measuring the outcome from those.

	Melanie acknowledged that and said that as we have been commissioned that this is not acceptable and will take this opportunity to improve quality care and improve patient safety. Melanie thanked Maria.	
4.0	Electronic Sign off Dr Damian Gormley and Dr Andrew Murdock to discuss electronic sign off. Damian provided update on electronic sign off. We are best in NI regarding electronic sign off. However, we know there were lots of issues discussed last month, Kate's role is missing due to leave and this post will be replaced. Damian- acknowledged a lot of the good work. There is no denominator in the report to look at the percentages. Quite a large number of areas that have a low number of sign off. He acknowledged this doesn't reflect that results are not being looked at. But we don't have assurances that all results are being signed off. He is aware that the NIECR have issues. Abnormal results when patients are discharged are particular risk. Melanie opened the floor for discussion. Gareth said a specialist post would be required to sign off for ED. Pat- said it works reasonably well for inpatients but very difficult for outpatients. The system is very clunky. Damian agreed it is difficult to sign of multiple results, but individually it is easier. Gareth said it is difficult to sign of radiology reports- can be sorted out quickly on paper but electronically results are back later. Philip- process are not robust enough to remove the paper results. Damian advised if there is a robust system then keep going. However there are abnormal results are still not being followed up. He cautioned that were there are electronic sign off these are not being completed despite paperless. Seamus said the system needs improved to be quicker. In preparation for encampass but it is few years away. Damian advised electronic system is the only way to provide assurance. Melanie asked how do we assure ourselves that as some wards are paperless and the electronic results are not signed off – how can be assured the results are actioned. Erskine said that there are still multiple cases of x rays not being followed up. X ray carried out in ED and patient going to the ward. The admitting physician not following up. These need to be followed up. This has been raised before but despite electronic and paper we don't have a good process of dealing with the results.	Dr Gormley

	Damian advised there is a process from radiology but the failsafe needs audited. Particularly from outsources. It is the images that flag up a repeat x ray required. These are the issues. The GP colleagues will not follow up on reasonable requests to deal with these x ray follow up. GP will decline the results. This needs to be agreed. Primary care and secondary care need a better process. Anne said it is also an issue with physician of the week to follow up. Gareth Erskine/ radiologist and Rose/ Frances to address the issues. There is an issue for the patient who move from ED and Inpatient doctors. Melanie asked the operational teams to set up please. Shahid and Barry to follow up also.	
5.0	SAIs IMWH Aoife - OK Aoife presented the case of a patient admitted with prolonged preterm rupture of membranes. Antenatal issues with the clinic management. Midwives escalated concerns which were not followed up by medical team. she becomes septic and suffers an intrauterine death. She is very unwell. The report addresses the concerns in the report. Cultural issues, woman raised concerns which were not listened to. Midwives raised concerns but not listened to. She advised there are long term concerns for the baby when preterm rupture, but you must involve the woman in the discussion and make her totally aware of the issues. This didn't happen in this case. The CTG issue is a long term issue and we have worked very hard to address this. Moving to a computerised system called dawes Redmond. Cultural issues – more concern. Escalation did not result in action. The risks and benefits were not discussed with her. Don't know if the outcome could have been different. The recommendations are good. Human factors quality of ultrasound setting up a preterm labour clinic to tighten up on it. Where woman are admitted of preterm labour should be auditing it in the report. Melanie asked what site it is and have some of the recommendations have been actioned.it occurred on the DHH site. Comments- approved. ED cyp incident will be presented by Ellie McCormick and Phil Quinn Ellie attended to present the report. Summary of the report but reminded it was well presented last month. Baby short history of illness reattended ED three days later. There was a long delay for paed assessment and the baby required a rocky course in ICU.	AMDs/ CD

There report didn't address there were two paediatricians talked to the parents that they didn't get antibiotics following a discussion about the provision of antibiotics. This has been added into the report but given may not have done. The doctors could prescribe and give antibiotics and nurses could check. There was some discussion about who can prescribe antibiotics and administration of antibiotics. Phil advised there are safety concerns regarding prescribing and administrating antibiotics. Some paeds will do in practice. But not necessarily best practice to prescribe and administer antibiotics. There was also an opinion as to whether nurses should be prepared to give antibiotics. There is a skill mix and if a doctor can run a resuscitation that nurses should given antibiotics. There are good guidelines to support staff to give antibiotics. There is no recommendations to say antibiotics should be given as soon as possible. Mary advised there is an issue with paediatric trained nurses. All nursing staff will give iv antibiotic in the emergency situation. They may not be the best person to give antibiotics. There is specific training that staff were to attend but the CEC had stopped training. She plans to send all the nurses both to have training and be signed off as competencies. This is more difficult.

The issues have been raised more on the DHH ED. It is very much team work. Erskine advised that it can be very difficult if the nurses are not trained. That someone can give antibiotics.

Gareth – was concerned that the wording in the report – the child was under care of ED this was not accurate – the child was in ED under the care of paediatrician.

The report shows the sepsis was missed and ED

Ellie will change that child was in ED as opposed to under the care of ED.

Advice leaflet is a patient safety issue and should give parents good advice.

Maria summed up some issues – patient is the main concerns. She feels the report is a very defensive report and she doesn't know how the child is doing. From a medical point of view is there is no reason why the doctor could not have given the antibiotics. We should put the patient first. The family won't care who give the antibiotics. The clinical decision was made to admit to the ward and there was antibiotics. the Phil cautioned - The patient factors – normal vital signs. He advised that there was no recognition that the child was ill during the day until the night team took over. The decision was only made by the night team when the child was admitted. The antibiotics were given as soon as the child deteriorated. There was a failure to detect the child had sepsis. Gareth said the plan was to give antibiotics at 20:45. The recommendation should be about recognition.

Plan to relook at the report and amend to not approve.

Anne highlighted there is a lack of paediatric trained nurses – perhaps needs to go on the risk register.

Phil doesn't agree that there are any inaccuracies in the report and he read out the recommendations.

Not approved until final version brought back.
Thanked Ellie and Phil.

- Gareth

Gareth presented a case of a patient who was admitted with mental health issues and was taken to DHH as opposed to UHD.
He was known to the PSNI for carrying weapons. The patient absconded and was escalated to the PSNI call handler who refused to take the call. The phoned back to the PSNI , the patient was found following a self-inflicted wound to the abdomen. Recommendation. There is no guidance re: phoning the police.
The recommendation regarding concealed weapons, who is the recommendation for. This should be a recommendation to interagency to consider not necessarily the health team.
Ted if patients are going to a holding cell in a PSNI station if a patient is going to an ED the PSNI should be doing this as a routine.

The report will be shared with PSNI, change recommendation 1+2 to interagency approach.

- Erskine on behalf of MHD

Erskine present the case of a Personal Information redacted by the USI old patient who develop covid at the beginning of covid outbreak when were only learning about the covid infection.
He discussed the report. The discussed the number of attendances to ED and the rationale to keep him in hospital in view of his x ray results. A DNAR was communicated with the patient's mother and brother regarding the decision not to resuscitate a Personal Information redacted by the USI old man. The DNAR was removed following the mother's providing a solicitors request. Despite efforts this man deteriorated and died.
The recommendations are already changed. 9.1 the patient should have a carer there who knows the patient to facilitate and support the patient. It probably needs reworded. There is an electronic health passport for learning difficulty patients to support their care.
Recommendations are fair enough but they need to be the patient's advocate or family (NOK).
Findings section 6 – is this right from a family perspective, relating to the mother's solicitor letter – how does this look from a family perspective.- this may need to be reworded. We need to look at that the care was amended from a threat from a solicitor.

	Damian scullion advised that this case was discussed at length. This was brought up at the regional ethics forum. Anne advised there is a lot of work being done for caring for learning disability. Report – approve pending removal of section 6 at the Philip/ Pat Mark/Ted	
6.0	Effectiveness and Evaluation Patient Safety Report	ADs and AMDs
7.0 7.1	Monthly Acute Governance report Complaints Position – (communication and staff attitudes main complaints) • Current Complaints • Weekly reopened complaints • Open 36 (13 overdue) Reopened- 23 Ombudsman- 11	

8.0	Medicine Incidents Incident Management Position Major Catastrophic	
9.0	Risk Registers – additions, amendments and closures to the governance team.	ADs & AMDs
10.0	Mandatory training	
11.0	Any Other Business	
12.0	Date of Next Meeting: 8.00 am Friday 14 May 2021 Via zoom link	

Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES

Director: Mrs Melanie McClement

Tel: Personal Information redacted by the USI

ACUTE CLINICAL GOVERNANCE

Date: Friday 9 April 2021

8am Melanie's meeting space. Personal Information redacted by the USI

1.0	Apologies: Attendance	
2.0	Notes from last meeting 12.3.021 Action notes Acute Clinical G	
3.0	Chairs business Dr OKane – to share the learning from urology SAI	Dr OKane
4.0	Electronic Sign off SIGNOFF_2021_02_ SHSCT.pdf Dr Damian Gormley and Dr Andrew Murdock to discuss electronic sign off.	Dr Gormley
5.0	SAIs IMWH Aoife - SAI Perso 250321 draft.docx ED SAI report ID Personal Information comments frc cyp incident will be presented by Ellie McCormick 1. Level 1 Report Personal Information draft for ACG.d - Gareth	AMDs/ CD

	Final Draft Personal SAI Report v300321 NTC - Erskine on behalf of MHD Philip/ Pat Personal Information Report - draft for ACG.docx Level 1 SAI draft report Personal.docx Personal Information Draft for ACG Approval.docx Mark/Ted 1. Level 1 Report Personal for March ACG.docx	
6.0	Effectiveness and Evaluation 4) Clinical audit summary for Acute Cl Patient Safety Report Acute Governance Report April21.doc	ADs and AMDs
7.0	Monthly Acute Governance report February 2021 Acute SMT Governan	
7.1	Complaints Position – (communication and staff attitudes main complaints) • Current Complaints Current Complaints.xlsx • Weekly reopened complaints Reopened Complaints Report 08 • Open 36 (13 overdue) Reopened- 23	

	Ombudsman- 11  Ombudsman 23.03.2021.xlsx	
8.0	Medicine Incidents  February 2021 Acute.xlsx Incident Management Position  Acute Incidents March 2021.xlsx Major Catastrophic  Major & Catastrophic Incidents March 2021	
9.0	Risk Registers – additions, amendments and closures to the governance team.  Corporate Risk Register August 202( Directorate RR February 2021.xlsx  SEC.ATICS Div.HOS.Team RR Ja  CCS Div.HOS.TEAM RR February 2021.xl  FSS Div.HOS.Team RR February 2021.xl  IMWH Div.HOS.Team RR February 2021.xl  Pharmacy Div.HOS.Team RR Fe  ED february 2021.xlsx	ADs & AMDs
10.0	Mandatory training  Copy of Trustwide CMT Compliance Sum	
11.0	Any Other Business	
12.0	Date of Next Meeting:	

Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES

Director: Mrs Melanie McClement

Tel: Personal Information redacted by the USI

ACUTE CLINICAL GOVERNANCE

Date: Friday 12 March 2021

8am Melanie's meeting space. Personal Information redacted by the USI

1.0	Apologies: Tracey Boyce, Anne McVey Attendances: Melanie McClements, Patricia Kingsnorth, Philip Murphy, Seamus Murphy, Ted McNaboe, Aoife Currie, Barry Conway, Ronan Carroll, Kay Carroll, Claire McGalie, Shahid Tariq, Una Bradley, Neville Rutherford Jones, Imran Yousuf, Pat McCaffery, Gareth Hampton, Mary Burke and Damian Scullion.	
2.0	Notes from last meeting last meeting January 2021	
3.0	Chairs business Both sure of the summary possession – patient gets e discharge unsure what is meant by notes. Go back to Caroline to look at current processes. Discussion about the summary position regarding the SAI Personal Information. Who would be the best person to represent the trust on this issue. Consensus was it should be the medical review Strategy for Acute services which will be framed which will look at every speciality and interface with community re: preventing admission and timely discharge. It will be discussed with the senior team is taking place today, Melanie will sent a questionnaire with Ads/ CDs to discuss issues. There will be themed events to discuss before 5 year plan is agreed. This will be circulated today. Draft should be completed by September. A high level draft by July. To inform the work in acute services. There was some discussion about what is the clear vision for services. The urology SAI is nearing its end point the public enquiry chair has been announced. No details on TOR. Learning from current SAI will be shared with us as acute clinical forum and the clinical teams as soon as possible	

4.0	Electronic Sign off General thoughts for electronic sign off issues. Seamus said that education to see how to work it effectively. A trust wide training programme. Neill Morgan, Donna Muckian real champions for it. Some staff feel it is not user friendly. Seamus advised that the champions can advise how it works really well. Ted advised about electronic referral letters there is a weakness that the emails all correspondence need the letters go through an ECR system for consultant to consultant referrals. Barry and Ronan are looking at the systems around this how to address internal referrals internally. Ted suggested a simple solution any internal referrals are carried out by one standard form through the electronic system.- picked up by system if this email is not picked up. Barry advised Anita going to look at SOP in place – what is the back up with secretary – look at an electronic process. She will discuss with Mark Toal. Needs a resolution. Ronan clarifies- two type of referrals in patient and out patient referrals. The outpatient referral will possibly be at risk. Gareth- electronic sign off for ED cannot be done without additional resources. Mary advised the internal referrals need to be looked at. In patient sign off is going very well for most areas but clinics is more difficult. These processes are crucial and would require a working group – with Damian Gormley and Neill Morgan to set it up. Action go back to Damian Gormley and see if it is workable.- PK Una said there are not enough computers . Barry- advised that Donna Muckian had some technical issues regarding the lack of results being shared with the clinical teams- locum consultants/ need index of consultant codes/ issues around minimum data set- need a more robust safety net. There is further discussion to take place. Claire advised there needs to be very clear rationale as to the benefits of the requirements of ECR. There are some results are not transferrable to ECR. There was recognition it would work well in smaller specialities but more difficult on larger scales. Extend an invite to Damian	
5.0	*SAIs* *There are 4 CYP reviews which have through the paediatric scrutiny process and need sign off from acute perspective. One acute case for representation following non approval in January (Personal information redacted by the).* *Aoife/Meeta for paeds*	AMDs/ CD

Aoife presented this case lady antenatal care and intrapartum care. Comments. There are no signs of sepsis with the mother most of these infections are vertical transmissions. The issues with the care she shouldn't have been in MLU and issues with CTG. The lack of lessons learnt. No issues with would have impacted on the care- Approve.

ED Gareth/ Erskine

Case presented by Gareth- child attended ED. Discharged home but reattended 2 days later referred to paeds- gastroenteritis. Bloods done noted raised crp. Baby diagnosed with meningitis.
Recommendations page 15 paragraph 4. The wording of the recommendations in 4,5,6 and 7. Needs to be reviewed.
Mary advised there are only a few staff trained in administering antibiotics to children in ED- as soon as staff get trained, they leave.
Mary and Bernie looking at working with cores staff in CAH to trained in Paed antibiotics PLS. new consultant with special interest in paeds.
There is an issue with the overcrowding in the department. Such a sick child should have been admitted. Pat asked can be assured that a sick child could be administered antibiotics. Could any consultants give antibiotics? There was a reg and SHO explaining to the parents that the child would get antibiotics to wait to go to the ward.
Need to work with Gareth re: appropriateness of recommendations.
Sepsis in a 4 month old is difficult to recognise. There are other issues which are not addressed in the report. Not approved.
This is a wider issues which needs address through interface with ED and paeds.

Discussion that would be useful for paeds to be present at SMT meeting to speak on behalf of the reports Melanie to discuss with Paul Morgan.
Damian/ Shahid
Tooth extraction Personal Information redacted by the USI *old and* Personal Information redacted by the USI *old child*

Shahid to present these cases needs to be present to present the case.
Personal Information redacted by the USI - The starting point in the case for dental extraction. This is the wrong tooth extraction. This was the second case following a similar incident.
The recommendations. – 1. No problem.
The recommendation 3- training for recovery staff as more difficulty
He highlighted the issues with compliments of nursing theatre staff.

Personal Information redacted by the occurred in Nov 2017
Learning disability child – wrong tooth taken out.
Shahid advised the CD for dental and look at the pathway and how they are going to move forward.

	Need to develop procedures in dental. If change is implemented very quickly they are more likely to make mistakes. Needs to have consultation and explanation before process changed. Recommendation – if the same thing happens it would make sense to have the same panel to look at the problems to join up the learning. Ronan- no comments but would be appropriate with key stakeholders to work through the process and address any weakness in the link. There is no joined up discussion between CYP and Acute. Ted asked if there is any learning from private dentistry- perhaps a communication with dentist in general practice. Shahid advised it is a higher risk for the dentist in hospital were the dentist can't look and assess the child before the procedure. Approve the reports.- Action there is learning to look at the system and process to address. *case represented- Philip* *Philip presented – representation of a lady who was brought into emergency department, referred to medicine – asked for surgical opinion. Surgeon not surgical issues, patient transferred to AMU and no communication between surgery and medicine.* *Issues- new recommendations- admission flow process document.* *Which has been in several drafts – agreed by most people but not surgery. Team needs to take ownership of the patient. If other specialty to refer. Issues around specialist surgical team.* *3 recommendations – number one needs a decision.* *TED comments that this happens frequently in ENT but very happy to champion shared care. Where there is a blurring of the edges between specialities for a period of shared care should be made. This works effectively. There is an emphasis acute medical problems and shared care should be established practice.* *Philip advised there should be better communication about who owns the patient.* *It should be ED responsibility.* *PK to recirculate the ED proforma for action.* *Seamus asked for the facility for shared care – the white board is not functioning for joint ownership.* *Report – approved* *There are 19 ongoing SAI reviews.*	
6.0	Effectiveness and Evaluation Patient Safety Report	

		ADs and AMDs
7.0 7.1	Monthly Acute Governance report Complaints Position – (communication and staff attitudes main complaints) • Current Complaints • Weekly reopened complaints • Open 40 20 overdue) Reopened- 20 – 10 planned meetings Ombudsman- 9	
8.0	Medicine Incidents/ Report sent separately Incident Management Position Major Catastrophic	
9.0	Risk Registers – additions, amendments and closures to the governance team.	ADs & AMDs
10.0	Mandatory training	
11.0	Any Other Business Management of children in adults ward- training is not good, there is a need for an real effort to move the training to get 3 elements to hyponatraemia training.	

	BMJ/ CEC training/ Face to face Pk to send the training matrix for medical staff again. Damian – concern of over sight from his department needs a robust system to see which staff are trained. Revalidation have a record of safeguarding and hyponatraemia need to see the weakness. Need to have a read across from medical director. Ronan The drive through phlebotomy is open – he asked that all clinicians can use it. Patients can have bloods done within a week. to reduce footfall for patients. Need to ramp up the capacity. The details have been circulated. Martin King invited for presented on patients experience. Gareth, Mary Melanie and I spoke after the meeting to discuss the issues with a prominent SAI involving a mental health patient. Many of the issues are as a result of the PSNI and NAIS repeating the same issues as a previous high profile case. The criticism in the last report was that the PSNI were not contacted soon enough, this time the PSNI handler refused to take the referral. Gareth advised there has been a huge amount of work done from a mental health perspective which is largely working well. We need support from PSNI and NIAS to complete the circuit.	
12.0	Date of Next Meeting: 8.00 am Friday 9 April 2021 Via zoom link	

SIGN OFF REPORTS

Time period: **01/02/2021 to 28/02/2021**

Total Sign Off for all trusts for current month and previous two months

Trust	December	January	February
Southern	52060	54317	52979
Western	28181	28163	30040
South-Eastern	10313	12409	13447
Belfast	10054	10529	12012
Northern	6355	5721	5908
Total	**106963**	**111139**	**114386**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	8025	51030	15.7%
Histopathology	745	5904	12.6%
Cytology	177	9157	1.9%
Blood Sciences	87963	1175252	7.5%
Microbiology	17453	164593	10.6%
Blood Bank	23	6992	0.3%
Total	**114386**	**1412928**	**8.1%**

Total Sign Off for Southern Trust previous three months

Month	November	December	January
Total	51016	52060	54317

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2830	43550	6305	254	27	13	0	**52979**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1758	25508	4045	119	13	13	0	**31456**
Daisy Hill Hospital	953	13955	1807	132	14	0	0	**16861**
Lurgan Hospital	81	2929	327	0	0	0	0	**3337**
South Tyrone Hospital	0	517	44	0	0	0	0	**561**
0	37	110	22	3	0	0	0	**172**
Community	1	229	7	0	0	0	0	**237**
St Luke's	0	35	0	0	0	0	0	**35**
Drumglass Lodge Community	0	257	0	0	0	0	0	**257**
Mullinure Health & Wellbein	0	10	53	0	0	0	0	**63**
	2830	**43550**	**6305**	**254**	**27**	**13**	**0**	52979

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1758**	**25508**	**4045**	**119**	**13**	**13**	**0**	**31456**
Doctor	533	12203	930	40	2	0	0	**13708**
Consultant	1188	8976	1019	79	11	12	0	**11285**
Midwife	0	2541	1874	0	0	0	0	**4415**
Nurse	37	1569	199	0	0	1	0	**1806**
Pharmacist	0	129	0	0	0	0	0	**129**
AHP	0	90	21	0	0	0	0	**111**
GP	0	0	2	0	0	0	0	**2**
Daisy Hill Hospital	**953**	**13955**	**1807**	**132**	**14**	**0**	**0**	**16861**
Doctor	375	9534	789	2	3	0	0	**10703**
Consultant	569	2019	648	130	11	0	0	**3377**
Physician Associate	7	1425	20	0	0	0	0	**1452**
Midwife	1	512	310	0	0	0	0	**823**
Nurse	0	297	36	0	0	0	0	**333**
Pharmacist	0	59	0	0	0	0	0	**59**
0	1	109	4	0	0	0	0	**114**
Grand Total	**2711**	**39463**	**5852**	**251**	**27**	**13**	**0**	**48317**

SIGN OFF REPORTS

Time period: **01/02/2021 to 28/02/2021**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

Personal Information redacted by the USI

Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Mark Haynes	Consultant	Craigavon Area Hospital	201	899	173	16	2	6	**1297**
Gerrard Sloan	Consultant	Craigavon Area Hospital	67	1077	124	1	0	6	**1275**
Michelle Portis	Midwife	Craigavon Area Hospital	0	592	479	0	0	0	**1071**
Grainne Tallon	Consultant	Craigavon Area Hospital	63	805	82	0	0	0	**950**
Christopher Sharkey	Doctor	Daisy Hill Hospital	88	709	128	0	0	0	**925**
Andrea Green	Consultant	Craigavon Area Hospital	117	624	99	5	1	0	**846**
Christina Bradford	Consultant	Craigavon Area Hospital	18	737	54	5	0	0	**814**
Plamena Peneva	Doctor	Lurgan Hospital	26	636	148	0	0	0	**810**
Eoghan McCloskey	Doctor	Craigavon Area Hospital	51	603	93	2	0	0	**749**
Lesley-Ann McKee	Midwife	Craigavon Area Hospital	0	491	163	0	0	0	**654**
James Doyle	Consultant	Daisy Hill Hospital	74	383	145	15	1	0	**618**
Cathy Clarke	Midwife	Craigavon Area Hospital	0	375	207	0	0	0	**582**
Zita Okeke	Doctor	Craigavon Area Hospital	30	511	25	0	0	0	**566**
Janice Quinn	Doctor	Lurgan Hospital	22	466	70	0	0	0	**558**
Declan Keenan	Consultant	Craigavon Area Hospital	3	496	39	1	0	0	**539**
Charles Oloan	Doctor	Daisy Hill Hospital	13	521	3	0	0	0	**537**
Claire Mawhinney	Doctor	Daisy Hill Hospital	74	390	69	0	0	0	**533**
Gemma Clements	Doctor	Craigavon Area Hospital	18	408	76	0	0	0	**502**
Alana Catherwood	Physician Associate	Daisy Hill Hospital	1	491	5	0	0	0	**497**
Katie Whan	Doctor	Craigavon Area Hospital	17	431	38	0	0	0	**486**
Ahmed Bannaga	Consultant	Craigavon Area Hospital	2	463	18	0	0	0	**483**
Cucki Vanitha Thomas	Doctor	Daisy Hill Hospital	13	432	28	0	0	0	**473**
Ushagowri Mavuri	Consultant	Craigavon Area Hospital	7	424	36	0	0	0	**467**
Helen Campbell	Doctor	Daisy Hill Hospital	18	410	22	0	0	0	**450**
Catherine Conway	Doctor	South Tyrone Hospital	0	398	43	0	0	0	**441**
		Grand Total	**923**	**13772**	**2367**	**45**	**4**	**12**	**17123**

SIGN OFF REPORTS

Time period: **01/01/2021 to 31/01/2021**

Total Sign Off for all trusts for current month and previous two months

Trust	November	December	January
Southern	51016	52060	54317
Western	28940	28181	28163
South-Eastern	10693	10313	12409
Belfast	8850	10054	10529
Northern	6428	6355	5721
Total	**105927**	**106963**	**111139**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	8306	53113	15.6%
Histopathology	720	6033	11.9%
Cytology	180	8966	2.0%
Blood Sciences	83176	1164815	7.1%
Microbiology	18742	183445	10.2%
Blood Bank	15	7027	0.2%
Total	**111139**	**1423399**	**7.8%**

Total Sign Off for Southern Trust previous three months

Month	October	November	December
Total	47310	51016	52060

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2628	44611	6734	259	76	9	0	**54317**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1549	24090	3932	127	35	9	0	**29742**
Daisy Hill Hospital	928	15193	2125	125	41	0	0	**18412**
Lurgan Hospital	87	3714	483	0	0	0	0	**4284**
South Tyrone Hospital	0	583	67	0	0	0	0	**650**
Undefined*	62	679	53	7	0	0	0	**801**
Community	2	162	11	0	0	0	0	**175**
St Luke's	0	42	1	0	0	0	0	**43**
Drumglass Lodge Community	0	141	0	0	0	0	0	**141**
Mullinure Health & Wellbein	0	7	62	0	0	0	0	**69**
	2628	**44611**	**6734**	**259**	**76**	**9**	**0**	54317

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1549**	**24090**	**3932**	**127**	**35**	**9**	**0**	**29742**
Doctor	409	11137	910	32	3	5	0	**12496**
Consultant	1078	8877	886	93	32	3	0	**10969**
Midwife	0	2200	1935	0	0	0	0	**4135**
Nurse	36	1413	197	2	0	1	0	**1649**
AHP	26	281	4	0	0	0	0	**311**
Pharmacist	0	180	0	0	0	0	0	**180**
Physician Associate	0	2	0	0	0	0	0	**2**
Daisy Hill Hospital	**928**	**15193**	**2125**	**125**	**41**	**0**	**0**	**18412**
Doctor	348	10202	825	2	11	0	0	**11388**
Consultant	564	2242	834	123	30	0	0	**3793**
Physician Associate	11	1720	42	0	0	0	0	**1773**
Midwife	3	626	363	0	0	0	0	**992**
Nurse	1	160	37	0	0	0	0	**198**
Pharmacist	0	39	0	0	0	0	0	**39**
0	1	80	24	0	0	0	0	**105**
AHP	0	124	0	0	0	0	0	**124**
Grand Total	**2477**	**39283**	**6057**	**252**	**76**	**9**	**0**	48154

SIGN OFF REPORTS

Time period: **01/01/2021 to 31/01/2021**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USI	Grainne Tallon	Consultant	Craigavon Area Hospital	86	1360	109	0	0	0	**1555**
	Eoghan McCloskey	Doctor	Craigavon Area Hospital	58	914	103	0	0	0	**1075**
	Plamena Peneva	Doctor	Lurgan Hospital	41	811	135	0	0	0	**987**
	Ioan Davies	Doctor	Daisy Hill Hospital	12	928	35	0	0	0	**975**
	Claire Mawhinney	Doctor	Daisy Hill Hospital	63	789	114	0	0	0	**966**
	Michelle Portis	Midwife	Craigavon Area Hospital	0	509	443	0	0	0	**952**
	Andrea Green	Consultant	Craigavon Area Hospital	128	617	113	0	4	0	**862**
	Christopher Elliott	Doctor	Daisy Hill Hospital	3	738	105	0	0	0	**846**
	Allister Foy	Consultant	Craigavon Area Hospital	25	693	32	10	0	0	**760**
	Christopher Sharkey	Doctor	Daisy Hill Hospital	71	572	113	0	0	0	**756**
	Gerrard Sloan	Consultant	Craigavon Area Hospital	42	622	89	1	0	0	**754**
	Christina Bradford	Consultant	Craigavon Area Hospital	20	682	42	4	0	0	**748**
	Ushagowri Mavuri	Consultant	Craigavon Area Hospital	7	670	50	0	0	0	**727**
	Catherine Fegan	Doctor	Lurgan Hospital	1	650	64	0	0	0	**715**
	Janice Quinn	Doctor	Lurgan Hospital	12	535	104	0	0	0	**651**
	James Doyle	Consultant	Daisy Hill Hospital	105	365	113	17	1	0	**601**
	Cucki Vanitha Thomas	Doctor	Daisy Hill Hospital	14	561	9	0	0	0	**584**
	Laura Carr	Doctor	Craigavon Area Hospital	17	397	136	0	0	0	**550**
	Catherine Conway	Doctor	South Tyrone Hospital	0	470	46	0	0	0	**516**
	Gemma Clements	Doctor	Craigavon Area Hospital	38	394	74	0	0	0	**506**
	Elaine Nelson	Consultant	Craigavon Area Hospital	16	381	105	0	0	0	**502**
	Anthony Glackin	Consultant	Craigavon Area Hospital	86	324	63	14	2	0	**489**
	Declan Keenan	Consultant	Craigavon Area Hospital	12	422	42	1	0	0	**477**
	Naomi Burns	Doctor	Daisy Hill Hospital	8	458	4	0	0	0	**470**
	Fraser Morton	Midwife	Daisy Hill Hospital	3	392	72	0	0	0	**467**
			Grand Total	**868**	**15254**	**2315**	**47**	**7**	**0**	**18491**

SIGN OFF REPORTS

Time period: **01/12/2020 to 31/12/2020**

Total Sign Off for all trusts for current month and previous two months

Trust	October	November	December
Southern	45007	51016	52060
Western	29442	28940	28181
South-Eastern	9276	10693	10313
Belfast	7379	8850	10054
Northern	4742	6428	6355
Total	**95846**	**105927**	**106963**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	7450	50109	14.9%
Histopathology	707	6614	10.7%
Cytology	152	9458	1.6%
Blood Sciences	80614	1149446	7.0%
Microbiology	18028	175478	10.3%
Blood Bank	12	8135	0.1%
Total	**106963**	**1399240**	**7.6%**

Total Sign Off for Southern Trust previous three months

Month	September	October	November
Total	45007	47310	51016

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2526	42741	6466	254	62	11	0	**52060**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1558	23699	3711	142	25	11	0	**29146**
Daisy Hill Hospital	841	14486	2150	100	37	0	0	**17614**
Lurgan Hospital	62	2949	422	1	0	0	0	**3434**
South Tyrone Hospital	0	401	55	0	0	0	0	**456**
0	64	649	93	11	0	0	0	**817**
Community	1	164	10	0	0	0	0	**175**
St Luke's	0	170	1	0	0	0	0	**171**
Drumglass Lodge Community	0	214	0	0	0	0	0	**214**
Mullinure Health & Wellbein	0	9	24	0	0	0	0	**33**
	2526	**42741**	**6466**	**254**	**62**	**11**	**0**	52060

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1558**	**23699**	**3711**	**142**	**25**	**11**	**0**	**29146**
Doctor	484	11199	903	38	2	2	0	**12628**
Consultant	1016	7028	681	101	23	9	0	**8858**
Midwife	1	2773	1876	0	0	0	0	**4650**
Nurse	57	2161	251	2	0	0	0	**2471**
AHP	0	368	0	0	0	0	0	**368**
Pharmacist	0	170	0	0	0	0	0	**170**
GP	0	0	0	1	0	0	0	**1**
Daisy Hill Hospital	**841**	**14486**	**2150**	**100**	**37**	**0**	**0**	**17614**
Doctor	308	9785	973	0	1	0	0	**11067**
Consultant	507	2607	908	100	36	0	0	**4158**
Physician Associate	9	954	24	0	0	0	0	**987**
Midwife	13	632	220	0	0	0	0	**865**
Nurse	1	219	16	0	0	0	0	**236**
Pharmacist	0	55	0	0	0	0	0	**55**
0	3	55	8	0	0	0	0	**66**
AHP	0	179	1	0	0	0	0	**180**
Grand Total	**2399**	**38185**	**5861**	**242**	**62**	**11**	**0**	**46760**

SIGN OFF REPORTS

Time period: **01/12/2020 to 31/12/2020**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USI	Eoghan McCloskey	Doctor	Craigavon Area Hospital	86	1108	93	2	0	0	**1289**
	Andrew Gibson	Doctor	Craigavon Area Hospital	72	951	140	3	1	0	**1167**
	Claire Mawhinney	Doctor	Daisy Hill Hospital	53	914	121	0	0	0	**1088**
	Michelle Portis	Midwife	Craigavon Area Hospital	0	676	351	0	0	0	**1027**
	Janice Quinn	Doctor	Lurgan Hospital	17	774	108	1	0	0	**900**
	Plamena Peneva	Doctor	Lurgan Hospital	18	667	202	0	0	0	**887**
	Christopher Elliott	Doctor	Daisy Hill Hospital	6	604	92	0	0	0	**702**
	Christina Bradford	Consultant	Craigavon Area Hospital	21	632	35	5	0	0	**693**
	James Doyle	Consultant	Daisy Hill Hospital	102	396	177	8	0	0	**683**
	Christopher Sharkey	Doctor	Daisy Hill Hospital	49	433	100	0	0	0	**582**
	Gemma Clements	Doctor	Craigavon Area Hospital	26	475	79	0	0	0	**580**
	Barry Walls	Doctor	Daisy Hill Hospital	26	343	206	0	0	0	**575**
	Naomi Burns	Doctor	Daisy Hill Hospital	7	513	51	0	0	0	**571**
	Declan Keenan	Consultant	Craigavon Area Hospital	3	495	71	1	0	0	**570**
	Helen Campbell	Doctor	Daisy Hill Hospital	14	481	49	0	0	0	**544**
	Lesley-Ann McKee	Midwife	Craigavon Area Hospital	0	320	220	0	0	0	**540**
	Nicola Melarkey	Doctor	Daisy Hill Hospital	31	463	33	0	0	0	**527**
	Cucki Vanitha Thomas	Doctor	Daisy Hill Hospital	9	492	14	0	0	0	**515**
	Laura Carr	Doctor	Craigavon Area Hospital	25	339	141	0	0	0	**505**
	Eimear Savage	Consultant	Craigavon Area Hospital	84	394	21	0	0	0	**499**
	Mark Haynes	Consultant	Craigavon Area Hospital	110	286	64	16	4	8	**488**
	Catherine Fegan	Doctor	Lurgan Hospital	0	445	40	0	0	0	**485**
	Kirsty Kirk	Doctor	Craigavon Area Hospital	22	422	36	3	0	0	**483**
	Catherine Carville	Nurse	Craigavon Area Hospital	31	376	76	0	0	0	**483**
	Ugochukwu Onubeze	Doctor	Craigavon Area Hospital	4	459	11	0	0	0	**474**
			Grand Total	**816**	**13458**	**2531**	**39**	**5**	**8**	**16857**

SIGN OFF REPORTS

Time period: **01/11/2020 to 30/11/2020**

Total Sign Off for all trusts for current month and previous two months

Trust	September	October	November
Southern	45007	47310	51016
Western	29442	27592	28940
South-Eastern	9276	8865	10693
Belfast	7379	6214	8850
Northern	4742	4949	6428
Total	**95846**	**94930**	**105927**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	7315	53551	13.7%
Histopathology	676	6362	10.6%
Cytology	180	9827	1.8%
Blood Sciences	79629	1163333	6.8%
Microbiology	18118	174790	10.4%
Blood Bank	9	7826	0.1%
Total	**105927**	**1415689**	**7.5%**

Total Sign Off for Southern Trust previous three months

Month	August	September	October
Total	43070	45007	47310

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2338	42157	6225	210	80	6	0	**51016**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1513	24777	3766	129	40	4	0	**30229**
Daisy Hill Hospital	669	12012	1793	81	40	2	0	**14597**
Lurgan Hospital	97	3673	431	0	0	0	0	**4201**
South Tyrone Hospital	4	915	121	0	0	0	0	**1040**
0	52	510	52	0	0	0	0	**614**
Community	3	188	37	0	0	0	0	**228**
St Luke's	0	34	4	0	0	0	0	**38**
Drumglass Lodge Community	0	36	0	0	0	0	0	**36**
Mullinure Health & Wellbein	0	12	21	0	0	0	0	**33**
	2338	**42157**	**6225**	**210**	**80**	**6**	**0**	51016

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1513**	**24777**	**3766**	**129**	**40**	**4**	**0**	**30229**
Doctor	427	11246	1015	46	4	1	0	**12739**
Consultant	1050	8687	790	83	36	2	0	**10648**
Midwife	0	2141	1806	0	0	0	0	**3947**
Nurse	36	2133	155	0	0	1	0	**2325**
AHP	0	368	0	0	0	0	0	**368**
Pharmacist	0	201	0	0	0	0	0	**201**
GP	0	1	0	0	0	0	0	**1**
Daisy Hill Hospital	**669**	**12012**	**1793**	**81**	**40**	**2**	**0**	**14597**
Doctor	193	8076	697	0	6	2	0	**8974**
Consultant	467	1976	648	81	34	0	0	**3206**
Physician Associate	2	1047	40	0	0	0	0	**1089**
Midwife	4	518	384	0	0	0	0	**906**
Nurse	1	311	21	0	0	0	0	**333**
Pharmacist	0	34	0	0	0	0	0	**34**
0	2	50	1	0	0	0	0	**53**
AHP	0	0	2	0	0	0	0	**2**
Grand Total	**2182**	**36789**	**5559**	**210**	**80**	**6**	**0**	**44826**

SIGN OFF REPORTS

Time period: **01/11/2020 to 30/11/2020**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USI	Eoghan McCloskey	Doctor	Craigavon Area Hospital	112	1473	185	0	0	0	**1770**
	Plamena Peneva	Doctor	Lurgan Hospital	47	1403	213	0	0	0	**1663**
	Gerrard Sloan	Consultant	Craigavon Area Hospital	50	1044	92	0	0	2	**1188**
	Claire Mawhinney	Doctor	Daisy Hill Hospital	18	865	101	0	0	0	**984**
	Janice Quinn	Doctor	Lurgan Hospital	12	711	78	0	0	0	**801**
	Grainne Tallon	Consultant	Craigavon Area Hospital	67	644	71	0	0	0	**782**
	Declan Keenan	Consultant	Craigavon Area Hospital	10	694	60	0	0	0	**764**
	Catherine Conway	Doctor	South Tyrone Hospital	1	687	73	0	0	0	**761**
	Allister Foy	Consultant	Craigavon Area Hospital	27	647	42	3	0	0	**719**
	Christina Bradford	Consultant	Craigavon Area Hospital	17	610	50	6	0	0	**683**
	Eimear Tubman	Midwife	Craigavon Area Hospital	0	366	294	0	0	0	**660**
	Christopher Elliott	Doctor	Daisy Hill Hospital	3	564	82	0	0	2	**651**
	Cathy Clarke	Midwife	Craigavon Area Hospital	0	341	270	0	0	0	**611**
	Colm Darby	Nurse	Craigavon Area Hospital	20	441	108	0	0	1	**570**
	Gemma Clements	Doctor	Craigavon Area Hospital	17	489	47	0	0	0	**553**
	Christopher McCauley	Consultant	Craigavon Area Hospital	29	502	19	1	1	0	**552**
	Eimear Savage	Consultant	Craigavon Area Hospital	153	373	24	0	0	0	**550**
	Helen Campbell	Doctor	Daisy Hill Hospital	52	441	46	0	0	0	**539**
	Charles Oloan	Doctor	Daisy Hill Hospital	1	532	1	0	0	0	**534**
	Kirsty Kirk	Doctor	Craigavon Area Hospital	15	472	41	0	0	0	**528**
	Andrea Green	Consultant	Craigavon Area Hospital	77	377	72	1	0	0	**527**
	Elizabeth Sealey	Doctor	Craigavon Area Hospital	1	400	99	0	1	0	**501**
	Anthony Glackin	Consultant	Craigavon Area Hospital	119	291	72	18	1	0	**501**
	James Doyle	Consultant	Daisy Hill Hospital	81	324	86	8	0	0	**499**
	Ushagowri Mavuri	Doctor	Craigavon Area Hospital	9	439	49	0	0	0	**497**
			Grand Total	**938**	**15130**	**2275**	**37**	**3**	**5**	**18388**

SIGN OFF REPORTS

Time period: **01/10/2020 to 31/10/2020**

Total Sign Off for all trusts for current month and previous two months

Trust	August	September	October
Southern	43070	45007	47310
Western	22875	29442	27592
South-Eastern	9431	9276	8865
Belfast	7025	7379	6214
Northern	3522	4742	4949
Total	**85923**	**95846**	**94930**

Total Sign Off for Southern Trust previous three months

Month	July	August	September
Total	53263	43070	45007

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2234	39098	5659	215	102	2	0	**47310**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1476	23476	3635	112	34	2	0	**28735**
Daisy Hill Hospital	662	10834	1476	103	68	0	0	**13143**
Lurgan Hospital	71	3065	333	0	0	0	0	**3469**
South Tyrone Hospital	0	543	48	0	0	0	0	**591**
0	25	450	74	0	0	0	0	**549**
St Luke's	0	400	4	0	0	0	0	**404**
Community	0	278	35	0	0	0	0	**313**
Mullinure Health & Wellbein	0	11	54	0	0	0	0	**65**
Drumglass Lodge Community	0	41	0	0	0	0	0	**41**
	2234	**39098**	**5659**	**215**	**102**	**2**	**0**	47310

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill
**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1476**	**23476**	**3635**	**112**	**34**	**2**	**0**	**28735**
Doctor	382	11009	876	35	4	0	0	**12306**
Consultant	1057	7649	730	75	30	1	0	**9542**
Midwife	0	2173	1808	0	0	1	0	**3982**
Nurse	35	2133	217	1	0	0	0	**2386**
AHP	1	334	2	0	0	0	0	**337**
Pharmacist	0	178	0	0	0	0	0	**178**
GP	1	0	2	1	0	0	0	**4**
Daisy Hill Hospital	**662**	**10834**	**1476**	**103**	**68**	**0**	**0**	**13143**
Doctor	247	7255	624	0	6	0	0	**8132**
Consultant	391	1671	492	102	62	0	0	**2718**
Physician Associate	7	1331	38	0	0	0	0	**1376**
Midwife	16	349	302	1	0	0	0	**668**
Nurse	0	176	18	0	0	0	0	**194**
Pharmacist	0	38	0	0	0	0	0	**38**
0	1	14	1	0	0	0	0	**16**
AHP	0	0	1	0	0	0	0	**1**
Grand Total	**2138**	**34310**	**5111**	**215**	**102**	**2**	**0**	**41878**

SIGN OFF REPORTS

Time period: **01/10/2020 to 31/10/2020**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the US	Eoghan McCloskey	Doctor	Craigavon Area Hospital	66	1168	90	0	0	0	**1324**
	Plamena Peneva	Doctor	Lurgan Hospital	20	976	152	0	0	0	**1148**
	Grainne Tallon	Consultant	Craigavon Area Hospital	62	822	66	0	0	0	**950**
	Cathy Clarke	Midwife	Craigavon Area Hospital	0	382	565	0	0	0	**947**
	Claire Mawhinney	Doctor	Daisy Hill Hospital	40	800	66	0	1	0	**907**
	Richard Fox	Doctor	Craigavon Area Hospital	29	747	98	1	1	0	**876**
	Anthony Glackin	Consultant	Craigavon Area Hospital	147	541	94	8	2	0	**792**
	Christopher Sharkey	Doctor	Daisy Hill Hospital	44	625	79	0	0	0	**748**
	Christopher McCauley	Consultant	Craigavon Area Hospital	28	639	35	11	1	1	**715**
	Eimear Savage	Consultant	Craigavon Area Hospital	157	508	17	0	0	0	**682**
	Christina Bradford	Consultant	Craigavon Area Hospital	24	561	41	10	0	0	**636**
	Ushagowri Mavuri	Doctor	Craigavon Area Hospital	8	526	39	0	0	0	**573**
	Janice Quinn	Doctor	Lurgan Hospital	16	483	69	0	0	0	**568**
	Laura Carr	Doctor	Craigavon Area Hospital	14	390	103	0	1	0	**508**
	Olga Michail	Doctor	Craigavon Area Hospital	25	408	50	0	0	0	**483**
	Gerrard Sloan	Consultant	Craigavon Area Hospital	30	403	43	0	0	0	**476**
	Allister Foy	Consultant	Craigavon Area Hospital	20	416	34	4	0	0	**474**
	Ahmed Bannaga	Consultant	Craigavon Area Hospital	0	462	8	0	0	0	**470**
	Declan Keenan	Consultant	Craigavon Area Hospital	6	426	23	0	0	0	**455**
	Colm Darby	Nurse	Craigavon Area Hospital	16	377	54	0	0	0	**447**
	Catherine Conway	Doctor	South Tyrone Hospital	0	411	32	0	0	0	**443**
	Helen Campbell	Doctor	Daisy Hill Hospital	5	410	27	0	0	0	**442**
	Joanne McCaughey	Nurse	Craigavon Area Hospital	13	320	97	0	0	0	**430**
	Barry Walls	Doctor	Daisy Hill Hospital	17	271	134	0	0	0	**422**
	Lesley-Ann McKee	Midwife	Craigavon Area Hospital	0	237	181	0	0	0	**418**
			Grand Total	**787**	**13309**	**2197**	**34**	**6**	**1**	**16334**

SIGN OFF REPORTS

Time period: **01/09/2020 to 30/09/2020**

Total Sign Off for all trusts for current month and previous two months

Trust	July	August	September
Southern	53263	43070	45007
Western	27688	22875	29442
South-Eastern	7841	9431	9276
Belfast	5054	7025	7379
Northern	4063	3522	4742
Total	**97909**	**85923**	**95846**

Total Sign Off for Southern Trust previous three months

Month	June	July	August
Total	55627	53263	43070

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2162	36663	5796	274	95	17	0	**45007**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1544	21458	3554	177	53	16	0	**26802**
Daisy Hill Hospital	543	10912	1661	94	42	1	0	**13253**
Lurgan Hospital	60	3020	355	1	0	0	0	**3436**
*Undefined	11	572	50	2	0	0	0	**635**
South Tyrone Hospital	4	388	62	0	0	0	0	**454**
Community	0	273	45	0	0	0	0	**318**
Mullinure Health & Wellbein	0	7	65	0	0	0	0	**72**
St Luke's	0	32	2	0	0	0	0	**34**
Community Health Office	0	0	2	0	0	0	0	**2**
Drumglass Lodge Community	0	1	0	0	0	0	0	**1**
	2162	**36663**	**5796**	**274**	**95**	**17**	**0**	45007

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1544**	**21458**	**3554**	**177**	**53**	**16**	**0**	**26802**
Doctor	375	9057	732	61	3	0	0	**10228**
Consultant	1141	7805	758	109	50	15	0	**9878**
Midwife	0	2318	1815	0	0	1	0	**4134**
Nurse	28	1871	249	7	0	0	0	**2155**
Pharmacist	0	203	0	0	0	0	0	**203**
AHP	0	204	0	0	0	0	0	**204**
Daisy Hill Hospital	**543**	**10912**	**1661**	**94**	**42**	**1**	**0**	**13253**
Doctor	148	6267	523	0	0	1	0	**6939**
Consultant	378	2473	675	94	42	0	0	**3662**
Physician Associate	9	1273	47	0	0	0	0	**1329**
Midwife	8	501	400	0	0	0	0	**909**
Nurse	0	321	14	0	0	0	0	**335**
Pharmacist	0	76	0	0	0	0	0	**76**
AHP	0	0	2	0	0	0	0	**2**
GP	0	1	0	0	0	0	0	**1**
Grand Total	**2087**	**32370**	**5215**	**271**	**95**	**17**	**0**	40055

SIGN OFF REPORTS

Time period: **01/09/2020 to 30/09/2020**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the	Grainne Tallon	Consultant	Craigavon Area Hospital	95	1025	92	1	0	0	**1213**
	Richard Fox	Doctor	Craigavon Area Hospital	58	930	75	3	1	0	**1067**
	Plamena Peneva	Doctor	Lurgan Hospital	20	868	173	0	0	0	**1061**
	Cathy Clarke	Midwife	Craigavon Area Hospital	0	534	345	0	0	0	**879**
	Christopher Sharkey	Doctor	Daisy Hill Hospital	44	680	53	0	0	0	**777**
	Donna Muckian	Consultant	Daisy Hill Hospital	5	653	59	0	0	0	**717**
	Mark Haynes	Consultant	Craigavon Area Hospital	147	418	119	6	3	13	**706**
	Laura Carr	Doctor	Craigavon Area Hospital	28	537	99	0	0	0	**664**
	Anthony Glackin	Consultant	Craigavon Area Hospital	170	380	73	13	2	0	**638**
	Gerrard Sloan	Consultant	Craigavon Area Hospital	18	486	48	0	0	0	**552**
	Helen Campbell	Doctor	Daisy Hill Hospital	3	512	14	0	0	0	**529**
	Andrea Green	Consultant	Craigavon Area Hospital	101	346	58	0	4	0	**509**
	Amy Eakin	Midwife	Craigavon Area Hospital	0	307	191	0	0	0	**498**
	Kirsty Kirk	Doctor	Craigavon Area Hospital	23	440	22	0	0	0	**485**
	Shane Moan	Consultant	Daisy Hill Hospital	48	370	60	1	1	0	**480**
	David Waddell	Doctor		1	451	16	0	0	0	**468**
	Janice Quinn	Doctor	Lurgan Hospital	10	395	62	0	0	0	**467**
	Fraser Morton	Midwife	Daisy Hill Hospital	8	267	191	0	0	0	**466**
	Claire Mawhinney	Doctor	Daisy Hill Hospital	28	370	64	0	0	0	**462**
	Ahmed Bannaga	Consultant	Craigavon Area Hospital	0	426	20	1	0	0	**447**
	Kathryn Maxwell	Midwife	Craigavon Area Hospital	0	299	139	0	0	0	**438**
	Catherine Carville	Nurse	Craigavon Area Hospital	14	314	98	0	0	0	**426**
	Ushagowri Mavuri	Doctor	Craigavon Area Hospital	14	361	49	0	0	0	**424**
	Stephanie Walker	Consultant	Craigavon Area Hospital	34	385	3	0	0	0	**422**
	Allister Foy	Consultant	Craigavon Area Hospital	11	381	22	1	0	0	**415**
			Grand Total	**880**	**12135**	**2145**	**26**	**11**	**13**	**15210**

SIGN OFF REPORTS

Time period: **01/08/2020 to 31/08/2020**

Total Sign Off for all trusts for current month and previous two months

Trust	June	July	August
Southern	55627	53263	43070
Western	27038	27688	22875
South-Eastern	7474	7841	9431
Belfast	6583	5054	7025
Northern	4504	4063	3522
Total	**101226**	**97909**	**85923**

Total Sign Off for Southern Trust previous three months

Month	May	June	July
Total	48799	55627	53263

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	1999	35642	5171	186	68	4	0	**43070**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1259	20471	2984	99	8	4	0	**24825**
Daisy Hill Hospital	641	11503	1700	87	60	0	0	**13991**
Lurgan Hospital	72	2613	297	0	0	0	0	**2982**
Undefined*	23	482	40	0	0	0	0	**545**
South Tyrone Hospital	2	355	84	0	0	0	0	**441**
Community	2	162	31	0	0	0	0	**195**
Mullinure Health & Wellbein	0	18	30	0	0	0	0	**48**
Drumglass Lodge Community	0	33	0	0	0	0	0	**33**
St Luke's	0	5	5	0	0	0	0	**10**
	1999	**35642**	**5171**	**186**	**68**	**4**	**0**	**43070**

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1259**	**20471**	**2984**	**99**	**8**	**4**	**0**	**24825**
Doctor	335	9848	659	37	3	2	0	**10884**
Consultant	872	7025	597	62	5	2	0	**8563**
Midwife	0	1783	1556	0	0	0	0	**3339**
Nurse	52	1541	172	0	0	0	0	**1765**
Pharmacist	0	140	0	0	0	0	0	**140**
AHP	0	134	0	0	0	0	0	**134**
Daisy Hill Hospital	**641**	**11503**	**1700**	**87**	**60**	**0**	**0**	13991
Doctor	161	7138	529	2	11	0	0	**7841**
Consultant	430	1577	508	85	49	0	0	**2649**
Physician Associate	17	1660	135	0	0	0	0	**1812**
Midwife	33	670	503	0	0	0	0	**1206**
Nurse	0	448	24	0	0	0	0	**472**
Pharmacist	0	10	0	0	0	0	0	**10**
AHP	0	0	1	0	0	0	0	**1**
Grand Total	**1900**	**31974**	**4684**	**186**	**68**	**4**	**0**	**38816**

SIGN OFF REPORTS

Time period: **01/08/2020 to 31/08/2020**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USI	Eoghan McCloskey	Doctor	Craigavon Area Hospital	47	934	55	0	0	0	**1036**
	Grainne Tallon	Consultant	Craigavon Area Hospital	75	820	81	0	0	0	**976**
	Plamena Peneva	Doctor	Lurgan Hospital	28	723	138	0	0	0	**889**
	Christopher Sharkey	Doctor	Daisy Hill Hospital	35	736	106	0	0	0	**877**
	Christina Bradford	Consultant	Craigavon Area Hospital	26	722	43	3	0	0	**794**
	Naomi Burns	Doctor	Daisy Hill Hospital	8	761	24	0	0	0	**793**
	James Doyle	Consultant	Daisy Hill Hospital	118	536	120	5	1	0	**780**
	Allister Foy	Consultant	Craigavon Area Hospital	7	618	42	1	0	0	**668**
	Cathy Clarke	Midwife	Craigavon Area Hospital	0	249	414	0	0	0	**663**
	Mark Haynes	Consultant	Craigavon Area Hospital	54	518	54	2	0	2	**630**
	Adam Crawford	Physician Associate	Daisy Hill Hospital	13	481	123	0	0	0	**617**
	Marie Magean	Doctor	Craigavon Area Hospital	13	508	63	6	0	0	**590**
	Declan Keenan	Consultant	Craigavon Area Hospital	2	555	25	0	0	0	**582**
	Anthony Glackin	Consultant	Craigavon Area Hospital	152	292	84	13	0	0	**541**
	Janice Quinn	Doctor	Lurgan Hospital	21	442	69	0	0	0	**532**
	Fraser Morton	Midwife	Daisy Hill Hospital	33	312	164	0	0	0	**509**
	Kathryn Maxwell	Midwife	Craigavon Area Hospital	0	360	128	0	0	0	**488**
	Christopher Elliott	Doctor	Daisy Hill Hospital	4	390	40	0	0	0	**434**
	Clare Rush	Physician Associate	Daisy Hill Hospital	0	429	2	0	0	0	**431**
	Olga Michail	Doctor	Craigavon Area Hospital	19	357	42	0	0	0	**418**
	Christopher McCauley	Consultant	Craigavon Area Hospital	22	376	11	3	0	0	**412**
	Gerrard Sloan	Consultant	Craigavon Area Hospital	40	327	36	0	0	0	**403**
	Eimear Savage	Consultant	Craigavon Area Hospital	81	306	13	0	0	0	**400**
	Huajian Liu	Doctor	Craigavon Area Hospital	0	397	0	0	0	0	**397**
	Claire Mawhinney	Doctor	Daisy Hill Hospital	16	339	40	0	0	0	**395**
			Grand Total	**814**	**12488**	**1917**	**33**	**1**	**2**	**15255**

SIGN OFF REPORTS

Time period: **01/07/2020 to 31/07/2020**

Total Sign Off for all trusts for current month and previous two months

Trust	May	June	July
Southern	48799	55627	53263
Western	24242	27038	27688
South-Eastern	5727	7474	7841
Northern	4883	6583	5054
Belfast	4641	4504	4063
Total	**88292**	**101226**	**97909**

Total Sign Off for Southern Trust previous three months

Month	April	May	June
Total	40680	48799	55627

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2396	44885	5647	234	79	22	0	**53263**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1504	28400	3207	144	10	22	0	**33287**
Daisy Hill Hospital	827	12682	1860	90	69	0	0	**15528**
Lurgan Hospital	44	2720	407	0	0	0	0	**3171**
Drumglass Lodge Community	2	56	1	0	0	0	0	**59**
Community	0	425	77	0	0	0	0	**502**
South Tyrone Hospital	3	489	57	0	0	0	0	**549**
Undefined*	16	105	28	0	0	0	0	**149**
Mullinure Health & Wellbein	0	8	5	0	0	0	0	**13**
St Luke's	0	0	2	0	0	0	0	**2**
Community Health Office	0	0	3	0	0	0	0	**3**
	2396	**44885**	**5647**	**234**	**79**	**22**	**0**	53263

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1504**	**28400**	**3207**	**144**	**10**	**22**	**0**	**33287**
Doctor	596	16738	1001	59	1	5	0	**18400**
Consultant	878	7729	719	82	9	16	0	**9433**
Midwife	0	2158	1340	0	0	1	0	**3499**
Nurse	30	1594	147	2	0	0	0	**1773**
Pharmacist	0	169	0	0	0	0	0	**169**
AHP	0	12	0	0	0	0	0	**12**
GP	0	0	0	1	0	0	0	**1**
Daisy Hill Hospital	**827**	**12682**	**1860**	**90**	**69**	**0**	**0**	**15528**
Doctor	356	8244	701	2	2	0	0	**9305**
Consultant	446	2269	675	87	67	0	0	**3544**
Physician Associate	19	1469	106	0	0	0	0	**1594**
Midwife	6	459	350	1	0	0	0	**816**
Nurse	0	215	26	0	0	0	0	**241**
Pharmacist	0	26	0	0	0	0	0	**26**
AHP	0	0	2	0	0	0	0	**2**
Grand Total	**2331**	**41082**	**5067**	**234**	**79**	**22**	**0**	48815

SIGN OFF REPORTS

Time period: **01/07/2020 to 31/07/2020**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USI	Richard Fox	Doctor	Craigavon Area Hospital	52	961	127	3	1	0	**1144**
	Gemma Clements	Doctor	Craigavon Area Hospital	66	910	137	0	0	0	**1113**
	Grainne Tallon	Consultant	Craigavon Area Hospital	70	900	91	1	0	0	**1062**
	Plamena Peneva	Doctor	Lurgan Hospital	16	685	222	0	0	0	**923**
	Mark Haynes	Consultant	Craigavon Area Hospital	152	498	103	7	1	16	**777**
	Eoghan McCloskey	Doctor	Craigavon Area Hospital	41	635	64	0	0	0	**740**
	Allister Foy	Consultant	Craigavon Area Hospital	25	594	44	3	0	0	**666**
	Steven Rice	Doctor	Daisy Hill Hospital	25	603	8	1	0	0	**637**
	James Doyle	Consultant	Daisy Hill Hospital	79	435	80	10	2	0	**606**
	Mohd Radzi Rodzlan Akib	Consultant	Craigavon Area Hospital	24	538	11	0	0	0	**573**
	Kathryn Maxwell	Midwife	Craigavon Area Hospital	0	370	182	0	0	0	**552**
	Anthony Glackin	Consultant	Craigavon Area Hospital	118	330	97	5	1	0	**551**
	Edward Barrington	Doctor	Daisy Hill Hospital	50	472	28	0	0	0	**550**
	Awadalla Abdelrazig	Consultant	Daisy Hill Hospital	98	352	78	0	0	0	**528**
	Christina Bradford	Consultant	Craigavon Area Hospital	19	450	57	2	0	0	**528**
	Janice Quinn	Doctor	Lurgan Hospital	15	452	58	0	0	0	**525**
	Naomi Burns	Doctor	Daisy Hill Hospital	7	468	42	0	0	0	**517**
	Declan Keenan	Consultant	Craigavon Area Hospital	2	505	9	0	0	0	**516**
	Christopher McCauley	Consultant	Craigavon Area Hospital	7	486	5	0	0	0	**498**
	Simon Wright	Doctor	Craigavon Area Hospital	6	454	35	0	0	0	**495**
	Naomi Thompson	Doctor	Craigavon Area Hospital	53	395	29	0	0	1	**478**
	Ahmed Bannaga	Consultant	Craigavon Area Hospital	1	458	6	0	0	0	**465**
	Christopher Sharkey	Doctor	Daisy Hill Hospital	33	386	44	0	0	0	**463**
	Rachel Glass	Doctor	Craigavon Area Hospital	24	429	7	0	0	0	**460**
	Donna Muckian	Consultant	Daisy Hill Hospital	3	427	27	0	0	0	**457**
			Grand Total	**986**	**13193**	**1591**	**32**	**5**	**17**	**15824**

SIGN OFF REPORTS

Time period: **01/06/2020 to 30/06/2020**

Total Sign Off for all trusts for current month and previous two months

Trust	April	May	June
Southern	40680	48799	55627
Western	18035	24242	27038
South-Eastern	4834	5727	7474
Belfast	3720	4883	6583
Northern	3162	4641	4504
Total	**70431**	**88292**	**101226**

Total Sign Off for Southern Trust previous three months

Month	March	April	May
Total	51700	40680	48799

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2954	46518	5830	234	43	48	0	**55627**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1969	30780	3581	133	16	47	0	**36526**
Daisy Hill Hospital	923	12093	1800	100	27	1	0	**14944**
Lurgan Hospital	43	3106	355	0	0	0	0	**3504**
Drumglass Lodge Community	1	209	3	0	0	0	0	**213**
Community	1	146	47	0	0	0	0	**194**
South Tyrone Hospital	0	99	22	0	0	0	0	**121**
*Undefined	17	80	13	1	0	0	0	**111**
Mullinure Health & Wellbein	0	3	6	0	0	0	0	**9**
St Luke's	0	2	2	0	0	0	0	**4**
Community Health Office	0	0	1	0	0	0	0	**1**
	2954	**46518**	**5830**	**234**	**43**	**48**	**0**	55627

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1969**	**30780**	**3581**	**133**	**16**	**47**	**0**	36526
Doctor	873	19869	1360	60	7	2	0	**22171**
Consultant	1054	7320	767	72	9	45	0	**9267**
Midwife	0	1889	1297	0	0	0	0	**3186**
Nurse	42	1558	157	1	0	0	0	**1758**
Pharmacist	0	143	0	0	0	0	0	**143**
GP	0	1	0	0	0	0	0	**1**
Daisy Hill Hospital	**923**	**12093**	**1800**	**100**	**27**	**1**	**0**	14944
Doctor	422	8753	808	6	3	1	0	**9993**
Consultant	476	2066	626	94	24	0	0	**3286**
Midwife	25	527	359	0	0	0	0	**911**
Physician Associate	0	494	4	0	0	0	0	**498**
Nurse	0	70	2	0	0	0	0	**72**
Other	0	116	1	0	0	0	0	**117**
Pharmacist	0	67	0	0	0	0	0	**67**
Grand Total	**2892**	**42873**	**5381**	**233**	**43**	**48**	**0**	51470

SIGN OFF REPORTS

Time period: **01/06/2020 to 30/06/2020**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
[redacted]	Andrew Gibson	Doctor	Craigavon Area Hospital	91	1683	155	2	1	0	**1932**
	Eoghan McCloskey	Doctor	Craigavon Area Hospital	91	1013	101	0	1	0	**1206**
	Plamena Peneva	Doctor	Lurgan Hospital	24	691	192	0	0	0	**907**
	Grainne Tallon	Consultant	Craigavon Area Hospital	95	725	79	0	1	0	**900**
	Gemma Clements	Doctor	Craigavon Area Hospital	53	722	68	0	0	0	**843**
	Mark Haynes	Consultant	Craigavon Area Hospital	121	523	112	16	3	45	**820**
	Naomi Burns	Doctor	Daisy Hill Hospital	11	726	41	0	0	0	**778**
	Andrea Green	Consultant	Craigavon Area Hospital	65	572	111	3	1	0	**752**
	Christina Bradford	Consultant	Craigavon Area Hospital	23	652	33	7	0	0	**715**
	Naomi Thompson	Doctor	Craigavon Area Hospital	60	596	52	0	0	0	**708**
	Declan Keenan	Consultant	Craigavon Area Hospital	3	641	25	0	0	0	**669**
	Wesam Elbaroni	Doctor	Craigavon Area Hospital	38	563	62	2	0	0	**665**
	Janice Quinn	Doctor	Lurgan Hospital	9	602	49	0	0	0	**660**
	Michael Magee	Doctor	Craigavon Area Hospital	27	564	40	0	0	0	**631**
	Donna Muckian	Consultant	Daisy Hill Hospital	34	524	66	0	0	0	**624**
	Awadalla Abdelrazig	Consultant	Daisy Hill Hospital	88	410	113	0	0	0	**611**
	Olga Michail	Doctor	Craigavon Area Hospital	19	533	46	1	0	0	**599**
	Anthony Glackin	Consultant	Craigavon Area Hospital	169	348	55	17	1	0	**590**
	Edward Barrington	Doctor	Daisy Hill Hospital	60	466	54	0	0	0	**580**
	James Doyle	Consultant	Daisy Hill Hospital	66	377	97	13	1	0	**554**
	Ben Loughrey	Doctor	Craigavon Area Hospital	37	485	27	0	0	0	**549**
	Adrienn Zarandi	Doctor	Daisy Hill Hospital	120	261	144	0	0	0	**525**
	Christopher McCauley	Consultant	Craigavon Area Hospital	14	505	0	0	0	0	**519**
	Gerrard Sloan	Consultant	Craigavon Area Hospital	33	409	44	0	1	0	**487**
	Orlaith McManus	Doctor	Craigavon Area Hospital	7	464	1	0	0	0	**472**
			Grand Total	**1358**	**15055**	**1767**	**61**	**10**	**45**	**18296**

SIGN OFF REPORTS

Time period: **01/05/2020 to 31/05/2020**

Total Sign Off for all trusts for current month and previous two months

Trust	March	April	May
Southern	51700	40680	48799
Western	24973	18035	24242
South-Eastern	6493	4834	5727
Belfast	6654	3720	4883
Northern	1731	3162	4641
Total	**91551**	**70431**	**88292**

Total Sign Off for Southern Trust previous three months

Month	February	March	April
Total	55381	51700	40680

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2647	40072	5954	84	33	9	0	**48799**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1748	26336	3896	53	18	6	0	**32057**
Daisy Hill Hospital	820	10332	1548	31	15	0	0	**12746**
Lurgan Hospital	55	3041	351	0	0	3	0	**3450**
Community	0	171	24	0	0	0	0	**195**
*Undefined	24	69	35	0	0	0	0	**128**
St Luke's	0	1	89	0	0	0	0	**90**
South Tyrone Hospital	0	80	10	0	0	0	0	**90**
Drumglass Lodge Community	0	42	1	0	0	0	0	**43**
	2647	**40072**	**5954**	**84**	**33**	**9**	**0**	**48799**

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1748**	**26336**	**3896**	**53**	**18**	**6**	**0**	**32057**
Doctor	846	16493	1474	25	3	3	0	**18844**
Consultant	851	6015	890	27	15	3	0	**7801**
Midwife	3	2149	1322	0	0	0	0	**3474**
Nurse	48	1487	210	1	0	0	0	**1746**
Pharmacist	0	189	0	0	0	0	0	**189**
GP	0	3	0	0	0	0	0	**3**
Daisy Hill Hospital	**820**	**10332**	**1548**	**31**	**15**	**0**	**0**	**12746**
Doctor	360	7753	776	3	6	0	0	**8898**
Consultant	377	1681	490	28	9	0	0	**2585**
Midwife	82	438	266	0	0	0	0	**786**
Physician Associate	0	259	2	0	0	0	0	**261**
Nurse	1	96	14	0	0	0	0	**111**
Other	0	70	0	0	0	0	0	**70**
Pharmacist	0	35	0	0	0	0	0	**35**
Grand Total	**2568**	**36668**	**5444**	**84**	**33**	**6**	**0**	**44803**

SIGN OFF REPORTS

Time period: **01/05/2020 to 31/05/2020**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USI	Grainne Tallon	Consultant	Craigavon Area Hospital	175	1465	144	0	1	0	**1785**
	Andrew Gibson	Doctor	Craigavon Area Hospital	53	1040	122	0	0	0	**1215**
	Richard Fox	Doctor	Craigavon Area Hospital	83	944	109	1	1	0	**1138**
	Michelle Portis	Midwife	Craigavon Area Hospital	0	686	315	0	0	0	**1001**
	Plamena Peneva	Doctor	Lurgan Hospital	29	644	177	0	0	3	**853**
	Eoghan McCloskey	Doctor	Craigavon Area Hospital	70	602	76	0	0	0	**748**
	Awadalla Abdelrazig	Consultant	Daisy Hill Hospital	95	541	92	2	0	0	**730**
	Laura Carr	Doctor	Craigavon Area Hospital	93	433	141	1	1	0	**669**
	Allister Foy	Consultant	Craigavon Area Hospital	24	552	48	1	0	0	**625**
	Wesam Elbaroni	Doctor	Craigavon Area Hospital	21	515	35	4	0	2	**577**
	Olga Michail	Doctor	Craigavon Area Hospital	25	484	60	0	0	0	**569**
	Janet Acheson	Consultant	Daisy Hill Hospital	21	378	165	2	2	0	**568**
	Gemma Clements	Doctor	Craigavon Area Hospital	65	441	53	0	0	0	**559**
	Christina Bradford	Consultant	Craigavon Area Hospital	20	484	37	2	1	0	**544**
	Ben Loughrey	Doctor	Craigavon Area Hospital	54	384	55	0	0	0	**493**
	Andrea Green	Consultant	Craigavon Area Hospital	79	312	83	1	3	0	**478**
	Fraser Morton	Midwife	Daisy Hill Hospital	82	277	107	0	0	0	**466**
	Christopher Elliott	Doctor	Daisy Hill Hospital	0	414	49	0	0	0	**463**
	Catherine Fegan	Doctor	Lurgan Hospital	0	424	24	0	0	0	**448**
	Stuart McIlwaine	Doctor	Daisy Hill Hospital	6	424	11	0	0	0	**441**
	Anthony Glackin	Consultant	Craigavon Area Hospital	121	236	71	9	2	0	**439**
	Peter Reel	Doctor	Daisy Hill Hospital	40	325	51	0	0	0	**416**
	Christopher McCauley	Consultant	Craigavon Area Hospital	9	371	23	0	0	0	**403**
	Ushagowri Mavuri	Doctor	Craigavon Area Hospital	15	337	19	0	0	0	**371**
	Adrienn Zarandi	Doctor	Daisy Hill Hospital	69	217	62	2	0	0	**350**
			Grand Total	**1249**	**12930**	**2129**	**25**	**11**	**5**	**16349**

SIGN OFF REPORTS

Time period: **01/04/2020 to 30/04/2020**

Total Sign Off for all trusts for current month and previous two months

Trust	February	March	April
Southern	55381	51700	40680
Western	31488	24973	18035
South-Eastern	5227	6493	4834
Belfast	8120	6654	3720
Northern	1719	1731	3162
Total	**101935**	**91551**	**70431**

Total Sign Off for Southern Trust previous three months

Month	January	February	March
Total	56354	55381	51700

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2412	33596	4526	111	23	12	0	**40680**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1612	21353	3009	98	10	11	0	**26093**
Daisy Hill Hospital	718	8848	1118	13	13	1	0	**10711**
Lurgan Hospital	55	2833	352	0	0	0	0	**3240**
Community	0	260	10	0	0	0	0	**270**
Undefined*	27	199	26	0	0	0	0	**252**
South Tyrone Hospital	0	97	11	0	0	0	0	**108**
Community Health Office	0	3	0	0	0	0	0	**3**
St Luke's	0	3	0	0	0	0	0	**3**
	2412	**33596**	**4526**	**111**	**23**	**12**	**0**	**40680**

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1612**	**21353**	**3009**	**98**	**10**	**11**	**0**	**26093**
Doctor	940	14048	1353	24	1	2	0	**16368**
Consultant	645	4289	591	73	9	8	0	**5615**
Midwife	0	1784	916	0	0	0	0	**2700**
Nurse	27	1044	145	1	0	1	0	**1218**
Pharmacist	0	184	0	0	0	0	0	**184**
GP	0	3	4	0	0	0	0	**7**
AHP	0	1	0	0	0	0	0	**1**
Daisy Hill Hospital	**718**	**8848**	**1118**	**13**	**13**	**1**	**0**	**10711**
Doctor	344	6819	522	0	0	0	0	**7685**
Consultant	367	1496	365	13	13	1	0	**2255**
Midwife	7	271	220	0	0	0	0	**498**
Nurse	0	109	8	0	0	0	0	**117**
Physician Associate	0	110	2	0	0	0	0	**112**
Pharmacist	0	43	0	0	0	0	0	**43**
AHP	0	0	1	0	0	0	0	**1**
Grand Total	**2330**	**30201**	**4127**	**111**	**23**	**12**	**0**	**36804**

SIGN OFF REPORTS

Time period: **01/04/2020 to 30/04/2020**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USI	Grainne Tallon	Doctor	Craigavon Area Hospital	179	1188	78	0	0	1	**1446**
	Richard Fox	Doctor	Craigavon Area Hospital	125	1040	190	0	1	0	**1356**
	Laura Carr	Doctor	Craigavon Area Hospital	71	580	247	0	0	0	**898**
	Plamena Peneva	Doctor	Lurgan Hospital	30	695	147	0	0	0	**872**
	Allister Foy	Consultant	Craigavon Area Hospital	40	661	74	3	0	0	**778**
	Andrea Green	Consultant	Craigavon Area Hospital	89	479	102	1	2	0	**673**
	Andrew Gibson	Doctor	Craigavon Area Hospital	79	521	52	0	0	0	**652**
	Simon Wright	Doctor	Craigavon Area Hospital	16	594	37	0	0	0	**647**
	Catherine Fegan	Doctor	Lurgan Hospital	0	600	36	0	0	0	**636**
	Michelle Portis	Midwife	Craigavon Area Hospital	0	407	199	0	0	0	**606**
	Eoghan McCloskey	Doctor	Craigavon Area Hospital	60	487	44	0	0	0	**591**
	Awadalla Abdelrazig	Consultant	Daisy Hill Hospital	106	296	91	0	0	0	**493**
	Alice Mclean	Doctor	Daisy Hill Hospital	2	482	2	0	0	0	**486**
	Christina Bradford	Consultant	Craigavon Area Hospital	22	438	17	3	0	0	**480**
	Amy Eakin	Midwife	Craigavon Area Hospital	0	235	235	0	0	0	**470**
	Naomi Burns	Doctor	Daisy Hill Hospital	2	455	9	0	0	0	**466**
	Janet Acheson	Consultant	Daisy Hill Hospital	39	255	125	3	10	1	**433**
	Kathryn Maxwell	Midwife	Craigavon Area Hospital	0	308	121	0	0	0	**429**
	Edward Barrington	Doctor	Daisy Hill Hospital	27	368	23	0	0	0	**418**
	Gail Nicholson	Consultant	Craigavon Area Hospital	1	385	22	0	0	0	**408**
	Janice Quinn	Doctor	Lurgan Hospital	11	346	46	0	0	0	**403**
	Salman Khwaja	Consultant	Daisy Hill Hospital	32	339	26	0	0	0	**397**
	Efstathios Bonanos	Doctor	Craigavon Area Hospital	25	336	30	0	0	0	**391**
	Christopher Elliott	Doctor	Daisy Hill Hospital	1	352	35	0	0	0	**388**
	Barry Walls	Doctor	Daisy Hill Hospital	6	237	123	0	0	0	**366**
			Grand Total	**963**	**12084**	**2111**	**10**	**13**	**2**	**15183**

SIGN OFF REPORTS

Time period: **01/03/2020 to 31/03/2020**

Total Sign Off for all trusts for current month and previous two months

Trust	January	February	March
Southern	56354	55381	51700
Western	29664	31488	24973
South-Eastern	6845	5227	6493
Belfast	9099	8120	6654
Northern	1430	1719	1731
Total	**103392**	**101935**	**91551**

Total Sign Off for Southern Trust previous three months

Month	December	January	February
Total	48936	56354	51700

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2395	44800	4222	211	41	31	0	**51700**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1799	30984	2836	183	19	31	0	**35852**
Daisy Hill Hospital	446	10189	1071	27	22	0	0	**11755**
Lurgan Hospital	68	3152	257	1	0	0	0	**3478**
Undefined*	82	254	26	0	0	0	0	**362**
Community	0	115	17	0	0	0	0	**132**
South Tyrone Hospital	0	98	14	0	0	0	0	**112**
St Luke's	0	8	0	0	0	0	0	**8**
Mullinure Health & Wellbein	0	0	1	0	0	0	0	**1**
	2395	**44800**	**4222**	**211**	**41**	**31**	**0**	**51700**

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1799**	**30984**	**2836**	**183**	**19**	**31**	**0**	**35852**
Doctor	831	21620	1249	65	2	11	0	**23778**
Consultant	929	5061	459	116	17	20	0	**6602**
Midwife	5	1735	967	0	0	0	0	**2707**
Nurse	33	2063	158	2	0	0	0	**2256**
Pharmacist	0	176	0	0	0	0	0	**176**
Other	1	167	3	0	0	0	0	**171**
AHP	0	162	0	0	0	0	0	**162**
Daisy Hill Hospital	**446**	**10189**	**1071**	**27**	**22**	**0**	**0**	**11755**
Doctor	262	8576	559	12	14	0	0	**9423**
Consultant	180	631	155	15	8	0	0	**989**
Midwife	4	466	335	0	0	0	0	**805**
Nurse	0	262	17	0	0	0	0	**279**
Pharmacist	0	83	0	0	0	0	0	**83**
AHP	0	171	5	0	0	0	0	**176**
Grand Total	**2245**	**41173**	**3907**	**210**	**41**	**31**	**0**	**47607**

SIGN OFF REPORTS

Time period: **01/03/2020 to 31/03/2020**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the	Andrew Gibson	Doctor	Craigavon Area Hospital	144	2648	190	4	1	5	**2992**
	Grainne Tallon	Doctor	Craigavon Area Hospital	166	1171	129	1	0	0	**1467**
	Plamena Peneva	Doctor	Lurgan Hospital	19	940	144	0	0	0	**1103**
	Amy Eakin	Midwife	Craigavon Area Hospital	0	530	543	0	0	0	**1073**
	Mark Haynes	Consultant	Craigavon Area Hospital	161	637	73	18	4	18	**911**
	Richard Fox	Doctor	Craigavon Area Hospital	44	752	109	1	0	0	**906**
	Eoghan McCloskey	Doctor	Craigavon Area Hospital	41	780	48	0	0	0	**869**
	Simon Wright	Doctor	Craigavon Area Hospital	21	779	47	0	0	0	**847**
	Janice Quinn	Doctor	Lurgan Hospital	33	744	54	1	0	0	**832**
	Peter Reel	Doctor	Daisy Hill Hospital	29	618	19	0	0	0	**666**
	Barry Walls	Doctor	Daisy Hill Hospital	16	418	175	0	1	0	**610**
	Lisa Watt	Doctor	Daisy Hill Hospital	51	513	37	0	0	0	**601**
	Alice Mclean	Doctor	Daisy Hill Hospital	0	578	2	0	0	0	**580**
	Kathryn Maxwell	Midwife	Craigavon Area Hospital	0	392	152	0	0	0	**544**
	Sophie Murtagh	Doctor	Craigavon Area Hospital	1	527	7	0	0	0	**535**
	Rachel Glass	Doctor	Craigavon Area Hospital	25	497	4	0	0	0	**526**
	Gemma Clements	Doctor	Craigavon Area Hospital	16	412	75	0	0	0	**503**
	Eimear Savage	Consultant	Craigavon Area Hospital	94	374	22	0	0	0	**490**
	Christina Bradford	Consultant	Craigavon Area Hospital	20	435	15	3	0	0	**473**
	Efstathios Bonanos	Doctor	Craigavon Area Hospital	9	424	40	0	0	0	**473**
	Jordan Armstrong	Doctor	Craigavon Area Hospital	6	456	0	0	0	0	**462**
	Stuart McIlwaine	Doctor	Daisy Hill Hospital	2	442	10	0	0	0	**454**
	Andrea Green	Consultant	Craigavon Area Hospital	119	257	61	4	4	0	**445**
	Andrea Livingstone	Doctor	Daisy Hill Hospital	9	417	16	0	0	0	**442**
	Sarah Jayne White	Doctor	Craigavon Area Hospital	20	395	21	0	0	0	**436**
			Grand Total	**1046**	**16136**	**1993**	**32**	**10**	**23**	**19240**

SIGN OFF REPORTS

Time period: **01/02/2020 to 29/02/2020**

Total Sign Off for all trusts for current month and previous two months

Trust	December	January	February
Southern	48936	56354	55381
Western	27867	29664	31488
South-Eastern	5833	6845	5227
Belfast	8713	9099	8120
Northern	1672	1430	1719
Total	**93021**	**103392**	**101935**

Total Sign Off for Southern Trust previous three months

Month	November	December	January
Total	46900	48936	56354

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2741	48298	4026	240	54	22	0	**55381**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2006	34618	2679	179	28	22	0	**39532**
Daisy Hill Hospital	591	10424	1100	61	26	0	0	**12202**
Lurgan Hospital	89	2781	185	0	0	0	0	**3055**
Undefined*	52	149	12	0	0	0	0	**213**
Community	2	165	32	0	0	0	0	**199**
South Tyrone Hospital	1	158	18	0	0	0	0	**177**
Downe Hospital	0	0	0	0	0	0	0	**0**
Mullinure Health & Wellbein	0	1	0	0	0	0	0	**1**
St Luke's	0	2	0	0	0	0	0	**2**
	2741	**48298**	**4026**	**240**	**54**	**22**	**0**	**55381**

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**2006**	**34618**	**2679**	**179**	**28**	**22**	**0**	**39532**
Doctor	978	24105	1229	64	7	5	0	**26388**
Consultant	1008	6236	535	107	21	16	0	**7923**
Midwife	2	2104	763	0	0	1	0	**2870**
Nurse	18	2004	152	8	0	0	0	**2182**
Pharmacist	0	121	0	0	0	0	0	**121**
Other	0	40	0	0	0	0	0	**40**
AHP	0	8	0	0	0	0	0	**8**
Daisy Hill Hospital	**591**	**10424**	**1100**	**61**	**26**	**0**	**0**	**12202**
Doctor	246	8114	506	31	11	0	0	**8908**
Consultant	297	1475	227	30	15	0	0	**2044**
Midwife	48	440	362	0	0	0	0	**850**
Nurse	0	117	3	0	0	0	0	**120**
Pharmacist	0	33	0	0	0	0	0	**33**
AHP	0	245	2	0	0	0	0	**247**
Grand Total	**2597**	**45042**	**3779**	**240**	**54**	**22**	**0**	**51734**

SIGN OFF REPORTS

Time period: **01/02/2020 to 29/02/2020**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USI	Grainne Tallon	Doctor	Craigavon Area Hospital	194	1670	107	0	2	2	**1975**
	Jonathan Palmer	Doctor	Craigavon Area Hospital	50	1354	198	4	2	0	**1608**
	Lorraine Sproule	Doctor	Craigavon Area Hospital	56	1232	125	0	0	0	**1413**
	Eoghan McCloskey	Doctor	Craigavon Area Hospital	60	832	86	0	0	0	**978**
	Rachel Glass	Doctor	Craigavon Area Hospital	30	907	10	1	0	0	**948**
	Awadalla Abdelrazig	Consultant	Daisy Hill Hospital	102	648	113	0	1	0	**864**
	Janice Quinn	Doctor	Lurgan Hospital	45	742	52	0	0	0	**839**
	Mark Haynes	Consultant	Craigavon Area Hospital	149	502	55	16	5	16	**743**
	Richard Fox	Doctor	Craigavon Area Hospital	56	597	75	1	0	0	**729**
	Peter Reel	Doctor	Daisy Hill Hospital	22	679	21	0	0	0	**722**
	Barry Walls	Doctor	Daisy Hill Hospital	21	503	161	0	2	0	**687**
	Andrea Green	Consultant	Craigavon Area Hospital	121	461	91	2	7	0	**682**
	Emma Maxwell	Doctor	Craigavon Area Hospital	3	643	0	0	0	0	**646**
	Lisa Watt	Doctor	Daisy Hill Hospital	45	572	27	0	0	0	**644**
	Sophie Murtagh	Doctor	Craigavon Area Hospital	0	636	0	0	0	0	**636**
	Adam Longwell	Doctor	Craigavon Area Hospital	1	630	4	0	0	0	**635**
	Fiona Moore	Doctor	Craigavon Area Hospital	4	572	40	0	0	3	**619**
	Kathryn Maxwell	Midwife	Craigavon Area Hospital	0	385	214	0	0	0	**599**
	Victoria Lamont	Doctor	Craigavon Area Hospital	3	586	6	0	0	0	**595**
	Eimear Savage	Consultant	Craigavon Area Hospital	90	432	28	0	0	0	**550**
	Sabahat Hasnain	Doctor	Craigavon Area Hospital	50	442	44	2	0	0	**538**
	Gerrard Sloan	Consultant	Craigavon Area Hospital	38	470	30	0	0	0	**538**
	Plamena Peneva	Doctor	Lurgan Hospital	16	431	80	0	0	0	**527**
	Shane Moan	Consultant	Daisy Hill Hospital	76	414	21	9	5	0	**525**
	Simon Wright	Doctor	Craigavon Area Hospital	28	458	29	0	0	0	**515**
			Grand Total	**1260**	**16798**	**1617**	**35**	**24**	**21**	**19755**

SIGN OFF REPORTS

Time period: **01/01/2020 to 31/01/2020**

Total Sign Off for all trusts for current month and previous two months

Trust	November	December	January
Southern	46900	48936	56354
Western	29093	27867	29664
South-Eastern	6100	5833	6845
Belfast	9278	8713	9099
Northern	1519	1672	1430
Total	**92890**	**93021**	**103392**

Total Sign Off for Southern Trust previous three months

Month	October	November	December
Total	41383	46900	48936

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2842	49438	3777	233	49	15	0	**56354**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2151	36302	2582	191	21	15	0	**41262**
Daisy Hill Hospital	571	9392	949	42	28	0	0	**10982**
Lurgan Hospital	56	2935	175	0	0	0	0	**3166**
Undefined*	62	513	56	0	0	0	0	**631**
Community	1	154	2	0	0	0	0	**157**
South Tyrone Hospital	1	130	13	0	0	0	0	**144**
Downe Hospital	0	0	0	0	0	0	0	**0**
Mullinure Health & Wellbein	0	0	0	0	0	0	0	**0**
St Luke's	0	12	0	0	0	0	0	**12**
	2842	**49438**	**3777**	**233**	**49**	**15**	**0**	56354

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**2151**	**36302**	**2582**	**191**	**21**	**15**	**0**	**41262**
Doctor	1006	23900	1198	66	6	6	0	**26182**
Consultant	1110	7941	666	115	15	8	0	**9855**
Midwife	6	2062	540	0	0	0	0	**2608**
Nurse	29	2302	178	10	0	1	0	**2520**
Pharmacist	0	96	0	0	0	0	0	**96**
AHP	0	0	0	0	0	0	0	**0**
Clinical Admin	0	0	0	0	0	0	0	**0**
GP	0	1	0	0	0	0	0	**1**
Daisy Hill Hospital	**571**	**9392**	**949**	**42**	**28**	**0**	**0**	**10982**
Doctor	147	6884	293	11	20	0	0	**7355**
Consultant	359	1802	233	31	8	0	0	**2433**
Midwife	64	556	409	0	0	0	0	**1029**
Nurse	1	116	14	0	0	0	0	**131**
Pharmacist	0	32	0	0	0	0	0	**32**
AHP	0	2	0	0	0	0	0	**2**
Grand Total	**2722**	**45694**	**3531**	**233**	**49**	**15**	**0**	52244

SIGN OFF REPORTS

Time period: **01/01/2020 to 31/01/2020**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal information redacted by the U	Grainne Tallon	Doctor	Craigavon Area Hospital	226	1260	153	1	1	1	**1642**
	Richard Fox	Doctor	Craigavon Area Hospital	126	1210	193	1	0	0	**1530**
	Sarah Gilmour	Doctor	Craigavon Area Hospital	86	1067	100	0	0	0	**1253**
	Eoghan McCloskey	Doctor	Craigavon Area Hospital	91	1077	82	0	0	1	**1251**
	Adam Longwell	Doctor	Craigavon Area Hospital	0	1183	1	0	0	0	**1184**
	Andrew Gibson	Doctor	Craigavon Area Hospital	91	869	28	2	0	0	**990**
	Declan Keenan	Consultant	Craigavon Area Hospital	42	830	43	1	0	0	**916**
	Mark Haynes	Consultant	Craigavon Area Hospital	183	646	64	9	2	8	**912**
	Sarah J Morgan	Doctor	Craigavon Area Hospital	10	764	8	0	0	0	**782**
	Janice Quinn	Doctor	Lurgan Hospital	20	694	46	0	0	0	**760**
	Eimear Savage	Consultant	Craigavon Area Hospital	50	681	2	1	0	0	**734**
	Awadalla Abdelrazig	Consultant	Daisy Hill Hospital	122	516	63	0	0	0	**701**
	Plamena Peneva	Doctor	Lurgan Hospital	3	577	91	0	0	0	**671**
	Coral Trainor	Doctor	Craigavon Area Hospital	37	548	58	0	0	0	**643**
	Andrea Green	Consultant	Craigavon Area Hospital	97	450	53	6	5	0	**611**
	Sarah Craig	Doctor	Craigavon Area Hospital	1	583	0	0	0	0	**584**
	Samuel Edward	Doctor	Craigavon Area Hospital	21	555	3	1	0	0	**580**
	Lisa Watt	Doctor	Daisy Hill Hospital	14	537	26	0	0	0	**577**
	Helen Kerr	Doctor	Craigavon Area Hospital	0	577	0	0	0	0	**577**
	Fraser Morton	Midwife	Daisy Hill Hospital	64	293	197	0	0	0	**554**
	Lorraine Sproule	Doctor	Craigavon Area Hospital	32	481	29	0	0	0	**542**
	Anthony Glackin	Consultant	Craigavon Area Hospital	108	362	50	14	2	0	**536**
	Conor Flaherty	Doctor	Craigavon Area Hospital	0	526	3	2	0	0	**531**
	Kathryn Maxwell	Midwife	Craigavon Area Hospital	0	345	179	0	0	0	**524**
	Alice Mclean	Doctor	Daisy Hill Hospital	1	504	1	0	0	0	**506**
			Grand Total	**1425**	**17135**	**1473**	**38**	**10**	**10**	**20091**

Southern Health and Social Care Trust

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier:

Date of Incident/Event: **22 April 2020**

HSCB Unique Case Identifier: [redacted]

Service User Details: (*complete where relevant*)
D.O.B: [redacted] Gender: **Female**
Age: [redacted] **years**

Responsible Lead Officer: **Dr Beverley Adams**

Designation: **Consultant Obstetrician and Gynaecologist**

Report Author: **The Review Team**

Date report signed off:

Date submitted to HSCB:

1.0 EXECUTIVE SUMMARY

Patient XX experienced preterm pre-labour rupture of membranes on [redacted] at 31 weeks' gestation.

Despite treatment with oral antibiotics, she developed infection of the membranes around the fetus and presented with sepsis on [redacted], when intrauterine fetal death was diagnosed. Clinical signs became abnormal from [redacted] onwards. The option of earlier delivery was not discussed with Patient XX, given her preterm gestation. It is not clear if earlier delivery would have prevented Patient XX developing such a severe infection.

It is not clear if Baby XX would have survived, given the major factors of prematurity and intrauterine infection.

However, the parents are clear that they would have liked to have discussed the option for delivery and the associated risks.

2.0 THE REVIEW TEAM

Dr Beverley Adams – Consultant Obstetrician and Gynaecology (Chair)
Mrs Mary Dawson – Lead Midwife
Mrs Ursula Gaffney – Risk Management Midwife

3.0 SAI REVIEW TERMS OF REFERENCE

The terms of reference for the review of the care and treatment provided to Patient XX were:

- To carry out a review of the care provided to Patient XX by the Southern Health and Social Care Trust from 22/11/19 involving care in Integrated Maternity and Women's Health
- To identify key causal and contributory factors leading to the stillbirth of infant Patient XX
- To use a multidisciplinary approach to the review using a systems analysis methodology
- To engage with Patient XX's family in line with Regional Guidance on Engagement with Service Users, Families and Carers
- To agree the outcome of the review and subsequent recommendations, actions and lessons to be learned
- To adhere to principles of confidentiality throughout the review
- To report the findings and the recommendations of the review to the Director of Acute Services SHSCT, and disseminate to the staff associated with care and Patient XX and her family

4.0 REVIEW METHODOLOGY

- The review of Maternity Hand Held Health Records
- Discussion with staff involved
- Inclusion of comments and questions from Patient XX and her husband

5.0 DESCRIPTION OF INCIDENT/CASE

A summary of the case follows; Appendix 2 is a detailed timeline of events.

Patient XX booked for consultant led antenatal care in her second pregnancy.

She was a healthy Personal Information redacted by the USI-old woman, with a history of treatment to her cervix because of abnormal smears.

Her booking BMI was 36.15 kg/m^2.

Patient XX attended a consultant led clinic for assessment of cervical length by ultrasound scan.

She self-referred to the Maternity Assessment Unit on Personal Information redacted by the USI at 01:15 (31 weeks' gestation); a diagnosis of premature pre-labour rupture of membranes was made.

Patient XX was admitted and was treated with oral antibiotics in keeping with the contemporaneous guidance.

Concerns were raised about her heart rate and the fetal heart rate pattern on cardiotocography (CTG) recordings.

Patient XX was reviewed by a consultant each day and was discharged to home on Personal Information redacted by the USI.

She returned for review on Personal Information redacted by the USI at 09:30 and was reassessed by a Trust Grade doctor, before being discharged home in and around 12:30.

Patient XX contacted the Maternity Assessment Unit again on Personal Information redacted by the USI at 13:00, when she described feeling shivery and had some brown vaginal staining.

When she returned at 13:30 on Personal Information redacted by the USI, she was felt to be in labour and was transferred quickly to the Delivery Suite.

The Sepsis 6 bundle was implemented at 13:42.

The fetal heartbeat could not be heard and intrauterine fetal death was confirmed by ultrasound scan at around 13:43.

5.0 DESCRIPTION OF INCIDENT/CASE

Patient XX proceeded to augmentation of labour with a Syntocinon infusion as well as treatment with intravenous antibiotics.

She delivered a stillborn Personal Information redacted by the USI at 02:35 on Personal Information redacted by the USI, of birthweight 1770g.

Patient XX continued to receive intravenous antibiotic treatment until review on Personal Information redacted by the USI at 09:25, when oral antibiotics were recommended.

She was discharged to home on Personal Information redacted by the USI at 10:30 but reattended later that day at 23:30 with a history of feeling unwell at home and of a high temperature.

Patient XX was readmitted and treated with intravenous antibiotics until review on Personal Information redacted by the USI, when treatment was changed to oral antibiotics before discharge to home.

Patient XX and her husband have been offered support from the Bereavement Midwife and continue to engage with this.

Patient XX contacted the Maternity Assessment Unit again on Personal Information redacted by the USI, describing an increased temperature, and was advised to attend.

She was reviewed by a consultant and underwent repeat examination, ultrasound scan and explanation of results before discharge to home.

Histopathological analysis of Patient XX's placenta was reported on Personal Information redacted by the USI and concluded that there had been evidence of ascending maternal genital tract infection with a severe fetal inflammatory response.

The cause of death of Patient XX's Personal Information redacted by the USI is therefore understood to be infection.

6.0 FINDINGS

Patient XX submitted questions after a consultation with a Consultant on Personal Information redacted by the USI and after discussion with the Bereavement Midwife on 22 September 2020.

The review team engaged with Patient XX on 17 September 2020.

The SAI Chair spoke with Patient XX and her husband on 17 December 2020, when some additional issues were addressed.

The original table of questions and subsequent additional questions submitted by Patient XX are found at Appendix 1, along with responses from the review team.

The review team met with staff involved over two separate morning sessions, 28 September 2020 and 5 October 2020.

The team reviewed the care of Patient XX with the aim of identifying causative and contributory factors, using a fishbone analysis.

6.0 FINDINGS

The cause of the death of Patient XX's baby, Baby X, was infection.

Despite having systems in place to aid interpretation of CTG traces, i.e. the proforma from the NI Regional Maternity Collaborative, abnormalities were apparent from Personal Information redacted by the USI Personal Information redacted by the USI onwards but were not actioned.

Similarly, maternal observations were checked but an increase in Patient XX's heart rate was not acted on (Personal Information redacted by the USI onwards).

It is not clear if earlier delivery of Patient XX's baby would have resulted in survival of Baby X or if it would have prevented Patient XX developing sepsis.

Several factors were felt to be contributory.

1. Interpretation of CTG traces at gestations less than 34 weeks is difficult. The normal patterns of fetal brain activity are not completely established at this stage. This can make it difficult to know if the beat to beat variability is normal or reduced.

2. When reduced variability was noted on the CTG, the trace was continued for various lengths of time[1].There seemed to be a reluctance to classify the CTG as being not normal (usually 40 minutes is adequate)and a tendency to keep it in place to see if it improved over time.

3. The 'buddy' stickers available to facilitate systematic interpretation of the CTG were used well by the midwives, but not always by the doctors, although it is not clear if using the sticker as an aide memoire would have resulted in a different assessment of CTG features.

4. At discussion the midwife allocated to antenatal patients seems to have been responsible for care of several high-risk patients without additional help from colleagues on several different shifts.

5. At the time in question, the doctors seem to have been covering multiple clinical areas at the same time, because of working patterns during Covid

6. A lack of overview of the whole clinical picture and the changing patterns of CTG traces, maternal observations and blood results was apparent.

7. The midwifery staff identified concerns at several different times but were reassured when the doctors did not find the concerns raised to be worrying. With the benefit of reflection, the midwives were correct.

8. The most recent professional advice[2] regarding prevention of preterm labour and cervical length scans recommends transvaginal ultrasound scans, as opposed to transabdominal scans (as were used in this case). It is not clear if this

[1] Appendix 4 is a summary of results of tests and observations over time, to demonstrate trends; this includes the duration of CTG recordings.
[2] See Appendix 3 which is a summary of the professional guidance in place at the time of Patient XX's delivery.

6.0 FINDINGS

difference in scanning practice would have affected the eventual outcome or affected whether or not a cervical stitch was indicated.

9. Delivery at 31 weeks' gestation is associated with many complications, the most significant being breathing difficulties, although other longer-term complications are also important, such as cerebral palsy and developmental problems[3]. There is no evidence of any discussion between Patient XX and the attending staff about the balance between risks of delivery and risks of supportive management.

10. Earlier delivery of Baby X was indicated but there is no assurance that Baby X would have survived after delivery, given the severe sepsis identified in the histopathology report. To date, there is no reliable clinical sign to check which identifies the onset of infection in the membranes and fluid around the baby. It is not uncommon for histopathology results to demonstrate severe infection in the umbilical cord and membranes and for the mother to have been clinically asymptomatic. Nor is there any way to predict the long-term survival rates of Baby X.

7.0 CONCLUSIONS

It is not clear if Baby X would have survived if delivery had been achieved before Personal Information redacted by the USI.
Infection of the membranes around the baby is recognized as a cause of stillbirth but is not completely understood. It is not uncommon for histopathology reports to include information about infection around the membranes and the baby when the maternal observations were completely normal.

However, maternal observations were not normal in this case, nor were the CTGs or blood test results.

Despite recognition of abnormal findings, the option of delivery, albeit associated with many complications for the baby, was not considered.

The review team has reflected on the findings and makes several recommendations (as below) to mitigate the risks of recurrence of this clinical scenario in the future.

8.0 LESSONS LEARNED

1. CTG interpretation can be difficult, especially for antepartum preterm babies and inter-observer variation is a significant risk factor. The use of Dawes Redman system will provide an independent assessment with removal of inter-

[3] The patient information published on the Tommy's website is useful and includes discussion of problems with hearing, vision and cerebral palsy. https://www.tommys.org/pregnancy-information/premature-birth/taking-your-baby-home/health-problems-and-disability.

observer variation: this is the best way to inform decision and inform escalation.

2. Decisions at gestations less than 34 weeks are difficult and consultant peer discussion and review may be useful and should be encouraged. If the CTG assessment is not normal after 60 minutes of a continuous trace, review of the treatment plan, the consultant of the week or consultant on call should review the patient's clinical findings and treatment plan urgently.

3. In common with other reports, it is important to highlight the importance of retaining a clinical overview for each patient, to include their clinical history and trends especially when workload pressures are high; it is easy to become task focused.

4. If any member of the MDT has a concern about a patient, this should be explored in full, with an 'open eyes' approach to review of the clinical features.

5. Measurement of cervical length should be completed by using transvaginal scan by an appropriately skilled clinician.

6. Full discussion of the clinical findings, risks and options for treatment with the patient should be facilitated by a senior obstetrician (preferably the consultant) for pregnant women, especially in the context of preterm delivery and uncertainty about long-term survival.

7. All Consultants in O&G should be aware of the option to discuss findings and options for treatment with a consultant peer. During daytime hours, this can usually be achieved with another consultant peer on site. For discussions out of hours, each of the Maternity Units has a consultant on call and who should be available for peer review.

9.0 RECOMMENDATIONS AND ACTION PLANNING

1. Consideration of the Dawes-Redman assessment for antenatal CTGs. This is a computerised assessment comparing CTG features against a large database of normal features and is already used within other units in the region. It aims to reduce inter-observer variation in interpretation of antenatal CTGs by assessing fetal heart rate patterns against a database of reassuring features.

2. The MDT teaching programme should include sessions aimed at learning from incidents relating to Human Factors and 'helicopter views' on alternate months; this should include appropriate communication with the mother This teaching should embed an 'open eyes' approach to reviewing clinical situations.

3. All ultrasound scans to measure cervical length should be transvaginal unless the woman declines to consent.

4. Women admitted with clinically complex problems should be made aware of the available treatment options and associated risks, including clinical

9.0	RECOMMENDATIONS AND ACTION PLANNING
	uncertainties. These discussions should be summarised in the clinical notes along with a provisional plan for treatment as agreed by the mother and clinical team. We suggest identification and audit of the charts of these patients at 6 & 12 months.

10.0	DISTRIBUTION LIST

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

(This checklist should be completed in full and submitted to the HSCB along with the completed SAI Review Report for all levels of SAI reviews)

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, a number of service users or if the SAI relates **only** to a HSC Child Death notification *(SAI criterion 4.2.2)* **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		**HSC Child Death Notification only**		
	Comment: ****If multiple service users involved please indicate the number involved***						
2) Was the Service User[1] / Family / Carer informed the incident was being investigated as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date informed**:						
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being investigated as a SAI						
	a) No contact or Next of Kin details or Unable to contact						
	b) Not applicable as this SAI is not 'patient/service user' related						
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user						
	d) Case involved suspected or actual abuse by family						
	e) Case identified as a result of review exercise						
	f) Case is environmental or infrastructure related with no harm to patient/service user						
	g) Other rationale						
	If you selected c), d), e), f) or g) above please provide further details:						
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**							
Content with rationale?	**YES**		**NO**				

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being investigated as a SAI)

3) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			
	c) Report not shared but contents discussed (***if you select this option please also complete 'I' below***)			
	d) No contact or Next of Kin or Unable to contact			
Continued overleaf	**e)** No response to correspondence			

[1]*Service User or their nominated representative*

This checklist should be completed in line with the HSCB Procedure for the reporting and follow up of SAIs October 2013 and the HSC Guidance for staff on engagement/communication with Service Users[1] / Families/Carers following a SAI

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being investigated as a SAI)*		
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SECTION 2

INFORMING THE CORONER'S OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) *(complete this section for all death related SAIs)*				
1) Was there a Statutory Duty to notify the Coroner at the time of death? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
2) Following or during the review of the SAI was there a Statutory Duty to notify the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
3) If you have selected 'YES' to any of the above **'1' or '2'** has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date report shared**:			
	If **NO**, please provide details:			

DATE CHECKLIST COMPLETED	

[1]*Service User or their nominated representative*

This checklist should be completed in line with the HSCB Procedure for the reporting and follow up of SAIs October 2013 and the HSC Guidance for staff on engagement/communication with Service Users[1] / Families/Carers following a SAI

Southern Health and Social Care Trust

Quality Care - for you, with you

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier: **ID:** Personal Information redacted by the USI

Date of Incident/Event: Personal Information redacted by the USI

HSCB Unique Case Identifier: Personal Information redacted by the USI

Service User Details: (*complete where relevant*)
D.O.B: Personal Information redacted by the USI Gender: **F** Age: Personal Information redacted by the USI

Responsible Lead Officer: **Dr Phil Quinn**

Designation: **Consultant Paediatrician**

Report Author: **Review Team**

Date report signed off:

Content

Key to Staff

Key to staff	Grade
ED Doctor 1	Locum Middle Grade, ED
ED Doctor 2	Staff Grade Emergency Doctor
ED Nurse 1	Emergency Department Staff Nurse
ED Nurse 2	Emergency Department Staff Nurse
ED Nurse 3	Emergency Department Staff Nurse
Paediatric Doctor 1	Paediatric SHO (day shift)
Paediatric Doctor 2	Paediatric Registrar (day shift)
Paediatric Doctor 3	Paediatric SHO (night shift)
Paediatric Doctor 4	Consultant Paediatrician (On Call)
Paediatric Doctor 5	Paediatric Registrar (night shift)
Paediatric Doctor 6	Paediatric SHO (day shift)
Paediatric Doctor 7	SHO Locum Doctor
Paediatric Nurse 1	Paediatric Staff Nurse
Paediatric Nurse 2	Paediatric Staff Nurse

1.0 EXECUTIVE SUMMARY

XX, a young infant, Personal Information redacted by the USI old, was brought to the Emergency Department by her parents on Personal Information redacted by the USI presenting with 'high temperature, being sick (vomiting), not drinking'. XX was assessed, then reviewed after a relatively short time, before being discharged home with advice to re-attend if any further concerns. The review team consider that XX should have been observed for up to 4 hours to confirm inadequate feeding/behaviours on her first presentation to ED. This would have enabled a more adequate assessment which should have involved urine analysis, consideration of blood tests and possible admission depending on findings.

On Personal Information redacted by the USI XX re-attended the Emergency Department (ED) at 12:00 hours with concerns regarding not feeding, vomiting, high temperature, very lethargic and irritable. XX was reviewed and admitted to the Paediatric Ward at 23:00 hours.

Salient features pointing to the high likelihood of serious bacterial illness (and possibly meningitis) in this infant included poor feeding, vomiting, fevers and 'clinginess' (abnormal behaviour) plus crying and irritability.

A series of factors contributed to a delay of approximately 12 hours from re-attendance, to administration of antibiotic treatment. Significant delay occurred between the time when decision to 'admit' was made, to actual paediatric admission. The patient flow between the Emergency Department and the Paediatric Ward was unsatisfactory.

The review has established that there was a delay in administration of antibiotics to XX. When serious bacterial illness is likely and/or there are predicted or actual delays in admission to hospital wards for treatment antibiotics should be given in Emergency Departments.

The review of this case has identified a number of factors which resulted in the delayed diagnosis and provision of emergency treatment for meningitis.

1. **Recognition of the sick child**

The review team has identified that ED and paediatric medical staff failed to recognise how sick XX was. The review team consider that staff failed to consider differential diagnoses while assessing XX. This resulted in blinkered thinking and the inappropriately narrow focus on a diagnosis of viral illness/gastroenteritis.

2. **Assessment/Task Factors**

The review team identified that consideration was not given by ED and Paediatric staff to commence antibiotic treatment in the ED. This missed opportunity contributed to the delay in provision of appropriate antibiotic treatment.

3. **Organisational Factors/Resources**

The review team identified that demands within the ED and paediatric ward led to delay in assessment and appropriate treatment for XX. In addition, the review team consider that the shortage of paediatric trained nurses working in ED may have compromised medical decision making and multidisciplinary input on both

presentations to ED.

4. **Individual staff factors**

The review team consider that doctors working in the Emergency Department as well as a doctor in the Paediatric Department failed to recognise a number of signs to potential sepsis/serious bacterial illness when assessing XX on Personal Information redacted by the USI Personal Information redacted by the USI .

5. **Communication**

The review team consider that the delay in transfer from ED to the paediatric ward on the Personal Information redacted by the USI was impacted by capacity limitations on the paediatric ward and inter-team and intra-team communication difficulties, delayed handover and multiple demands on the paediatric service.

6. **Education and training**

The review team consider that the lack of paediatric trained/experienced nursing and medical staff in the ED led to delayed recognition of XX's presenting signs, and deteriorating condition.

7. **Patient factors**

The review team acknowledge that XX had relatively reassuring vital signs on both presentations. The 'Paediatric Early Warning Score' recorded at presentation on Personal Information redacted by the USI was normal ('0'), albeit with no reference to blood pressure. Unremarkable vital signs may have contributed to the failure of health professionals to pick up on the other clues to potential sepsis that were evident from the history.

The review team identified good practice relating to the treatment and care provided to XX when she arrived onto the paediatric where treatment for sepsis was provided in line with Sepsis Six guidance.

The review team identified the following recommendations:

1. The review team recommend that the HSCB/Department of Health/Trust seek to enhance permanent medical staffing numbers and acquire paediatric trained nursing staff to work in all Trust Emergency Departments.

2. Uptake of two National e-Learning resources, namely 'Sepsis in Children' from the Sepsis Trust (UK) (2020) and 'Spotting the Sick Child' (RCPCH,) (2020), should in future be required of newly appointed medical and nursing staff involved in clinical decision-making with regards children including:

    a. Paediatric, Primary Care and Emergency Trainee Doctors
    b. Paediatric Nursing Staff
    c. Triage Nurses in Emergency and Primary Care

3. Medical staff involved in the assessment and management of XX should undertake reflective learning and complete the online course 'Spotting the Sick Child', with successful certification, also the Sepsis Trust e-learning modules 'Introduction to Sepsis' and 'Sepsis in Children'.

4. The review team recommend that long term or regular locums should receive the same induction, supervision and support to maintain competencies as other staff.

5. Where a decision is made to discharge a child with ongoing symptoms/signs, parents/carers should be advised of timeframes in which they should return if symptoms persist, as well as specific triggers which require earlier review. It is good practice to provide written advice in addition to documented verbal advice.

6. The Trust should have a principle of encouraging early prescription and administration of intravenous antibiotics to infants/children that are considered to have actual or possible sepsis/serious bacterial illness prior to transfer to the Paediatric Ward, unless immediate transfer is in process, in keeping with the 'Sepsis 6' care bundle.

7. All staff should be actively encouraged to alert their Line Managers (including On Call Consultants) in a timely fashion, where concerns exist in relation to service capacity. Ward Mission Statements that include 'Trigger Points for Escalation', displayed in relevant clinical areas, may be a means of communicating this, as well as specific reference to the principle at induction.

2.0 THE REVIEW TEAM

Dr Phil Quinn, Consultant Paediatrician, Chair
Anne O'Reilly, Lead Nurse, Paediatric Services
Eleanor McCormick, Emergency Department Consultant
Sharon Holmes, Ward Manager, Emergency Department
Marita Magennis, Clinical & Social Care Governance Co-ordinator, CYPS
Dr Jenny Hughes, Consultant Paediatrician, Independent Paediatric Expert

3.0 SAI REVIEW TERMS OF REFERENCE

- To carry out a review of the care and treatment provided to XX by the Southern Health and Social Care Trust from initial presentation at the Emergency Department on Personal Information redacted by the USI until her transfer to the Paediatric Intensive Care Unit in Royal Belfast Hospital for Sick Children on Personal Information redacted by the USI.
- To use a multidisciplinary team approach to the review.
- To provide an agreed chronology based on documented evidence and staff accounts of events.
- To engage with XX's family in line with Regional Guidance on Engagement with Service Users, Families and Carers (November 2016).
- To carry out an analysis into the care provided to XX using the National Patient Safety Agency Root Cause Analysis methodology and SAI Guidance.
- To ensure that any relevant recommendations are made in line with evidenced based practice.
- To set out the findings, and if relevant lessons learned, recommendations, and actions in an anonymous report.

3.0 SAI REVIEW TERMS OF REFERENCE

- To adhere to the principles of confidentiality throughout the review.
- To report the findings and recommendations of the SAI Review to the Director of CYPS and Director of Acute Services, Southern Health & Social Care Trust (SHSCT), the staff associated with the care of XX, the Health & Social Care Board (HSCB), Public Health Agency (PHA) and XX's family.

4.0 REVIEW METHODOLOGY

- Review of patient/service user records and compile a timeline.
- Review of staff/witness statements.
- Interviews with relevant staff concerned

  Organisation-wide

  Directorate Team

  Ward/Team Managers and front line staff

  Other staff involved

  Other professionals (including Primary Care)
- Specific reports requested from and provided by staff.
- Outline engagement with service users/family members.
- Review of local, regional and national policies and procedures, including professional codes of conduct in operation at the time of the incident.

Review of documentation, eg consent form(s), risk assessments, care plan(s), photographs, diagrams or drawings, training records, service/maintenance records, including specific reports requested from and provided by staff etc.

5.0 DESCRIPTION OF INCIDENT/CASE

XX attended the Emergency Department (ED) at 09.15 hours on Personal Information redacted by the USI due to concerns regarding not feeding, a high temperature and had vomited morning feed. XX was reviewed by ED Doctor 1 (Locum Middle Grade) at 10.10 hours. Heart rate (HR) 180, respiratory rate (RR) 34, temperature (TEMP) 37.5, saturations (SpO2) 96%, blood glucose (BM) 6, capillary refill time (CRT) 0-2, alert. No diarrhoea, cough or rash noted. Examination of ear, nose and throat was normal. XX's abdomen was soft and non-tender. There was good air entry in the chest. The differential diagnosis was a viral infection or gastroenteritis.

XX had observations recorded onto the Regional Paediatric Early Warning Score Chart ('PEWS' chart) at 10.25 hours, 11.50 hours and 12.30 hours but without blood pressure recordings. Capillary refill was entered as less than 2 seconds, and her heart rate moved from outside normal limits (169) to within normal limits (158) during

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this time. As a result XX's total 'PEWS score was only 1 or 'zero'.

At 10.25 hours XX's temperature was recorded by ED Nurse 1 as pyrexia 38.0. XX was given paracetamol at 11.15 hours by ED Nurse 1 and tolerated 3 ounces of Dioralyte. Cyclizine was prescribed, however was not administered with nursing documentation recording 'not available in ED'.

XX was reviewed at 12.30 hours and was noted to be settled and sleeping, no further vomits. XX was discharged with the advice to continue Dioralyte and to re-attend if further concerns.

XX re-attended the ED on [redacted] at 11.57 hours due to concerns regarding not feeding, high temperature, vomiting and was very lethargic and irritable. Observations undertaken at triage at 12.11 hours were noted to be HR 131, RR38, Temp 37.6, Spo2 99%, Glasgow comma scale (GCS) 15, CRT 0-2, BM 6.7, alert.

XX was reviewed at 14.00 hours by ED Doctor 2 (Staff Grade Emergency Doctor). XX's mother reported that XX had been vomiting following every feed, and for the previous three days had loose dirty nappies (no wet nappies). XX's mother reported that XX had a 5 ounce feed on [redacted] (previous day). XX's temperature had been up and down for a number of days, she had a history of bronchiolitis 2 weeks ago but has now recovered. Vaccines are up to date except for the last set which were delayed due to bronchiolitis.

On examination by ED Doctor 2 XX was noted to be pale, sleepy, with a high pitched cry, CRT 2-3 seconds, fontanelle normal, no rash, chest clear, abdomen soft and non tender, Kernig's sign negative. XX's ears were described as waxy, unable to see thematic membrane, nose (NAD) and throat was red, however tonsils were not enlarged. XX's tongue was coated. Paracetamol was administered at 14.50 hours by ED nurse 3.

ED Doctor 2 discussed XX's condition with Paediatric Doctor 1 (Paediatric Day SHO) by phone. The assumed diagnosis was viral gastroenteritis with poor fluid intake. Paediatric Doctor 1 informed the supervising Paediatric Doctor 2 (Paediatric Day Registrar) of XX's condition. Paediatric Doctor 2 and Paediatric Doctor 1 were busy with a baby in the Special Care Baby Unit (SCBU) which required transfer out of hospital. It was agreed that the paediatric team would review XX in ED and to encourage fluids in ED until then. ED Doctor 2 noted that XX seemed to be uncomfortable, moaning and unhappy.

At 16.50 hours Paediatric Doctor 2 attended ED and undertook a review of XX. A history and examination was undertaken. It was noted that XX had re-attended ED with a history of vomiting for two days, one loose stool yesterday and 3 to 4 vomits since yesterday. XX had reduced oral intake and no wet nappies, however had two wet nappies this morning. XX was noted to be unwell since Thursday with vomiting, crying and being clingy. XX had been vomiting from Friday (4 to 5 vomits), Saturday one loose stool. XX had a history of fever for 2 days, maximum temperature 38.8 degrees on [redacted]. It was recorded by Paediatric Doctor 2 that XX had no temperature on examination. XX had not had any sick contacts, no recent travel or previous admission to hospital.

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On examination XX was unsettled, with a normal CRT, bedside glucose level was checked and normal (6.7 mmol/L) , as were XX's 'vital signs' - respiratory rate 40, heart rate 142/min, temperature 36.7 and haemoglobin saturation was 99% in room air. PEWS 0. Respiratory system examination documented bilateral air entry equal, throat red with no exudate, ears not examined. Heart sounds were normal, the abdomen was soft with no guarding. 'Good femoral pulses' were recorded. Although Paediatric Doctor 2 did not document anything in relation to fontanelle examination in the notes, the doctor stated in interview with the review team that the baby's anterior fontanelle was examined and not considered to be tense or raised.

Paediatric Doctor 2's preliminary differential diagnoses were either viral upper respiratory tract infection or viral gastroenteritis. Paediatric Doctor 2's management plan was to increase oral fluids and undertake bloods. Although nothing was noted in the chart relating to urine, Paediatric Doctor 2 stated to the review team that the nursing staff were asked to obtain a urine sample. Paediatric Doctor 2 wrote in the notes that if bloods are normal XX can be reviewed and discharged home and stated that reassurance was given to XX's parents. At 17.30 hours ED nurse 2 recorded the paediatric early warning score (PEWS) as 0. '*Awaiting bloods and urine specimen. Paediatricians will review after bloods'.* ED nurse 2 administered ondansetron (an anti-emetic).

Paediatric Doctor 2 checked to see if blood results were available at 19.00 hours, however they were not on the computer system.

The paediatric team were busy with tasks remaining outstanding from the morning round, other duties and referrals and another acutely unwell baby in the Special Care Baby Unit (SCBU) at around 19.30 hours. The paediatric ward was at full capacity.

At 20.15 hours XX's PEWS were noted to be 0. The baby was with her mother in a seated area ('the seats') in the Emergency Department and not in a 'high dependency' area. ED nurse 2 bleeped the Paediatric Doctor 1 to advise that bloods were available and of the high CRP 382 (normal range less than 5mg/L) at around 20.15 hours. Paediatric Doctor 1 informed Paediatric Doctor 2 and was advised that the ED team should arrange for XX to be admitted to the paediatric ward. Paediatric Doctor 1 phoned the Emergency Department stating same but also advising that the paediatric ward would need to 'create bed space' for the admission. Paediatric Doctor 1 then spoke to the nursing team on the Paediatric Ward (approx. 20.20 hours) and advised of the need to make a bed available for XX's admission. This discussion occurred around the time of nursing handover. The need for bed space was reiterated at 20.40 hours by Paediatric Doctor 1 to the nursing staff. Nursing staff contacted the Head of Service at 20.40 hours to discuss moving another patient to make room for XX. A patient was subsequently moved to the ENT bay on the ward and the domestic staff were tasked to prepare the room.

At around 20.45 hours the Paediatric Doctor 1 recorded XX's blood results and advised her parents in the ED that XX should be admitted to the ward due to consideration of 'infection, dehydration, anaemia'. Paediatric Doctor 2 attended ED also. XX's parents were advised that the paediatric ward were arranging a bed for XX and that they would be kept informed.

The plan was documented 'for admission/ IV access/urine sampling/IV antibiotics and

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consideration of lumbar puncture'. It was noted that 'observations were stable at present'.

Medical handover commenced late at 21.30 hours and finished at 22.15 hours due to the day team remaining busy with outstanding tasks and paperwork. The on-call consultant, Paediatric Doctor 4, was in SCBU tending to an acutely unwell baby. Paediatric Doctor 4 listened to the handover via telephone. At the end of medical handover it was reported by the day team that XX was awaiting admission from ED with a possible diagnosis of gastroenteritis and an elevated CRP of 382. The day team advised that the baby was not considered to be dehydrated, however was not taking enough fluids and appeared well. During interview, Paediatric Doctor 2 advised that XX's blood sample had been undertaken 'because she was a re-attender'. Following this the night team advised that XX should be brought to the ward urgently to enable culture sampling and the commencement of intravenous antibiotics.

It is not clear exactly when the bed space for XX was ready and how this was communicated between the Paediatric and Emergency Department nursing staff. The 'night team' Paediatric Doctor 3 (Paediatric Night SHO) spoke to the nursing staff after medical handover and asked that they contact ED to arrange for XX to be brought to the ward as soon as possible.

At approximately 22.50hrs XX was brought to the treatment room on the paediatric ward from ED. It is thought that XX was possibly carried by her mother with the accompaniment of ED Nurse ('Seats' nurse). The facts around this are not clear from notes, nor staff recollection.

On arrival to the Paediatric ward at 23.00 hours XX's PEWS were recorded as 0. Paediatric Doctor 3 and Paediatric Doctor 4 assessed XX and a preliminary diagnosis of sepsis and query meningitis was made.

XX was noted to be very ill on her arrival into the ward. Paediatric Doctor 3 documented a brief history and that XX was 'pale ++' 'grunty++' 'very irritable to handle' with temperature 38.7, heart rate between 160-170 and 'sick baby on admission'. Paediatric Doctor 4 documented the history including 'grunty respirations and high pitched cry today' and examination findings including 'pale +' 'cap refill time 2-3 seconds, irritable on handling, peripherally a little mottled, AF (anterior fontanelle) sl (slightly) bulging/full'. XX was cannulated and an IV bolus administered of 10 mls/kg of normal saline. IV antibiotic ceftriaxone 500mgs (80mgs per kg) was prescribed and it was administered at 23.50 hours. Bloods were taken for blood cultures, polymerase chain reaction (PCR) for meningococcal, calcium and magnesium. Urine was tested by dipstick with nothing abnormal detected. Portable chest X-ray was undertaken with nothing abnormal detected.

Paediatric Doctor 4 undertook a further review of XX at 00.30 hours. CRT 2 seconds, HR 130-150, pale, not mottled. Paediatric Doctor 4 recommended to check XX's coagulation screen and repeat lactate and pH. Paediatric Doctor 4 requested a throat swab and central nervous system (CNS) observations. Paediatric Doctor 3 prescribed maintenance fluids of 0.9%, plus 5% dextrose at 25mls/hr ('100%' maintenance rate).

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On [redacted] (overnight Sunday/Monday morning) at 02.11 hours blood results were recorded (blood gas, FBP, CRP, lactate and it was documented that the coagulation studies and 'Bone [Calcium etc] / Mg' sent). PEWS and CNS observations were recorded hourly overnight. The PEWS score was between 0 and 2 due to raised systolic blood pressure (113/77). CNS observations recorded as 14/15 throughout the night due to irritable cry. Ibuprofen was administered at 04.10 hours. It was noted at 06.00 hours by Paediatric Nurse 1 that XX's 'fontanelle remains tense'. XX was noted to be unwell throughout the night.

XX was reviewed by Paediatric Doctor 5 (Paediatric Night Reg, ST3) at 08.20 hours. It was noted that XX was irritable throughout the night, grunting, crying and difficult to handle. PEWS was noted to be 2 due to increased blood pressure (113/77 mmHg). XX was receiving IV fluids and tolerated a 30 ml bottle feed and was sleeping. Bedside monitoring showed Haemoglobin oxygen saturations above 94% in room air.

At the Multidisciplinary Medical/Nursing handover on [redacted] XX was identified as being sick and was prioritised for discussion at the start of the meeting by the night medical team. The history, examination (including her bulging fontanelle) and investigation results were discussed. The nursing team expressed concerns that the baby's PEWS score did not reflect the severity of her illness. Paediatric Nurse 2 alerted Paediatric Doctor 7 (SHO Locum Doctor) that XX was unwell and requested XX to be seen first during the ward round.

XX was reviewed first on the ward round at 10.00 hours by Paediatric Doctor 4. It was noted that XX continued to grunt, tolerated a bottle feed at 08.00 hours. XX's mother reported XX was lying with her head to the right side only. On examination CRT less than 2 seconds, irritable on handling, anterior fontanelle bulging, moaning and grunting, partly opening eyes, eyes deviated to the right. XX had increased tone to both lower limbs, pupils 6mm, both reacting to light, stiff upper limbs. Paediatric Doctor 4 instituted treatment for raised intracranial pressure, as well as broadening treatment to cover for herpes encephalitis and initiated XX's transfer to the RBHSC Paediatric Intensive Care Unit for neuro-intensive care.

The documented ward round plan for XX was to reduce IV fluids to two thirds maintenance, commence IV acylovir and IV dexamethasone (administered at 10.00 hours), repeat bloods to include full blood picture (FBP), UE, CRP and venous blood gas (VBG). Consider a stat dose of hypertonic saline of 3% (infused at 11.00 hours). Discuss with Paediatric Intensive Care Unit (PICU) to consider mannitol. Contact anaesthetic team for urgent review of XX on the ward. Paediatric Doctor 4's working diagnosis was raised intracranial pressure (ICP)/meningitis.

At 11.00 hours Paediatric Doctor 6 (Paediatric Day SHO) and Paediatric Doctor 4 reviewed XX due to an episode of desaturation of SpO2 to 84%, HR decreased to 89, skin mottled, mouth movements and possible seizure activity. BM recorded at 4.9. CRT 3-4 seconds. A fluid bolus of 10 mls per kg was administered immediately. XX was re-assessed and CRT less than 2 seconds. HR and saturations improved. XX was in receipt of 15 litres of oxygen. The anaesthetic team attended to assist. The baby was transferred to theatre (11.10 hours) and intubated (11.20 hours). Dexamethasone was given (documented at 10.00hrs) and IV acyclovir. Following

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intubation XX was sedated with an infusion of morphine and midazolam. Hypertonic saline (3% NaCl) was administered intravenously at 12.05 hours. Additional intravenous access was attempted but was very difficult to obtain. Arrangements were made for a CT scan which was offered at 12.15 hours but not undertaken due to the practicalities and risk associated with transporting XX to the scanning site.

The paediatric transfer team arrived at 13.00 hours and XX was transferred to PICU at 14.40 hours. Paediatric Doctor 4 explained to XX's parents that XX was very ill with suspected meningitis and an uncertain prognosis prior to transfer.

6.0 FINDINGS

The review team acknowledges that XX presented to ED with vague non-specific symptoms with a wide differential diagnosis, varying from common viral illnesses, including viral gastroenteritis, to serious invasive bacterial infections (SBI) and less common surgical disorders, metabolic disorders etc. The team acknowledges that it is challenging to distinguish benign conditions from those that are serious or potentially serious especially in infants (children 12 months or younger) and harder again in patients around XX's age of [redacted].

The review team note that although XX had a very high heart rate of 180 on her first presentation on [redacted] her PEWS score was subsequently 'low' (1 or zero), capillary refill times were normal and therefore the common systemic signs of sepsis were not present in XX. However, the review team consider that from the history, there were warning features which suggested sepsis, including the report of fevers and poor feeding with irritability. In addition, on XX's second presentation on [redacted], there were also warning features which suggested sepsis from examination findings. The review team consider that the warning signs of sepsis were missed on both presentations to the Emergency Department and by the Paediatric Team on first review in the Emergency Department on [redacted].

The review of this case has identified a number of factors which resulted in the delayed diagnosis and subsequently the delayed provision of emergency treatment for sepsis/meningitis in the case of XX.

Recognition of the sick child

The review team consider that the decision to discharge XX on [redacted], after less than 4 hours in the ED was premature, given that XX had a temperature of 38 degrees and no investigations had been undertaken to explore the potential for serious bacterial illness. Investigations such as urinalysis at minimum, with consideration for blood tests such as inflammatory markers – C Reactive Protein 'CRP' and white cell count [WCC] were indicated, given the presentation of a young infant with a history of poor feeding, vomiting, tachycardia and a documented fever of 38 degrees. At any age, a tachycardia of 180 should be recognised as a sign of potentially significant pathophysiology and XX had a raised heart rate documented two further times during her first assessment.

The review team consider that it would have been appropriate to consider discussing XX's presentation with an experienced paediatric doctor and to have kept XX under close hospital assessment to facilitate observation of vital signs plus several feeds, as

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well as obtaining results and interpreting basic investigations outlined above. Such observation would often require at least 4 hours of assessment in hospital, either in an appropriately staffed and supported Emergency Department, or within an appropriately staffed and supported Short Stay Assessment Unit or the equivalent.

The review team note that XX was prescribed cyclizine however this was not administered. NICE guidelines do not recommend the use of anti-emetic therapy in children with suspected gastroenteritis and it would not be usual practice in ED to use it in children <1 year.

On XX's second presentation on Personal Information redacted by the USI, the review team note that the examining doctor in ED Doctor 2 did not ask for urine sampling from the baby, which would be routine practice, and recommended in NICE guidance, in the assessment of a febrile infant such as XX.

The review team note that XX's blood pressure was not recorded in ED. The PEWS scores were '1' at presentation on Personal Information redacted by the USI and '0' at presentation on Personal Information redacted by the USI (temperature does not contribute to scoring; any abnormal systolic blood pressures if recorded would have done.) Best practice involves measurement and recording of blood pressure at least once along with 'vital signs'. The review team acknowledge that it can be difficult to obtain blood pressure readings on small children, and the interpretation of high blood pressure recordings in irritable children of all ages presents difficulties. Documentation of capillary refill times is useful and a short capillary refill time (less than 2 seconds) can be an index of appropriate systemic perfusion (and by inference, blood pressure) in many instances. The review team notes that capillary refill times were assessed for XX and results were normal when she was in the Emergency Department.

XX was prescribed an anti-emetic (ondansetron 2mg) which was administered. This symptomatic treatment is not in line with NICE guidance for gastroenteritis in this age-range and not licensed. The review team do not consider that the administration of the medicine had any harmful effect on XX.

The review team considers that admission should have been recommended at an earlier stage. It is noted that XX was appropriately categorized as 'Category 3' following triage at 11.57 hours on Personal Information redacted by the USI, indicating that medical assessment should take place within 1 hour. However, XX was not seen until 14.00 hours.

The review team consider that on XX's second presentation on Personal Information redacted by the USI, (75 hours later) the Emergency Department failed to recognise the salience of the history and non-specific but serious examination findings. The failure to recognise the serious illness meant that the opportunity to either institute timely treatment or flag the case as urgent and seek immediate help from the on call Paediatric Team was missed.

The review team note that on XX's second attendance no differential diagnosis was documented within the main body of the notes by Emergency Doctor 2, although 'gastroenteritis' was entered as a diagnosis on the flip side of notes. There was no initial documentation to suggest urine should be tested and no evidence of consideration of blood tests, radiology or immediate admission to paediatrics.

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The review team consider that blood and urine samples should have been taken and intravenous antibiotics commenced and/or the immediate request for assistance from paediatrics after the 14.00 hours assessment by Emergency Doctor 2. The review team acknowledges this would have been dependent on the ED team recognising possible/probable meningitis/serious bacterial illness. Triggers to consider possible Sepsis (altered mental status, pale, reduced wet nappies) were present, with a Red Flag (high pitched cry) therefore XX required senior review and investigations within one hour, plus prompt IV antibiotics (Sepsis 6 2006, updated 2019). Consideration should have been given to commence antibiotic administration in ED and request for a fast track admission to the paediatric ward.

The review team note that Paedatric Doctor 2 on day duty on Sunday [redacted] sent some blood samples as a 'screening' exercise, as well as to check XX's electrolytes (to assess for evidence for dehydration) and it was when the CRP was returned that admission was recommended. Whilst blood tests are often used in conjunction with clinical assessment, the review team note that there appears to have been a reliance on biochemical markers of inflammation to justify admission rather than the clinical features that were present.

The review team consider that on receipt of the deranged blood results the Paediatric Day Team should have considered immediate review of the patient in the ED and immediate escalation of investigations and treatment to include taking blood cultures and starting broad spectrum antibiotics for presumed sepsis. It appears to the Review Team that notwithstanding the abnormal results the Paediatric Day Registrar remained of the opinion that XX was a 'well' baby and not 'ill' needing emergency treatment.

Good practice at handover requires good situational awareness and involves the early handover of the 'sickest patients' and priority issues to the receiving team. This did not happen in this case as the Paediatric Day team had failed to understand that XX was very ill when she was seen in ED.

The review team consider that staff failed to consider differential diagnoses while assessing XX. This resulted in blinkered thinking and the inappropriately narrow focus on a diagnosis of viral illness/gastroenteritis.

Assessment/Task Factors

The review team acknowledge that when XX was being discharged on the first presentation, [redacted], general advice was given to 're-attend if further concerns. It is not clear from chart review what 'further concerns' might have meant, leading to questions as to whether the absolute significance of fever or reduced feeding and vomiting in young infants was understood to be important to the discharging team. As such XX was discharged without time-limited, detailed 'safety-net' advice being provided to XX's parents.

The review team note that Paracetamol was prescribed as 90mg, however '2.5mls' was written on the prescription implying 60mg was given if the usual strength of 120/5ml paediatric solution was used. The review team consider that the medicine's Kardex should have noted the dose administered in mg.

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In this specific case neither the ED doctors nor the Paediatric Doctor 2 actively considered instituting antibiotic therapy in the ED pending transfer, whilst 'fast-track' admission was not feasible. These factors represent missed opportunities which contributed to the delayed empiric treatment for sepsis.

The review team notes that XX had raised blood pressure on admission but for most of the time in ED was afebrile and had low or 'normal' PEWS scoring. Raised blood pressure, coupled with bradycardia, is a sign of raised intracranial pressure (ICP), as is a prominent anterior fontanelle in infants, and XX had a bulging fontanelle on admission to the paediatric ward. The latter finding can be present in meningitis. Raised blood pressure is a common finding in unsettled, irritable and uncomfortable infants/patients and whilst in retrospect in this instance it may have been due to raised ICP this could not have been ascertained initially.

Organisational Factors/Resources

The review team note that XX was assessed on both presentations in ED by Locum Staff with limited paediatric experience. In addition, the review team is aware of the shortage of paediatric trained nurses working in ED. The review team consider that this may have compromised medical decision making and multidisciplinary input on both presentations to ED.

The review team note the delay in review of the lab results i.e. not seen by ED staff until approximately 3 hours from sampling time. The review team consider that the turnaround time was beyond a reasonable timeframe and resulted in delay in the appropriate escalation of treatment.

Commented [KP1]: The child was referred to paeds – appears to be blaming ED.

The review team note that XX was in the care of the Emergency Department for almost 11 hours. Within this timeframe there is a lack of evidence of appropriate medical review of XX which may have impacted on the Emergency Doctors' awareness of XX's changing condition.

The review team acknowledge the pressures experienced by both the Emergency Department and the Paediatric Services, especially during the winter period. The review team note that due to workload pressures within the paediatric team, over 2 hours had passed before Paediatric Doctor 2 was available to review XX in the ED.

The review team consider that the demands on the Paediatric Day Team impacted on the timeliness of the evening handover which contributed further to the delay in appropriate recognition and treatment of XX. The review team note that the pressures faced by the Paediatric Day Team were not escalated to the Paediatric On Call Consultant.

The review team acknowledge the multiple pressures faced by ED and paediatric service, including issues of overcrowding, increased workload and busy departments. The review team consider that these systemic problems may have resulted in it becoming 'normal' for patients to wait many hours in ED for a definitive management plan. The review team recognise that these issues are beyond the control of staff within the Health and Social Care Trust.

The review team note the delay in reporting the blood results i.e. over 2 hours. There

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is some consideration amongst members of the Royal College of Biochemical Pathologists to suggest that best practice aims to have 'Turnaround Times' ('TATs') of less than 1 hour for 'Emergency Samples' and that turnarounds of over 2hrs are not acceptable. The review team does consider that the turnaround time in this instance fell below standards. The team acknowledges that if in fact the highly deranged CRP result had been available at 19.00hrs when the Day Paediatric Registrar, PD2, reports seeking the same, escalation of treatment may have taken place earlier than it did.

Individual staff factors

The review team consider that doctors working in the Emergency Department as well as a doctor in the Paediatric Department failed to recognise a number of signs to potential sepsis/serious bacterial illness when assessing XX on Personal Information redacted by the USI and Personal Information redacted by the USI. The review team consider the decision making by ED staff may have been as a result of limited paediatric knowledge and experience.

Communication

The review team note that on discharge from ED, XX's parents were not provided with a timeframe within which they should re-attend if further concerns. This may have resulted in delay in re-presenting to ED and a correct diagnosis and treatment plan instituted.

The review team note that the request for on-call paediatric team review within the Emergency Department did not alert the paediatric team to the urgency of XX's condition.

The review team note the considerable delay in transfer from ED to the paediatric ward, despite direction from Paediatric Doctor 2 that XX should be admitted as soon as possible. The review team have been unable to ascertain all the reasons for this. The review team consider that the delay in transfer from ED to the paediatric ward was impacted by capacity limitations on the paediatric ward and inter-team and intra-team communication difficulties, delayed handover and the multiple demands on the paediatric service.

The review team note that the handover meeting did not prioritise the early handover of the 'sickest patients' to the receiving team. The review team consider that this was due to the Paediatric Day team not recognising that XX was very ill.

The review team acknowledge that the paediatric ward was at full capacity when XX was identified as requiring admission. Clarification was appropriately sought from the Head of Service at 20.40 hours as to which other patient could be moved in order to free space up for XX's admission.

Education and training

The review team consider that the lack of paediatric trained/experienced nursing and medical staff in the ED led to delayed recognition of XX's presenting symptoms and deteriorating condition.

Patient factors

6.0 FINDINGS

The review team acknowledge that XX had reassuring PEWS scores recorded on both presentations, despite the first recorded heart rate of 180. XX's heart rate values were in the normal range for most of the time that she was in the ED on Personal Information redacted by the USI Personal Information redacted. Capillary refill times were also normal in the ED. The recorded PEWS score 'numbers', therefore, may have misled the attending Clinicians and betrayed the fact that she had a serious bacterial illness.

Good Practice

The review team note that it was good practice for Paediatric Doctor 1 to speak to XX's family once the deranged blood results had been returned and document the decision for admission, plus outline some diagnostic considerations and treatment planned.

The review team note that on arrival to the Paediatric Ward it was immediately evident to the ward nursing and medical staff that XX was very ill and received immediate attention and appropriate emergency treatment for presumed meningitis/sepsis from that point onwards. Within 50 to 60 minutes of arrival to the paediatric ward she received antibiotics. This was acceptable and within the recommended timeframe as detailed in 'Sepsis Six' guidance. Further to this XX was appropriately identified as a priority patient immediately after the morning handover by Paediatric Doctor 4 and the decision was made to transfer her to the Paediatric Intensive Care Unit (PICU).

The review team acknowledge the timely stabilisation for transfer, and the provision of emergency treatments on Personal Information redacted by the USI.

The review team consider that the medical and nursing management and care of XX following arrival to the paediatric ward to discharge to PICU was of a good standard.

Current advice for the treatment of bacterial meningitis does not support immediate or 'elective' fluid restriction (which historically has been to 50-66% of maintenance fluids) and the review team supports the Consultant decision to prescribe full maintenance fluids initially given the known history of poor intake and reduced output. When XX deteriorated by the morning of Personal Information redacted by the USI with focal (or potentially 'false localising signs, and possibly features of 'coning') it was the correct decision to restrict fluids and give emergency treatment for raised ICP and to ventilate, sedate and transfer for Neuro-intensive care. The addition of antiviral 'cover' with acyclovir was also good practice in view of focal signs at that stage.

7.0 CONCLUSIONS

XX was a young infant, Personal Information redacted by the USI age, who presented on two occasions with non-specific but important features to suggest possible bacterial illness which went unrecognised by doctors in the Emergency and Paediatric Department.

Salient features pointing to the high likelihood of serious bacterial illness (and possibly meningitis) in this infant included poor feeding, vomiting, fevers and 'clinginess' (abnormal behaviour) plus crying and irritability. XX had a significantly raised heart rate of 180 on her initial presentation, although this reduced towards normal, and her

heart rate was consistently in the normal range on her second presentation. The documentation of 'normal' Paediatric Early Warning Scores in this case may have served to distract the assessing doctors initially, who appear to have been falsely reassured in this regard. XX appears to have had isolated meningitis, without 'septicaemia', and hence maintained vital signs, leading to PEWS scores in the normal range (aside from blood pressure) despite being very unwell.

The Emergency Department which XX attended is of small size and has few Paediatric Trained Nurses to support decision making, and none were available either day of presentation. XX presented to a busy ED and was moved to an area with limited opportunity for ongoing surveillance during a long wait for paediatric assessment.

Both the Emergency Department and the Paediatric Department have a reliance on Locum staff to maintain cover, and it is recognised that Locum staff do not necessarily receive the same training opportunities and feedback as permanent staff and trainees. In addition it is difficult for Supervising Consultants to be sure of Locum Doctors' competencies in different areas of practice. It is suggested that investment in a robust staffing model, which is not reliant on ad hoc locums, is the ideal. The review team suggest that long term or regular locums should receive the same induction, supervision and support, to obtain competencies, as other staff.

The review team recognise the value and importance of trained paediatric nurses (including Advanced Paediatric Nurse Practitioners) in providing expertise and assistance in a multidisciplinary model of Paediatric Urgent Care. The review team note that such specialist nurses were not available in the ED in question and recognise that this is due to national shortages.

The review team consider that XX should have been observed for up to 4 hours observation to confirm adequate feeding/behaviours on her first presentation to ED on [redacted]. This would have enabled a full assessment, investigation and consideration of admission for treatment. It is possible that XX had pneumococcal infection at that stage and if so that earlier identification and treatment may have reduced illness severity.

On [redacted], a series of factors contributed to a delay of approximately 12 hours from re-attendance, to administration of antibiotic treatment. Significant delay occurred between the time when decision to 'admit' was recommended, to actual paediatric admission. The patient flow between the Emergency Department and the Paediatric Ward was unsatisfactory. The review team acknowledge that it is impossible to maintain bed availability 100% of the time, especially during the peak seasons (Autumn and Winter). The review team consider that whilst some of the delay was explained by the requirement to free up bed space in the ward which was 'at capacity', communication issues were significant.

The review has established that there was a delay in administration of antibiotics to XX. Antibiotics can and should be given in Emergency Departments when serious bacterial illness is likely and/or there are predicted or actual delays in admission to hospital wards for treatment.

Viral illnesses, including viral gastroenteritis, constitute the most common reasons for non-specific illnesses in infants and children and are an important differential

diagnosis. The review team consider that serious bacterial illness, more commonly urinary tract infection but also bacteraemia, pneumonia, meningitis etc, remain important alternative differential diagnoses in infants and young children and should be considered in most presentations to medical care.

Bacterial urine tract infections (UTI) are one of the most common causes of SBI in immunized infants. Although a UTI was not diagnosed in this case, ED staff appeared unaware of the importance of sending urine samples for analysis to 'screen' for UTIs in young infants with non-specific illness, especially when fevers are reported

It is impossible to predict which infants/children with non-specific features of illness have serious bacterial illness unless careful medical assessment takes place, often with augmented periods of observation, utilisation of tailored investigations in some instances and/or input from experienced paediatric staff.

In this case, whilst there were shortcomings in the interpretation of findings by the assessing Paediatric Registrar first to see XX, the same Registrar was reported to be very busy with the pressures of Winter workload coupled with sequential emergencies in the hospital Neonatal Unit and all of these factors contributed to delays in medical assessment.

The on-call Paediatric Consultant was unaware that the Paediatric Registrar considered workload to be heavy on the afternoon of [redacted] but with awareness may have been able to offer assistance and attend to help. An earlier consultant presence may have enabled earlier identification of illness etc.

Independent Expert Advice:

8.0 LESSONS LEARNED

Serious bacterial illness (SBI) can be challenging to diagnose in infants, requiring a good index of suspicion plus some fundamental paediatric knowledge, often coupled with an appropriate period of observation and sometimes basic investigations including urine and blood tests. The review team identified that there were missed opportunities in the identification of sepsis/pneumoccocal meningitis in this case.

Doctors assessing young infants require training to be able to identify 'sick' or 'potentially sick' infants. Emergency Departments with permanent medical staff that have undertaken training in the assessment of medical illness in children, as well as paediatric-trained nurses, are better placed to assess infants and young children compared to those without.

The review team note that many children may present with non-specific features of a serious bacterial illness, and within a busy Emergency Department it can be difficult to identify a very ill child with meningitis from the many other children presenting with similar features.

Kernig's sign is not usually elicited in young infants, and clinicians cannot rely on

identification of classic 'meningeal' signs such as photophobia and neck stiffness in children below 18 months – 2 years: absence of 'meningitis signs' does not imply absence of meningitis.

A history of significantly reduced feeding or vomiting and fevers in any infant below 6 months, should always lead to a detailed assessment to exclude serious bacterial illness.

All patients (of any age) with a heart rate between 160 and 180 or more must have sufficiently detailed medical assessments completed to explain the primary cause for the tachycardia and to address and manage this.

When infants with feeding difficulties and/or reports of fever are discharged from hospital care it is good practice to provide specific recommendations regarding 'targets' for feeding, warn of the significance of fevers and set a time-frame and illness trajectory for anticipated improvement.

9.0 RECOMMENDATIONS AND ACTION PLANNING

1. The review team recommend that the HSCB/Department of Health/Trust seek to enhance permanent medical staffing numbers and acquire paediatric trained nursing staff to work in all Trust Emergency Departments.

2. Uptake of two National e-Learning resources, namely 'Sepsis in Children' from the Sepsis Trust (UK) (2020) and 'Spotting the Sick Child' (RCPCH,) (2020), should in future be required of newly appointed medical and nursing staff involved in clinical decision-making with regards children including:

    a. Paediatric, Primary Care and Emergency Trainee Doctors
    b. Paediatric Nursing Staff
    c. Triage Nurses in Emergency and Primary Care

3. Medical staff involved in the assessment and management of XX should undertake reflective learning and complete the online course 'Spotting the Sick Child', with successful certification, also the Sepsis Trust e-learning modules 'Introduction to Sepsis' and 'Sepsis in Children'.

4. The review team recommend that long term or regular locums should receive the same induction, supervision and support to maintain competencies as other staff.

5. Where a decision is made to discharge a child with ongoing symptoms/signs, parents/carers should be advised of timeframes in which they should return if symptoms persist, as well as specific triggers which require earlier review. It is good practice to provide written advice in addition to documented verbal advice.

6. The Trust should have a principle of encouraging early prescription and administration of intravenous antibiotics to infants/children that are considered to have actual or possible sepsis/serious bacterial illness prior to transfer to the Paediatric Ward, unless immediate transfer is in process, in keeping with the 'Sepsis 6' care bundle.

Commented [KP2]: ED not sure about this recommendation for ED not sure how he could implement.

Commented [KP3]: No written advise from ED is this coming from CYP?

Commented [KP4]: Paediatric doctors don't feel they are trained to give iv antibiotics in ED. Child under care of paeds and should have administered by paeds.

9.0 RECOMMENDATIONS AND ACTION PLANNING

7. All staff should be actively encouraged to alert their Line Managers (including On Call Consultants) in a timely fashion, where concerns exist in relation to service capacity. Ward Mission Statements that include 'Trigger Points for Escalation', displayed in relevant clinical areas, may be a means of communicating this, as well as specific reference to the principle at induction.

Commented [KP5]: Concerns about the wording of these recommendations.

10.0 DISTRIBUTION LIST

Director of CYPS and Director of Acute Services, Southern Health & Social Care Trust (SHSCT), the staff associated with the care of XX, the Health & Social Care Board (HSCB), Public Health Agency (PHA), and XX's parents.

Appendix 1

Emergency Department and Paediatric Timeline

Date of Incident: [redacted]

ID: [redacted]

Date/ time	Facts from Records	Staff
[redacted] 09:15	Attended ED. '***Not feeding, pyrexia, vomited am bottle'***. HR 180, RR34, TEMP 37.5, SATS 96%, BM 6., CRT 0-2, Alert.	
10:10	Seen by ED Doctor 1. No diarrhoea, no cough, no rash noted. ENT-NAD. Abdo soft and non-tender, good air entry. Imp: viral gastro. Plan: Antiemetic, diaorlyte, observe and review.	ED Doctor 1
10:40	ED Nurse 1 - RV temp 38. Cyclizine not available in ED or paeds and nurse records ED Doctor 1 happy to proceed without.	ED Nurse 1
11:15	Paracetamol given and tolerated milk and diaorlyte	ED Nurse 1
12:25	Review '***settled and sleeping, took 30ml feed and no vomiting. Discharged with diarolyte and advised to re-attend if further concerns.'***	ED Doctor 1
[redacted] 12:11	Re-attender at ED, '***not feeding, high temps and vomiting, very lethargic and irritable'***. HR 131, RR38, Temp- 37.6, Spo2- 99, GSC 15, CRT 0-2, BM 6.7 Alert.	
14:00	ED Dr review. '***Vomiting every feed, last good feed three days ago, last good wet nappy 3 days ago. Loose dirty nappies, temp up and down for days. Bronchiolitis 2 weeks ago but has done well. Vaccine up to date except last one due to bronchiolitis'. 'Pale, sleepy, high pitched cry, CRT2-3 Secs, Fontanelle normal, No rash. ENT: Ears: (unreadable), Nose, NAD- throat: red but tonsils not enlarged. Tongue coated. Paeds will review, encourage fluids until then. Seems (unreadable ? uncomfortable and unhappy) tried calpol and feed'.***	ED Doctor 2
14:30	ED Nurse: PEWS=0. '***Awaiting bloods. Paeds will review, cotton put into nappy to catch urine'*** ondansetron given	ED Nurse 2
14:50	Paracetamol given	ED Nurse 3

16:50	Paeds rv in ED. '***H/O vomiting for two days, one loose stool yesterday, 3-4 vomits since yesterday reduced oral intake and wet nappies. Unwell since Thursday and vomiting and crying and clingy. H/O fever for 2 days 38.8 on Friday, no temp today. No H/O sick contact, no recent travel, no previous admission to hospital. Development normal. Bil Air entry. Throat red. Ears not examined. Imp ? viral URTI ? Viral GE. Plan oral fluids, bloods, if bloods ok then home. R/w before discharge.'***	Paediatric Doctor 1
20:15	ED Nurse 2- ***'Bloods back, paeds bleeped at 20:00 regards same'.*** Pews=0.	ED Nurse 2
20:20	ED Nurse ***'Spoke to Paediatric Doctor 2, pt for admission a/w space on ward'***	ED nurse 2 Paediatric Doctor 2
20:55	Paediatric Doctor 1 and Paediatric Doctor 2. Bloods HB 86, Pt 180, WCC 9, CRP, 382, NA 140, K 4.3, UR 7.7, CR 43. '***Informed parents she will be for admission at present the ward is full but I will let them know what is happening.' Plan: Admission, Venflon, Check Urine, IVAB, ? LP.'***	Paediatric Doctor 2 Paediatric Doctor 1
21:00	(Not recorded in the notes – noted following discussion as part of SAI staff engagement). Paediatric nurse in charge on night duty. Nursing handover commenced at 20:30 hours, nurses alerted that child in ED and needed a bed by Paediatric Doctor 1. Nurses reported no direct contact with ED with regard to the child needing admission. All 13 side ward spaces taken on ward so needed to move a child out of a side ward close to nurse station and into the 4 bedded ENT bed. This was done immediately after handover to ensure bed space ready.	Paediatric Nurse 1
21:30	Medical handover commenced, handover didn't finish until 22:00 as reported by Paediatric Doctor 3. Mop up workload for Paediatric Doctor 3 and Paediatric Doctor 5 from day team after handover reported as extensive.	Paediatric Doctor 2, 3 and 5
22:00	Paediatric Doctor 3 reported that he requested that nursing staff arrange for transfer to paediatric ward.	Paediatric Doctor 3
22:50	Nurse ED noted '***Baby taken to children's ward'*** PEWS= 0 whilst child in ED	
23:00	Arrived to the children ward, PEWS= 2. Bulging	Paediatric

	fontanelle noted in nursing assessment by Paediatric Nurse 1.	Nurse 1
23:00	R/v Paeds ***'CRT 2-3, Pale, irritable, high pitched dry, mottled, fontanelle bulging. Imp: Sepsis-possible meningitis. Administer IVAB. FBC, U&E, MEN PCR, VBG. IV Ceftriaxone administered. RV Dr Hughes, plan : continue IVF bolus & maintenance, BD cultures, IVAB, PCR for meningitis, defer LP. Throat swab, CNS obs.'***	Paediatric Doctor 3
Personal Information redacted by the USI 00:00	IV fluids commenced. Overnight reviewed regularly by medical and nursing teams. Pews remained 2. '***Irritable and poor handling.'*** Retrospective note: Paediatric Nurse 2- expressed concerns to Paediatric Doctor 5 who was on overnight the morning of the Personal Information redacted by the USI. Paediatric Nurse 2 reported that Paediatric Doctor 5 did not review the child immediately and said she had no concerns re the child as their PEWS were only 2. Paediatric Doctor 5 reported in morning medical handover that the child was settled.	Paediatric Nurse 2 Paediatric Doctor 5
00:30	Paediatric Doctor 4 undertook a further review of XX. CRP was noted to be 2 seconds, HR 130-150, pale, not mottled. Continue with the plan and check coagulation screen, PCR for meningococcal and repeat lactate PH calcium and magnesium. Paediatric Doctor 4 requested a throat swab and central neuro system (CNS) observations. Paediatric Doctor 3 prescribed maintenance of normal saline plus 5% dextrose at 25 mls per hour.	Paediatric Doctor 4 Paediatric Doctor 3
02:11	Blood result recorded, CRP 313. PEWS and CNS observations were recorded hourly overnight. PEWS Score was between 0 and 2 due to raised systolic blood pressure. CNS observations recorded as 14/15 throughout the night due to irritable cry.	
04:10	Ibuprofen was administered at 04.10 hours.	
06:00	Noted 1 that fontanelle remains tense.	Paediatric Nurse 1
08:00	Review by Paediatric Doctor 5.	Paediatric Doctor 5
10:00	Review by Paediatric Doctor 4 during ward round, ***'GSC 14 PEARL,'- grunty & moany, bulging fontelle, increased tone lower limbs, stiff upper limbs. Plan: rpt bloods, IV Acyclovir and***	Paediatric Doctor 4

	dexamethasone,? start hypertonic saline 3%, D/S PICU ? mannitol, contact anaesthetics.'	
11:00	Seizure activity noted. Transferred to theatres for intubation at 11:10	
12:49	Blood gas: pH 7.524, Pco2 3.33, pO2 6.62,	
14.40	Transferred to PICU.	

LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1

1. ORGANISATION: SHSCT	**2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:** Personal Information redacted by the USI
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE	**4. DATE OF INCIDENT EVENT:** Personal Information redacted by the USI
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: No	**6. IF 'YES' TO 5. PLEASE PROVIDE DETAILS:**
7. DATE OF SEA MEETING: 23 October 2020	

8. SUMMARY OF EVENT:

Personal Information redacted by the USI was brought by ambulance from Downpatrick to Daisy Hill Hospital (DHH) Emergency Department (ED). It was reported Personal Information redacted by the USI was found lying on the street, alcohol taken, stating he fell and hit the back of his head. Personal Information redacted by the USI had a known psychiatric history of self-harm. Personal Information redacted by the USI was noted to be distressed and hallucinating, stating his deceased sister was in the back of the ambulance with him. The nearest hospital would have been Ulster Hospital Dundonald (UHD) which has an alongside psychiatric unit. The Northern Ireland Ambulance Service (NIAS) duty manager was advised by DHH ED Sister that Personal Information redacted by the USI should have been taken to the nearest ED which was UHD. The ED Sister also advised NIAS that Personal Information redacted by the USI may have been brought into the department with a concealed weapon.

At triage Personal Information redacted by the USI denied any suicidal ideation. Following discussion with NIAS it was noted Personal Information redacted by the USI had absconded. The absconding policy was implemented, a search of the building and grounds was commenced and the PSNI were contacted. The PSNI call handler declined to take details as security had not completed their search of the grounds. It was highlighted to the operator by the nurse that Personal Information redacted by the USI was a high risk patient, however the PSNI call handler still declined to take details.

Less than an hour later Personal Information redacted by the USI was brought back to DHH ED by the PSNI. Personal Information redacted by the USI had a self-inflicted stab wound to his abdomen with the knife still insitu and was in severe pain. Personal Information redacted by the USI's condition deteriorated, his GCS dropped and he became unresponsive and was subsequently intubated and transferred for a CT scan and management in theatre.

SECTION 2

9. SEA LEAD OFFICER: Dr Michael Perry, Consultant in Emergency Medicine	**10. TEAM MEMBERS PRESENT:** Dr Ruth Thornberry, Consultant Psychiatrist Mr Paul Smyth, HoS Unscheduled Care Ms Emma Boylan, Clinical Incident Lead, NIAS Mrs Carly Connolly, Clinical Governance Manager

11. SERVICE USER DETAILS: Personal Information redacted by the USI old male patient.

12. WHAT HAPPENED?

On Personal Information redacted by the USI at 01:59 Personal Information was brought by ambulance to DHH ED. Personal Information was triaged by staff nurse 1 on arrival and it was documented Personal Information had alcohol on board and was found lying on the street. Personal Information stated he had fallen and hit the back of his head. It was documented Personal Information stated his deceased sister was sitting in the ambulance with him. Personal Information had a history of self-harm and a previous head injury following a road traffic collision. A handwritten note was added documenting Personal Information denied suicidal ideation and had no delirium. Personal Information 's observations were checked and were noted as pulse (P) 86 bpm; blood pressure (BP) 183/63; respiratory rate (RR) 18; Temperature (T) 36ºC; SpO_2 96% and Glasgow comma scale (GCS) 15/15. Personal Information was triaged as a priority 3, i.e. to be seen within 60 minutes. Nurse 1 commenced the Regional Emergency Department Risk Assessment Form.

Staff nurse 1 discussed Personal Information with doctor 1. Staff nurse 1 expressed her concerns to Doctor 1. Personal Information wanted to leave ED. Personal Information was taken into Resus 1, majors area.

At 02:20 it was documented that staff nurse 2 was discussing Personal Information with NIAS paramedics. Staff nurse 1 noted Personal Information was no longer in the cubicle. All areas in the ED were searched. Security was contacted to search the hospital grounds and the absconding checklist was completed. It was documented that the nurse in charge contacted the PSNI.

At 02:30 security were contacted to ascertain the whereabouts of Personal Information . The PSNI were contacted to report Personal Information was missing. It was documented the PSNI call handler refused to take complete details of the patient as the staff nurse had stated security had not completed their search of the grounds. Staff Nurse 1 emphasised that Personal Information was a high risk of absconding and needed the call handler to take complete details. It was documented the call handler refused.

At 03:18 Personal Information was brought back to DHH ED by the PSNI with a stab wound to his abdomen. Personal Information was triaged on arrival and it was documented he was in severe pain. It was reported Personal Information had stabbed himself in the abdomen with a knife. A hand written note was added to ED documentation stating Personal Information was high risk of self-harm. Doctor 2 was in attendance and surgeons were contacted to review. Personal Information 's airway was patent and he was talking. Observations were noted: RR was 18, (P) 108bpm, Blood Pressure (BP) 160/69 and SpO2 99%. Personal Information was commenced on 15 litres (l) of oxygen. Cardiac monitoring was commenced and an echocardiogram carried out. Bloods were completed and intravenous access was obtained. Personal Information 's GCS score was 14/15.

At 03:50 it was documented Personal Information had become unresponsive. Personal Information was noted to be groaning with rigors. A guedel airway was inserted. Personal Information NEWS score was 3 due to hypertension and his GCS dropped to 7/15. Doctor 3 (Dr Craig) was contacted to attend.

At 04:00 Personal Information was commenced on intravenous antibiotics (IVA) and a second dose of tranexamic acid. The guedel airway was removed and it was noted Personal Information was coming round. Personal Information 's GCS score was noted to be 12/15 and NEWS was 3.

At 04:15 the consultant anaesthetist arrived. Personal Information was transferred to a trauma mattress for a CT scan. Further antibiotics were administered. Nursing notes document Doctor 3 was present. At 04:30 Personal Information was intubated.

Staff Nurse 2 contacted NIAS and spoke with the duty manager. Staff Nurse 2 highlighted that Personal Information was brought to the ED from Downpatrick and highlighted to the duty manager with Personal Information 's presenting history, he should have been brought to the nearest ED which was the UHD which has the provision of a mental health unit on site. The duty manager informed Staff Nurse 2 that the crew were not familiar with the area and they had spoken to the controller who advised to attend DHH ED. Staff nurse 2

advised the duty manager that Personal Information potentially had a concealed weapon when transported via ambulance to DHH ED.

At 04:48 Personal Information was reviewed by Doctor 3. Doctor 3 documented Personal Information's history of an angulated stab wound to the umbilicus / left flank area. It was noted Personal Information had taken alcohol and that his GCS had dropped after being agitated. Subsequently Personal Information was transferred to the CT scanner and then to theatre for ongoing management and care. The surgeon and anaesthetist were present during transfer.

The CT scan concluded 'no acute intra-abdominal or intracranial pathology. Small 13mm complex cyst in the inter-polar region of the right kidney'. Personal Information was taken to theatre for removal of knife and wound closure.

On the same day Personal Information was reviewed by the Psychiatry team and it was documented Personal Information reported no current thoughts of life not worth living and that he was regretful of this self-harm attempt. An urgent referral was made to Mental Health and Community Addiction team. Following assessment by Psychiatry Personal Information was deemed low risk of harm to himself or others. Personal Information did not wish to stay in hospital, the risks were explained to him and he was advised to stay for observation. Personal Information had full capacity to understand the risks of leaving hospital and signed a discharge contrary to medical advice (CTMA) form prior to self-discharge.

13. WHY DID IT HAPPEN?

Patient Factors

Personal Information was a Personal Information old male at the time of the incident and was known to mental health services and known to the PSNI. Personal Information had a past medical history of self-harm, alcohol dependency and a history of a brain injury. Personal Information was found lying in the Street in Downpatrick intoxicated and complaining of abdominal pain and a head injury. The PSNI were alerted by a member of the public and attended. The PSNI subsequently contacted NIAS due to Personal Information's presentation.

NIAS

The review team acknowledge NIAS received a call to attend an intoxicated male patient complaining of abdominal pain at a location in the town of Downpatrick. On arrival the PSNI officer informed NIAS crew Personal Information was known to them and that the PSNI would attend Personal Information frequently with similar behaviour. NIAS reported Personal Information appeared agitated and was having hallucinations of his deceased sister at the time. NIAS have recounted the crew dispatched to attend Personal Information were unfamiliar with the area and consequently asked the PSNI officers the location of the nearest ED department. Personal Information was subsequently taken to DHH ED under the direction of the PSNI. The PSNI have since advised they do not work under HealthTrust boundaries and would transfer to the nearest ED by road. The review team acknowledged DHH ED is not the nearest ED from Downpatrick (30.5miles / 52 minutes) and determined Personal Information should have been brought to the Ulster Hospital (21.8miles/ 37 minutes). NIAS have since reviewed the case and confirmed paramedics should have contacted NIAS Control Office if they were unfamiliar with the area for advice on where to appropriately transfer Personal Information, this would be normal procedure. NIAS have confirmed Personal Information was taken to DHHED in error.

PSNI

The review team suggest that Personal Information potentially had a concealed weapon and therefore a high risk of causing harm not only to himself but to NIAS and ED staff. The review team are conscious Personal Information was known to the PSNI, they were familiar with Personal Information's history and potential for carrying a concealed weapon and unpredictable behaviour. The review team recognise that Personal Information was found in a public

place and was suffering from a mental disorder, the PSNI were aware of Personal Information redacted by 's history. The PSNI could have considered detaining Personal Information redacted by under the Mental Health Order, article 130 and provided an escort to the nearest ED for his safety and the safety of others.

The question was asked of the PSNI what rational would the PSNI have to perform a search for a suspected weapon. The Chair was advised this is a grey area, a decision to search is made on an individual basis, taking into consideration the patients forensic history and how well known to the PSNI. The review team determined the PSNI could have considered performing a search given Personal Information redacted by 's known history of self-harm and unpredictable behaviour due to his mental health disorder.

Emergency Department. 1st Attendance

The review team have reviewed Personal Information redacted by 's ED notes and confirmed Personal Information redacted by arrived at DHH ED by ambulance at 01:59. The review team determined Personal Information redacted by was triaged immediately at the time of arrival by nurse 1 in observation room 1. Nurse 1 completed observations and noted Personal Information redacted by was behaving strangely stating his deceased sister was in the back of the ambulance with him. The review team can confirm nurse 1 appropriately commenced the Regional Emergency Department Risk Assessment Form as per Trust protocol. Nurse 1 required further information and whilst obtaining this information from NIAS the review team determined Personal Information redacted by absconded. The review team acknowledge the Regional AWOL protocol was immediately initiated and security were appropriately contacted to search the hospital grounds for Personal Information redacted by as per Trust procedure.

The review team can confirm Personal Information redacted by was not located and therefore nurse 1 appropriately contacted the PSNI to report Personal Information redacted by had absconded and was missing. Nurse 1 aptly highlighted to the PSNI call handler that Personal Information redacted by was a high risk patient. The review team are conscious the PSNI call handler declined to take full details as CAH security personnel had not completed their search of the grounds. As part of the review the Chair of the review panel discussed the case with the PSNI and it was agreed if nurse 1 highlighted Personal Information redacted by was a high risk patient i.e. risk to himself or others the call handler should have actioned the call immediately. The review team note the Regional AWOL protocol should be reviewed to re-consider suitable terminology to be used in high risk cases to ensure immediate action is taken by the relevant Departments.

Emergency Department 2nd Attendance

The review team acknowledge Personal Information redacted by returned to DHH ED by police with a self-inflicted stab wound to the abdomen. The review team reviewed ED notes from the second attendance and determined Personal Information redacted by 's treatment and care was appropriate.

Policies and Procedures.

The review team determined triage nurse 1 appropriately commenced the Regional Emergency Department Assessment Form at triage as per Trust procedure.

The review team acknowledge the SHSCT do not have a current policy/procedure for searching patients in the acute hospital setting. The review team determined such a policy would be beneficial to provide staff with guidance where a search of any patient is to be considered to ensure patients do not have in their possession items which may be harmful or inappropriate to themselves or others.

ED staff appropriately initiated the regional AWOL protocol immediately on recognition of Personal Information redacted by 's absence, followed by a 999 call to PSNI for a high risk missing patient as per Trust procedure.

SECTION 3 - LEARNING SUMMARY

14. WHAT HAS BEEN LEARNED:

Following review of notes the review team have determined Personal Information redacted by was inappropriately transferred to DHH ED. Best practice would be a transfer to the nearest ED defined by the Trust boundary and conclude Personal Information redacted by should have been transferred to the UHD. The review team are unable to determine if the outcome would have been any different with regards to absconding and self-harm had Personal Information redacted by been brought to UHD.

The review team recognise the PSNI were familiar with Personal Information redacted by's history and behaviour. Personal Information redacted by was found in a public place notable presenting with a mental health disorder. Article 130 of the mental health order could have been instigated and a police escort provided to a place of safety i.e.to the nearest ED where Personal Information redacted by presented.

The review team acknowledge the Regional AWOL protocol was immediately initiated and security was contacted to search the hospital grounds for Personal Information redacted by as per Trust procedure. The review team determined the PSNI call handler should have taken details from nurse 1, nurse 1 appropriately highlighted Personal Information redacted by was a high risk patient. The review team is mindful that this is the 3rd SAI in the SHSCT in relation to a patient absconding from the ED. The review team are conscious on each occasion Trust staff have had difficulty obtaining an immediate response from the PSNI to assist with a search for a high risk patient. The review team therefore determined the Regional Interagency Guidance on Dealing with Persons who go missing from Emergency Departments requires immediate review and inclusion of appropriate terminology to facilitate ED staff to trigger an immediate response from the PSNI.

The review team conclude the SHSCT do not have a current policy/procedure for searching patients in the acute hospital setting. The review team determined such a policy would be beneficial to provide staff with guidance where a search of any patient or visitor is to be considered to ensure patients do not have in their possession items which may be harmful or inappropriate to themselves or others.

15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

The report will be shared with all ED staff, NIAS and PSNI for learning.

An alert has been added to Personal Information redacted by's NIECR record to highlight the risk of potential possession of a concealed weapon and absconding.

There is ongoing security work in DHHED including implementation of controlled entry and exit system into the department. Security cameras have been upgraded.

Commented [CC1]: I have emailed Paul Chapman to confirm this

16. RECOMMENDATIONS (please state by whom and timescale)

1. HSCB/ PSNI to review the current Regional Interagency Guidance on Dealing with Persons who go missing from Emergency Departments and implement terminology to facilitate ED staff to trigger an immediate response from the PSNI for high risk patients. Actioned by HSCB/PSNI

2. The SHSCT Acute Directorate (mental health already have one) should produce a policy within RCEM guidelines that will provide staff with guidance where a search of any patient is to be considered to ensure patients do not have in their possession items which may be harmful or inappropriate to themselves or others. Actioned by: AD for Unscheduled.

3. The Trust should review ED Risk Assessment Form to include a risk assessment for potential possession of a concealed weapon. Actioned by :AD for Unscheduled Care

4. The report will be shared with NIAS / PSNI/ HSCB for learning. Actioned by (Corporate Governance)

5. The report will be shared at ED M&M for learning. Actioned by (Acute Governance)

17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

18. FURTHER REVIEW REQUIRED? YES / NO
Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A <u>FURTHER REVIEW IS</u> REQUIRED)	
19. PLEASE INDICATE LEVEL OF REVIEW: LEVEL 2 / LEVEL 3 **Please select as appropriate**	**20.** PROPOSED TIMESCALE FOR COMPLETION: DD / MM / YYYY
21. REVIEW TEAM MEMBERSHIP *(If known or submit asap)*:	

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22. TERMS OF REFERENCE *(If known or submit asap)*:

SECTION 5	
APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR	
23. NAME:	**24. DATE APPROVED:**
25. DESIGANTION:	

SECTION 6
26. DISTRIBUTION LIST:

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1					
INFORMING THE SERVICE USER[1] / FAMILY / CARER					
1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert **date informed**:				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER ***(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)***				
5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	c) Report not shared but contents discussed (***if you select this option please also complete 'l' below***)	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SECTION 2								
INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) *(complete this section for all death related SAIs)*								
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**					
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**					
	If **YES**, insert **date report shared**:							
	If **NO**, please provide details:							
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**	
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

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APPENDIX 6

Revised November 2016 (Version 1.1)

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier: [redacted]

Date of Incident/Event: [redacted]

HSCB Unique Case Identifier: [redacted]

Service User Details: (complete where relevant)

DOB: [redacted] GENDER: Male AGE: [redacted]

Responsible Lead Officer: Dr John Simpson

Designation: Consultant Psychiatrist, Independent Chair

Report Author: The Review Team

Date report signed off:

1.0 EXECUTIVE SUMMARY

Granville Manor is a Supported Living facility with 5 separate houses for Adults with Learning Disability. [redacted] where Mr "X" lived, has 5 bedrooms with en-suites, a shared kitchen and utility, and two shared living rooms. Mr "X" became ill on the [redacted] whilst residing at his home in [redacted] Granville Manor.

The Out of Hours GP Service (GP OOH) was first consulted on [redacted] and advice was received. Following testing on [redacted] he was diagnosed as being positive for Covid-19. On [redacted] his general health deteriorated, necessitating a second referral to GPOOH. He was assessed but not brought to an Emergency Department (ED). There were two contacts with GPOOH on [redacted]. On [redacted] @05.20hrs he was transferred to CAH (Craigavon Area Hospital) ED and subsequently discharged back to Granville. Later that same day (21:00hrs) he was returned to CAH ED via the Northern Ireland Ambulance Service (NIAS) and returned again to Granville Manor on [redacted] at "03.40hrs" as per NIAS record or " 04.00hrs" as per Granville notes (day 9 of symptoms).

On the [redacted] @14.20hrs Granville Manor staff contacted his GP requesting medical assessment. A primary care senior paramedic telephoned back @15:25hrs and advised staff to complete observations and contact 999 if there was deterioration. The Ambulance crew were advised by an ED consultant to bring Mr "X" to hospital for assessment, where he was admitted to a ward via ED on [redacted] @03.15hrs. His condition further deteriorated and he passed away in CAH on [redacted].

The overall care provided to Mr "X" was of an appropriate standard and at times was exemplary given the understandable difficulties experienced by all health and care staff in responding to the emerging pandemic. The adverse outcome resulting in his untimely death was unavoidable, the singular causative factor being infection with the Covid virus bringing about respiratory failure.

The care delivered by Granville Manor staff was timely and appropriate in responding to his symptomatology and Covid diagnosis. Their frequent and detailed communication with his family was an example of good practice. Granville Manor staff managed interactions with the OOH GP, NIAS and CAH ED extremely well whilst at all

times advocating for Mr "X" to the best of their ability in a complex and rapidly evolving situation. His illness followed what is now a well-recognised pattern, however at that point it was an emerging illness which presented a difficult challenge to their staff, OOH GP, NIAS paramedics as well as CAH staff.

The ~~decision by Granville management~~ decision by Senior Support Worker on duty (following advice from Directorate On-Call) - not to have Mr "X" accompanied by care home staff on his first visit to CAH ED, as would have been normal practice, was because of concerns raised by the NIAS paramedics that staff may not be admitted because of Covid restrictions. Whilst this was understandable, it was subsequently clarified that he could be accompanied into ED and was so on his second visit, and third visit, but not into the inpatient ward. It did, however, result in that ED assessment being incomplete.

There appeared to be differing views as to whether or not Mr "X" should have been brought to CAH ED on the second occasion, GP OOH having advised Granville staff to call 999 if there was deterioration, as had been the advice when sent home from ED on the first occasion. These varying views are understandable in the context of Covid being an emerging illness whereby the pattern of deterioration was still being understood and was difficult to predict.

The initial decision regarding his Do Not Attempt Resuscitation (DNAR) status was unsatisfactory from his mother's point of view. Although Dr A concluded that she was in agreement with the assessment, she subsequently stated that she did not agree and asked that the DNAR be rescinded. After further detailed discussions with respiratory and Intensive Care Unit (ICU) medical staff, which also included Mr "X's" brother, she did gain a better understanding of the rationale behind this difficult decision. It is clear that their decision was based on his overall clinical presentation rather than simply based on his frailty as a result of his learning disability and that resuscitation and ICU admission would not have been in Mr "X's" best interests.

Given the above, it is a recommendation that the care home or community key worker should be engaged to mediate in advanced care planning including DNAR decision in patients with learning disability. It is also recommended that a multidisciplinary risk assessment (as has been developed by CAH ED for patients with mental health

issues) be revised to consider all aspects including whether staff should accompany a patient from ED throughout the inpatient stay.

Granville care home staff training in infection prevention and control has already been augmented and has since been updated on a regular basis. They are now trained and capable of following SHSCT procedures for donning and doffing of PPE attire in order to accompany learning disability patients into inpatient units.

Involvement of Family:

The Review Team and all staff members who knew Mr "X" wish to offer their sincere condolences to his family. The Trust acknowledges that this is a particularly distressing time for the family and would like to offer any support that it can. The Trust advised Mr "X's" family that an SAI review was to be conducted on 17th July 2020. The chair of the review and Corporate Governance Coordinator then met with the family on 21 July 2020 and also provided updates to them during the review process.

2.0 THE REVIEW TEAM

Chair:

Dr John Simpson, Consultant Psychiatrist, Independent Chair, SHSCT

Review Team:

- Emma Boylan, Northern Ireland Ambulance Service (NIAS) Serious Incident Lead (Clinical).
- Catherine Reid, Head of Service for GPOOH Service SHSCT
- Dr Erskine Holmes, Emergency Department (ED) Consultant, SHSCT
- Pat Burke, Acting Head of Supported Living (Learning Disability) SHSCT

3.0 SAI REVIEW TERMS OF REFERENCE

The Level 2 SAI review will consider the following areas:

- To review the actions taken by care staff within Granville Manor in respect of the care provided to Mr "X" from the point at which he was suspected of having Covid.

- To examine the role undertaken by staff at Granville Manor during each

3.0 SAI REVIEW TERMS OF REFERENCE

interaction with the Ambulance (NIAS) and ED, to review information shared with emergency services and to review whether advice provided by Ambulance service and ED was adhered to within Granville Manor.

- To determine if a comprehensive medical assessment was conducted by each medical professional prior to his admission onto a ward in CAH. These contact points occurred between [Personal Information redacted by the USI] @ 03.15hrs.

- To establish that the treatment and advice provided was consistent with Mr "X's" medical presentation.

- To ascertain if factors relating to Mr "X's" diagnosis of a learning disability bore any influence on decisions taken in respect of assessment, treatment or advice conveyed especially in the context of "Equal Lives" and the development or application of the Hospital Passport. If so, to investigate if this factor contributed to an inequitable provision of assessment, treatment or advice.

- To identify learning which may inform the delivery of health services to people with a learning disability, particularly during the Covid pandemic.

- Engage with family member(s)* (where appropriate) ensuring sensitivity to his/her/their* needs and address, where possible, questions presented to the review team and/or SHSCT by the patient/relevant family member(s)*. Dr Simpson met with the mother and brother of Mr "X" on [Irrelevant information redacted by the US] after which the minutes and the Terms of Reference were sent to the family. These were approved by the family on 5 August 2020.

4.0 REVIEW METHODOLOGY

- Review of patient/service user case notes from Granville Manor and CAH.
- Review of Granville Manor emails.
- Interviews with key staff included: Granville Manor Manager, Respiratory Ward

Physician, ED Lead Nurse, ED Lead Consultant, ICU Consultant.

- Review of policies and procedures in operation at the time of the incident which are relevant to the care / treatment afforded to Mr "X".

5.0 DESCRIPTION OF INCIDENT/CASE

Mr "X" was a [redacted] old male with severe learning disability and autistic tendencies. He required staff to support him to manage his daily activities of living or daily routines. He required staff support to maintain his own safety both inside and outside of his home as he was unaware of common dangers. He was supported to be involved in community life and enjoyed going out for meals. He could not manage his health care needs and was supported by staff to access healthcare. He had limited verbal communication.

He had had generally good health. [redacted].

He appeared content and happy living in Granville Manor. He shared a 5 bedroom house with 3 other gentlemen. He preferred his own company but liked 1:1 interaction from staff, going for walks etc. His behaviour could be challenging at times. He contracted Covid-19 whilst residing at his home in [redacted] Granville Manor. Following testing on [redacted] he was diagnosed as Covid positive. There were interactions with GPOOH service, NIAS and CAH however Mr "X" sadly passed away in CAH on [redacted].

Timeline of Key Events as advised by Granville from 20 March 2020

Date	Information Source for Entry/Event	Name / Role of Practitioner / Clinician involved	Event - incl contacts, assessment, referral dates
20/03/20	EASY READ (Appendix 3a-g)	Granville	Shared with Staff team by Managers on different occasions- for sharing with tenants. Below shared with tenants: a. Coronavirus Easy read b. Easy Read Covid 19

5.0 DESCRIPTION OF INCIDENT/CASE			
			c. Handwashing DVD link d. How to keep your hands clean e. PPE Easy Read f. Washing my hands Social Story g. Updated info about Coronavirus
20/03/20	Email (Appendix 4)	Assistant Manager 1 Granville	Standard Operating Procedure (SOP) for Deep Clean for community residential settings shared with all staff
23/03/20	Email (Appendix 5)	Assistant Manager 2 Granville	Business Impact Analysis shared with staff
23/03/20	Timeline	Granville	Plan for Additional Staffing for Day Care to be redeployed to Granville as Day Care Closing due to Covid.
09/04/20	Easy Read information for sharing with tenants sent to all staff for action (Appendix 6a-h)	Granville Manager	a. Symptoms of Coronavirus b. Protecting against Coronavirus c. Testing for Coronavirus d. Treatment for Coronavirus e. Going out during Coronavirus f. Health Promotion during coronavirus g. Self-isolation/Stay at home h. My Anticipated Coronavirus Care Plan
09/04/20	Email re 'My Covid Care Plan'	Granville Manager	All "My Anticipated Covid plans" to be completed with tenants to help them understand what may happen should they be symptomatic/Covid positive
13/04/20	Email (Appendix 8)	Head of Service	Emails directing Amber PPE from Wednesday 15/04/2020
14/04/20	Night Duty	Granville	First Staff Member reporting as Covid symptomatic while at work, sent off duty 15/04/2020 @07.00hrs. Occupational Health and Covid testing team contacted. Staff member tested @10.30hrs
15/04/20	Situation Report	Granville Manager	AMBER PPE commenced as per direction for Supported Living services on Wednesday morning for 8am shift. All staff on site in Amber PPE going forward. Additional cleaning implemented. Tenants encouraged to

5.0 DESCRIPTION OF INCIDENT/CASE			
			social distance.
Personal Information redacted by the USI	Phone call to Family of Mr ”X”	Granville Manager	Mr “X’s” Mother contacted and informed of Covid Positive Case/Symptomatic case within his House. He was not symptomatic at this stage.
Personal Information redacted by the USI	Situation Report	Granville Manager	One Tenant being relocated to Woodlawn for 7 days from Personal Information redacted by the USI as a precaution due to age (Personal Information) as the Covid positive staff member had been working in his house. Three tenants remaining in the house, one isolating in his bedroom and staff are supporting the other two tenants to social distance in separate areas of the house (if non co-operative to remaining in their rooms).
Personal Information redacted by the USI	Diary entry	Personal Information redacted by the USI staff	Additional Deep Clean of house by Staff in Personal Information redacted by the USI Cleaning is ongoing on each shift day and night by staff.
Personal Information redacted by the USI	Daily Report Notes	Senior Support Worker	14:00hrs OOH GP phoned as Mr “X” had temperature of 37.2ºC. Paracetamol given with good effect. 19:30hrs Temperature 36.4ºC Mr ”X” social distancing in sitting area today. 19:40hrs OOH GP returned call she advised Mr “X” to isolate for 14 days, keep an eye on his temperature and encourage regular fluids. Give Paracetamol when needed. Temperature to be checked throughout day.
Personal Information redacted by the USI	Daily Report Notes	Nurse	22:00hrs Mr “X’s” temperature checked 36.4ºC. Good colour. Declined SpO2/BP/Pulse check. 02:00hrs Coughing frequently throughout night, Temperature 37.2ºC.
Personal Information redacted by the USI	Email trail	Assistant Manager	Mr “X” swabbed for Covid.
Personal Information redacted by the USI	Daily Report Notes	Nurse	10:00hrs Episodes of dry coughing. 11:00hrs Temperature 39.2ºC

5.0 DESCRIPTION OF INCIDENT/CASE			
			Paracetamol given. Refused all other clinical observations. 11.40hrs GP contacted re advice, informed GP that Mr "X" had been swabbed awaiting results. They would be updated re condition if deterioration. 12:00hrs Temperature 36.4C 13:30hrs dinner and fluids refused, alternatives offered and taken. 14:30hrs Head of Service (HoS) informed of difficulties obtaining clinical observations; query re possibility of sedative medication. HoS to contact Consultant Psychiatrist. Case Manager contacted via phone to inform of Covid Positive result. Discussion re DNR status. GP advice is that Mr "X" should be resuscitated if needed and transferred to the acute hospital if required. Contact with Client Family members throughout the day informing of condition and then result.
Personal Information redacted by the USI	Email	Consultant Psychiatrist	Regarding sedatives / respiratory depression /gaining clinical observations
Personal Information redacted by the USI	Email	Case Manager	Covid Positive result and discussion re DNAR.
Personal Information redacted by the USI	Daily report	Nurse	23:30hrs phone call from Mr "X's" brother – queried Oxygen therapy – advised he appears well, although could not get observations, but did not appear cyanosed.
Personal Information redacted by the USI	Daily Report notes	Nurse	Contact from Mr "X's" family and update given: Harsh persistent coughing–regular fluids offered. Refusing all observations 14:40hrs Temperature 36.7 doesn't appear in respiratory distress Respirations 20

5.0 DESCRIPTION OF INCIDENT/CASE			
			16:00hrs refused fluids, 17:00shrs took fluids and meal offered. 19:00hrs alert and content Temperature 36.8
Personal Information redacted by the USI	Daily Report Notes Day Duty	Nurse	09:30hrs Shower/dressed persistent coughing, breakfast taken, honey and lemon given. 10:30hrs Temperature 36.4 Persistent coughing- GP contact, antibiotic transcribed: amoxicillin 500mg capsules | In Drug ID | 21 capsules | 1 three times a day | Personal [redacted] 13:30hrs paracetamol given 14:30hrs Temperature 36.9
Personal Information redacted by the USI	Night duty Daily report notes	Nurse	22:15hrs fluids and food taken for supper Coughing persistently personal care needs met 02:30hrs appears comfortable sleeping not coughing
Personal Information redacted by the USI	Day duty Daily Report Notes	Nurse	10:30hrs Temperature 36.3 Fluids and alternative foods accepted 12:45hrs phone call from mother, reassurance given Mr “X” declined hot meal but accepted alterative and fluids 17:00hrs remains settled coughing occasionally – antibiotic administered 18:30hrs Temperature 36.5
Personal Information redacted by the USI	Night duty Daily Report Notes	Nurse	20:00hrs Appears alert, persistent cough, does not appear to show signs of distress 21:30hrs supper and fluids 22:00hrs Temperature 36.6

5.0 DESCRIPTION OF INCIDENT/CASE			
			Respirations 22, refused fluids 22:10hrs contact from Mother 0:00hrs Temperature 37.1 respirations 26
Personal Information redacted by the USI	Night duty continued Daily Report Notes	Nurse	03:00hrs Temperature 36.4 Respirations 28 declined all further observations 03:15hrs respirations 28 1g paracetamol given, excessive coughing, not accepting fluids 03:45hrs respirations 32 breathing shallow OOH GP contacted 04:15hrs contact with OOH GP, advised 999 04:30hrs paramedics arrived respirations 25-28 Temperature 38.7 SPo2 98% Pulse 92 Paramedics decision for Mr "X" to remain in Granville – left at 05:30hrs 07:00hrs Temp 37.3 respirations 25 declined further observations
Personal Information redacted by the USI 04:26 Personal Information redacted by the USI	SOE – sequence of events – digital log.	NIAS	999 call from Granville reporting staff had contacted out of hours about Mr "X". OOHrs advised contact 999 if concerned. First NIAS contact. 04:28 S420 allocated to call. 04:37 S420 arrived at call location. PRF requested ? Decision not to convey. 05:48 S420 clear from call location.
Personal Information redacted by the USI	Day Duty Daily Report Notes	Nurse	11:00hrs breakfast and fluids Lethargic 16:40hrs Temperature 37.5 Respirations 21 16:50hrs coughing
Personal Information redacted by the USI	Night duty Daily Report	Nurse	Isolating in the sitting room

5.0 DESCRIPTION OF INCIDENT/CASE			
	Notes		Phone call from Clients mother 20:50hrs Temperature 38.1 Paracetamol given Settled to sleep 02:30hrs Temp 36.7 coughing persistently Declined all clinical observations
Personal Information redacted by the USI	Night duty continued Daily Report Notes	Nurse	04:15hrs Temperature 39.3 respirations 26, other observations refused, paracetamol administered 05:20hrs Temperature 40, respirations 32 breathing shallow flushed skin clammy. OOH GP contacted advised 999 05:45hrs Paramedics arrived unable to take SP02 levels transferred to CAH decided. Query if staff should accompany – under normal circumstances staff would accompany due to communication – Paramedics advised staff may not get into ED – Contacted On call director – advised if staff felt happy that Client was settled in Ambulance to let him go, likely staff wouldn't be allowed into Covid ED. Client appeared relaxed. Accompanied by 2 male paramedics who client appeared to respond to. Hospital passport given to paramedics with direct line to Personal Information redacted by the USI Epilepsy management plan, MAR, SLT report given. 06:25hrs paramedics left with client. Message left with Clients brother. 06:50hrs Clients mother contacted to advise transfer to CAH – worried he was by himself – reassured he was settled in ambulance. 08:00hrs telephone call from Nurse in CAH ED, advising Mr "X" will be returning home shortly, Nurse advised his SP02 96% and Doctors happy with clinical presentation and no medical

5.0 DESCRIPTION OF INCIDENT/CASE			
			intervention required. ED Nurse expressed that this was an unnecessary admission to hospital. Granville nurse explained that they were acting on advice from OOH GP to contact 999 and were unable to get SP02 and neither were paramedics. Mr "X's" mother contacted and updated.
Personal Information redacted by the USI 05:17 Personal Information redacted by the USI	SOE / AUDIO	NIAS	999 Call from Granville reporting COVID +ve, Temp 40, Respiratory rate 32. Granville contacted OOHrs and they advised to contact 999. Second amb contact. 05:20 S423 arrive at call location. PRF requested. 06:30 S423 convey to CAH ED. 06:54 S423 arrive at CAH ED. *discharge to Granville to be sourced**
Personal Information redacted by the USI	Day duty Daily Report Notes	Nurse	10:30 Return to Granville settled well Fluids taken as per Speech & Language Therapist (SLT) guidelines. Temperature 36.5 Coughing persistently flu like symptoms 16:30 asleep – declining clinical observation fluids taken, remains in bed. Mother and brother updated. Difficulty breathing, distressed-declined observations – SP02 92% - cyanosed around lips 999 phoned Ambulance crew arrived – Spo2 92-95 remained uncomfortable, appeared struggling to get a breath – ambulance crew reluctant to take him to CAH – staff needed to be assertive. Ambulance crew sought advice – Client Respirations 32 SP02 94% agreed to take Client to CAH – staff member followed in car and Family informed.
Personal Information redacted by the USI	SOE / AUDIO	NIAS	999 call for Mr "X" reported as very drowsy, COVID +ve, has been at CAH

5.0 DESCRIPTION OF INCIDENT/CASE			
17:47 Personal Information redacted by the USI			this morning but discharged and has deteriorated, constant cough, difficulty breathing. Staff nurse does highlight that a staff member will travel with patient due to the difficulties encountered in ED earlier. Third NIAS contact. 18:02 S424 allocated to call. 18:09 S424 arrive at call location. PRF requested 19:01 S424 convey to CAH ED.
Personal Information redacted by the USI	Night duty Daily Report Notes	Nurse	22:00hrs contacted ED for update-nurse advised Mr "X" doing well, SpO2 satisfactory and will be sent home – nurse advised his 22:00hrs meds to be administered in CAH and transferred home. Expressed concerns re difficulty breathing and respirations and persistent coughing. Queried if anything could be prescribed to give relief because last two occasions OOHGP advised 999 due to respirations over 30 – nurse advised she would discuss with Doctor. 22:30hrs contact with brother re update from ED nurse – brother had been speaking with Doctor in ED and was happy with what Doctor had told him – brother agreed to inform Mr "X's" Mother. Staff to update brother on return to Granville if before 01:00hrs 02:00hrs No answer from ED requesting update – Personal Information redacted by the USI advised ambulance had arrived to collect Mr "X" to return to Granville. 03:00hrs Client had not returned – Personal Information redacted by the USI contacted – he advised he had left at 02:00hrs when ambulance arrived as per ED nurse. ED reception staff contacted – advised ambulance system stated left at 02:00 however may not represent actual time.

5.0 DESCRIPTION OF INCIDENT/CASE			
			04:00hrs Client arrived back to Granville incorrect post code given. Client presented well on journey, persistently coughing, incontinent of faeces. Supported with shower. Small amount of fluids accepted, food declined. DATIX IR1 incident form completed. 04:45hrs In bed. Temperature 38.3, windows opened, lighter bedclothes provided. Unsure of last dose of paracetamol, to be rechecked in 30 mins and contact ED for time of last paracetamol. 05:15hrs last dose of paracetamol 21:30hrs Temperature 39.9 Paracetamol administered, t shirt removed – attempted use of cool cloth declined. 05:40hrs temperature 40.4 respirations 29, cool cloth put around feet accepted. 06:30hrs temperature 39.3 respirations 26 Email sent to update Case Manager/Consultant Psychiatrist of hospital attendance. 06:45 temperature 38.5 7:30 temperature 38.6 respirations 24 08:20 temp 38.5 respirations 23 – sleeping in bed Contact with Mr "X's" mother to give update.
Personal Information redacted by the USI 23:08 Personal Information redacted by the USI	SOE / AUDIO	NIAS	ED call to Non-emergency ambulance control to book ambulance for Mr "X" returning to Granville. Caller from ED reported patient discharged, pt not staying in hospital, shouldn't have been here really, COVID +ve, coughing and they want him brought home asap. Address provided was XXXXX BTXX XXX.

5.0 DESCRIPTION OF INCIDENT/CASE			
Personal Information redacted by the USI 01:17 Personal Information redacted by the USI	SOE	NIAS	PCS amb – S272 allocated to call. 01:41 S272 arrive at CAH 02:21 S272 leave CAH and convey patient to Granville Pk. Incorrect address supplied – delayed transfer journey. 03:40 S272 and Mr "X" arrive at Granville. Journey time = 1 hour 19 minutes. Journey should have taken approx. 30 minutes.
Personal Information redacted by the USI	Day Duty Daily Report Notes	Nurse	11:00hrs Paracetamol given 14:00hrs Temperature 36.4 SP02 95% sleepy lethargic coughing persistent 16:00hrs coughing persists, OOH GP contacted re advice for coughing – nothing prescribed. Advised to call back if any deterioration.
Personal Information redacted by the USI continued	Day duty Daily Report Notes	Nurse	19:40hrs coughing persistently fluid taken Temperature 36.4 Contact with Mr "X's" Mother, update given
Personal Information redacted by the USI	Night duty Daily Report Notes	Nurse	21:00hrs T 40.9 Respirations 29 – swapped bed clothing for lighter, windows open, clothing removed Paracetamol given 00:45hrs Temperature 37.4 Cough not as apparent
Personal Information redacted by the USI continued	Night duty Daily Report Notes	Nurse	04:30hrs coughing excessively respirations 26 Temp 39.7 Paracetamol given honey and lemon drink accepted. 05:00hrs Temp 39.4 05:40hrs Client refused cool cloths-cool damp cloth to feet Accepted fluids 07:00hrs Temp 38.8 respirations 26 Fluids taken 07:45hrs Temp 37.8

5.0 DESCRIPTION OF INCIDENT/CASE			
Personal Information redacted by the USI	Day duty Daily Report Notes	Nurse	Appears bright and alert, 2 yogurts taken with morning medication 12:05hrs Temp 38.1 Paracetamol given 13:10hrs Brother contacted update given 14:10hrs Temp 37.8 Respirations 35 14:40hrs GP contacted for advice as respirations remained at 35 15:25hrs Senior Paramedic phoned back – check respirations – now 26 – advised if respirations remained high or client struggling to breath contact 999
Personal Information redacted by the USI continued	Day Duty Daily Report Notes	Nurse	16:00hrs T 37.8 respirations 24 Became breathless after tea – respirations 32 –increased 17:30hrs increased respirations 36 – propped up on bed, Sp02 from 95-90% 999 contacted Paramedics assessed Client – respirations 30 SpO2 90-92 18:30hrs Paracetamol given Taken to CAH ED – Hospital Passport, SLT, Epilepsy plan given Mr “X’s” mother contacted and informed Staff member accompanied to ED Second staff member took over at 20:15hrs. Mr “X” was attempting to pull out IV cannula.
Personal Information redacted by the USI 18:22 Personal Information redacted by the USI	SOE / AUDIO	NIAS	999 call COVID +ve, approx. day 8, unwell from 0400, sats are dropping, respiration rate 35-40, temp 38.7. Contacted own GP earlier in day with concerns, blue around lips Fourth amb contact. 18:28 S425 mobile to Mr “X” address 18:38 S425 arrive at call location PRF

5.0 DESCRIPTION OF INCIDENT/CASE

			available. 19:35 S425 leave call address and convey to CAH ED 19:53 S425 arrive at CAH.
Personal Information redacted by the USI	Night Duty Daily Report Notes	Senior Support Worker	03:30hrs Client admitted to CAH – Staff member returned to Granville 06:30hrs contact with mother – update given – she advised she and spoken to Doctor in ED at 01:00hrs and discussed a DNAR due to underlying health conditions.
Personal Information redacted by the USI	Day duty Daily Report Notes	Nurse	12:20hrs Mr "X" remains in CAH – Case Manager informed. Ward contacted – advised they would return following ward round. Case Manager contacted ward and then Granville – Client commenced IV antibiotics, fluids, not tolerating 02 therapy- SP02 saturations being maintained on room air.
Personal Information redacted by the USI	Day Duty Daily Report Notes	Nurse	10:00hrs phone call to Ward – advised temp 40 IV antibiotic/fluids continued SP02 on room air 90% persistent cough
Personal Information redacted by the USI	Day duty Daily Report Notes	Nurse	Phone call from Mr "X's" brother to inform that Mr "X" had passed away at 05:15hrs and that he was with him. **(06:29hrs according to medical notes)**

Timeline of Key Events as per CAH notes:

Date	Information Source for Entry/Event	Name / Role of Practitioner / Clinician involved	Event - incl contacts, assessment, referral dates

5.0 DESCRIPTION OF INCIDENT/CASE			
Personal Information redacted by the USI @ 07:14hrs	ED Notes	ED Staff	First ED attendance Personal Information redacted by the USI at 07:14hrs, with learning disability 'hospital passport' but unaccompanied by carer. Noted to be Covid positive since Personal Information redacted by the USI. Referred by GP with dry cough and raised temperature. Noted to have learning disability. Mr "X" was non-compliant with both mask/visor, also with investigations and CXR (chest X ray). He was noted to be removing the SpO2 (oxygen saturation) probe and BP cuff. However, the SpO2 of 96% and RR (respiratory rate) of 26 had been recorded by NIAS paramedics. ED doctor advises return home and to reattend if deterioration.
Personal Information redacted by the USI @ 19:24hrs	ED Notes	ED Staff	Second ED attendance Personal Information redacted by the USI at 19:24hrs, accompanied by carer. History of continuous cough and possible respiratory distress. Earlier attendance noted. On examination, mild increase in RR (but not using accessory muscles), cough evident, pyrexic, pulse less than 100, SpO2 97%, CXR showing mild bilateral changes in keeping with mild coronavirus. ED doctor explains to Mr "X's" brother per phone that Mr "X" can be managed in a care home.
Personal Information redacted by the USI @20:04hrs	ED notes	ED Staff	Third ED attendance Personal Information redacted by the USI at 20:04hrs, accompanied by carer. Worsening cough, SpO2 recorded at 94 by NIAS paramedics. On examination Mr "X" is noted to be restless, RR 19, pyrexic, pulse 112, SpO2 96, CXR showing bilateral infiltration in keeping with Covid infection, much worse than CXR on previous CXR attendance. ED Dr A discussed DNAR with Mr "X's" mother per phone. (He recorded a retrospective note of this conversation on the 30/04/20.) He explained Mr "X" was being treated with antibiotics in

5.0 DESCRIPTION OF INCIDENT/CASE			
			case of a secondary chest infection but that there was no medication to treat the Covid infection. In case of a further deterioration he explained that he would be unlikely to recover from admission to ICU (intensive care unit). He recalled that she agreed it was not in Mr "X's" best interests to go through this traumatic process and that she agreed with his DNAR (do not attempt resuscitation) assessment.
Personal Information redacted by the USI @ 03:15hrs	CAH Notes	Consultant	Mr "X" is admitted to medical ward 2 South on Personal Information redacted by the USI at 03:15, unaccompanied by carer. Uncooperative with nursing observations at times, non-compliant with assistance at times and sometimes 'hitting out' at staff. Seen on am ward round by Consultant B, Covid diagnosis, DNAR noted. Additional antibiotic prescribed.
Personal Information redacted by the USI @ 12:00hrs	CAH Notes	Respiratory physician	Personal Information redacted by the USI at 12:00hrs Respiratory physician Dr C discussed with Mr "X's" mother and brother per phone in response to a solicitor's letter dated 29/04/20 which expressed the view that his mother did not agree with the DNAR status. Dr C explained, because of his low oxygen level, there would be a trial of CPAP (continuous positive airway pressure) if he could tolerate it, but beyond that admission to ICU would not be in his best interests. Mr "X's" mother did not agree. Dr C referred the case to the ICU consultants for assessment. Mr "X's" DNAR is suspended at this point.
Personal Information redacted by the USI @ 14:00hrs	CAH Notes	ICU Consultant	Personal Information redacted by the USI at 14.00hrs. Assessment by ICU Consultant D, noted to have deteriorating oxygen levels since admission but not cooperating with oxygen therapy by facemask and other nursing interventions. The assessment concludes that Mr "X" would be unable

5.0 DESCRIPTION OF INCIDENT/CASE			
			to tolerate medical and nursing interventions in ICU and would therefore ultimately not survive an admission to ICU. A second opinion from another ICU consultant is requested and carried out on Personal Information redacted by the USI at 15:00hrs by Consultant E who agrees with the above and concludes that a positive outcome from admission to ICU is 'remote in the extreme', adding the comment that this is not simply because of the diagnosis of learning disability but because of the specific clinical presentation and the consequent problems of delivering care in ICU.
Personal Information redacted by the USI @ 16:00hrs	CAH Notes	Respiratory ward Consultant	Personal Information redacted by the USI at 16:00hrs Respiratory ward Consultant F explains ICU decision and the nature of the illness to Mr "X's" mother and brother and that he would be transferred to the respiratory ward 2 North for a trial of CPAP; notes that they are content to go along with the medical opinion at present. DNAR is reinstituted. CPAP trial is unsuccessful; Mr "X" is extremely agitated and pulling off mask despite sedation with Midazolam followed by Diamorphine. Mother contacted by phone to advise he is in respiratory failure and may not survive through the night.
Personal Information redacted by the USI @ 23:45hrs	CAH Notes		Personal Information redacted by the USI at 23:45 Mr "X's" brother is allowed visit in full PPE. Brother enquires about treatment with hydroxychloroquine but is advised that this is only a trial drug and is not indicated.
Personal Information redacted by the USI @06:40hrs			Personal Information redacted by the USI at 06:40hrs. Verification of life extinct, time of death confirmed as 06:29hrs. ***NB Granville timeline records 05:30 - as per message from Mr "X's" brother.***

6.0 FINDINGS

1. The care delivered by Granville Manor staff was timely and appropriate in responding to Mr “X’s” symptomatology and Covid diagnosis. Their frequent and detailed communication with his family was an example of good practice. Their note taking was detailed and displayed a high degree of attentiveness to his needs as his condition deteriorated.

2. Granville Manor staff managed a number of interactions with the OOH GP, NIAS and CAH ED extremely well whilst at all times advocating for Mr ”X” to the best of their ability in a complex and rapidly evolving situation. His illness followed what is now a well-recognised pattern, however at that point it was an emerging illness which presented a difficult challenge to their staff, OOH GP, NIAS paramedics and CAH medical and nursing staff, not to mention health and social care services worldwide. They followed the advice of the CAH ED, OOH GP and NIAS paramedics diligently.

   Their decision not to accompany Mr “X” on his first visit to CAH ED, as would have been normal practice, was because of concerns raised by the NIAS paramedics that staff may not be admitted because of Covid restrictions. Whilst this was understandable, it was subsequently clarified that he could be accompanied into ED and was so on his second visit and third visit, but not into the inpatient ward.

   The review team recommends that a multidisciplinary risk assessment (as has been developed by CAH ED for patients with mental health issues) be devised to assess risk, in particular whether or not learning disability staff should accompany patients from ED/admission through to inpatient stay.

   It is possible that learning disability staff assisting throughout the inpatient journey may have made a positive impact in helping to reduce Mr “X’s” distress and possibly allowing him to better engage with medical and nursing interventions. On interviewing the medical staff involved, it was thought this would have been unlikely when Mr “X’s” respiratory distress was overcoming him but may have been of assistance during the initial part of his admission.

6.0 FINDINGS

3. The medical and paramedical assessments by GP and GPOOH, NIAS paramedics, ED nurses and medics, respiratory ward medics and ICU medics were for the most part comprehensive and appropriate. The exception being Mr "X's" first attendance at CAH ED which, being unaccompanied by care home staff, made it difficult for ED staff to engage with him whereas in the subsequent two ED attendances the presence of a care home staff member proved to be beneficial. This proved to be particularly important in obtaining chest x-rays (CXR's) on both his second and third visits, being able to compare these was a key factor in the decision to admit to the inpatient ward.

   There appeared to be differing views as to whether or not he should have been brought to CAH ED on the second occasion, GP OOH having advised Granville staff to call 999 if there was deterioration, as had been the advice when sent home from ED on the first occasion. Granville staff adjudged that there was deterioration throughout the day of the Personal Information redacted by the USI between the first and second ED attendance. They commented that NIAS were reluctant to return him to ED and noted that they had had to be assertive and insist. However, after further consultation NIAS did agree. Later that evening feedback from ED nursing staff commented, according to Granville staff's notes, that the visit to ED had been unnecessary.

   These varying views are understandable in the context of Covid being an emerging illness whereby the pattern of deterioration was still being understood and was difficult to predict. Although it proved to be the case that there was no significant deterioration between the first and second ED attendances, the second attendance accompanied by care home staff proved productive in terms of establishing a very useful baseline assessment (including a CXR as mentioned above). This is testament to the care provided by Granville staff that they acted as effective advocates for their resident throughout this difficult time.

4. The treatment and advice provided to Mr "X" and his family by medical and nursing staff at all stages was carefully considered and appropriate to his needs. The thorough assessments by respiratory and ICU physicians concerning the DNAR issue and admission to ICU was an example of good practice, as was

6.0 FINDINGS

their recording of this in the inpatient notes and ongoing communication with his family. However, the initial discussion per phone by ED Dr A on the [redacted] regarding Mr "X's" DNAR status was unsatisfactory from his mother's point of view. Although Dr A concluded that she was in agreement with the assessment, she subsequently felt it necessary to send a solicitor's letter to the respiratory physician Dr C to state that she did not agree and to ask that the DNAR be rescinded.

One phone call to discuss the DNAR issue with a distressed nearest relative proved inadequate in this case. After further detailed discussions with respiratory and ICU medical staff, which also included Mr "X's" brother, she did gain a better understanding of the rationale behind this difficult decision. It is clear from the detailed medical notes that the decision was based on Mr "X's" overall clinical presentation rather than simply based on his frailty as a result of his learning disability, and that in their considered opinion resuscitation and ICU admission would not be in Mr "X's" best interests.

The review team recommends that that the care home or community key worker should be engaged to mediate in advanced care planning including DNAR decision in patients with learning disability.

5. Taking into account all of the above, it would be incorrect to conclude that Mr "X's" learning disability diagnosis per se was such an influence on his treatment that it rendered that treatment inequitable.

7.0 CONCLUSIONS

The overall care provided to Mr "X" was of an appropriate standard and at times was exemplary given the understandable difficulties experienced by all health and care staff in responding to the emerging pandemic. The adverse outcome resulting in his untimely death was unavoidable, the singular causative factor being infection with the Covid virus bringing about respiratory failure. Further engagement will take place with Mr "X's" family in relation to sharing and discussing this report.

8.0 LESSONS LEARNED

1. Granville care home staff training in infection prevention and control (IPC) has been augmented with the assistance of SHSCT IPC staff after an IPC 'walk through' and has since been updated on a regular basis.

2. Granville care home staff are now trained and capable of following SHSCT procedures for donning and doffing of PPE attire in order to accompany learning disability patients into inpatient units during the pandemic.

3. Engagement of care home or community key worker staff in mediation regarding advanced care planning including DNAR decision in patients with learning disability.

4. There is learning from ~~NIAS~~ / CAH ED interaction re Mr "X" being brought to the incorrect address from ED on Personal Information redacted by the USI resulting in approx. 2 hours unnecessary delay for Mr "X" in the ambulance.

5. Out of hours service to contact 999 directly when advising ambulance attendance rather than requesting care home staff to ring 999, as OOHrs will have access to clinical information that will enable appropriate triage of 999 call.

9.0 RECOMMENDATIONS AND ACTION PLANNING

Recommendation	Person(s) Responsible	Timescales / Progress
9.1 The multidisciplinary risk assessment (as has been developed by CAH ED for patients with mental health issues) should be revised to consider if staff should accompany a patient from ED/admission to inpatient stay and any other risks?	Acute Directorate to nominate.	Acute Directorate to specify
9.2 Care home or community key workers should be engaged to mediate in	Assistant Director of Disability Services to	Assistant Director of Disability Services to

9.0 RECOMMENDATIONS AND ACTION PLANNING		
advanced care planning including DNAR decisions in patients with a learning disability.	nominate	specify
9.3 OOHrs service should contact 999 directly when advising ambulance attendance rather than requesting care home staff to ring 999, as OOHrs will have access to clinical information that will enable appropriate triage of 999 call.	HoS for Out of Hours Service	TBA

10.0 DISTRIBUTION LIST

In addition to the review team, the following:

Barney McNeany, Director of Mental Health and Disability Services

John McEntee, Assistant Director of Disability Services

Dr Pat McMahon, Associate Medical Director

Dr Arun Subramanian, Clinical Director Learning Disability

Geraldine Rushe, Head of Service Supported Living

Aaron Coulter, Community Mental Health Pharmacist

Corporate Governance Department

RQIA

HSCB

NI Coroner

Family of Mr “X”

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:	Personal Information redacted by the USI	**HSCB Ref Number:**	Personal Information redacted by the USI

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**	x	**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**	x	**NO**		
	If **YES**, insert **date informed**: 17/07/2020				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	x
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			x
	c) Report not shared but contents discussed (***if you select this option please also complete 'l' below***)			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SECTION 2							
INFORMING THE CORONERS OFFICE **(under section 7 of the Coroners Act (Northern Ireland) 1959)** ***(complete this section for all death related SAIs)***							
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**				**NO**		
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**				**NO**		**x**
	If **YES**, insert **date report shared**: Final Report to be shared post family engagement						
	If **NO**, please provide details:						
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						

DATE CHECKLIST COMPLETED	**17/02/21**

[1] *Service User or their nominated representative*

LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1

1. ORGANISATION: SHSCT	**2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:** Personal Information redacted by the USI
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE: Personal Information redacted by the USI	**4. DATE OF INCIDENT/ EVENT:** Personal Information redacted by the USI
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: No	**6. IF 'YES' TO 5. PLEASE PROVIDE DETAILS:**

7. DATE OF SEA MEETING / INCIDENT DEBRIEF: 03/12/2020, 04/03/2021 & 25/03/2021

8. SUMMARY OF EVENT:

On Personal Information redacted by the USI, Personal Information redacted by the USI was admitted to the Male Medical Ward (MMW) at Daisy Hill Hospital (DHH) following a collapse outside in the street. He was being treated for aspiration pneumonia, alcohol withdrawal and rib fractures when his condition deteriorated. He subsequently had increasing oxygen requirements and was transferred to High Dependency Unit (HDU) on Personal Information redacted by the USI for AIRVO management (a humidifier with integrated flow generator that delivers warmed and humidified respiratory gases to spontaneously breathing patients). On Personal Information redacted by the USI Personal Information redacted by the USI's condition deteriorated further there was difficulty obtaining medical assistance. Personal Information redacted by the USI subsequently required intubation and ventilation and post this was transferred to the Intensive Care Unit (ICU) at the Royal Victoria Hospital (RVH) for management. He was extubated on Personal Information redacted by the USI and returned to DHH on Personal Information redacted by the USI.

SECTION 2

9. SEA LEAD OFFICER: Dr A Green, Consultant Respiratory Physician	**10. TEAM MEMBERS PRESENT:** Mrs K Carroll, Head of Medicine Mr D Cardwell, Clinical Governance Manager

11. SERVICE USER DETAILS:

Personal Information redacted by the USI, Male aged Personal Information redacted by the USI

12. WHAT HAPPENED?

Personal Information redacted by the USI was brought in by ambulance to the Emergency Department (ED) of Craigavon Area Hospital on Personal Information redacted by the USI. The triage nurse who saw Personal Information redacted by the USI at 09:13 noted that he appeared to be behaving strangely and that he had an altered conscious level. She documented that he was found close to his home (outside) was conscious and confused. The triage nurse noted that Personal Information redacted by the USI had an unkempt appearance. His pulse (P) was 83, blood pressure (BP) 128/69, respiratory rate (RR) 17, temperature (T) 37, oxygen saturations (SpO2) 96% and Glasgow Coma Scale (GCS) 13. The triage nurse

completed a safeguarding (APP1) form and triaged [redacted] as a priority 2 patient (to be seen within 10 minutes).

At 10:11 [redacted] was seen by Doctor 1 (ED Senior House Officer) who noted that [redacted] was a [redacted] old male who was confused and elusive with answers. He documented that [redacted] drank copious amounts of vodka and that his last drink was the day previous. [redacted] stated that he had taken no other drugs and that the left side of his chest was sore to touch. Doctor 1 noted [redacted] background and social history. [redacted] was not short of breath and did not have a cough. On examination his chest was tender around the 3rd left rib. His heart sounds were normal and his pulse was regular. His abdomen was soft and non-tender. He was moving all 4 limbs, his GCS was 14, he had no obvious head or neck injury. His left eye was blood shot and the impression was that he had a query bleed and query alcohol related. The plan was to await blood results, have an ECG, a CT brain and GMAS +/- Librium.

At 13:21 [redacted] was discussed with Consultant 1 (Emergency Department Consultant) who advised that [redacted] was a vulnerable adult and needed admission for social assessment. [redacted] was accepted by MMW and he left ED at 15:43 for transfer to DHH.

On [redacted] was transferred to HDU and since then he was seen twice on a daily basis by the medical team. [redacted] was seen assessed and treated as required by a physiotherapist as he was experiencing chest secretions. He proceeded to have a CTPA which ruled out a pulmonary embolism. By [redacted] was noted to be feeling much better, sitting out and had come off AIRVO. He was reviewed by the anaesthetic team who were happy that [redacted] appeared well and his condition was controlled.

On [redacted] it was noted that some of [redacted]'s arterial blood gasses (ABG's) were abnormal and he had become breathless. It was noted that a chest x-ray from the previous day reported worsening shadowing. The plan was for an anaesthetic review as [redacted] was tired and had increased work of breathing. This review was carried out at 11:30 at which stage [redacted] was on AIRVO at 60%, 60L. His Sp02 was 100%, RR 23, BP 132/64 and P 78. He was noted as sitting in the chair and appeared frail, and whilst confused was able to understand. He was noted to be comfortable from a pain point of view and able to take deep breaths. The plan was to continue medical management as [redacted] appeared to be responding well and in the right direction. [redacted] had a further anaesthetic review at 16:45 and 20:20 as there was a reduction in his GCS. On review [redacted] appeared stable vitally, his ABG's reviewed and the plan was to continue medical management. The anaesthetic team were happy to review [redacted] again if needed. They noted that [redacted] was responding well to antibiotics and that he was comfortable from a pain point of view. They also noted they would consider CPAP/intubation if the situation dictated so.

On [redacted] [redacted] became very unsettled from 00:00 until 01:00 and was climbing, was disorientated and asked for the toilet. He was re-orientated and settled back to sleep at 1am. He woke again at 04:30 when he was confused and was climbing again. Lorazepam 1mg was given intra-muscular (IM) with little effect. He settled again from 06:00 for 30 minutes and then wanted out of bed. He was given the assistance of one person at 07:00 and helped out to the chair. His bloods were obtained and sent. IV Tazocin and IV Pabrinex was administered and nebulisers given. His arterial line was intact and recalibrated. Input was recorded as 1960mls and output 1490mls.

[redacted] was seen by Doctor 2 (Staff Grade Medicine) at 08:40. She noted that [redacted] was day 5 admission following a fall and alcohol excess. It was noted that [redacted] had aspiration pneumonia, was on Librium and had a rib fracture. Doctor 2 noted that [redacted] was chesty ++, though had minimal pain and a strong cough. It was noted that [redacted] pulled off the AIRVO for 2 minutes that morning and his saturations were 94% on room air but still needed AIRVO for work of breathing. Doctor 2 noted that

there were bilateral crackles heard on Personal Information redacted by the USI's chest and reviewed his blood results. She highlighted that whilst Personal Information redacted by the USI was haemodynamically stable, he was vulnerable to deterioration and at risk of aspiration so asked for him to fast until there was a review by the Speech and Language Therapist (SLT). Doctor 2 noted that Personal Information redacted by the USI's chest x-ray looked slightly full and that there was a reduced threshold for diuretic. Doctor 2's plan included sitting Personal Information redacted by the USI out as much as possible, reduce FO2 and continue with the increased flow, chase sputum, hold intravenous fluids, review the remainder of the lab results, give 7 days of Tazocin, PRN lorazepam & document GMAWS (Glasgow Modified Alcohol Withdrawal Score.)

During the course of the morning Personal Information redacted by the USI was cared for by nurse 1 who assisted to get Personal Information redacted by the USI out to sit and encouraged deep breathing. She sent a sputum sample for testing and reduced AIRVO from 60% to 50% as per Doctor 2. Personal Information redacted by the USI's oxygen saturations were 97-100% on same. His ABG's were reviewed and to be repeated at 12:00. GMAWS at 12:00 were 3. Staff nurse 1 noted at 12:45 that Personal Information redacted by the USI was reviewed by the medical team who were happy with his ABG's. His AIRVO was to be reduced slowly with a view to stopping same. ABG's and daily bloods were to continue. At 15:00 staff nurse 1 contacted Doctor 3 (FY1) in relation to the decrease in Personal Information redacted by the USI's urine output.

Doctor 3 reviewed Personal Information redacted by the USI at 15:45 who reviewed Personal Information redacted by the USI's fluid output. His NEWS (National Early Warning Score - an early warning score is a guide used by medical services to quickly determine the degree of illness of a patient) were 4. His RR was 24, SpO2 95% on 40% 60L AIRVO, T 36.3, BP 142/70, P 89 and Egfr >60. Doctor 3 noted that Personal Information redacted by the USI was waiting on a SLT review and that he was unable to get any oral intake. His case was discussed with Doctor 2 and the plan was for 40mg IV furosemide stat, continue hourly urometer reading, repeat arterial blood gas in 1 hour and monitor K+. At 17:00 staff nurse 1 shared the results of the arterial blood gases with Doctor 3 who asked for them to be repeated again at 19:45. Staff nurse 1 noted that Personal Information redacted by the USI remained very agitated, confused and was attempting to climb out of bed.

He was seen by Physiotherapist 1 at 17:30 who noted that Personal Information redacted by the USI was agitated and he had increased work of breathing with a respiratory rate of 30. A droop in Personal Information redacted by the USI's mouth was noted though his CT brain did not detect any abnormality. AIRVO was increased to 90% oxygen on 60L Spo2 97-100%. His RR remained at 30-37. It was noted that Personal Information redacted by the USI had poor compliance with chest physio and that yanker suction was of no benefit. There was an increase in Personal Information redacted by the USI's agitation with increased attempts of chest physio and no sputum expectorated. Physiotherapist 1 noted that Personal Information redacted by the USI was at risk of fatigue due to increased work of breathing and that CPAP was unlikely to be beneficial due to compliance with mask.

Later that evening (time not documented) Doctor 4 (Registrar) was asked to see Personal Information redacted by the USI due to reduced oxygen on ABG results. Doctor 4's impression was that Personal Information redacted by the USI had aspiration but there was no suggestion that it was worsening, he had pulmonary oedema, good diuresis and mucous plugging. The plan was for repeat ABG's with hourly observations, physiotherapy, cover with Tazocin, blood cultures if temperature >38, ECG, not fit for CPAP, discuss with ICU if failure to improve, further sputum sample, test urine for legionella and pneumococcus and also short viral screen. There was then another review by Doctor 4 – again time not documented. Noted there had been a good diuresis, oxygen levels were satisfactory. Plan was to continue with the same, reduce oxygen as able, await sputum and contact medics if there were concerns regarding Personal Information redacted by the USI's condition.

At 20:00 Personal Information redacted by the USI was seen again by Physiotherapist 1 who attempted further chest physiotherapy. She noted that Personal Information redacted by the USI's cough was ineffective and he was unable to clear secretions. There was minimal sputum cleared, he became agitated and pulled off AIRVO. The plan was to review Personal Information redacted by the USI the following morning and continue AIRVO as able.

At 21:30 staff nurse 2 introduced herself to Personal Information redacted by the USI following handover. She documented Personal Information redacted by the USI's

observations as RR 23, SpO2 98% on AIRVO 60L, T 36.3, BP 130/69, P 106. His NEWS was 5 and he was on 1 hourly observations. Staff nurse 2 noted that Personal Information redacted by the USI was very unsettled in bed, climbing out and taking AIRVO off. His GMAWS was 3, GCS 14/15 and it was noted that latest ABG's which were PH 7.44, PO2 7.64, PCO2 5.77. This indicated that is oxygen levels were slightly low at this point - other levels were satisfactory. He was given 1mg of lorazepam @ 20:35 with great effect. She noted that Personal Information redacted by the USI had an arterial line to his right hand. Personal Information redacted by the USI had slight bruising and discolouration to both hands and was awaiting SLT review.

Subsequent to this Personal Information redacted by the USI's NEWS increased to 6 and this was escalated to Doctor 5 (Registrar) who advised that he would not review Personal Information redacted by the USI as the physiotherapist could deal with the AIRVO and that Personal Information redacted by the USI would have high NEWS scores. Staff nurse 2 contacted the physiotherapist for assistance. At 21:50 Personal Information redacted by the USI was given intravenous antibiotics and paracetamol and Pabrinex given as per kardex. The ABG was repeated and reported as PH 7.4112, PCO2 5.91, PO2 11.4 K+ 3.6; Na+ 142; Glu 4.4. These indicated that his oxygen level was improved from the previous reading – all other levels were still satisfactory. Nebulisers were given as per kardex as well as constant reassurance. Staff nurse 2 documented that Personal Information redacted by the USI needed 24/7 supervision.

At 23:59 Personal Information redacted by the USI was seen by Doctor 5 who noted that Personal Information redacted by the USI was agitated, there was no other clinical change and therefore lorazepam PRN should be given. No NEWS score documented in medical notes.

At 00:00 on 24 July 2020, staff nurse 2 noted that Personal Information redacted by the USI was very confused, unsettled trying to get out of bed and pulled his arterial line out. Doctor 5 was bleeped, the situation explained and he was asked to review the patient. Doctor 5 refused to carry out a face to face review. Personal Information redacted by the USI pulled off his AIRVO and was violent towards staff and pulled off the wires attached to the monitor. Staff nurse 2 tried to reassure Personal Information redacted by the USI without success. Staff nurse 2 bleeped the Bed Manager to ask for medical assistance. Staff nurse 2 managed to get Personal Information redacted by the USI back on AIRVO 60L 70% and he settled slightly.

At 00:45 Personal Information redacted by the USI became very aggressive again and took off AIRVO, saturations probe, ECG wires and used foul language towards staff nurse 2.

At 02:00 Personal Information redacted by the USI was seen by Doctor 6 (FY1) and following discussion with Doctor 5 prescribed furosemide 50mg given intravenously, metoclopramide and diamorphine PRN. Personal Information redacted by the USI was very agitated and restless.

At 03:30 Personal Information redacted by the USI pulled his hospital gown off and monitor leads. Staff nurse 2 noted he was in and out of sleep and managed to put the saturations probe back on his toe and hospital gown. At 05:00 his saturations had decreased to 86%. He was given saline and his saturations increased slowly up to 93%. At 05:30 Personal Information redacted by the USI's saturations were 98% and he was asleep. He was given IV paracetamol, Tazocin and Prabinex given as per kardex.

At 06:30 Personal Information redacted by the USI's saturations dropped to 83% and nebulisers were given. The on call physiotherapist was bleeped as was Doctor 5. At 07:00 staff nurse 2 had no response from Doctor 5 so bleeped him again. Doctor 5 advised that he would not be reviewing Personal Information redacted by the USI. Subsequent to that Doctor 5 was contacted a third time and he came to ward, spoke to the nurse but did not review Personal Information redacted by the USI. At 08:00 staff nurse 3 (nurse in charge) documented that she had reviewed Personal Information redacted by the USI along with Doctor 5. Personal Information redacted by the USI appeared more settled, his breathing had improved slightly and it was noted that his saturations were up and down, overall similar to the start of the night. NEWS not documented in medical notes. The plan was for further physiotherapy, oxygen as required and a further chest x-ray. They felt further ABG would not change management.

The physiotherapy review took place at 07.20 (entry was written at 08.30) when it was noted that

Personal Information redacted by the USI had ongoing confusion, was unsettled in bed and kept trying to take the AIRVO off during the night. The physiotherapist noted pain described as central chest pain. Personal Information redacted by the USI's BP was 136/90, P 94 and RR 30. His SpO2 was 97% on AIRVO 60L/86% oxygen. Treatment was attempted but there was poor compliance and Personal Information redacted by the USI struggled with same and became fatigued quickly. The physiotherapist suggested a repeat x-ray to determine the cause of deterioration.

Personal Information redacted by the USI was seen by Doctor 2 at 09:15 regarding his deterioration and noted that she was worried about Personal Information redacted by the USI who had ongoing respiratory failure, a clear clinical deterioration and fluid overload. Her plan included an urgent chest x-ray, anaesthetic referral, start diuretic, see labs, micro ? meropenum, repeat gas in 1 hour and update next of kin. At 10:15 Doctor 2 attended with Doctor 7 (grade) when Personal Information redacted by the USI's breathing was laboured and his left chest wall was depressed. The plan was to have a discussion with theatres and if there was any deterioration the medical team were to be re-contacted. At 11:50 Personal Information redacted by the USI's brother was spoken to by Doctor 2. Personal Information redacted by the USI was then seen on the ward round by Doctor 8 (Consultant Physician) when advice was sought from the surgical team, cardiothoracic team and the anaesthetic team. At 12:00 Personal Information redacted by the USI was seen again by Doctor 2 as his condition had deteriorated. Doctor 7 attended also and advised that Personal Information redacted by the USI needed to be intubated and ventilated. He was transferred at 12:00 to theatres where he remained until his transfer to ICU at RVH at 18:40.

13. WHY DID IT HAPPEN?

Patient Factors

The review team noted on admission Personal Information redacted by the USI looked frail and unkempt but had no previous medical admissions and no significant medical history. Personal Information redacted by the USI was noted to be a heavy smoker, take alcohol in excess and had suffered from a fall sustaining multiple left sided rib fractures. The review team have highlighted that Personal Information redacted by the USI was agitated and as a result was difficult to manage, however this would not be uncommon for patients who are detoxifying from alcohol especially with other medical issues.

Clinical Assessment

The review team have examined the medical notes associated with Personal Information redacted by the USI's admission. They are satisfied that he was on an appropriate antibiotic and that his pain was being managed. They are cognisant of the fact Personal Information redacted by the USI was being detoxified from alcohol, this can be a difficult balance to achieve with over sedation and under sedation being issues both having potential effects on the patient. This may have had some impact on Personal Information redacted by the USI clinical course but management of this was appropriate. The day team had noted a clear plan which was documented by the Anaesthetic Team which detailed the steps to be taken if Personal Information redacted by the USI deteriorated.

The review team have identified that Personal Information redacted by the USI deteriorated on the morning Personal Information redacted by the USI between 05:00 and 06:30 with his NEWS score climbing from a baseline of 5-6 overnight to a score of 8 secondary to an increase in respiratory rate (an important factor) and a drop in SpO2 this subsequently moved to 9. The review team believe a thorough medical review should have taken place then and earlier than when it did. They have clarified that the pre-determined escalation plan should have been referred to and Personal Information redacted by the USI's condition should have been escalated to the Anaesthetic Team. Whilst this may not have changed the outcome for Personal Information redacted by the USI it would have changed his immediate management. The review team have noted that a thorough (excellent) review took place at 09:15. There was a recognition that his condition had changed significantly from the previous day and an appropriate plan was initiated including an anaesthetics review. There was further deterioration over the course of the morning prompting intubation and transfer to ICU.

Supervision and Leadership

The review team have noted that after doctor 5 reviewed Personal Information redacted by the USI at 07:00 on Personal Information redacted by the USI, there was no reference to a discussion with the consultant on call. The review team felt that the consultant on call could have been contacted at this time for advice.

Workload

HDU is an 8-bedded ward and on the night in question there were 5 patients being nursed there. The review team understand that there were 4 registered nurses on night shift which would have been the normative staffing for this clinical area. Although 1 to 1 nursing was required for Personal Information redacted by the USI this would have been possible with these ratios.

Team Factors

The review team note that staff nurse 2 escalated Personal Information redacted by the USI's NEWS of 6 at 21:30 on Personal Information redacted by the USI however Personal Information redacted by the USI did not receive a face to face review until 23:59 that evening. The review team feel that had a medical review taken place at this time it would not have changed Personal Information redacted by the USI's management. They have noted that at this time Personal Information redacted by the USI's issue was agitation rather than concerns with his chest and breathing. Nonetheless the review team accept that this left staff nurse 2 feeling isolated and have identified that staff nurse 2 could have escalated her concerns to the site manager. The notes reference a call for assistance from the Bed Manager and the advice given was that staff nurse 2 should try liaising again directly with medical staff. The review team advise it would have been helpful for staff nurse 2 to have had additional support from senior nursing staff to impartially resolve her concerns about Personal Information redacted by the USI.

Whilst none of the review team were present on the night in question and they are relying on the documentation to formulate an opinion, they feel that the teams could have worked more effectively together to care for Personal Information redacted by the USI on the evening of Personal Information redacted by the USI and into the morning of Personal Information redacted by the USI. The review team believe that effective multi-disciplinary working leads to improved patient care.

Communication and Documentation

The review team have examined the Hospital at Night handover sheet for the night in question, Personal Information redacted by the USI was not on this handover document, this would have been an appropriate forum to do a formal handover.

The NEWS score is a key tool to assess sick patients. The review team note the trend of Personal Information redacted by the USI's NEWS overnight on the night in question gradually increased highlighting his gradual deterioration. This should be used as one method to communicate the issues. A trigger could also have been set by the medical team so the nursing team would know at what point to re-contact them and the urgency this would need to be done.

The review team are mindful of the fact that good communication is integral to good patient care and that all teams should work collaboratively, respecting each other's skills and contributions. The review team have commented that staff should be aware of how their behaviour may influence others and that everyone should be treated fairly and with respect. Listening to concerns of other staff members is part of this process.

In relation to documentation, whilst the review team have been able to identify good examples of clear and detailed medical entries both before and after Personal Information redacted by the USI's deterioration, some lacked detail e.g., time of assessment. The assessment on the morning of the deterioration was not as comprehensive as it could have been and missed so details such as NEWS scores.

SECTION 3 - LEARNING SUMMARY

14. WHAT HAS BEEN LEARNED:

Good communication, which is clear and effective between teams is vital to ensure that the multi-disciplinary team works collaboratively to maintain or improve patient care.

Personal Information redacted by the Urol...'s case has highlighted that the accurate recording of NEWS is absolutely crucial in assisting with the identification of a deteriorating patient. The use of a trigger score should be used as another method of communicating changes in a patient's condition. Each member of staff needs to be fully informed about and aware of pre-discussed plans for the event of deterioration and put these into place as required. The medical/hospital at night handover meeting is a crucial part of this and needs to be facilitated by the most senior members of the team to ensure safe management of patients.

The review team have emphasised that if nursing staff are not satisfied with how a patient is being managed medically out of hours that they should escalate their concerns to the registrar and/or the site manager if necessary.

15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

All nursing staff will be reminded of the requirement to follow the recognised escalation process should they have ongoing clinical concerns about the medical management of a patient.

In addition the Trust will continue to review findings of NEWS audits which are carried out as part of the Nursing Quality Indicators and act on any recommendations noted.

16. RECOMMENDATIONS (please state by whom and timescale)

All nursing staff should be adequately trained in the use of the NEWS tool and be aware that they can agree trigger points with medical teams. This issue will be placed on the agenda of the Senior Nursing and Midwifery Governance Forum within 3 months of the publication of this report.

All nursing staff will be reminded of the requirement to follow the recognised escalation process should they have ongoing clinical concerns about the medical management of a patient. This should be carried out within 3 months by the Executive Directorate of Nursing.

The Trust should ensure it has arrangements in place for the safe and effective handover of patients, during the out of hours period, so therefore a complete review of the hospital at night process should be undertaken to include details of how patients are added to the report, how outcomes are listed and how discussions are noted and kept for future reference. This should be led by the Assistant Director of Acute Services with responsibility for Patient Flow within 6 months of the publication of this report.

17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

None.

18. FURTHER REVIEW REQUIRED? No.
Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A <u>FURTHER REVIEW IS</u> REQUIRED)	
19. PLEASE INDICATE LEVEL OF REVIEW: LEVEL 2 / LEVEL 3 **Please select as appropriate**	**20.** PROPOSED TIMESCALE FOR COMPLETION: DD / MM / YYYY
21. REVIEW TEAM MEMBERSHIP *(If known or submit asap)*:	
22. TERMS OF REFERENCE *(If known or submit asap)*:	

SECTION 5	
APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR	
23. NAME:	**24.** DATE APPROVED:
25. DESIGANTION:	

SECTION 6
26. DISTRIBUTION LIST:

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1					
INFORMING THE SERVICE USER[1] / FAMILY / CARER					
1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert **date informed**:				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER ***(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)***				
5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	b) Plan to share final review report at a later date and further engagement planned	
	c) Report not shared but contents discussed (***if you select this option please also complete 'l' below***)	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**)				
Content with rationale?	**YES**		**NO**	

SECTION 2								
INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) ***(complete this section for all death related SAIs)***								
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**					
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**					
	If **YES**, insert **date report shared**:							
	If **NO**, please provide details:							
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**	
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1

1. ORGANISATION: SHSCT	**2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:** Personal Information redacted by the USI
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE	**4. DATE OF INCIDENT/ EVENT:** Personal Information redacted by the USI
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: No	**6. IF 'YES' TO 5. PLEASE PROVIDE DETAILS:**
7. DATE OF SEA MEETING / INCIDENT DEBRIEF:	**30/09/2020**

8. SUMMARY OF EVENT:

On the Personal Information redacted by the USI a stroke lysis call was made to Craigavon Area Hospital Emergency Department. NIAS received call at 13:25, and an ambulance was dispatched, it was noted the patient was FAST positive. A standby call was made to CAHED and patient arrived at CAH ED at 15:19. A CT brain was carried out at 16:15, followed by a CTA. The patient was accepted by RVH for thrombectomy. ED nurse contacted NIAS and requested a 999 blue light ambulance for transfer to the RVH for potential thrombectomy, however the ambulance did not arrive at CAHED for almost two hours later. The RVH were unable to offer thrombectomy treatment as the service was unavailable at that time of the patient's arrival at 19:50.

SECTION 2

9. SEA LEAD OFFICER: Dr David Patton	**10. TEAM MEMBERS PRESENT:** Dr Patricia McCaffrey, Consultant Physician Dr Kerry Maxwell, Speciality Registrar Dr Aaron Milligan, Consultant Radiologist Mrs Sharon Holmes, Lead Nurse ED Sr Elaine Campbell, ED Mr Sean Mullan, NIAS Mrs Patricia Kingsnorth, Clinical Governance Co-Ordinator Mrs Carly Connolly- Clinical Governance Manager

11. SERVICE USER DETAILS:

DOB : [redacted] FEMALE AGE : [redacted]

12. WHAT HAPPENED?

On the [redacted] at 13:23 NIAS received a call. An ambulance was dispatched and arrived at the scene at 13:37 leaving the scene at 14:20. [redacted] was FAST positive and a standby call was made to Craigavon Area Hospital Emergency Department CAH ED.

[redacted] arrived at CAH ED at 15:19, registered at 15:32. It was reported [redacted] had a new acute neurological deficit less than 24 hours ago. It had been reported [redacted] was at work that morning and became unwell, she started to act strange, her speech became slurred and she vomited. Observations were taken on arrival and were noted as Pulse 103bpm, Blood pressure (BP) 128/94mmHg; Temperature 36.6 ºC ; Spo2 95%, GCS 11/15. The Stroke Lysis team was immediately called and reviewed [redacted] at 15:40.

On review [redacted]'s past history was documented, it was noted [redacted] was a previous smoker and it was reported [redacted] had been well the last few days and drove into work herself that morning at 05:00. An account taken from a work colleague advised [redacted] became suddenly unwell at approximately 10:00. [redacted] was unable to control her arms, [redacted] was unable to speak and appeared confused. A work colleague drove her home.

On assessment [redacted] had a NIHSS score of 11. A CT brain scan was ordered at 15:43 the request was lifted off the system at 16:03, the examination was performed at 16:40 and reported at 16:54. A verbal report was available which concluded a left MCA territory > 5cm diameter subacute infarction.

[redacted] was discussed with the Senior Stroke Physician and it was determined [redacted] arrived outside the thrombolysis window and she was for a potential thrombectomy. A working diagnosis was made of a left total anterior circulation stroke (TACS) and it was documented [redacted] had fast arterial fibrillation (FAF). A management plan was made for an echocardiogram, to review bloods, prescribe intravenous fluids 500ml bolus, Bisoprolol 2.5mg and Metoprolol 5mg to be prescribed due to an increased heart rate of 160bpm.

At 16:34 [redacted] was discussed with the Royal Victoria Hospital (RVH) regarding possibility of a thrombectomy.

Following discussion with RVH, [redacted] was accepted for transfer for potential clot retrieval. At 17:15 NIAS were contacted to provide a 999 ambulance transfer to the RVH. [redacted] did not leave CAH ED until 19:00. The delay in transfer resulted in thrombectomy not being offered. [redacted] arrived at the RVH at 19:50 and subsequently arrived at the Stroke Unit at 20:05.

[redacted] was admitted to the RVH overnight for monitoring as there was a query of malignant MCA syndrome however her GCS remained stable. NIHSS score at RVH was 14, and NIHSS score post 24 hour period was 18. [redacted] was commenced on Aspirin and Clexane.

On the [redacted] [redacted] was transferred back to CAH stroke unit the following day for ongoing management and care. On the [redacted] [redacted] was transferred to DHH for rehabilitation. Prior to discharge home on [redacted] it was reported [redacted] had some subjective reduction in power on her right side and her balance and gait still required some development and that she was able to perform basic ADLs. It was documented [redacted] however had significant expressive aphasia and would be very vulnerable and requires supervision at all times while at home.

13. WHY DID IT HAPPEN?

The above incident was discussed in depth to identify any immediate learning. Following debrief with staff involved it was determined there were numerous factors for the delay in treatment and learning extracted.

NIAS explained that a rapid response vehicle was dispatched to Personal Information's home and arrived promptly, followed by back up crew. NIAS have confirmed Personal Information was unable to speak English and her son assisted with interpretation. NIAS highlighted the language barrier subsequently slowed the initial assessment and acquired history and thus explains the reason for the lengthy period of time spent at Personal Information's home prior to departure. NIAS confirmed the rapid response paramedic arrived 15 minutes after being dispatched. The paramedic requested urgent assistance 8 minutes later and the ambulance vehicle arrived 7 minutes later. The RRV paramedic travelled with the patient. The total on scene time assessment, waiting time for conveyance ambulance and package was 43 minutes from RRV paramedic arrived at the scene in Personal Information redacted by the USI.

At the time of the call DHH ED was closed due to the current Covid 19 pandemic. NIAS advised their protocol is to go to the nearest ED, in this case CAH ED which took 1 hour 11 minutes. NIAS emphasised prior to Covid Personal Information would have been taken directly to DHH ED which would have taken only 30 minutes. Paramedics appropriately contacted CAH ED for a standby call at 14:36. Personal Information arrived at CAH ED at 15:19, and was triaged at 15:34 and the Stroke lysis team was called. It has been identified that the stroke team was already dealing with another stroke lysis patient in the department at the time of Personal Information's arrival. Doctor 1 was immediately made aware of the stroke lysis call and aware of Personal Information's arrival and subsequently attended to Personal Information within minutes. Discussions during debrief highlighted it is not practical to have a stroke team on standby for a lengthy period of time in ED waiting for a long distance ambulance to arrive. An ambulance pre alert call 5 minutes prior to arrival to ED was suggested to rectify this issue. NIAS emphasised this would not always be practical as paramedics would generally be dealing with an unwell patient in a moving ambulance and they may not be able to communicate the message in time. NIAS advised paramedics are advised to provide an ATMIST pre alert which should include an estimated time of arrival. It was suggested that if a NIAS HALO (Hospital Ambulance Liaison Officer) was on duty they could track ambulance better and provide a more accurate time of arrival from the estimated arrivals screen on longer journeys.

Doctor 1 noted the communication barrier with Personal Information, again highlighting Personal Information was unable to speak English. Getting a medical history was difficult at the time and the unset time of stroke was unclear. Doctor 1 therefore appropriately contacted Personal Information's workplace to acquire more information and discussed the case with Doctor 2. Doctor 1 also noted difficulties getting through to the CT department for CT brain scan and acceptance for a CT scan. Following CT it was established Personal Information was not a suitable candidate for lysis but queried if thrombectomy would be an alternative option and the RVH was appropriately contacted.

The On call Radiologist (doctor 3) explained at the debrief that there can be issues getting through to the radiology department at times, this is a Trust known problem. The radiology department could receive up to 100 calls and that they too also have the same issue getting through to other Wards and departments. The radiologist highlighted that thrombectomy service operates from 9am - 5pm Monday to Friday and had queried at the time if [redacted] was a suitable candidate for CT. Given the time of day doctor 3 queried was there any treatment available for [redacted] and also mindful the list of other patients requiring urgent use of the CT scanner.

Doctor 2 agreed thrombectomy service operates between the hours 9-5 Monday to Friday but underlined we should always give patients the best chance. A CT scan would always support and persuade a decision to transfer a patient to RVH for further treatment even if outside the service time. Ad hoc there may-be an interventionalist working on the RVH site who could potentially offer treatment outside service hours. Doctor 2 emphasised it is always in the patient's best interests that we consider all possibilities in such cases and this has been learned through previous teaching. This was a lady in her [redacted]'s and it is vital we done everything we possibly could to improve the outcome for her. Following discussion it was determined not all staff working in CAH are aware there may be potential for thrombectomy or perfusion scans in RVH outside service hours. This was discussed and was agreed potential learning for all medical and radiology staff. It was agreed details should be distributed among all medical and radiology staff working in SHSCT.

Doctor 1 advised that following the CT scan and discussion with RVH, [redacted] was accepted by the RVH for consideration of profusion scan and possible thrombectomy and doctor 1 advised nurse 1 to contact NIAS for 999 blue light ambulance for urgent transfer. Nurse 1 advised a request was made for a 999 blue light ambulance transfer to the RVH.

NIAS were able to provide detail of the call made advising a 999 ambulance was requested to come immediately. Nurse 1 advised there was no ambulance after a while and she tried checking NIAS HALO staff to acquire the cause of the delay. Nurse 1 advised the NIAS HALO staff member was on a break and when returned contacted ambulance control who advised an ambulance would arrive after shift handover. Nurse 1 advised another call was made to ambulance control to advise [redacted] was deteriorating significantly and they required ambulance immediately. It was following this further telephone call to NIAS that an ambulance was immediately dispatched and arrived at CAH ED for transfer to RVH. Unfortunately due to the in delay transfer [redacted] did not receive thrombectomy in RVH.

Discussion were had during the debrief for expediting an ambulance in such circumstances. Consideration was given in relation to HALO and whether HALO could potentially expedite an ambulance in cases like this one. NIAS determined that this would not be an option as HALO still must go through public line and the call may be delayed.

NIAS advised the initial call made to ambulance control did not specify that the request for an ambulance was 'time critical' and as a consequence the call was categorised as a category 3 i.e. to be there within 120 minutes and an ambulance was therefore not immediately dispatched for transfer. Another call happened to proceed nurse 1's request for an ambulance which was categorised as a higher critical call and therefore took priority over Personal Information's transfer. NIAS advised the words 'time critical' should have been used in this case and also stressed the caller must provide a valid medical reason for a time critical ambulance i.e. in this case for urgent thrombectomy. Following further discussion among staff it was determined all CAH staff involved were not aware they must specifically say 'time critical' in such circumstances. The general consensus was to ask for 999 blue light ambulance for emergency transfer to RVH for thrombectomy. It was agreed this was a major learning point for all staff involved and highlighted that there is the potential risk that there are many other medical and nursing staff not only in SHSCT but other Trusts who are potentially unfamiliar with NIAS's Standard Operating Procedures (SOP) for 'time critical' ambulance requests. NIAS advised the PHA had previously agreed in 2016 with all Northern Ireland HSC Trusts a pathway for inter-hospital emergency transfer for thrombectomy at the RVH. This was reviewed in 2019 and emphasised the words 'time critical' should be used. It was agreed NIAS would forward the necessary SOP for sharing with all medical and nursing staff for learning.

Doctor 2 advised it was difficult to determine if Personal Information had arrived to RVH at an earlier stage could Personal Information have had a better outcome. The CT scan did confirm an established stroke however doctor 2 stressed it is in the patients best interests that all opportunities are explored before a final decision is made. Doctor 2 advised the CT scan confirmed Personal Information's stroke was very well established evidencing that the stroke happened earlier in the day and Personal Information redacted was therefore outside the window for stroke lysis therapy at that time, however following discussion with RVH it was agreed Personal Information was for transfer to the RVH for perfusion scan and consideration for thrombectomy if considered suitable.

SECTION 3 - LEARNING SUMMARY

14. WHAT HAS BEEN LEARNED:

Stroke is time critical and earlier identification and treatment is paramount for the patient's outcome. It is imperative all staff including paramedics, nurses, doctors, radiologists work together and act proficiently to increase the patients chance of survival and improved outcome. Communication and misconception of service were evidently factors in this case and learning has being extracted from the debrief meeting to be shared with all relevant staff.

15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

Regional Thrombectomy service Guidance and ad hoc availability is to be shared with all relevant staff.

HOS to update current SHSCT SOP for 'time critical' ambulance request in accordance with NIAS guidance and disseminate among relevant staff.

16. RECOMMENDATIONS (please state by whom and timescale)

1. NIAS to share SOP for 'time critical' ambulance requests. Responsible person - Personal Information redacted by the USI NIAS
2. HOS to update current SHSCT SOP for 'time critical' ambulance request in accordance with NIAS guidance and disseminate among relevant staff. Responsible person – AD and HOS for ED
3. Regional Thrombectomy service Guidance and ad hoc availability is to be shared with all relevant staff. Responsible person – CD and HOS.

17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

The general consensus was to ask for 999 blue light ambulance for emergency transfer to RVH for thrombectomy. It was agreed this was a major learning point for all staff involved and highlighted that there is the potential risk that there are many other medical and nursing staff not only in SHSCT but other Trusts who are potentially unfamiliar with NIAS's Standard Operating Procedures (SOP) for 'time critical' ambulance requests.

18. FURTHER REVIEW REQUIRED? NO
Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A <u>FURTHER REVIEW IS</u> REQUIRED)

19. PLEASE INDICATE LEVEL OF REVIEW: LEVEL 2 / LEVEL 3 **Please select as appropriate**	**20.** PROPOSED TIMESCALE FOR COMPLETION: DD / MM / YYYY

21. REVIEW TEAM MEMBERSHIP *(If known or submit asap)*:

22. TERMS OF REFERENCE *(If known or submit asap)*:

SECTION 5	
APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR	
23. NAME:	**24.** DATE APPROVED:
25. DESIGANTION:	

SECTION 6
26. DISTRIBUTION LIST:

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1					
INFORMING THE SERVICE USER[1] / FAMILY / CARER					
1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert **date informed**:				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER ***(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)***				
5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	b) Plan to share final review report at a later date and further engagement planned	
	c) Report not shared but contents discussed (***if you select this option please also complete 'l' below***)	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SECTION 2							
INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) *(complete this section for all death related SAIs)*							
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date report shared**:						
	If **NO**, please provide details:						
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1

1. ORGANISATION: SHSCT	**2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:** Personal Information redacted by the USI
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE: Personal Information redacted by the USI	**4. DATE OF INCIDENT/ EVENT:** Personal Information redacted by the USI
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: No	**6. IF 'YES' TO 5. PLEASE PROVIDE DETAILS:**

7. DATE OF SEA MEETING / INCIDENT DEBRIEF: 11/02/2021, 16/03/2021 & 26/03/2021

8. SUMMARY OF EVENT:

Personal Information redacted by the USI was admitted to Daisy Hill Hospital (DHH) on Personal Information redacted by the USI with a worsening shortness of breath, lethargy and decreased appetite. A diagnosis of severe Covid-19 pneumonia was made and considering his background medical conditions, including Personal Information redacted by the USI, his ceiling of care was the High Dependency Unit (HDU).

Personal Information redacted by the USI had haemodialysis (using a machine to clean and filter the blood) on Personal Information redacted by the USI. On Personal Information redacted by the USI he had an unwitnessed fall in the bathroom. At the time the floor was noted to be wet. A CT brain scan showed a traumatic subarachnoid haemorrhage (a life-threatening type of stroke caused by bleeding into the space surrounding the brain). Personal Information redacted by the USI was discussed with the Neurosurgery Team but was not for intervention by their team. His condition deteriorated and end of life comfort care was discussed with his family on Personal Information redacted by the USI and he was commenced on syringe driver. Personal Information redacted by the USI died peacefully on Personal Information redacted by the USI.

The review team wish to express to Personal Information redacted by the USI's wife and family circle their sincerest condolences on the untimely passing of Personal Information redacted by the USI.

SECTION 2

9. SEA LEAD OFFICER: Dr B Adams, Consultant Obstetrician & Gynaecologist (SAI Chair)	**10. TEAM MEMBERS PRESENT:** Mrs K Carroll, Head of Service for Medicine Mr D Cardwell, Clinical Governance Manager

11. SERVICE USER DETAILS:

DOB@ Personal Information redacted by the USI, Male, Aged Personal Information.

12. WHAT HAPPENED?

Personal Information redacted by the USI was brought by ambulance to DHH ED on Personal Information redacted by the USI arriving at 15:56. He was triaged by Staff Nurse 1 at 16:03 who noted that his presenting complaint was weakness and lethargy. It was documented that he had very low oxygen saturations (Sp02) and that he was on a nebuliser whilst in the care of the Northern Ireland Ambulance Service (NIAS) running at 15L/minute. His pulse (P) was 71 beats per minute (normal), respiratory rate (RR) 24 breaths per minute (fast), temperature (T) 36.1ºC (normal), SpO2 93% (he required the nebuliser to maintain this level) and blood glucose (BM) 5.7 mmol/l (normal). He was seen by Doctor 1 (Senior House Officer (SHO)) and Doctor 2 (Specialty Registrar Emergency Department (ED). They noted that Personal Information redacted by the USI was a Personal Information redacted by the USI old male who had arrived with shortness of breath and documented that his SpO2 was 76% on room air (very low). Personal Information redacted by the USI complained of shortness of breath and lethargy for 3 days. Doctor 2 noted that Personal Information redacted by the USI had no temperature or cough, that he had a reduced appetite and that his last bowel movement was 3 days earlier. Doctor 2 also noted that Personal Information redacted by the USI had longstanding lower back pain. Personal Information redacted by the USI denied any chest pain, any palpitations and any abdominal pain.

On examination Personal Information redacted by the USI's heart sounds were I+II (normal), his lungs were clear, abdomen soft and non-tender, bowel sounds were present and his calves were soft and non-tender. The plan was for Personal Information redacted by the USI to have a chest x-ray, as per Covid pathway nebulisers, dexamethasone, oxygen, antibiotics after the chest x-ray, Covid swab and arterial blood gasses (ABG) done.

Personal Information redacted by the USI was then reviewed by Doctor 3 (Locum Consultant Physician) who noted the past medical history and documented that Personal Information redacted by the USI was not clinically well. He advised that Personal Information redacted by the USI's Echocardiogram was not consistent with Heart Failure and that he needed to be managed as a Covid-19 positive patient. Doctor 3 advised that Personal Information redacted by the USI needed to have a troponin test and d-dimers carried out.

Doctor 3 noted that Personal Information redacted by the USI's P/F ratio (is the level of oxygen measured on blood gas in comparison to the level of oxygen patient is breathing in on room air – the lower the score the sicker the patient is) was 8.4. (A P/F Ratio less than 300 indicates acute respiratory failure.) Personal Information redacted by the USI was discussed with Dr 4 (Consultant Physician) who advised there was a high chance of mortality even if Personal Information redacted by the USI went to the Intensive Care Unit (ICU); therefore given his multiple co-morbidities the ceiling of care would be in the High Dependency Unit (HDU).

At 18:45 Personal Information redacted by the USI was reviewed by Doctor 5 (Medical Registrar) and he discussed resuscitation with Personal Information redacted by the USI and his step-daughter. There was an agreement that Cardiopulmonary Resuscitation (CPR) would likely be unsuccessful and therefore not in Personal Information redacted by the USI's best interests and a Do Not Attempt CPR Order was put in place. A Covid swab was taken at this time.

Personal Information redacted by the USI was seen by Doctor 6 (Senior House Officer) as part of the clerk-in process. Doctor 6 noted that Personal Information redacted by the USI's SpO2 was 76% on room air, that he had shortness of breath and lethargy for 3 days with a decreased appetite. They documented that Personal Information redacted by the USI had no temperature, no cough, his bowels opened 3 days previously and that he was passing urine as normal. His longstanding lower back pain was noted and again Personal Information redacted by the USI denied any chest pain, any palpations and any abdominal pain. Doctor 6 noted the past medical history to be Personal Information redacted by the USI.

Doctor 6 noted Personal Information redacted by the USI's observations to be RR 26, BP 109/52, SpO2 93% on 10L, P 80, T 37.3, and his National Early Warning Score (NEWS - determines the degree of illness of a patient and prompts critical care intervention) was 8. It was noted that Personal Information redacted by the USI's lungs were clear, abdomen soft and non-tender and bowel sounds were present. The plan was for Personal Information redacted by the USI to be treated according to the Covid pathway based on his clinical presentation, have a troponin test and a d-dimer test.

At 02:30 on Personal Information redacted by the USI, Doctor 7 (Specialty Registrar) was asked to see Personal Information redacted by the USI regarding a reduction in his SpO2. On arrival Personal Information redacted by the USI did not appear in any respiratory distress and did not have any increased work of breathing. His SpO2 was 86% on venture mask. Doctor 7 noted Personal Information redacted by the USI's past medical history and his presenting complaint. Doctor 7 noted that Personal Information redacted by the USI's SpO2 was fluctuating between 85% to 92% but mostly was 86% average. Personal Information redacted by the USI was sleeping but easily rousable and when asked stated he felt alright and had no shortness of breath and did not feel dizzy, drowsy or exhausted. On examination Personal Information redacted by the USI had chest crepitations on the left side (all over) and right base. Air entry seemed good all over. His abdomen was soft and non-tender and bowel sounds were present. At one point his SpO2 dropped to 84% and his mask was switched to 15L non-rebreather. His SpO2 gradually improved to 93% and then slowly to 96%. As Personal Information redacted by the USI was sleeping it was difficult for Doctor 7 to check if Personal Information redacted by the USI was getting drowsy with the increased oxygen so his mask was changed back to the 15L venturi mask. At that point Personal Information redacted by the USI's observations were SpO2 90-91%, BP 129/66, P 54 and T 36.5.

Doctor 7's plan was to continue with the 15L venturi mask and aim for a target of > 90% but >88% was also acceptable unless Personal Information redacted by the USI had an increased RR and reduced BP. He was to be stepped down to 10L if his SpO2 was >94% and any concerns were to be escalated. Doctor 7's impression was that Personal Information redacted by the USI was currently stable and not for HDU. Hourly observations were recommended.

At 09:00 Personal Information redacted by the USI was seen by Doctor 3 and Doctor 8 (Staff Grade) who noted the past medical history and presenting complaint. They noted that Personal Information redacted by the USI was for haemodialysis. On examination his lungs were clear and his observations were recorded as RR 18, SpO2 94.7 on 10L, T 36.5, BP 115/60, P 51 and his BM was 8.8. The plan was to discuss Personal Information redacted by the USI with the renal team and move him to a side room.

At 10:00 Personal Information redacted by the USI was seen by Doctor 9 (Consultant Nephrologist) who noted that Personal Information redacted by the USI was feeling well. His temperature was normal, SpO2 92% on 60%, BP 130/58, P 51, his chest was clear and he had no swelling. Doctor 9's plan was to proceed with haemodialysis that afternoon.

At 10:40 Personal Information redacted by the USI was seen by Physiotherapist 1. He noted that Personal Information redacted by the USI advised he was unsteady when on his feet. Physiotherapist 1 titrated Personal Information redacted by the USI's oxygen and assisted him to sit on the side of the bed and then assisted him to lie on his side. At this point Personal Information redacted by the USI's SpO2 decreased to 73% so his oxygen was increased again and he was left comfortable.

At 16:30 Personal Information redacted by the USI had his pre haemodialysis review carried out by Doctor 9 and this commenced at 16:40 and lasted for 1.5 hours.

At 17:08 the result of Personal Information redacted by the USI's Covid swab indicated that he was positive.

On Personal Information redacted by the USI, Personal Information redacted by the USI was seen by physiotherapist 2 at 09:30 when he reported that he felt much improved from the previous day, although he did report feeling fatigued following mobilising to the bathroom earlier and this took him time to recover. Personal Information redacted by the USI was alert and sitting in a chair and the plan was to review him the following day to progress his exercise tolerance.

At 10:00 Personal Information redacted by the USI was seen by Doctor 9 during the renal ward round. He was noted to be clinically stable and his SpO2 was 92% on 60%. His BP was 130/58. He was also seen by the medical team who noted that he was sitting out in a chair and alert. On examination he had mild crackles in his lungs, heart sounds were normal and he had mild peripheral oedema (swelling). The plan was to continue with Enoxaparin 20mg twice daily, chase D-dimer, daily bloods and liver function test. It was noted that Personal Information redacted by the USI was on Dexamethasone 6mg once daily for 10 days and if his oxygenation worsened he was for continuous positive airway pressure (CPAP).

On Personal Information redacted by the USI, Personal Information redacted by the USI was seen by Doctor 10 (Specialty Registrar) and Doctor 11 (Senior House Officer) at 04:00 as it was reported he had an unwitnessed fall. They were advised by nursing staff that Personal Information redacted by the USI had gone into the bathroom to urinate, they heard a bang and found Personal Information redacted by the USI on the floor, bleeding from the nose with right supra orbital swelling. Personal Information redacted by the USI told nursing staff that he was trying to get up from the toilet and could not remember what happened afterwards. He reported that he hurt everywhere, had no chest pain, no seizures and no vomiting. Doctors 10 and 11 noted that Personal Information redacted by the USI was able to follow commands and move all 4 limbs. They noted that the floor in the bathroom was wet. A cervical collar was applied and he was transferred back to bed.

On examination Personal Information redacted by the USI was alert and his observations were RR 22, BP 97/59, SpO2 92% on 60% 15L and P 66. He had equal air entry bilaterally and his heart sounds were normal. His Glasgow Coma Scale was 15/15. His abdomen was soft and non-tender, he had no spinal tenderness and a full range of movement in all limbs. It was noted that he had minimal bleeding from both nostrils with haematoma. He had right supra orbital swelling, No rhinorrhoea (discharge from the nose) nor any battle sign/racoon eyes.

The plan was for a CT brain and CT cervical spine with neurological observations and pain relief. Personal Information redacted by the USI was to have an ECG and venous blood gasses (VBG). His clexane and aspirin were held until the report of the CT brain was available.

Doctor 11 reviewed Personal Information redacted by the USI an hour later after returning from the CT scanner. Personal Information redacted by the USI denied any chest pain, was slightly short of breath, had no nausea, vomiting and was not in pain. On examination he was sitting in the bed, alert and orientated. His GCS was 15/15 and the power in all limbs was 5/5. His SpO2 was 91% on 15L. The plan was to await the results of the CT brain, continue neurological observations, continue with oxygen and update the family.

At 05:40 Doctor 12 (FY1) received a verbal report from the CT brain which confirmed an Intraparencyhrnal haemorrhage but it could not completely exclude a fractured cervical spine because of movement artefact. It was advised that if there were clinical signs of fracture Personal Information redacted by the USI was to be re-scanned and if not his collar could be removed. Personal Information redacted by the USI reported no neck pain but discomfort and on examination there was no visible injury to his neck. There was no spinal tenderness and no paraspinal tenderness. The plan was to remove the collar and contact neurosurgery.

At 06:15 Doctor 12 reviewed Personal Information redacted by the USI before discussion with neurosurgery. Personal Information redacted by the USI was orientated to place and his GCS was 15/15. His RR was 21, SpO2 94% on 40%, BP 102/60, P 89.

At 06:35 discussions took place with the neurosurgeons when the clinical care and CT scan report was relayed. The neurosurgeons suggested one off tranexamic acid 1g and to stop clexane and aspirin. It was noted that Personal Information redacted by the USI was unlikely for neurosurgical intervention considering his co-morbidities and that if he GCS deteriorated he was to be re-scanned and reviewed. They also recommended a discussion with the haematologist which took place at 06:58. Doctor 13 (Consultant Haematologist) agreed with the neurosurgeons plan.

At 07:20 Doctor 11 updated Personal Information redacted by the USI's step-daughter.

At 10:00 Personal Information redacted by the USI had a physiotherapy assessment carried out by physiotherapist 3 (Clinical Lead Physiotherapist). Personal Information redacted by the USI complained of pain in his right arm. He had reduced air entry at the left base and his breathing pattern was irregular. His SpO2 was fluctuating between 88 - 93% on 60% oxygen and require a medical review. He was seen at 11:51 by Doctor 14 (Specialty Registrar) who noted the history to date. On examination Personal Information redacted by the USI was sitting in bed, his GCS was 15/15, and a bruise was noted at his right eye. He had chest crepitations in both lungs and it was noted that he would likely require haemodialysis.

At 12:40 he was seen by Doctor 4 who noted that Personal Information redacted by the USI's breathing is not too laboured at times. His abdomen was soft and non-tender and he had mild oedema in his feet. His GCS was 15/15 and he was not for haemodialysis that day. At 17:40 the results of the VBG were known and noted.

On Personal Information redacted by the USI Personal Information redacted by the USI was seen by Doctor 14 at 11:30. On examination he was agitated but orientated and able to follow commands. His GCS was 15/15. He looked dehydrated and was still having pain in his back. His observations were taken and his SpO2 was 96% on 60% oxygen, BP 133/67 and T 35.2. The plan was for an x-ray of his lumbar spine and shortec 2.5mg to help with pain. He was seen by physiotherapist 3 at 12:00 when he had no complaints of pain. His breathing pattern remained irregular and episodes of shallow breathing followed by increased rate/depth of effort. He was repositioned to high sitting and encouraged to breathe deeply.

At 16:20 he was reviewed in relation to increased confusion. He was rousable to speech, denied pain and able to respond to questions. He was groaning with discomfort but able to stand up and walk a few steps. His blood glucose level was 10. He was non-compliant with neurological examination and his GCS was 13/15. At this time he was able to move all 4 limbs, had no slurring of speech, was not clammy, his abdomen was soft and his bladder was palpable. He was discussed with Doctor 14 who advised a further CT brain, bladder scan and to check when his bowels last opened and commence a stool chart.

At 21:00 Doctor 10 was asked to review Personal Information redacted by the USI again and follow up on the CT brain. Personal Information redacted by the USI's airway was patent with no added sounds, his RR was 24, SpO2 91% on 60% oxygen, heart sounds normal, P 86, BP 122/82. Atrial fibrillation was noted on telemetry. Personal Information redacted by the USI's hands were warm and he was well perfused. His capillary refill time was less than 2 seconds. There was no sign of any DVT or cellulitis and his fluid intake/output was noted as fluids in 650 ml and out 550 ml.

His abdomen was soft, not peritonitic/guarding and bowel sounds were present. He was draining clear urine. His GCS was 11/15 and his BM was 10.8. Doctor 10 noted Personal Information redacted by the USI to be moving all 4 limbs normally, making groaning noises but not answering any questions and was unable to say where he was. He observed that Personal Information redacted by the USI kept putting his hand to his ear and was moving his neck by himself. His whole spine was felt and there was no obvious bony tenderness noted. He had no bony hip pain and had been mobilising by himself that day.

Doctor 10's impression was that Personal Information redacted by the USI had delirium (multi-factorial) and the plan included regular analgesia, oxycodone 1mg subcutaneously 4 hourly, ensure bowels were opening and to avoid any sedation at present. It was noted that Personal Information redacted by the USI should try to keep his oxygen in place and that he would benefit from 1:1 Nursing. This was in place from Personal Information redacted by the USI until the morning of Personal Information redacted by the USI Personal Information redacted by the USI.

On Personal Information redacted by the USI at 03:30 Doctor 12 was asked to see Personal Information redacted by the USI regarding jerking movements of his limbs, clenched fists and legs and tongue biting. The priority was to maintain Personal Information redacted by the USI's airway with head tilt. His RR was 14, SpO2 96% on 100% oxygen. His lungs were clear, chest clear and he had no increased work of breathing. His P was 69 regular, BP 188/80 which was 113/64 when re-checked. His GCS was 3/15 which improved to 7/15. Doctor 12 noted that it was difficult to assess Personal Information redacted by the USI's level of pain. The plan was that if there was any further seizure activity Personal Information redacted by the USI was to be considered for of Keppra (medicine to treat seizures) and that Doctor 12 should be re-contacted if Personal Information redacted by the USI's systolic BP increased over 170 repeatedly.

Personal Information redacted by the USI was reviewed at 06:45 by Doctor 15 (SHO) as he was having a seizure which had resolved by the time she arrived. Personal Information redacted by the USI's RR was 16, SpO2 97% on 15L, P 70 and BP 156/79. His GCS was 7/15 and he was not verbally responsive, with his left eye gazing to left side when eyelid lifted and

right eye pointing forward. Personal Information redacted by the USI was drowsy post seizure and his arms were floppy. On examination he was moving his legs himself, making groaning sounds and flexed away from pain. The impression was that the seizure was secondary to his bleed. At that time Personal Information redacted by the USI was very unwell and he was discussed with Doctor 10 who telephoned Personal Information redacted by the USI's step-daughter at 07:55 to provide an update. Personal Information redacted by the USI was then seen by Doctor 16 (Consultant Physician) who advised that Personal Information redacted by the USI was not for haemodialysis and that no further bloods should be carried out unless there was a significant improvement. Non-essential medications were stopped and the renal team updated. Personal Information redacted by the USI was seen by Doctor 17 (Consultant Nephrologist) at 11:30 who ruled out haemodialysis that day.

On Personal Information redacted by the USI, Personal Information redacted by the USI was reviewed by the palliative care team who noted that he was restless and agitated, groaning to touch/movement and appeared sore on moving. It was noted that Personal Information redacted by the USI's step-daughter had requested use of a syringe driver to prevent fluctuating symptoms so the plan was to keep Personal Information redacted by the USI comfortable. He was reviewed at 09:35 by Doctor 16 and again by Doctor 18 at 19:55 when there was a query about the syringe driver.

On Personal Information redacted by the USI Personal Information redacted by the USI was reviewed by Doctor 3 at 09:08 and the family updated. When seen by the palliative care team at 10:00 they noted a deterioration in Personal Information redacted by the USI. Personal Information redacted by the USI had sadly died when Doctor 19 (FY1) was called to his bedside at 12:55.

13. WHY DID IT HAPPEN?

Patient Factors

The review team understand that Personal Information redacted by the USI was a spritely gentleman with a good outlook on life. Up until two days before Personal Information redacted by the USI was brought to ED at DHH he had been well and independently mobile and did not require any assistance with the activities of daily living. They understand that on the morning of admission Personal Information redacted by the USI was so unwell that he required assistance into the ambulance for his transfer. The review team have noted that Personal Information redacted by the USI had a past medical history of Personal Information redacted by the USI It was noted in the admission documentation that Personal Information redacted by the USI had no previous history of falls.

Task Characteristics

The review team have identified that on the morning of Personal Information redacted by the USI, Personal Information redacted by the USI was unaided when he went to use the bathroom and there is no recollection of him being on portable oxygen whilst mobilising. The nursing staff who were on duty can recollect that Personal Information redacted by the USI greeted them on passing the nurses station and he appeared alert and was wearing appropriate footwear. The review team understand that patients who have low oxygen saturations are more susceptible to falls. On reflection nursing staff involved with the care of Personal Information redacted by the USI now fully appreciate the importance of patients who have been diagnosed with Covid-19 being accompanied and using portable oxygen when mobilising.

The review team understands that Personal Information redacted by the USI had used the toilet before he fell as he could be heard dispensing toilet paper in the area next to the bathroom. A short time later there was a noise from the bathroom and on investigation a staff nurse found that he had fallen. The staff nurse observed that the floor was wet but could not determine if the liquid was water or urine. The review team have been advised that Personal Information redacted by the USI experienced a 1 minute loss of consciousness and he came round again by himself prior to the arrival of the medical team. As part of the assessment and examination Doctor 10 queried if Personal Information redacted by the USI had suffered a seizure or if he had been incontinent causing a mechanical fall, but as Personal Information redacted by the USI was alert and orientated he ruled out a seizure. Doctor 10 though the fall was more likely to have been as a result of Personal Information redacted by the USI being hypoxic (deprived of adequate oxygen supply).

Training and Education

The review team are aware that in light of the Covid-19 pandemic, the ward on which [redacted] was nursed had previously been a Surgical Ward and at the time of [redacted]'s admission nursing staff were caring for medical patients. The review team accept that the nursing staff who were caring for [redacted] were skilled in and knowledgeable about the management of surgical patients but less so in the management of medical patients. They do understand however that some initial training was provided to nursing staff on the management of Covid-19 patients, but recognise that until the time of [redacted]'s fall staff did not fully appreciate how quickly these patients can desaturate when mobilising without portable oxygen. The review team have emphasised that at the time of [redacted]'s admission staff were dealing with a continuing global pandemic and are mindful of the fact that wards were and can continue to be opened at short notice to cater for an increasing demand. In these circumstances these wards need to have an appropriate skill mix of suitably trained staff.

Environment and Staffing

The review team are aware that Ward 3b is an eighteen bedded ward consisting of two, six bedded bays and six side wards (four of which had ensuites). It was identified that [redacted] was nursed in sideward 4 and that the closest bathroom to him would have been 5/6 meters away. On the night in question the ward was staffed by three staff nurses and one healthcare assistant. It is noted that two of the staff nurses were core staff and the remaining staff nurse was employed by the Southern Trust Bank and was familiar with the workings of the ward. It was noted that the healthcare assistant was also one of the ward's core staff.

In terms of the acuity of patients being nursed at the time of [redacted]'s fall, the review team understand there were five confused patients, one of who required all night 1:1 supervision. As a result of this during the shift only one member of staff left the ward for breaks at a time. The review team are satisfied that the ward was adequately staffed.

The review team are mindful that as part of the SAI notification process there was information to report that the bathroom floor was wet, however they could not identify if this contributed to [redacted]'s fall. The review team discussed this with staff members and it was not clear if the wet floor was due to a running tap (which staff turned off on arrival) or if [redacted] had been incontinent.

Policies and Procedures

The review team have noted that [redacted] received good clinical care which was in line with best practice guidelines. They have noted that [redacted] was managed on the appropriate falls pathway post falls and that follow up examinations were comprehensive and care was provided without delay.

Communication and Documentation

The review team have noted that the medical, nursing and allied health professional teams worked well together and had a cohesive approach to [redacted]'s care. It is recognised that communication with other specialities took place in a timely manner and his case was escalated through the medical management structures appropriately. It is noted that the written documentation contained in [redacted]'s notes was to a high standard. The review team have also determined that the family were kept fully up to date in relation to [redacted]'s prognosis and management plan.

SECTION 3 - LEARNING SUMMARY

14. WHAT HAS BEEN LEARNED:

The review team have determined that there were two causative factors in Personal Information redacted by the USI's death, the first being Covid-19 and the second being an intracerebral bleed for which Personal Information redacted by the USI received appropriate treatment and care.

The review team have learned at the time of Personal Information redacted by the USI's admission there was not an in-depth appreciation of how quickly Covid-19 patients could desaturate whilst mobilising in the absence of portable oxygen.

The Clinical staff involved are now aware of the very rapid speed with which Covid patients can desaturate.

Whilst the outcome for Personal Information redacted by the USI and his family has been devastating the review team feel that the quality of care given to him at admission and after his fall was of a high standard.

Staff and Family Engagement

The review team wishes to highlight that the members of staff from whom statements have been taken, as part of this review, have been co-operative and extremely open and honest which the review team have appreciated. The review team wish to note that it is clear from the conversations which have taken place that staff have reflected on this incident, learned from it and put in place a number of changes to their practice with regard to the management of Covid-19 patients.

The review team wish also to highlight the constructive and understanding attitude of Personal Information redacted by the USI's family throughout the review process and for their patience whilst awaiting production of the report.

15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

1. Each ward with Covid patients has now been supplied with a number of rollators which can accommodate portable oxygen cylinders for those patients are deemed fit to be mobilising.

2. In addition for those patients that require oxygen on mobilisation, their requirement is notified on the whiteboard above each patient's bed.

16. RECOMMENDATIONS (please state by whom and timescale)

Each member of the multidisciplinary team involved in caring for patients with Covid should be made aware of:

(i) the speed with which Covid patients can desaturate during mobilization and
(ii) the need for oxygen to be available during mobilization and at a level indicated on the whiteboard above each patient's bed.

This information should be shared via a variety of mechanisms, as follows:

1. The Consultant responsible for Personal Information redacted by the USI's care will discuss this case and learning from this review at the Medical Morbidity and Mortality Meeting. This should take place within 8 weeks of the report's publication and should include cascading this learning to all doctors within the Trust.

2. The Ward Sister of the ward [redacted] was nursed on will share the experience of staff and the learning from this report at the Joint Sister's (both sites CAH & DHH) meeting. This should take place within 8 weeks of the report's publication and should include cascading this learning to ward level.

3. This report will also be discussed at the Lead Nurse Forum. This should take place within 8 weeks of the report's publication.

17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

The SHSCT's representative on the Regional Falls Prevention Group will provide a summary of this incident and its learning outcomes to the next meeting of group for shared learning.

18. FURTHER REVIEW REQUIRED? YES / NO
Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A <u>FURTHER REVIEW IS</u> REQUIRED)

19. PLEASE INDICATE LEVEL OF REVIEW: LEVEL 2 / LEVEL 3 **Please select as appropriate**	**20.** PROPOSED TIMESCALE FOR COMPLETION: DD / MM / YYYY

21. REVIEW TEAM MEMBERSHIP *(If known or submit asap)*:

22. TERMS OF REFERENCE *(If known or submit asap)*:

SECTION 5

APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR

23. NAME:	**24.** DATE APPROVED:

25. DESIGANTION:

SECTION 6

26. DISTRIBUTION LIST:

Personal Information redacted by the USI's family
The Health and Social Care Board
The Director of Acute Services
The Executive Director of Nursing
All Assistant Directors of Acute Services
The Head of Service for Acute Allied Health Professionals
The staff involved with Personal Information redacted by the USI's care

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		HSCB Ref Number:	

SECTION 1					
INFORMING THE SERVICE USER[1] / FAMILY / CARER					
1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert **date informed**:				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*				
5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	b) Plan to share final review report at a later date and further engagement planned	
	c) Report not shared but contents discussed (***if you select this option please also complete 'l' below***)	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**)				
Content with rationale?	**YES**		**NO**	

SECTION 2							
INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) ***(complete this section for all death related SAIs)***							
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date report shared**:						
	If **NO**, please provide details:						
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

Family Engagement; Questions submitted

Was [redacted] confined to bed before his fall or was he able to get up on his own?
The review team understand that prior to his fall [redacted] was mobile on the ward and had not been confined to bed.

Why did the RVH not accept [redacted] for treatment?
The review team have been advised that following the verbal report of the CT scan Doctor 11 telephoned neurosurgery and that on the basis of [redacted]'s co-morbidities he was not for intervention/surgery as the risk would have been too high. Doctor 11 was advised to treat [redacted] conservatively and administer tranexamic acid to stop his bleed and cease [redacted]'s blood thinning medication to prevent a further bleed.

Should [redacted] have been allowed to mobilise to the bathroom? Should the nurse have directed him back to bed?
The review team are sorry that [redacted] mobilised to the bathroom unaided. The Ward Sister has reported that [redacted] appeared to be an able gentleman and was independent. All staff involved have openly acknowledged that they have had a huge learning curve with the management of respiratory patients. The Ward Sister advises that on reflection, and since this incident staff, would be expected to stop any patient who was mobilising without oxygen and return them to their bed space. Staff are regretful that they did not appreciate the effect of a patient desaturating so quickly and if similar circumstances presented themselves now staff would be better equipped to deal with them.

Did [redacted] lose consciousness?
It is noted that [redacted] experienced a 1 minute loss of consciousness.

Are falls mats available and should one have been used?
The review team understand that falls mats are available, however as [redacted] was mobile the use of one would not have been necessary.

Had [redacted] been sedated prior to the fall?
The review team understand that [redacted] had not been sedated.

Would [redacted] have recovered from his Covid-19 diagnosis if he had not have experienced a fall?
The review team are advised that it is felt that [redacted]'s Covid was so severe that even if he had not had the fall he would not have survived. It is understood that if a dialysis patient contracted covid-19 they would be at an increased risk of death.

If Personal Information redacted by the USI would have had dialysis earlier would it have helped him?

It is the understanding of the review team that Doctor 4 had taken over the care of Personal Information redacted by the USI in Personal Information redacted by the USI and he had two virtual consultations with him before calling him to clinic in Personal Information redacted by the USI when dialysis was discussed. It is noted at that time Personal Information redacted by the USI's eGFR (test to measure level of kidney function and determine stage of kidney disease) was 6 and that this would have been the point for starting a patient on dialysis, however as Personal Information redacted by the USI appeared well, and after discussion with Personal Information redacted by the USI, a decision was made to defer. The review team cannot conclude if dialysis had been started any earlier that the outcome would have been different.

LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1

1. ORGANISATION: SHSCT	**2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:** Personal Information redacted by the USI
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE	**4. DATE OF INCIDENT/ EVENT:** Personal Information redacted by the USI
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: NO	**6. IF 'YES' TO 5. PLEASE PROVIDE DETAILS:**
7. DATE OF SEA MEETING / INCIDENT DEBRIEF:	**20/5/2020**

8. SUMMARY OF EVENT:

Personal Information redacted attended CAH ED on the Personal Information redacted by the USI following a referral from her GP reporting central abdominal pain radiating into the right iliac fossa area associated with dysuria. A possible diagnosis of appendicitis or urinary tract infection was made by Personal Information redacted's GP.

In CAH ED blood tests were carried out and a diagnosis of pyelonephritis was made and Personal Information redacted was admitted for treatment for same. On the Personal Information redacted by the USI, following diagnostic scans a decision was made to precede to an appendectomy and during procedure a perforated appendix was noted.

Post procedure Personal Information redacted became hemodynamically unstable with signs of significant bleeding. Personal Information redacted was taken back to theatre for a laparotomy on the Personal Information redacted by the USI and was found to have significant intra peritoneal bleeding arising from her spleen. It was noted Personal Information redacted had a delayed rupture of a splenic haematoma with complete detachment of splenic capsule from the spleen. No obvious laceration of the splenic parenchyma was noted and a splenectomy was carried out.

SECTION 2

9. SEA LEAD OFFICER: Chair Mr Gerarde McArdle - Consultant Surgeon	**10. TEAM MEMBERS PRESENT:** Mr Gerarde McArdle - Consultant Surgeon Mrs Dorothy Sharpe – Lead Nurse Surgery Carly Connolly – Clinical Governance Manager

11. SERVICE USER DETAILS:
DOB Personal Information redacted by the USI **Gender**: Female Age: Personal Information redacted

12. WHAT HAPPENED?

On Personal Information redacted by the USI at 16:01 Personal Information redacted presented to Craigavon Area Hospital (CAH) Emergency Department (ED) following a referral by her GP due to a 2 day history of vomiting and central abdominal pain with tenderness in the right iliac fossa (RIF) area with guarding. A urinalysis dipstick test was positive for leucocytes, ketones and blood. The GP queried appendicitis or urinary tract infection.

At 16:10 Personal Information redacted was triaged and Personal Information redacted's observations were noted by nurse 1. Pulse 113bpm, Blood Pressure (BP) 130/79; respiratory rate (RR) 16, Temperature 37.5ºC, $Sp0_2$ (oxygen levels) 100%. It was documented Personal Information redacted had a pain score of 8 out of 10. Personal Information redacted was triaged as a priority 2 i.e. to be seen within 10 minutes.

At 18:40 Personal Information redacted was seen by ED Doctor 1. Doctor 1 noted Personal Information redacted's recent history of abdominal pain, vomiting, urinary symptoms, lower back pain and temperature. Doctor 1 noted Personal Information redacted had abdominal pain in the left and right side with rebound. The impression was that of a urinary tract infection and the plan was to check ketones, bloods, protein and white cell count (WCC is a marker for inflammation). Bloods were checked and results were noted as WCC 22.7, c reactive protein (CRP) (CRP is a marker for inflammation in the body) 268, Urea & electrolytes (U&E kidney function) was normal, Liver function test was normal. Doctor 1 documented that Personal Information redacted's case was discussed with the medical registrar. Following discussion the plan was to admit Personal Information redacted with the possibility of scan in the morning.

On Personal Information redacted by the USI at 00:10 Personal Information redacted was reviewed by Doctor 2 (CT1 medicine). Doctor 2 noted Personal Information redacted's recent medical history. On examination it was noted Personal Information redacted had no loin tenderness and that Personal Information redacted had right flank tenderness with no guarding but with rebound. Personal Information redacted's abdomen was otherwise soft with bowel sounds present. Doctor 2 documented Personal Information redacted was sore on movement and had no history of urinary tract infections (UTI). Doctor 2 documented a differential diagnosis of a UTI, query pyelonephritis and to rule out appendicitis. Doctor 2 noted Personal Information redacted's blood results and that the urinalysis dipstick test was positive for protein, blood, ketones and leucocytes.

Doctor 2 noted Personal Information redacted was not vomiting since admission and was drinking well. Doctor 2 documented that if Personal Information redacted was to continue vomiting to prescribe Intravenous fluids (IVF). Doctor 2's plan was to continue with Gentamicin (antibiotic), for a surgical review, an ultrasound scan (USS) of abdomen, paracetamol and one hourly monitoring.

At 01:30 Personal Information redacted had a surgical review by doctor 3 (Core Trainee CT1 surgery). Doctor 3 noted Personal Information redacted's history. On examination doctor 3 noted Personal Information redacted's lower abdomen was tender, there was no peritonism, Personal Information redacted's temperature was 38.5ºC. Doctor 3 documented his impression was a UTI, that it was very unlikely appendicitis and suggested continuing with intravenous (IV) antibiotics and an USS of the renal tracts. Doctor 3 noted he was happy to review on request.

Personal Information redacted was reviewed again on the post take ward round on the Personal Information redacted by the USI by Doctor 4 (Consultant Physician). Again Personal Information redacted's history was noted. It was noted Personal Information redacted's temperature was 37.5ºC, Personal Information redacted had a 3 day history of abdominal pain with dysuria (increased frequency). Doctor 4 noted Personal Information redacted's abdomen was tender suprapubically, and CRP and WCC were increased. Personal Information redacted's pulse was noted to be 105bpm, BP 112/82mmHg and she had a positive urinalysis result. Doctor 4's plan was to continue with Gentamicin, and await MSSU and to chase cultures.

It was noted later by Doctor 5 that Personal Information redacted was discussed with the appointments office and was informed there was no USS list that evening, and there were no free rooms/ sonographers. The morning list was full from the previous days back log. Doctor 5 documented to continue with the current plan.

At 17:45 Doctor 6 (Foundation Year Foundation Year 2) was asked to see Personal Information redacted due to severe constant suprapubic pain. Doctor 6 noted Personal Information redacted felt nauseated and had a decreased appetite. Doctor 6 noted Personal Information redacted's temperature was 37.8ºC, she felt warm and appeared slightly confused. On examination Personal Information redacted appeared pale and sweaty and was reluctant to let Doctor 6 examine her due to a tender lower abdomen. Doctor 6 noted bowel sounds were present. Personal Information redacted's observations were noted; RR 16, $Sp0_2$ 98% on RA; Temp 37.7ºC, BP 160/80mmHg, pulse 124bpm. Doctor 6 documented a plan , IV morphine 6mg, IV cyclizine and IV fluids. Personal Information redacted was to have 15 minute observations for 1 hour. Doctor 6 documented he would review Personal Information redacted when her pain settled.

At 19:30 Personal Information redacted was reviewed again by Doctor 7 (Foundation Year FY1). On examination Personal Information redacted's observations were stable. Doctor 7 noted Personal Information redacted's abdomen tender throughout with voluntary guarding. Doctor 7 noted Personal Information redacted was alert and reporting that morphine had not helped her pain. Doctor 7 noted a plan to review blood results.

At 20:00 Doctor 7 noted bloods results as follows: Hb 140, WCC 14 (22), PLT 322, CRP 282 (269), amylase 26, Bone profile normal, U&E normal, Liver profile normal, Mg 0.80. Gent <0.4. Doctor 7's plan was to treat with gentamicin and to continue with the current management plan.

On Personal Information redacted by the USI the ward round was performed by Dr 8 (Consultant Physician) and noted Personal Information redacted's pain had improved and Personal Information redacted was passing urine, the plan was to check bloods, continue with antibiotics, paracetamol and to mobilise. Bloods were later recorded as WCC 10.8 and CRP 379.

On the Personal Information redacted by the USI at 01:00 Personal Information redacted was reviewed by Doctor 9 (FY1). Doctor 9 noted he was asked to see patient due to abdominal pain and query abdominal distension. Doctor 9 noted Personal Information redacted had vomited twice that day at 15:00 and 20:00. Personal Information redacted had one episode of diarrhoea type 7 stool recorded. Doctor 9 noted previous review by the surgical team who thought it unlikely appendicitis and was subsequently treated for UTI the last 3 days with gentamicin. Doctor 9 noted Personal Information redacted's WCC had reduced from admission and CRP had increased, MSSU reported no significant growth and that blood cultures were still awaited.

Observations were documented as RR16; BP 115/65mmHg, heart sounds were normal, pulse 106bpm and regular. Doctor 9 noted Personal Information redacted's abdomen felt firm and tender over suprapubic area, bowel sounds were faint but present. Doctor 9 noted Personal Information redacted had no guarding or rebound tenderness and there was no suspicion for peritonism. Doctor 9 documented he discussed Personal Information redacted with doctor 10 (surgical Senior House Officer). Doctor 10 kindly agreed to review. Doctor 9's plan was for an erect chest x-ray and abdominal x-ray, blood cultures and IV paracetamol if further temperature spike, a surgical review and to commence Tazocin for intra-abdominal sepsis.

Doctor 10, reviewed Personal Information redacted and noted Personal Information redacted's past medical history and completed a thorough examination. Doctor 10 documented Personal Information redacted's symptoms were not clinically suggestive of appendicitis at present but noted it would warrant investigation and consideration if Personal Information redacted's symptoms did not settle, a note was made of Personal Information redacted's temperature of 38.7ºC earlier in the day. Doctor 10's plan was for Tazocin for sepsis cover, IV fluids, ultrasound scan USS and fast for the ward round in the morning.

Personal Information redacted had an abdominal x-ray at 10:26 which reported multiple dilated loops of small bowel suggesting small bowel obstruction.

Personal Information redacted was reviewed on the ward round by Doctor 11 (Consultant Surgeon). Personal Information redacted's history of abdominal pain was noted. Doctor 11 noted Personal Information redacted was constipated but bowels had moved the previous night. Doctor 11 noted the x-ray result which reported distended small loops of bowel. On examination Personal Information redacted's abdomen was soft but bloated and tender generally throughout, no guarding was reported. Doctor 11's plan was for a CT abdomen and for Personal Information redacted to be transferred to surgical ward 4 North.

At 13:15 Personal Information redacted had a CT abdomen and pelvis. The report concluded the following:

'*Significant inflammatory process in the right iliac fossa and suprapubic region with extra luminal air, in keeping with localised perforation and a small collection. The appearances suggest either perforation of a Meckel's diverticulum or the appendix. A large volume of free inflammatory fluid in the pelvis. Small bowel obstruction'.*

At 15:15 it was noted by the nurse that Personal Information redacted was for theatre and that the Doctor 12 (Consultant Surgeon) had spoken to Personal Information redacted's parents.

19:30 Personal Information redacted was admitted to theatre for laparotomy.

Doctor 12 performed the surgery. Operation notes documented an inflammatory mass in the lower abdomen with pus and faeces, the appendix was perforated. Pus and faeces were released and sent for O&S, the appendix was immobilised and excised in three pieces, it was documented the appendix was friable and perforated and a wash out with saline was performed.

On Personal Information redacted by the USI Personal Information redacted was reviewed by Doctor 13 (Consultant Surgeon). Doctor 13 documented Personal Information redacted was day 1 post appendectomy; she had no temperature spikes and was feeling better. Doctor 13's plan was to continue with fluids and that she could try a light diet and to continue with Tazocin.

At 10:20 Personal Information redacted was reviewed by Doctor 4 (Consultant Physician) on the ward round. Doctor 4 noted the events over the weekend and appendectomy. Doctor 4 noted Personal Information redacted felt she was improving and was drinking fluids, Doctor 4 documented care was transferred to surgery.

On the Personal Information redacted by the USI Personal Information redacted was reviewed during the ward round by Doctor 11 (Consultant Surgeon). Doctor 11 noted Personal Information redacted's temperature spiked during the night and that blood cultures were reported as negative. Doctor 11's plan was to continue eating and drinking, take the drip and catheter out, to increase analgesia and for routine bloods.

Later on Personal Information redacted by the USI Doctor 14 (FY 1) was asked by nursing staff to review Personal Information redacted as she was feeling unwell with tachycardia (fast pulse). Doctor 14 noted Personal Information redacted was alert and responsive; her pulse was reported as 120 bpm, RR 17, oxygen saturations (SpO_2) 98%, BP 100/50. An electrocardiograph (ECG) reported normal sinus rhythm tachycardia, Personal Information redacted's calves were reported to be soft non tender and no dyspnoea (difficulty breathing) was noted. On abdominal examination Personal Information redacted had no guarding or rebound tenderness, there was slight tenderness in the right iliac fossa region near the wound was documented. Doctor 14 noted Personal Information redacted's bowels had not opened since Saturday and that she was complaining of fullness and needed to pass wind but was unable to do so. It was noted Personal Information redacted felt nauseated earlier but not currently. Dr 14 noted Personal Information redacted's recent bloods results and recent abdominal x-ray result reporting multiple dilated small bowel.

At 18:10 Doctor 15 (CT2 medicine) documented a cardiac arrest call was made. On arrival Personal Information redacted was sitting in the chair alert and talking. Doctor 15 noted Personal Information redacted looked pale and that she complained of abdominal pain. On examination observations were noted: oxygen saturations 93% room air; BP 78/58mmHg; pulse 160bpm. Doctor 15 noted Personal Information redacted had not arrested, she was in bed, stood up and blacked out. Doctor 15 documented Personal Information redacted's airway was patent, her chest was clear, heart sounds were normal, capillary refill time (CRT) was 3 seconds, calves were soft non tender; GCS score was 15/15, it was documented the wound was satisfactory with no ooze, there was mild tenderness and bowel sounds were minimal. Doctor 14's plan was for oxygen therapy, bloods to include full blood picture;

kidney function, CRP, magnesium; to call the surgical team, IVF over one hour and repeat observations every 15mins.

At 18:10 Personal Information redacted was reviewed by general surgical Doctor 16 (Core Trainee CT2). Doctor 16 documented he was asked to see Personal Information redacted due to a blackout episode. It was documented Personal Information redacted was day 2 mini laparotomy for a perforated gangrenous appendix with pus and faeculent material in the abdomen. Doctor 15 noted Personal Information redacted's medical history and admission to hospital. Doctor 15 noted Personal Information redacted had no chest pain or palpitations and that she complained of lower abdominal pain in the left side and around the wound. Personal Information redacted had no feverish symptoms. Observations were documented as BP 70/50 increasing to 110/70, pulse 130bpm reducing to 110bpm, temp 36.5^{o}C, SpO_2 100% on 2 litres of oxygen and RR 16. On examination Doctor 16 documented Personal Information redacted was tender around the wound and left side, her abdomen was slightly distended. Doctor 16 documented his impression was a vasovagal syncope secondary to current infection and recent surgery. Doctor 16 queried if Personal Information redacted was developing a collection. Doctor 16's plan was for IVF, repeat bloods, to continue with Tazocin and possibly add atypical cover. Doctor 16 would discuss Personal Information redacted with consultant surgeon Doctor 11 regarding USS in the morning.

At 20:25 Doctor 17 was asked to review Personal Information redacted by nursing staff. Doctor 17 documented Personal Information redacted's vasovagal episode earlier, observations were noted pulse 116bpm; BP 111/70 and that Personal Information redacted had no further temperature spike that day. On examination it was documented Personal Information redacted looked pale, her abdomen was soft with mild tenderness to the left side and she was slightly nauseated. Doctor 17 documented Personal Information redacted's recent bloods taken at 18;00, CRP was down to 336, haemoglobin down to 84 from 110, WCC increased 19.5 and platelets were 448. Doctor 17 documented an impression of vasovagal episode secondary to post op bleed (day 2 post op). Doctor 17's plan was to transfuse 2 units of blood, if Personal Information redacted was to remain hypotensive or tachycardia she would require a CT scan that night. Haemoglobin was to be checked early the following morning and observations to be checked regularly. Doctor 17 documented Personal Information redacted's mother and father were informed of the possibility of a post operation bleed and documented they confirmed they were happy to transfuse tonight and CT scan tomorrow.

Personal Information redacted was reviewed again at 22:00 by Doctor 17 who noted Personal Information redacted's recent haemoglobin result 67g/dl. Doctor 17 documented Personal Information redacted had 2 units of packed red cells (PRC) transfused and remained tachycardia and pale looking. Doctor 17 documented his impression was likely bleeding and that Personal Information redacted needed to return to theatre. Doctor 17 discussed Personal Information redacted with on call consultant surgeon Doctor 18. Doctor 18 advised that Personal Information redacted needed to return to theatre that night and that the CT scan would be of no value as it was likely post operation bleeding. Arrangements were made for Personal Information redacted to return to theatre for an exploration laparotomy and consent was obtained for same. A further 2 units of PRC were transfused prior to laparotomy.

The surgery was performed by Doctor 18 (Consultant Surgeon). Theatre notes documented there was a large amount of blood around the spleen, the capsule of the spleen was detached. The findings were in keeping with a delayed rupture of splenic haematoma. There was no significant deep splenic laceration seen. In view of ongoing bleeding the spleen could not be preserved. There was evidence of pelvic phelgmon (inflammation of soft tissue) involving the sigmoid, bladder, uterus and ileum. It was noted the bladder was tensely attached to the abdominal wall and that led to a small perforation which was repaired. Personal Information redacted was transferred to Intensive care unit (ICU) following surgery.

On the morning of the Personal Information redacted by the USI Personal Information redacted was extubated and reviewed post op by Dr 19 Consultant Intensivist. Dr 19 noted Personal Information redacted's past medical history and recent surgeries. Personal Information redacted's GCS score was noted

as 15/15 and that she was on no sedation or inotropes. Arrangements were made for Personal Information redacted to transfer to the ward. The plan was for Personal Information redacted to stay on Tazocin and to be prescribed further antibiotic cover and vaccinations due to splenectomy. The surgical team to be contacted regarding eating and drinking and the catheter to remain insitu for 2 weeks.

Personal Information redacted recovered on the ward post splenectomy and was discharged home on Personal Information redacted by the USI with arrangements for an outpatient gynaecology review for mid cycle bleeding, her catheter was to be removed on the Personal Information redacted by the USI, suture removal in 10 days and an outpatient surgical review in 2 – 3 months. Personal Information redacted's GP was to continue monitoring platelet and haemoglobin levels and review treatment for same.

SECTION 3 - LEARNING SUMMARY

13. Why did it happen?

Personal Information redacted was a Personal Information redacted by the USI old female at the time when she was referred to CAH ED by her GP on the Personal Information redacted by the USI. The review team acknowledge the GP referral letter documented a positive urine dipstick analysis taken at the GP surgery reported positive for leucocytes and ketones/blood. The GP reported Personal Information redacted was tender in the RIF area with rebound and had queried if Personal Information redacted had appendicitis or a urinary tract infection (UTI). The review team considered the GP's assessment referral was appropriate.

The review team acknowledge Personal Information redacted was appropriately triaged within 9 minutes of arrival as a priority 2 (to be seen with 10mins) as per Manchester Triage guidelines. ED Doctor 1 reviewed Personal Information redacted and completed a full medical review and assessment. The review team note Doctor 1 documented Personal Information redacted had urinary symptoms with a positive urinalysis for ketones, blood, protein and leucocytes, and blood results reported an increased WCC and CRP. A urine sample was sent to microbiology for further analysis. The review team accept there can be a wide presentation of symptoms and signs in patients presenting with appendicitis and ultimately it can be very difficult to make a diagnosis. However, central abdominal pain, vomiting and tenderness in RIF area are classical appendicitis symptoms. A high index of suspicion therefore should be maintained and in this particular case the migratory nature of the pain, elevated temperature with raised inflammatory markers should have pointed consideration towards a surgical admission or surgical review. The review team confirm Doctor 1 appropriately covered Personal Information redacted for sepsis prescribing IV Gentamycin (anti-biotic) which was administered prior to Personal Information redacted's transfer to the ward.

The review team are conscious sepsis is a medical emergency. The review team acknowledge Personal Information redacted was admitted to the ward and treated for a suspected UTI/ pyelonephritis with IV Gentamycin. The review team note a MSU sample was sent to microbiology for confirmation of UTI/pyelonephritis. The review team acknowledge nursing and medical notes document Personal Information redacted's symptoms worsened over the next couple of days. The review team confirm Personal Information redacted had 2 normal MSU results available from Personal Information redacted by the USI at 11:24 which excluded a UTI/ pyelonephritis diagnosis. Medical notes evidence Personal Information redacted was reviewed multiple times by numerous doctors and there was no consideration given for the normal MSU result. The review team determined the reported MSU result available on Personal Information redacted by the USI warranted a change in the management plan and for an earlier consideration of appendicitis.

The review team note Doctor 9 (FY1) was asked to review Personal Information redacted on Personal Information redacted by the USI at 1:00. The review team acknowledge Doctor 9 completed a thorough history and examination. Doctor 9 noted Personal Information redacted's previous surgical review on Personal Information redacted by the USI who advised appendicitis was unlikely. The review team acknowledge Doctor 9 noted Personal Information redacted's WCC had reduced but incorrectly reported Personal Information redacted's MSSU reported no significant growth. Doctor 9 appropriately discussed Personal Information redacted with Doctor 10 who agreed to review Personal Information redacted. The review team confirm Tazocin was correctly prescribed to cover intra – abdominal sepsis, a chest x ray, abdominal x ray and a surgical review were appropriately requested. Doctor 10 reviewed Personal Information redacted and again completed a thorough history and examination. Recent bloods were considered but again the review team note there was no documentation to indicate the MSU result was reviewed. The review team note Doctor 10 documented Personal Information redacted by the USI symptoms were not clinically very suggestive of appendicitis at the time but documented it would warrant investigation and consideration for laparoscopy if not settling. Tazocin was prescribed to cover sepsis, IV fluids, USS and Personal Information redacted was too fast for the ward round in preparation of the possibility of surgery.

The review team acknowledge there was an absence of continuity in Personal Information redacted's care. Personal Information redacted was reviewed multiple times by various doctors for the first 3 days. On each occasion consideration was not given for the normal MSU result and failed recognition of Personal Information redacted's worsening clinical symptoms which were suggestive of appendicitis. The review team are mindful a diagnosis of appendicitis was not made until 3 days after her admission following the CT scan report on Personal Information redacted by the USI at 13:49 which confirmed a perforated appendix or Meckel's diverticulum. The review team can confirm Personal Information redacted

was given high importance on the emergency theatre waiting list that day, theatre staff sent for [redacted] at 18:33 and surgery was commenced at 19:23.

The review team reviewed the theatre operation notes by Doctor 12 on [redacted] and confirm a lower mid-line laparotomy was performed which confirmed a perforated gangrenous appendix. The review team confirmed that this is an acceptable approach when dealing with a presumed difficult perforated appendix with generalised tenderness. The review team conclude a lower midline laparotomy offers good access to the pelvis to perform a difficult appendectomy and thorough wash out. The review team note there were no documented issues with the procedure and samples were appropriately taken for histopathology. The review team can confirm histopathology results confirmed acute perforated necrotic appendicitis. The review team confirm microbiology testing from an intraabdominal swab taken at the time of surgery confirmed coliforms present and Gentamycin (commenced on [redacted] was the appropriate treatment.

The review team note that following appendectomy it was reported during the ward round on the morning of the [redacted] that [redacted] felt she was improving. On the [redacted] the review team note it was documented that [redacted] had a temperature spike post laparotomy and determined this can sometimes be a typical response following a laparotomy for a perforated appendicitis. Haematological investigations were appropriately requested and [redacted] was able to eat and drink. It was documented [redacted]'s WCC was elevated which again the review team determined would be understandable after a perforated appendix and laparotomy. It was documented [redacted] had no peritonism on examination. The review team are conscious [redacted] became tachycardia and hypotensive and had a syncope episode and was again reviewed by the surgical team. In hindsight the review team acknowledge [redacted]'s symptoms and syncope episode was probably due to haemorrhagic shock. The review team are conscious [redacted]'s symptoms (tachycardia, feeling unwell) were not unusual following a ruptured gangrenous appendectomy and therefore consideration was not given until later in the evening for a post operation bleed. The review team acknowledge Doctor 16's decision at 22:00 to proceed to an explorative laparotomy without CT imaging was appropriate considering [redacted] had significantly deteriorated.

The review team are aware intraabdominal sepsis is a medical emergency. The review team determined [redacted] presented to CAH ED with symptoms of a possible UTI/ appendicitis. However the review team note medical staff did not review the MSU result which was available on [redacted] at 11:24. On two occasions it was noted [redacted] had rebound pain, there was no loin pain documented which is usually a classical symptom of Pyelonephritis. [redacted] was reviewed by a number of doctors who did not consider a change in diagnosis despite [redacted]'s worsening of symptoms. The review team determined there was enough information and clinical suspicion to warrant an earlier follow up review by the surgical team or escalation to more senior doctor to reassess and reconsider diagnosis due to [redacted]s worsening symptoms despite treatment. The review team are conscious [redacted] had an emergency appendectomy 3 days after admission. The review team determined the MSU result and [redacted]'s worsening symptoms should have warranted an earlier change to [redacted]s management plan and consideration for appendicitis.

The review team acknowledge there were no significant symptoms for 24 -36 hours post appendectomy. [redacted] however deteriorated with a temperature spike, tachycardia and hypotension and subsequently had a syncope episode. [redacted]'s symptoms of tachycardia, paleness and fainting

were symptoms consistent with shock and consideration should have being given earlier for a CT scan to rule out a post-operative bleed.

The review team reviewed the consultant surgeon's theatre operation notes of the Personal Information redacted by the USI and noted the operative findings documented there was a large amount of blood around the spleen, the capsule of the spleen was detached, and these findings were documented to be in keeping with a delayed rupture of a splenic haematoma. There was ongoing bleeding noted from the spleen and a splenectomy had to be performed as the spleen could not be preserved. The review team determined the initial laparotomy performed on Personal Information redacted by the USI used a lower midline incision to gain access to the abdominal cavity; the appendectomy was performed in a site distant from the spleen. A possible operative cause for a splenic haematoma may have happened during the washout of the abdominal cavity at the end of the procedure when suction may have been used to wash out the abdominal cavity.

14. What has been learned?

The review team determined earlier consideration should have been given for appendicitis in this case. Due to Personal Informati on redacted's worsening symptoms despite treatment for UTI / Pyelonephritis an appendicitis diagnosis should have been re-considered earlier. Following a mini-laparotomy Personal Informati on redacted deteriorated and symptoms warranted earlier consideration for post-operative bleed.

15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

If a patient is admitted with a possible diagnosis of a UTI and subsequently the MSU returns with negative result this should prompt an immediate review and raise the possibility of appendicitis as an underlying cause.

Whilst the actual cause of the splenic haematoma may never be identified in this particular case. Great care should be taken during laparotomy to avoid occult splenic injury especially when performing a wash out of the abdominal cavity at the end of the procedure.

16. RECOMMENDATIONS (please state by whom and timescale)

1. In patients presenting with a possible diagnosis of a query UTI or appendicitis a surgical review should be made in the ED, if admission is required it would be more appropriate for such patients to be admitted surgically.
   If a patient is admitted medically and there is a clinical suspicion of appendicitis daily surgical review should occur, recording patient details on the surgical handover sheet would enable this daily review. Actioned by: AD/ CD surgery

2. The report will be shared with staff involved for reflection and learning. Actioned by HOS for ED/Medicine/ Surgery.

3. The report will be presented at the ED, Surgical and Medical Morbidity & Mortality (M&M) meeting for learning. Actioned by: Acute Governance team to share report with M&M chairs.

17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

18. FURTHER REVIEW REQUIRED? NO
Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A <u>FURTHER REVIEW IS</u> REQUIRED)

19. PLEASE INDICATE LEVEL OF REVIEW:
LEVEL 2 / LEVEL 3
Please select as appropriate

20. PROPOSED TIMESCALE FOR COMPLETION:
DD / MM / YYYY

21. REVIEW TEAM MEMBERSHIP *(If known or submit asap)*:

22. TERMS OF REFERENCE *(If known or submit asap)*:

SECTION 5

APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR

23. NAME:

24. DATE APPROVED:

25. DESIGANTION:

SECTION 6

26. DISTRIBUTION LIST:

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1					
INFORMING THE SERVICE USER[1] / FAMILY / CARER					
1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert **date informed**:				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER ***(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)***				
5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	b) Plan to share final review report at a later date and further engagement planned	
	c) Report not shared but contents discussed ***(if you select this option please also complete 'l' below)***	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SECTION 2				
INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) ***(complete this section for all death related SAIs)***				
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date report shared**:			
	If **NO**, please provide details:			
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

Southern Health and Social Care Trust

Clinical Audit Summary Report to Acute Directorate Clinical Governance Meeting, 7th April 2021

	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate	Action
1	IV Fluids in children and Young People:	ADs		Continuous	Cases have been reviewed as below. Appendix 1 - Acute PIVFAIT_chart compli A funding application has been submitted to RQIA to undertake a Comprehensive NG29 Annual surveillance audit. This has been successful. The audit scheduled to commence April 2021.	Data to be shared at the next Hyponatraemia Oversight Group meeting Acute Directorate to run a monthly information request to identify 14/15 year olds in Acute wards Acute Directorate to ensure all wards accepting 14/15 year olds send return to Clinical Audit. Outstanding cases to be reviewed with Sr Sherry / nominated staff.
2	Clinical Audit work programme, Acute Directorate	All	Operational teams		Directorate's clinical audit work programme attached. Database Clinical Audit Acute as at 26 I	For information.
3	HQIP reports	All	Operational teams		HQIP reports have been disseminated and to be shared or disseminated within your structures please for learning that informs improvement plans and future audit.	For information.

	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate	Action
4	NCEPOD Dysphagia in people with Parkinson's Disease study	C McGoldrick	R Haffey	Data submitted Data submitted	NCEPOD are undertaking a study to look at the care of patients with Parkinson's Disease (PD) who are admitted to hospital when acutely unwell. Patient identification spreadsheet submitted to NCEPOD following approval. Case note extract and clinical questionnaires selected by NCEPOD have been forwarded to NCEPOD. Organisational questionnaires completed and submitted for Craigavon, Daisy Hill, Lurgan and South Tyrone Hospitals. The report is due for publication in the summer of 2021.	Await report
5	NCEPOD Acute Heart Failure Audit	Mrs K Carroll	Dr A Gray / nominee	To be advised	Report has been disseminated November 2018. Recommendation in the Report: Hospitals should audit against the standards contained in the final reports annually. Information request submitted re all adult patients admitted with diagnosis of Heart Failure from 1st April 19 to 31st March 2020. Kay Carroll to complete template with Dr Gray.	Kay Carroll to complete template with Dr Gray. Information request also submitted.
6	NCEPOD: Physical Healthcare of Inpatients in a Mental Health Hospital	All	R Haffey	26/03/2021 02/04/2021	• Organisational Questionnaire dissemination - Trust-Level" questionnaire for each Mental Health Trust/ Health & Social Care Trust/ Local Health Board. – deadline to submit is 26th March 2021 • 7 Clinician questionnaires to be completed via online link by Mental Health Consultants / 7 case note extracts requested – deadline to submit is 2nd April 2021	Clinical and organisational Questionnaires to be completed by MHLD
7	NCEPOD: Alcohol Related Liver Disease	All	R Haffey	30/06/2021	Organisational questionnaires to be assigned for CAH and DHH. Completion of these via online link. Mrs McVey to liaise with Dr P Murphy re nomination to complete.	Organisational Questionnaires to be completed. **Nominee to be identified by Acute to complete these.**

	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate	Action
8	National End of Life Audit (NACEL) – Round 2	Mr B Conway	Mr D Calvin, Dr G Nicholson	Report	Reports have been emailed to Director, Associate Medical Director, Assistant Director and Mrs Leeman. **<u>Update from Mr D Calvin</u>** A meeting is to be scheduled to discuss the locality findings and how we plan to address the recommendations for our Trust.	Reports to be shared / disseminated within the structures for learning that informs improvement plans and future audit
9	National End of Life Audit (NACEL) – Round 3	Mr B Conway	Mr D Calvin, Dr G Nicholson	To be advised	The NACEL Round Three elements were: • Organisational level audit: which comprises of a hospital/site overview and a Trust/Health Board overview. • Case Note Review: similar to round two, will focus on the themes of recognition of dying and individual plan of care. • Quality Survey: a survey of bereaved carers to gather feedback on their experience of care delivered during the patient's final admission into hospital. • Staff Reported Measure: NEW element. A survey to garner staff experience and confidence in delivering care to dying patients and those important to them.	
10	ED Palliative Care Audit		Dr Paul Webster and David Calvin		The audit will focus on attendances at CAH on 1st May 2019. From these attendances any patient that was 18 years/18 years plus of age and admitted to a hospital bed will be part of the audit.	

	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate	Action
11	NHS Benchmarking Audit Managing Frailty in Acute Settings 2019	K McGoldrick	P Fearon (User Audit)	Data submitted (User Audit) Data submitted	Two elements Submissions from Craigavon and Daisy Hill Hospitals required. a) Service User Audit – 50 cases from CAH and DHH. Data collection completed and signed off for submission. b) Organisational Benchmarking data - Managing Frailty and Delayed Transfers of Care in the Acute Setting. Data submitted. Service User Audit 2019 FINAL - BLANK (Managing Frailty spec 2019 - FINAL.xls	Await report
12	NHS Benchmarking Audit Managing Frailty in Acute Settings 2020	K McGoldrick		20/11/2020	Registration for the 2020 Managing Frailty and Delayed Transfers of Care in the Acute Setting benchmarking project is now open. The project will be collecting 2019/20 financial year data. **Project key dates** • Data collection opens: 14th September 2020 • Data collection closes: 20th November 2020 • Reporting and events: February/March 2021	Await report
13	IBD UK – IBD Benchmarking Tool	Ms L Devlin	Dr Bhat	Data submitted (Survey) Data submitted (Benchmarking)	Benchmarking audit with the quality markers being drawn from the recent standards review. 3 reports will be generated – The patient survey for the site, the site specific assessment and a national report. Benchmarking data submitted by Dr Bhat.	Await report

	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate	Action
14	Royal College of Emergency Medicine audits 2019-20. ➢ Mental Health	Mrs A McVey, Mrs M Burke	Dr Patton, Dr Perry, Dr Mawhinney	Data submitted	**Methodology / Inclusion criteria** Data should be collected on patients attending from 1 August 2019 – 31 January 2020. Data is entered directly by a Doctor to the RCEM audit tool - direct entry changes the usual process for internal sign-off / approval.	Await report
15	Royal College of Emergency Medicine audits 2020-21.	Mrs A McVey, Mrs M Burke, Mr P Smith	Dr D Patton		**Royal College of Emergency Medicine 2020/2021** • 2020/2021 Audit and QIP programme • Pilot in spring 2020, registration from July 2020, data entry from Aug 2020. • Fractured Neck of Femur • Pain in Children • Infection Control • Please note that the planned Homeless Inclusion Health topic has been postponed and replaced with Infection Control to better support safe and high quality care at the current time.	

	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate	Action
16	Audit of the perioperative management of anaemia in children undergoing elective surgery, NHS Blood and Transplant				The NHS Blood and Transplant have indicated that in April 2020 they will be looking at an audit on the management of anaemia in children who are admitted for elective surgery. This audit will be undertaken by anaesthetists. They have not yet started to recruit, because the audit is still in its pilot stage. They will let Trusts know when an anaesthetist has signed up for the audit, or if an anaesthetist has not signed up they would like the Trust to identify one of this team. A REVIEW OF THE 2020/21 AUDIT PROGRAMME - In light of COVID-19, the Project Group has decided to postpone the audit of the perioperative management of anaemia in children undergoing elective surgery until early summer, so I will keep you advised about progress with that. Similarly, we were planning a short survey to look at the use of FFP, Cryo and PCC, but that, too, may be placed on hold. Pending resumption of those audits, we will continue to process data for and report the outstanding 3 audits.	Email has been sent to Dr Scullion and Mr Carroll and Mrs P Watt on 6/3/2020 for awareness. Update from NHS Blood and Transplant
17	NG 29 Annual Surveillance audit	All	Mrs F Davidson	Audit postponed to 1/4/2021	A submission regarding the Innovative NG 29 Annual Surveillance audit was forwarded to RQIA for their consideration. Rationale for the audit: The DHSSPSNI endorsed the NICE guidance (NG 29) for intravenous fluid therapy in children and young persons. As part of the SHSCT's accountability responsibilities for Standards and Guidelines (S&G), all of the guideline's 32 recommendations have been reviewed. The outcome has provided a scoping specification of the evidence that would demonstrate that effective systems and processes are in place to ensure the NG 29 Guidance is met. Referenced in Item 1 above also. Meeting to be held with RQIA prior to commencement of the audit.	The audit, co-project lead and Mr Haffey attended a meeting with RQIA on 20/1/20 with members of the funding allocation panel to discuss the application. Notification has been received that RQIA have approved the NG29 project proposal for an annual surveillance audit. Postponement of audit as discussed with RQIA to 01/04/2021. Meeting to be held with RQIA

	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate	Action
18	British Thoracic Society (BTS) Pilot Audit of Outpatient Management of Pulmonary Embolism				BTS will run a pilot audit of Outpatient Management of Pulmonary Embolism in April 2021 (pilot audit period 1 Feb 2021- 30 April 2021, data entry period 1 April- 30 April 2021). This audit will help prepare for the National Audit which will be held later in the year (see below). If you have been chosen to participate, **please email the completed registration form to** Personal Information redacted by the USI [redacted]	
19	British Thoracic Society (BTS) National Pleural Services Organisational Audit				The new national organisational audit of Pleural Services will open in April 2021 (national audit period 1 April – 30 April 2021, data entry period 1 April 2021 to 30 June 2021). This audit will collect information on organisational resources related to Pleural Procedures, which will inform the development of future standards. Please note that this audit will only require **one response per institution**. If you are interested in participating, please download and complete the registration from found here, and email the completed form to Personal Information redacted by the USI [redacted]	
20	British Thoracic Society (BTS) National Smoking Cessation Audit				The next National Smoking Cessation Audit will run in 2021 (national audit period 1 July – 31 August 2021, data entry period 1 July- 31 October 2021). Further details will be provided on the BTS website and forthcoming audit emails within the coming months.	
21	British Thoracic Society (BTS) National Outpatient Management of Pulmonary Embolism Audit				The new national Audit of Outpatient Management of Pulmonary Embolism will run in 2021 (national audit period 1 August – 30 September 2021, data entry period 1 August- 30 November 2021), depending on successful completion of the pilot. Further details will be provided on the BTS website and forthcoming audit emails within the coming months.	

	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate	Action
22	British Thoracic Society (BTS) Call for case studies				We at BTS are keen to expand our range of case studies on the BTS website related to audit and quality improvement. If you have a project you would like to share, please contact Louise Preston via email at Personal Information redacted by the USI [redacted].	
23	Dissemination to M&M Chairs	All			Dissemination of Safety and Quality Reminders, E-Alerts and PHA Letters to M&M Chairs.	All of these three items will continue to be shared with M&M Chairs by Clinical Audit / M&M team
24	MCCD book - contingency arrangements for death certification when RM&MRS is down	All	Operational teams		The MCCD booklets are now stored on the Patient flow office, in both CAH &DHH and Sister office Ward 1, Lurgan Hospital. These booklets are for only for use in as a contingency when the NIECR system is down. A communication from the Medical Director's office has been shared regarding this matter.  Location of Paper Death Certificates.do	
25	Feedback on Process for Emailing of MCCD to GRO	All			All MCCD are to be emailed to the GRO. The attached guidance was also most recently issued to all medical staff on 28/07/2020. **Memo - Update to Process for Emailing MCCDs with IMMEDIATE EFFECT – sent to M&M Chairs 28/7/2020** • As a result of on-going difficulties in ensuring that all Medical Certificates of Cause of Death (MCCDs) are emailed to: Personal Information [redacted] - mortuary staff have agreed to undertake this process on RMMRs **with immediate effect**. • This change has been agreed with the Death Certification Branch of the DoH and the General Registrar's Office. The process of MCCD completion via RMMRs by medical staff remains unaffected, but stops short of the email step to the GRO.	

	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate	Action
26	Morbidity and Mortality meetings	All			CMO letter on Coronavirus COVD 19 - reducing Mortality and Morbidity review advised the following: 1. All deaths in hospital should continue to be recorded on RM&MRS. This is important as the Medical Certificate of Cause of Death (MCCD) needs to be printed from that system. 2. Where possible, the MCCD should continue to be reviewed by a consultant as is currently the case. This is particularly true of those cases where COVID-19 is a suspected contributor. 3. M&M meetings should no longer be held to review all deaths occurring in hospital. Instead, Trusts will be given flexibility to determine what deaths should be reviewed and are asked to undertake a risk-based approach. This may mean that only those deaths which are related to COVID-19 or those deaths where potential harm has been caused will be reviewed. It is also understood that any such review will not take the form of a normal M&M review but may be a much more high-level review. **Update received from Chief Executive on 25/6/2020 regarding Morbidity and Mortality reviews for adult deaths in hospital** • The CMO has requested that Trusts recommence M&M reviews for all adult deaths using the RM&MRS from 1 July 2020 and this has been shared with the M&M Chairs on 26/6/2020. Additional consideration is also requested, 'I would ask that when conducting M&M reviews, that consideration is given to whether COVID-19 had a direct or indirect impact on the death, reflecting on, for example, whether a delayed referral to hospital or non-accidental injury may have been a factor in the death. This information will be extremely helpful for any future considerations and plans'. • Difficulty for new Locum appointments completing death certificate on NIECR. These new appointments require to be added to their respective M&M team on NIECR. M&M facilitators to be advised of new starts.	

	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate	Action
27	Daily inpatient mortality surveillance reporting				We run a daily inpatient mortality surveillance report which is forwarded to the Chief Executive. There are two aspects to this: • Number of inpatient deaths reported to the PHA in the last 24hours, as meeting the definition (+ve C19 test within 28 days of death) • The patient is reported to the PHA Mortality Surveillance by the Doctor who has completed the Initial record of Death via the PHA reporting form **PHA COVID-19 Patient Deaths - Reporting Form** • Number of inpatient deaths enrolled on the NIECR mortality pathway containing C19 on the MCCD with negative virology. The completion of the MCCD as early in morning (pre-9am) if possible will assist with Mortality Surveillance timeframes.	

Appendix 1

Acute directorate (including ATICS): Paediatric IV fluid audit improvement tool (PIVFAIT) Results 1st May 2018- 21st March 2021[1]

The Acute Directorate Paediatric IV Fluid Audit Improvement Tool (PIVFAIT) assesses 9 indicators / questions for all patients aged 14-15 years who received IV fluids during their hospital admission.

The 9 indicators / questions are:

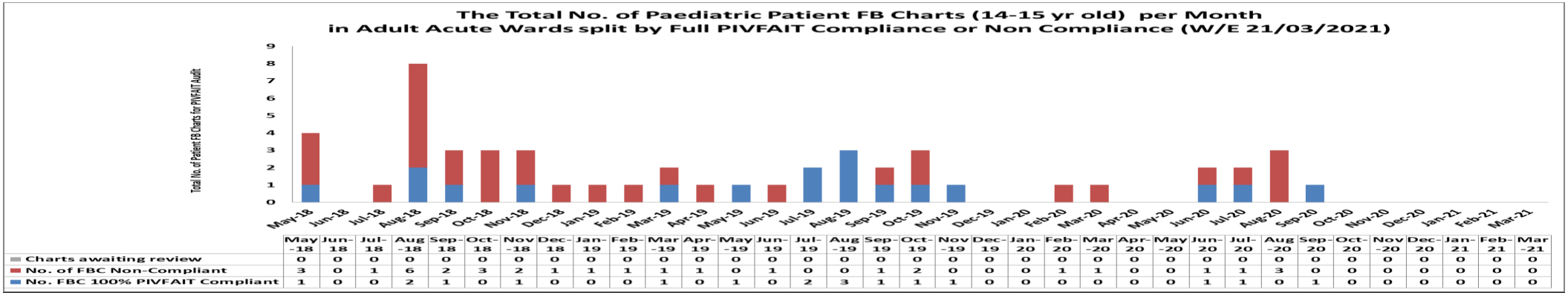
Indicator / Question		Details
1	**Patient identification**	Are ALL the following **patient identifiers** provided on both sides of the DFBC? 1. Full Name 2. Date of birth 3. Hospital number
2	**Glucose Monitoring**	While the child is receiving IV fluids, is there a **Blood Glucose result** recorded on the DFBC (in accordance with the 2017 Paediatric Therapy Wallchart) i.e. at least 12 hourly?
3		Were ALL **Blood Glucose** measurements greater than 3mmol/L? If answer = No; Enter Hospital Number of those below 3mmol/L for Trust audit dept. to check for treatment.
4	**Cumulative input and output totalling and fluid balance.**	Are ALL of the following amounts (in mls) recorded on the DFBC? 1. Oral/IV amounts, (all administered types of intake to be recorded). 2. Day and night totals. 3. Grand Total IN 4. Grand Total OUT 5. 24 hour Fluid Balance
5	**Patient weight**	Is there a patient weight in kgs, given on the DFBC?
6	**DFBC calculation guidance completed.**	Are the appropriate calculation guidance sections for the IV therapy completed?
7		Are there coded indications for the fluid administration provided?
8	**Electrolyte monitoring**	Is there an E&U result recorded on the DFBC, (in accordance with the 2017 Paediatric Therapy Wallchart)?
9	**12 hour assessment.**	When IV fluids are administered for longer than 12 hours. Is there a 12 hour Reassessment box* appropriately completed on the DFBC with an answer to the question: Is the infusion prescription still suitable - followed by a doctors signature? * Can be 10 - 14 hours .

Acute Directorate PIVFAIT OUTCOME

18 of the 51 FB charts (35%) recorded 100% PIVFAIT compliance in the last 32 months.

[1] Audit data is based on returns made by wards at this date.

Appendix 1



	May -18	Jun-18	Jul-18	Aug -18	Sep-18	Oct-18	Nov -18	Dec-18	Jan-19	Feb-19	Mar -19	Apr-19	May-19	Jun-19	Jul-19	Aug -19	Sep-19	Oct-19	Nov -19	Dec-19	Jan-20	Feb-20	Mar -20	Apr-20	May -20	Jun-20	Jul-20	Aug -20	Sep-20	Oct-20	Nov -20	Dec-20	Jan-21	Feb-21	Mar -21
Charts awaiting review	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
No. of FBC Non-Compliant	3	0	1	6	2	3	2	1	1	1	1	1	0	1	0	0	1	2	0	0	0	1	1	0	0	1	1	3	0	0	0	0	0	0	0
No. FBC 100% PIVFAIT Compliant	1	0	0	2	1	0	1	0	0	0	1	0	1	0	2	3	1	1	1	0	0	0	0	0	0	1	1	0	1	0	0	0	0	0	0

The bar chart and table show that 4 of the 11 Charts audited since Nov 19 has had full compliance.

Question Compliance	May 18	Ju 18	July 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
1. Patient identification	75%	n/a	100%	88%	33%	100%	67%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%	n/a	n/a	100%	100%	n/a	n/a	100%	100%	100%	100%	n/a	n/a	n/a	n/a	n/a	n/a
2. Glucose Monitoring (Blood Glucose result recorded on the DFBC)	75%	n/a	100%	88%	67%	100%	100%	0%	100%	0%	50%	100%	100%	100%	100%	100%	100%	67%	100%	n/a	n/a	0%	100%	n/a	n/a	50%	50%	33%	100%	n/a	n/a	n/a	n/a	n/a	n/a
3. Glucose Monitoring (Blood Glucose measurements greater than 3mmol/L?)	75%	n/a	100%	88%	100%	100%	100%	0%	100%	0%	50%	100%	100%	100%	100%	100%	100%	67%	100%	n/a	n/a	0%	100%	n/a	n/a	50%	50%	67%	100%	n/a	n/a	n/a	n/a	n/a	n/a
4. Cumulative input and output totalling and fluid balance	25%	n/a	0%	75%	100%	33%	33%	100%	100%	0%	100%	100%	100%	0%	100%	100%	100%	100%	100%	n/a	n/a	100%	0%	n/a	n/a	50%	100%	67%	100%	n/a	n/a	n/a	n/a	n/a	n/a
5. Patient weight	75%	n/a	100%	100%	100%	67%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	n/a	n/a	100%	100%	n/a	n/a	50%	100%	100%	100%	n/a	n/a	n/a	n/a	n/a	n/a
6. DFBC calculation guidance completed	50%	n/a	0%	50%	100%	33%	67%	100%	100%	100%	50%	0%	100%	0%	100%	100%	100%	100%	100%	n/a	n/a	100%	100%	n/a	n/a	50%	100%	67%	100%	n/a	n/a	n/a	n/a	n/a	n/a
7. DFBC calculation guidance completed/a	50%	n/a	100%	88%	33%	67%	67%	100%	0%	0%	100%	100%	100%	100%	100%	100%	100%	67%	100%	n/a	n/a	100%	100%	n/a	n/a	50%	100%	67%	100%	n/a	n/a	n/a	n/a	n/a	n/a
8. Electrolyte monitoring	75%	n/a	100%	88%	67%	100%	100%	0%	100%	0%	50%	100%	100%	100%	100%	100%	50%	67%	100%	n/a	n/a	100%	100%	n/a	n/a	50%	50%	67%	100%	n/a	n/a	n/a	n/a	n/a	n/a
9. 12 hour assessment	75%	n/a	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	n/a	n/a	100%	100%	n/a	n/a	100%	100%	67%	100%	n/a	n/a	n/a	n/a	n/a	n/a

Appendix 1

Acute Directorate: ATICS: Paediatric IV fluid audit improvement tool (PIVFAIT)
Results 31st May 2019 – 21st March 2021

The Acute Directorate ATICS specific audit tool assesses 6 indicators / questions for all patients up to their 16th birthday who received IV fluids whilst in theatre.

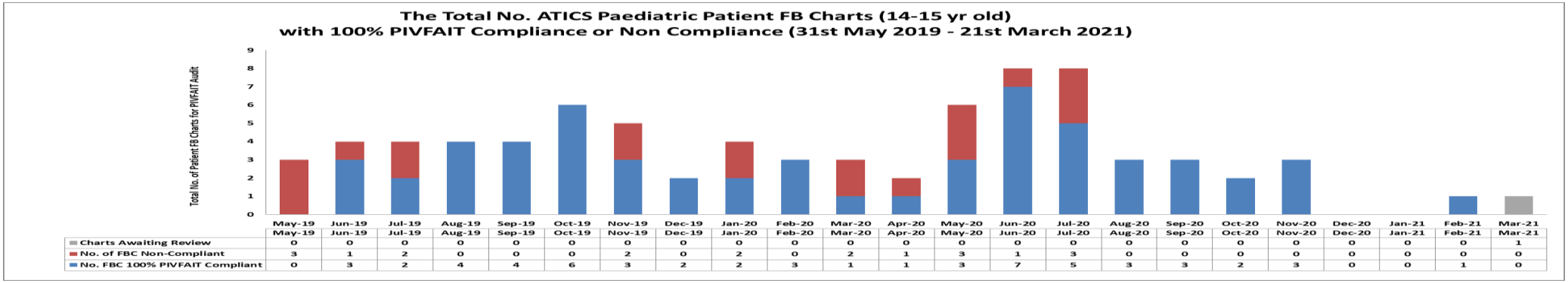
The 6 indicators / questions are:

Indicator / Question		Details
1	**Patient identification**	Are ALL the following **patient identifiers** provided on both sides of the DFBC? 1. Full Name 2. Date of birth 3. Hospital number
2	**Patient weight**	Is there a patient weight in kgs, given on the DFBC?
3	**Daily Fluid Balance & Prescription Chart**	Was the appropriate Daily Fluid Balance & Prescription Chart (Child up to 16th Birthday February 2017) chart commenced?
4	**Daily Fluid Balance & Prescription Chart**	Was the fluid volume given in Theatre / Recovery appropriately transferred onto the ward fluid balance chart prior to discharge from Theatre/Recovery
5	**Daily Fluid Balance & Prescription Chart**	If Fluids continue on to ward – were calculations done and coded?
6	**Fluids prescribed**	IF fluids were given in Theatre / Recovery please provide details A) Volume prescribed. B) Actual volume given. C)Type of fluid given
Additional information		
	Fluids prescribed	Did IV fluids continue when the patient was discharged to the ward on discharge from theatre/recovery? - Please note if the child continues to receive IV fluids outside the Theatre / Anaesthetics setting then the Ward is to complete the full audit

NB: 1 x ATICs cases in the period up to 21/03/2021 remain to be audited.

Appendix 1

58 of the 78 DFB charts (74%) recorded 100% ATICS Specific PIVFAIT compliance. 1 case await ATICS PIVFAIT review



The bar chart and table show that 24/28 charts audited since May 2020 have had full compliance.

Indicator / % Compliance by Month	May 19 (n=3)	Jun 19 (n=4)	July 19 (n=4)	Aug 19 (n=4)	Sept 19 (n=4)	Oct 19 (n=6)	Nov 19 (n=5)	Dec 19 (n=2)	Jan 20 (n=4)	Feb 20 (n=3)	March 20 (n=3)	April 20 (n=2)	May 20 (n=6)	Jun 20 (n=8)	Jul 20 (n=8)	Aug 20 (n=3)	Sep 20 (n=3)	Oct 20 (n=2)	Nov 20 (n=3)	Dec 20 (n=0)	Jan 21 (n=0)	Feb 21 (n=1)	Mar 21 (n=1)
1.Patient identification	33%	100%	75%	100%	100%	100%	60%	100%	50%	100%	67%	50%	83%	88%	100%	100%	100%	100%	100%	-	-	100%	-
2. Patient weight	67%	75%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	83%	88%	100%	100%	100%	100%	100%	-	-	100%	-
3. Appropriate Daily Fluid Balance & Prescription Chart	100%	100%	75%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-	-	100%	-
4. Daily Fluid Balance & Prescription Chart - volume appropriately transferred to ward fluid balance chart	67%	100%	100%	100%	100%	100%	80%	100%	100%	100%	67%	100%	50%	100%	88%	100%	100%	100%	100%	-	-	100%	-
5. Daily Fluid Balance & Prescription Chart - calculations done and coded?	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	67%	100%	100%	100%	75%	100%	100%	100%	100%	-	-	100%	-
6. Fluids prescribed	100%	75%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	83%	100%	100%	100%	100%	100%	100%	-	-	100%	-

Appendix 1

Charts Awaiting Review from previous report-

ATICS

Theatre CAH:

1 case from the following date is awaiting review.

- 04/03/2021 – for review

SHSCT Clinical Audit Work Plan

Audit type (National, Regional, Local)	HQIP Audit Level tba=to be advised	Audit Year	Audit title	Name of Junior Doctor/HCP/ Auditor	Audit lead	Site	Acute Division	Status tba=to be advised
National	1	2021-22	National Audit of End of Life Care (NACEL)	David Calvin	Barry Conway	CAH/DHH	All	Planned audit
National	1	2020-21	Breast cancer management pathways during the covid-19 pandemic-A national Audit	Dr N Scally	Ms Helen Mathers	CAH	CCS/SEC	Live Audit
National	1	2020-21	PROTECT-ASUC Covid 19 Pandemic response of assessment, endoscopy and treatment in AcuteSevere Ulcerative Colitis. A Multi-centre case control study	Dr G Morrison	Mr S Bhat	CAH	MUSC	Live Audit
National	1	2020-21	GlobalSurg-CovidSurg Week	Dr L Armstrong	Mr K McElvanna	CAH	SEC	Planned Audit
National	1	2020-21	Determining the optimal timing for surgery following SARS-CoV-2 infection	Dr D Angelou	Mr R Thompson	DHH	SEC	Ongoing
National	2	2021-22	Covid-19 Impact on Pancreatic Cancer Care Pathway	Dr R Fox	Mr Epanomeritakis	CAH/DHH	CCS	live audit
National	2	2020-21	The impact of COVID on maternity services	Dr R. DeCourcy-Wheeler	Dr R. DeCourcy-Wheeler	CAH/DHH	IMWH	Live Audit
National	2	2020-21	Paediatric Left Before Treatment		Dr R Spedding	DHH	MUSC	Live Audit
National	2	2020-21	HAREM Study.Had Appendicitis and Recovered/Recurred Emergency Morbidity/Mortality Dr G Nixon	Dr G Nixon	Mr D McKay	CAH	MUSC/SEC	Live Audit
National	2	2020-21	COVID Stones: An observational multi-centre cohort study investigating the clinical management and outcomes of ureteric stones during the COVID-19 pandemic in the United Kingdom	Dr Mahmoud Nosseir	Mr M Young	CAH	SEC	Continuous
National	2	2020-21	Integrate Covid-19 Emergency Care Audit	Dr B Wright	Mr E Reddy	CAH	SEC/ENT	Live Audit
National	2	2020-21	ENT UK 2 week wait telephone triage:service evaluation	Dr B Wright	Mr Ramesh Gurunathan	CAH	SEC/ENT	Live Audit
National	2	2020-21	Covid-19 Laryngectomy Impact-RCSLT	Dr Conor McKenna	Mr R Gurunathan	CAH	SEC/ENT	Planned audit
Regional	2	2020-21	Audit of number of patients with diagnosis of gastric polyp and benign neoplasm of the stomach from 1st July 2018 to 30th June 2019	Dr K Tang	Dr Seamus Murphy	DHH	MUSC	Planned Audit
Regional	3	2020-21	Investigation of Drug Charts in accordance with current guidelines	Dr Rait/Dr Greene	Dr M Eltom	CAH	MUSC	Completed
Regional	3	2020-21	ED Palliative Care Audit	David Calvin	Martina Thompson	CAH	MUSC	Planned Audit
Regional	3	2020-21	Audit of lumbar puncture rates and application of McDonnell diagnostic criteria for multiple sclerosis in N Ireland	Dr Jamie Campbell	Dr Jamie Campbell	CAH, DHH	MUSC	Planned audit
Regional	3	2020-21	Standard interval dosing Vs extended interval dosing with Natalizumab in patients with Multiple Sclerosis		Dr Jamie Campbell	CAH	SEC	Planned Audit
Regional	3	2021-22	Restarting DOAC's Post -operatively in Trauma Patients	Dr J Clarke	Mr B Watson	CAH/DHH	SEC	live audit
Trust	2	2021-22	Audit of prescribing of anti-androgen medicine "Bicalutamide"		Mr M Haynes	CAH/DHH	CCS	live audit
Trust	2	2021-22	Impact of the pandemic on ectopic pregnancy outcomes	Dr Tsveta Hadjieva	Dr S Finnegan	CAH/DHH	IMWH	Planned Audit
Trust	2	2020-21	Should we change the way we cast ankle fractures	Dr P Karayiannis	Miss Veronica Roberts	CAH	SEC/T&O	Planned Audit
Trust	2	2020-21	Incidence of "cortical blow out" in DHS in Craigavon Area Hospital	Dr P Karayiannis	Mr P Magill	CAH	SEC/T&O	Planned Audit
Trust	2	2020-21	Impact of Elective Orthopaedic Telephone Clinics on waiting times and patient satisfaction	Dr P Karayiannis	Miss Lynn Wilson	CAH	SEC/T&O	Planned Audit
Trust	3	2020-21	Documentation Audit of the Blood Transfusion Process	Patricia Watt	Dr Mark Bridgham	CAH/DHH	ALL	Planned audit
Trust	3	2020-21	Peri-operative diabetic audit	n/a	Dr Anna Laird	CAH	ATICS	Planned audit
Trust	3	2020-21	Audit of Post operative analgesic use after 3 months	Dr B Campbell	Dr P McConaghy	CAH	ATICS	Planned Audit
Trust	3	2021-22	National Emergency Laparotomy Audit	Dr K Foreman	Dr A O'Neill	CAH/DHH	ATICS/Theatres	Planned Audit
Trust	3	2020-21	Documentation Audit of the Blood Transfusion Service	Patricia Watt	Dr Mark Bridgham	CAH	CCS	Live Audit
Trust	3	2020-21	" Go with the flow"	Dr Laura Johnston/Lauren Heatherington	Dr Shilpa Shah/Dr Veena Vasi	CAH	CYP	Planned Audit
Trust	3	2020-21	Use of Valproate in women of childbearing age in neurology service	Dr E McKeever	Dr K McKnight	CAH	IMWH	Planned Audit
Trust	3	2020-21	Obstetric complications in women of East Timor origin	Dr Colm Coyne	Dr K Niblock	CAH	IMWH	Live Audit
Trust	3	2020-21	Completion of VTE risk assessment in post natal women	Dr Laeticia Ezeilo	Dr K Loane	CAH	IMWH	Live Audit
Trust	3	2021-22	Sepsis	Dr B Barbulescu	Dr Cara McKeating	CAH/DHH	Medicine	Planned Audit
Trust	3	2020-21	Audit of time to diagnosis of Multiple Sclerosis when CCG service has been utilised in primary care	Dr Catherine Donaldson	Dr Jamie Campbell	CAH	MUSC	Planned Audit
Trust	3	2020-21	Audit of pulmonary embolism follow up in Craigavon Area Hospital	Dr Conor Hagan	Dr R Convery	CAH	MUSC	tba
Trust	3	2020-21	Integrated Medicines Management Pharmacy Technician	Jane Haydock	Anne McCorry	CAH	Pharmacy	Planned Audit
Trust	3	2020-21	A Service evaluation of the reformed OPAT service in the SHSCT	Lisa Lennon	Dr Geraldine Conlon-Bingham	CAH	Pharmacy	Live Audit
Trust	3	2021-22	Procalcitonin testing and antibiotic use in suspected Covid-19	Geraldine Conlon-Bingham,	Dr Cara McKeating	CAH/DHH	Pharmacy	Ongoing
Trust	3	2020-21	Planning staff reserves for future Covd-19 outbreaks based on specialty specific risk stratification for obtaining Covid-19 infection	Dr Dimitrious Angelou	Mr David Mark	CAH	SEC	Ongoing
Trust	3	2020-21	Incidence of male breast cancer in Southern Trust		Dr Reem Salman	CAH	SEC	Live Audit
Trust	3	2020-21	How should displaced ankle fractures requiring operative management be immobilised at presentation? A review of ankle fractures requiring external fixation in the period July 2019 – July 2020.	Dr Scarlett O'Brien	Ms Veronica Roberts	CAH	SEC	Live Audit
Trust	3	2020-21	Compliance with DKA Protocol in patients admitted to DHH	Dr H Mustafa	Dr Y Abdelaal	DHH	SEC	Planned Audit
Trust	3	2020-21	Close assessment of pre-op for FESS	Dr Chin Mun Soong	Mr T Farnan	CAH	SEC	Live Audit
Trust	3	2020-21	Breast cancer management for over 70 year olds Southern Trust		Dr Reem Salman	CAH	SEC	Live Audit
Trust	3	2020-21	Acute Ligamentous knee injuries-time	Dr R Espey/Dr I Kennedy	Dr J Rankin	CAH	SEC	Live Audit
Trust	3	2021-22	Audit into the management of intercranial bleeds	Dr L Watt	Dr M Rizeq	CAH/DHH	SEC/ATICS	Planned Audit
Trust	4	2020-21	Over transfusion in the Delivery Suite	Dr Mathew Ferguson	Mr Colin Winter	CAH/ DHH	ATICS	Live Audit
Trust	4	2020-21	Audit of neuroimaging in ICU against RCR iRefer standards	Dr T Patterson	Dr C Shevlin	CAH	ATICS	Planned audit
Trust	4	2021-22	Audit to determine the number of true penicillin allergy patients on the AMU in CAH	Michelle Murphy	Geraldine Conlon-Bingham	CAH	Pharmacy	Planned audit
Trust	4	2020-21	Satisfaction survey of pinnaplasty outcomes	Dr Aoife Mallon/ Dr Dominic McKenna	Mr E Reddy	CAH	SEC	Planned Audit
Trust	4	2020-21	Review of urgent cholesystectomy for acute bilairy colic, acute cholecystitis and gallstone pancreatitis	Stephanie O'Hare	Dr Susim Kumar	DHH	SEC	Planned Audit
Trust	4	2021-22	Parotid Surgery in the Southern Trust: An overview of techniques, complications and changing trends	Dr J Smith	Mr E Reddy	CAH/DHH	SEC	Planned Audit
Trust	tba	2020-21	e-CRABEL audit on standard of medical records	Dr J Beck		CAH	SEC	tba

MANAGING FRAILTY AND DELAYED TRANSFERS OF CARE IN ACUTE SETTINGS

GUIDANCE NOTES FOR THE SERVICE USER AUDIT 2019

British Geriatrics Society
Improving healthcare for older people

Benchmarking Network

This document provides guidance on completing the service user audit element of the managing frailty and delayed transfers of care in acute settings benchmarking project.

- Trusts/UHBs are requested to select one care of older people ward or medical ward for the service user audit.
- 50 consecutive discharges should be selected for the service user audit, running simultaneously with the main data collection period (15th July to 27th September 2019).
- A project lead should be allocated on the ward to co-ordinate and collate the results and use the information to complete the service user audit data collation tab on this workbook.

INSTRUCTIONS

1. The service user audit should be completed on the excel spreadsheet on the next tab.
   There is a printable version of the questions available in this workbook to assist with data collection on the ward
2. The care of older people ward should complete the service user audit for 50 consecutive service users who are discharged from the ward.
3. The service user audit should be completed on discharge from the care of older people's ward.
4. The definitions of the questions asked in the service user audit are available on the following tab.
5. The data collection period is from 15th July to 27th September 2019. The service user audit may be completed at any time during this period.
   It is suggested that the data is collected on the printable versions of the service user audit and then the results entered onto the excel spreadsheet once 50 consecutive discharges have been reached.
6. Please return the completed excel spreadsheet to [redacted]
7. If you need any further help with any aspect of the older people in acute settings service user audit, please e-mail [redacted] or call [redacted]

Please return this sheet to [redacted] **by 27th September 2019**

MANAGING FRAILTY AND DELAYED TRANSFERS OF CARE IN ACUTE SETTINGS - SERVICE USER AUDIT DATA COLLECTION TEMPLATE

This service user audit is part of the project looking at "Managing frailty and delayed transfers of care in acute settings". For any queries on the data collection please contact [redacted]

The below 11 questions should be completed on up to 50 consecutive discharges on one care of older people ward within your Trust/Health Board between 15th July and 27th September 2019

To support the completion of the service user audit, a printable sheet which can be used to collect data on the ward is available on the next tab.
Please use this sheet to collate data manually for the service user audit prior to submitting your data via e-mail.
All data for the service user audit must be **submitted on this excel spreadsheet** and e-mailed to [redacted] once data has been recorded for 50 service users discharged from the care of older people ward
If you have any queries, please e-mail [redacted]

No patient identifiable information should be submitted

Name of Trust/UHB/Hospital site:

Name of care of older people ward / medical ward:

Contact details (e-mail address) of contact for the service user audit data collection:

Question	1. Age of service user	2. What was the primary ICD-10 code that the service user was admitted with? (If ICD-10 code not in the list please select 'other')	3. Has this service user been diagnosed with Dementia?	4. What are the service user's normal living arrangements?	5. Has this service user had a hospital admission within the previous 12 months?	6. Has this service user had an emergency hospital re-admission within the last 30 days?	7. At what point in the pathway was CGA delivered to this service user?	8. What was the length of stay in days for this service user?	9. Was this patient a delayed transfer of care?	10. How many days was this patient delayed?	11. Where was this service user discharged to?
Definition	Age in years	**E46** - Unspecified protein-energy malnutrition **F00, F01, F02, F03, F05** - Dementia in Alzheimer's disease; Vascular Dementia; Dementia in other disease classified elsewhere; Unspecified dementia; Delirium due to known physiological condiotion **R15 -** Faecal incontinence **R26.2 & R26.8 -** Difficulty in walking, not elsewhere classified; Other and unspecified abnormalities of gait and mobility **R32** - Unspecified urinary incontinence **R40** - Somnolence, stupor and coma **R41** - Other symptoms and signs involving cognitive functions and awareness **R46.0** - Very low level of personal hygiene **R54** - Senility **W00-W19** - Falls **Z73.9** - Problem related to life-management difficulty, unspecified **Z74** - Problems related to care-provider dependency **Z99.3** - Dependence on wheelchair **Other** - ALL other ICD-10 codes This question is to assess whether the patient has been admitted with an ICD-10 code which may be a marker for frailty. If the code is not identified on the list please select other. If the service user has multiple ICD-10 codes please select the primary code.	Dementia diagnosis: Mild dementia Moderate or mid-stage Severe or late stage Terminal No diagnosis Please choose no diagnosis unless Dementia has been diagnosed clinically			If this current episode is a re-admission please select Yes	CGA is a multi-dimensional, multi-disciplinary process which identifies medical, social and functional needs, and the development of an integrated/co-ordinated care plan to meet those needs. Assessment unit = frailty unit, short-term assessment unit, CDU, acute medical unit, etc	Include length of stay on assessment units as well as inpatient ward if applicable	A delayed transfer of care occurs when an adult inpatient in hospital is ready to go home or move to a less acute stage of care but is prevented from doing so	Number of days the patient was ready to go home or move to a less acute stage of care but was prevented from doing so, all causes	Transitional arrangements include bed or home based intermediate care, re-ablement, time to think/assessment beds, awaiting continuing healthcare assessment, etc
	Numerical	**Choose one from the following:-** **E46** - Unspecified protein-energy malnutrition **F00, F01, F02, F03, F05** - Dementia in Alzheimer's disease; Vascular Dementia; Dementia in other disease classified elsewhere; Unspecified dementia; Delirium due to known physiological condiotion **R15** - Faecal incontinence **R26.2 & R26.8** - Difficulty in walking, not elsewhere classified; Other and unspecified abnormalities of gait and mobility **R32** - Unspecified urinary incontinence **R40** - Somnolence, stupor and coma **R41** - Other symptoms and signs involving cognitive functions and awareness **R46.0** - Very low level of personal hygiene **R54** - Senility **W00-W19** - Falls **Z73.9** - Problem related to life-management difficulty, unspecified **Z74** - Problems related to care-provider dependency **Z99.3** - Dependence on wheelchair **Other** - ALL other ICD-10 codes	**Choose one from the following:-** Mild Moderate or mid-stage Severe or late stage Terminal No diagnosis	**Choose one from the following:-** Own home Residential home Nursing home Sheltered housing Unknown Other	**Choose from the following:-** Yes No	**Choose one from the following:-** Yes No	**Choose one from the following:-** In the community/primary care A&E Assessment unit Inpatient ward CGA not delivered	**Numerical**	**Choose one from the following:-** No Yes - attributable to NHS Yes - attributable to social care Yes - attributable to both	**Numerical**	**Choose one from the following:-** Own home Residential home Nursing home Sheltered housing Transitional arrangements Hospice Died Other
Service user											
Service user 1											
Service user 2											
Service user 3											
Service user 4											
Service user 5											
Service user 6											
Service user 7											
Service user 8											
Service user 9											
Service user 10											

Service user 11											
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Service user 47											
Service user 48											
Service user 49											
Service user 50											

NHS Benchmarking Network - MANAGING FRAILITY AND DToCS IN ACUTE SETTINGS

SERVICE USER AUDIT 2019

This sheet may be used to collect individual data on the designated care of older people ward.
This printable sheet is to assist local data collection only. Do not submit the individual sheets
Please transfer data collected to the collation excel template for submission to us.
If you have any queries please contact [redacted] **or** [redacted]

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Improving healthcare for older people

No patient identifiable information should be noted on this sheet

Please complete for 50 consecutive patients discharged from **one** care of older people inpatient ward in the Trust/Health Board

1 Age of the service user (years)

2 What was the primary ICD-10 code that the service user was admitted with? (If ICD-10 code not in the list please select 'other')

Code	Admitting reason	Tick one
E46	Unspecified protein-energy malnutrition	
F00, F01, F02, F03, F05	Dementia in Alzheimer's disease	
	Vascular dementia	
	Dementai in other diseases classified elsewhere	
	Delirium due to known physiological condition	
R15	Faecal incontinence	
R26.2 & R26.8	Difficulty in walking, not elsewhere classified	
	Other and unspecified abnormalities of gait and mobility	
R32	Unspecified urinary incontinence	
R40	Somnolence, stupor and coma	
R41	Other symptoms and signs involving cognitive functions and awareness	
R46.0	Very low level of personal hygiene	
R54	Senility	
W00-W19	Falls	
Z73.9	Problem related to life-management difficulty, unspecified	
Z74	Problems related to care-provider dependency	
Z99.3	Dependence on wheelchair	
	Other	

3 Has the service user been diagnosed with dementia?

	Tick one
Mild dementia	
Moderate or mid-stage	
Severe or late stage	
Terminal	
No diagnosis	

4 What are the service user's normal living arrangements?

	Tick one
Own home	

Residential home	
Nursing home	
Sheltered Housing	
Unknown	
Other	

(Circle one)

5 Has this service user had a hospital admission within the previous 12 months? **Yes / No**

6 Has this service user had an emergency hospital re-admission within the last 30 days? **Yes / No**
(if this current episode is a re-admission please select Yes)

7 At what point in the pathway was CGA delivered to this service user?

	Tick one
In the community/primary care	
A&E	
Assessment unit	
Inpatient ward	
CGA not delivered	

8 What was the length of stay in days for this service user?
Include length of stay on assessment units as well as IP ward if applicable

9 Was this patient a delayed transfer of care?

	Tick one
No	
Yes - attributable to NHS	
Yes - attributable to social care	
Yes - attributable to both	

10 How many days was this patient delayed?

11 Where was this service user discharged to?

	Tick one
Own home	
Residential home	
Nursing home	
Sheltered Housing	
Transitional arrangements	
Hospice	
Died	
Other	

NHS Benchmarking Network

Managing Frailty and Delayed Transfers of Care in the Acute Setting

BENCHMARKING DATA SPECIFICATION

The deadline for submission of data is **27th September 2019**

Data should be entered into the online collection form: www.members.nhsbenchmarking.nhs.uk

Participation is open to acute providers of older people's care who are members of the NHS Benchmarking Network.

Introduction:

The Older People's Care in Acute Settings benchmarking project was first run in 2014 and ran for 3 years. In 2017, the project changed focused and a deeper dive of the management of Delayed Transfers of Care (DToCs) was undertaken. This was opened to acute, mental health and community hospital providers. Consultation with members in 2018 has requested a re-focus on the pathway of people living with frailty through secondary care, but with a focus on DToCs, as part of the supported discharge element of the project. The benchmarking project will cover the pathway of older people through A&E (linked to our Emergency Care project) to the supported discharge processes.

The project considers links with other sectors including primary care, community, mental health and social care particularly at the front and back end of hospitals.

If your Trust/UHB doesn't specifically operate care of older people wards, please respond in relation to the medical wards.

This project is in partnership with the British Geriatrics Society who have assisted with scoping the data collection.

If you would like to submit separately across multiple Hospital sites, please register each as a separate submission.

Service user audit

The NHS Benchmarking Network has worked with the BGS to develop a service user level audit for the Managing Frailty and DToC in the Acute Setting project.

The objective of the service user level audit is to provide comparative data at service user level to facilitate service improvement in Trusts/UHBs.

Trusts/UHBs are requested to select one care of older people ward where data for the service user audit can be collected. If your Trust/UHB doesn't have a care of older people ward, please select one medical ward.

Service user audit data must be collected via an excel spreadsheet which is available to download on the members' area www.members.nhsbenchmarking.nhs.uk

Completed excel spreadsheets must be returned via e-mail to [redacted] **by 27th September 2019**

Reporting:

An interactive online data analysis tool will be available once the submissions have been validated.

Members will also receive a bespoke dashboard report.

An event to present the findings of the project will take place on the 6th February 2020. Members can register to attend on the members' area of the website.

Project reports will be released in February 2020.

Please note:

- All cost figures must be entered in full. For example £ 1 million should be entered as 1000000
- If you do not have the data to answer the question, please leave blank, do not put zero
- Once data collection has closed your figures will be validated and you will be provided with an opportunity to make amendments. For this process to occur smoothly and ensure members get the most from the project it is important that the data is submitted on time.

Support:

Data definitions are provided, however, questions on interpretation of data items and queries can be submitted to: [redacted], [redacted])

IMPORTANT: This EXCEL document is provided to support data collation only and CANNOT be used to submit data
All data must be submitted via online data collection at: www.nhsbenchmarking.nhs.uk

Benchmarking Network

British Geriatrics Society
Improving healthcare for older people

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Data sharing

QUESTION	DATA	DATA TYPE	DATA DEFINITION
Sharing data with NHS Improvement GIRFT Team			
England only: The NHS Improvement GIRFT Geriatric Medicine workstream would like to use participants' data to inform their work with Trusts. Please select "Yes" if you are willing for your data to be shared with the GIRFT team. If you have any questions about this, please contact the Network team for further information.			
Are you willing to share your data with the NHSI GIRFT team?		Yes / No	Not applicable for Wales/Scotland/Northern Ireland. Please see the NHS Improvement privacy notice here: https://improvement.nhs.uk/privacy/.

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Qualification questions

The below questions provide a general view of provision for patients living with frailty in your Trust/UHB/Hospital site. Your responses to these yes/no questions will determine which question groups will be available to answer on the online data collection pages.

QUESTION	DATA	DATA TYPE	DATA DEFINITION	Section to appear when 'yes' selected
Does your Trust/UHB/Hospital site have an acute frailty service?		Drop-down menu:- Yes / No	"Acute frailty service" includes geriatric liaison, and dedicated geriatric teams	5.Acute frailty service
Do community services provide in-reach to the A&E department?		Drop-down menu:- Yes / No	This may include OPAL specialist nurses, community geriatrics, geriatric/frailty interface team, district nurses, community matrons	
Does your Trust/UHB/Hospital site have a frailty unit?		Drop-down menu:- Yes / No	A "frailty unit" is an acute care assessment unit, focused on the care of the frail and elderly	7.Frailty units
Does your Trust/UHB/Hospital site have a short-term assessment unit?		Drop-down menu:- Yes / No	"Short term assessment unit" includes emergency assessment units, CDU, or similar unit where patients are taken for time limited period (**up to 12 hours**) for assessment/diagnostics/decision. Exclude Surgical Assessment Units/Pre-operative Assessment Units or similar	8.Short term assessment units
Does your Trust/UHB/Hospital site have other assessment units (between 12 and 72 hours expected maximum length of stay)?		Drop-down menu:- Yes / No	"Other assessment units" include assessment units which don't fall under the definitions of "frailty unit" or "short term assessment unit" used in this project. Maternity, paediatric and surgical units should be excluded.	9.Other assessment units
Does your Trust/UHB/Hospital site operate a "Discharge to Assess" model?		Drop-down menu:- Yes / No	"Discharge to assess" schemes commonly operate as soon as the patient is clinically optimised ie the point at which care and assessment can safely be continued in a non-acute setting. The dischage to assess schemes will work with the patient/their carers to plan post-acute care in the person's own home or another community setting. This is in relation to immediate post-acute care & support needs and not the assessment for long-term care.	13.Discharge to assess
Does your Trust/UHB/Hospital site operate any Early Supported Discharge schemes?		Drop-down menu:- Yes / No		

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All data must be submitted via online data collection at: www.nhsbenchmarking.nhs.uk

Managing Frailty and Delayed Transfers of Care in the Acute Setting

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Organisation details

QUESTION	DATA	DATA TYPE	DATA DEFINITION
Baseline information			
Trust/UHB turnover 2018/19 (£)		Numeric in £ (whole number)	Turnover at year end 2018/19 - defined as Trust operating income 2018/19
Trust/UHB/Hospital site WTE staff employed		Numeric	WTE at year end 2018/19 (all staff)
Trust/UHB/Hospital site WTE consultants employed		Numeric	WTE consultants employed at year end 2018/19 (all staff)
Trust/UHB/Hospital site WTE Geriatricians employed		Numeric	WTE Geriatricians employed at year end 2018/19 (all staff)
Are community services vertically integrated with acute services in your Trust/UHB/Hospital site		Drop down menu: Yes/ No / N/A	England only Use N/A for Wales and Northern Ireland responses where all services are integrated

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Benchmarking Network

BGS British Geriatrics Society Improving healthcare for older people

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Governance & system linkages

QUESTION	DATA	DATA TYPE	DATA DEFINITION
Pathways/protocols			
Is there a recognised frailty tool/pathway in use in the health and social care economy?		Drop-down menu:- Yes / No	
Does the Trust have a clearly defined strategy/operational policy for the delivery of acute medical care to older people?		Drop-down menu:- Yes / No	
Do pathways/protocols exist which clearly state the roles and relationships between A&E, frailty units/short term assessment units/other assessment units and the wards?		Drop-down menu:- Yes / No	
Please describe what policies/procedures are in place locally with regard to the management of patients who are admitted from/are discharged to care homes locally		Narrative	Copies of any supporting information should be e-mailed to [redacted]
Please describe whether the “Red Bag” initiative is being implemented locally, and what benefits are being indicated as a result of its use.		Narrative	The innovative red bag scheme is helping to provide a better care experience for care home residents by improving communication between care homes and hospitals. The red bag is the most visible part of successful collaboration between care homes, hospitals and ambulance staff, known as the hospital transfer pathway. When a care home resident becomes unwell and is assessed as needing hospital care, care home staff pack a dedicated red bag that includes the resident’s standardised paperwork and their medication, as well as day-of-discharge clothes and other personal items. Further information can be found at this link https://www.england.nhs.uk/publication/redbag/
Please describe the local falls pathways and submit any relevant material describing local policies and procedures, particularly with reference to the management of frail patients in the acute setting		Narrative	Copies of any supporting information should be e-mailed to [redacted]
Please describe the local pathways in place for the management of people with delirium / acute confusion, particularly with reference to the management of frail patients in the acute setting.		Narrative	Copies of any supporting information should be e-mailed to [redacted]
Does your Trust/UHB/Hospital site have a RAID team which can be accessed for patients presenting with mental health issues?		Drop-down menu:- Yes / No	Rapid Assessment Interface and Discharge
Leadership			
Is there a designated Clinical Lead for Older People's services in the Trust/UHB/Hospital site?		Drop-down menu:- Yes / No	
Is there a designated Clinical Change champion for frailty within the Trust/UHB/Hospital site?		Drop-down menu:- Yes / No	From the Acute Frailty Network "10 principles of managing Acute Frailty'
Is there an executive sponsor within the Trust/UHB/Hospital site for the management of frail older people?		Drop-down menu:- Yes / No	
Older People specific policies			

Is there a policy which mentions for example, the management of outliers and the movement/transfer of older people within the acute setting		Drop-down menu:- Yes / No	
If yes, please briefly describe the policy		Narrative	

Received from Mary Burke on 01/07/2022. Annotated by the Urology Services Inquiry.

Older People policies - links with other services			
Is the Trust/UHB/Hospital site able to view the enriched Summary Care Record?		Yes / No / N/A	England only The new GP contract introduced in July 2017 requires all primary care practices in England to identify people who are 65 years plus who are living with moderate and severe frailty. The GP frailty assessment will form part of the enriched Summary Care Record and this can be made available to secondary care where patients have given their consent to sharing
Please describe any other systems/links in place (if any) with primary care for the identification of high risk, frail older people		Narrative	Please describe any other systems in place where secondary care is able to access primary / community care records where frailty has been identified
Does the Trust/UHB/Hospital site use a third sector scheme to enhance the care of older people?		Drop-down menu:- Yes / No	E.g. Dementia UK Admiral Nurses, Age UK, British Red Cross. May be used in admission avoidance schemes / supported discharge / transport schemes.
If yes, please describe the third sector schemes used		Narrative	
Do any other staff, not necessarily employed by this Trust/UHB, provide in-reach to acute services to assist with admission avoidance?		Drop-down menu:- Yes / No	

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Acute frailty service

QUESTION	DATA	DATA TYPE	DATA DEFINITION
Front end service model			
Please describe your acute frailty service		Narrative	
Is the acute frailty service located in the A&E department?		Drop-down menu:- Yes / No	"Acute frailty service" includes geriatric liaison, and dedicated geriatric teams
Is there an acute frailty service providing in-reach to the A&E department?		Drop-down menu:- Yes / No	This may be provided by the acute frailty team conducting dedicated input to A&E
How many hours is this team available over a 24 hour period?:-			
During the week		Numerical	Please express as, for example, 8 rather than 9-5
At weekends		Numerical	Please express as, for example, 8 rather than 9-5
Does the acute frailty service have rights to admit patients?		Drop-down menu:- Yes/No	

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A&E (admission avoidance services)

QUESTION	DATA	DATA TYPE	DATA DEFINITION
A&E (admission avoidance services)			
Is routine identification of frailty undertaken on entry to the accident and emergency department in older people?		Drop-down menu:- Yes / No	Routine identification of frailty should be undertaken using a recognised tool
Please indicate which tool is being used		Drop-down menu:- Rockwood Clinical Frailty Scale (CFS) Identification of Senior at Risk (ISAR) Silver code Prisma-7 Edmonton Frail Scale Locally agreed frailty tool Frailsafe Other	
If other, please indicate		Narrative	Please describe which other frailty tool is in use in this setting
For which age group is routine identification of frailty undertaken?		Drop-down menu:- All ages 65+ 70+ 75+ 80+ 85+ Other criteria for frailty identification in place	
If other, please describe		Narrative	
On average how long does it take for a patient to receive clinical frailty assessment following their arrival in A&E		Numerical	Time in minutes from arrival in A&E to the beginning of clinical frailty assessment
What percentage of patients in need of clinical frailty assessment are seen within 30 minutes of arrival at A&E		Numerical	
Are therapists available in A&E to assist with admission avoidance of older people?		Drop-down menu:- Yes / No	"Therapists" means physiotherapists and/or OTs

If yes, what are the hours of availability of the therapy team over a 24 hour period?			
During the week		Numerical	Please express as, for example, 8 rather than 9-5
At weekends		Numerical	Please express as, for example, 8 rather than 9-5
Can social workers be rapidly accessed by A&E to assist with admission avoidance of older people?		Drop-down menu:- Yes / No	
If yes, what are the hours of availability of the social work team over a 24 hour period?			
During the week		Numerical	Please express as, for example, 8 rather than 9-5
At weekends		Numerical	Please express as, for example, 8 rather than 9-5
Does the Hospital Discharge Team provide in-reach to A&E?		Drop-down menu:- Yes / No	This relates to the Hospital Discharge Team actively going into A&E review patients who may be suitable for discharge without an admission to MAU or to inpatient care
If yes, what are the hours of availability of the Hospital Discharge Team in A&E over a 24 hour period?			
During the week		Numerical	Please express as, for example, 8 rather than 9-5
At weekends		Numerical	Please express as, for example, 8 rather than 9-5
Do community matrons / specialist nurses provide in-reach to A&E to assist with admissions avoidance?		Drop-down menu:- Yes / No	
Does the Trust/UHB/Hospital site have a locally agreed strategy for providing more same day emergency care?		Drop-down menu:- Yes / No	NHSE believes that the move to provide same day emergency care will be a significant factor in easing pressure on secondary care. Long Term Plan: 'This model will be rolled out across all acute hospitals, increasing the proportion of acute admissions typically discharged on day of attendance from a fifth to a third.'
If yes, please give details		Narrative	

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Benchmarking Network

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Frailty units

QUESTION	DATA	DATA TYPE	DATA DEFINITION
Frailty unit - (answer this section in relation to the whole unit/process for all patients not just older people)			
Does your frailty unit have locally agreed referral criteria regarding the type of patient that can be accepted?		Drop-down menu:- Yes / No	
Please indicate what type of patient can be referred to the frailty unit		Narrative	Include here whether patients have mobility, continence, cognitive impairment. Do specific criteria apply to patients who have been admitted from a care home?
Is routine identification of frailty undertaken on admission/transfer to the frailty unit?		Yes/No/N/A	Use N/A where an assessment for frailty has been undertaken elsewhere in the system. Routine identification of frailty should be undertaken using a recognised tool
Please indicate which tool is being used		Drop-down menu: Rockwood Clinical Frailty Scale (CFS) Identification of Senior at Risk (ISAR) Silver code Prisma-7 Edmonton Frail Scale Locally agreed frailty tool Frailsafe Other	
If other, please indicate		Narrative	Please describe which other frailty tool is in use in this setting
For which age group is routine identification of frailty undertaken?		Drop-down menu:- All ages 65+ 70+ 75+ 80+ 85+ Other criteria for frailty identification in place	
If other, please describe		Narrative	
If a frailty tool is in use, is this tool used by the whole MDT or just the medical team?		Drop-down menu:- Whole MDT Medical Team Other	
Is the frailty tool used to identify who requires CGA?		Drop-down menu:- Yes / No	
How many beds does the frailty unit have?		Numerical	
What is the expected maximum length of stay on the frailty unit?		Drop-down menu:- 12 hours 24 hours 48 hours 72 hours Greater than 72 hours	
Who provides clinical leadership of the frailty unit?		Drop-down menu:- General Physician Geriatrician GPwSI Advanced Nurse Practitioner Other	

What is the frequency of senior clinical review in the frailty unit?		Drop-down menu: Twice per day Once per day Every other day Other	Senior clinical review is Consultant or Speciality Registrar level (not junior doctor) This would also include review by an ANP
Is senior clinical review undertaken at weekends?		Drop-down menu:- Yes/ / No	
Does the frailty unit provide an outreach service, working with primary & community care to case find individuals at risk of admission?		Drop-down menu:- Yes / No	
Do any other services provide in-reach to the frailty unit pulling appropriate patients out/signposting to other services?		Drop-down menu:- Yes / No	For example, could be in-reach by Intermediate Care, Mental Health services, therapy teams, social care teams, etc.
If yes, please describe which services		Narrative	
What are the hours of availability of senior medical cover to the frailty unit in a 24 hour period?			
During the week		Numerical	Please express as, for example, 8 rather than 9-5
At weekends		Numerical	Please express as, for example, 8 rather than 9-5
How is medical cover provided OOHs to the frailty unit?		Drop-down menu:- on-call rota (generic) on-call rota (specialist) dedicated cover - in house other	

Is there a dedicated geriatric team located in the frailty unit?		Drop-down menu:- Yes/No	Teams may comprise of medical and/or clinical staff dedicated to the care of older people in the frailty unit
If yes, what are the hours of availability of the dedicated geriatric team located in the frailty unit in a 24 hour period?			
During the week		Numerical	Please express as, for example, 8 rather than 9-5
At weekends		Numerical	Please express as, for example, 8 rather than 9-5
Does the Hospital Discharge Team provide dedicated support to the frailty unit?		Drop-down menu:- Yes / No	

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Short term assessment units

QUESTION	DATA	DATA TYPE	DATA DEFINITION
Short-term assessment unit (up to 12 hours expected length of stay only) (answer this section in relation to the whole unit/process for all patients not just older people)			
Is routine identification of frailty undertaken on admission/transfer to the short term assessment unit?		Yes/No/N/A	Use N/A where an assessment for frailty has been undertaken elsewhere in the system. Routine identification of frailty should be undertaken using a recognised tool
Please indicate which tool is being used		Drop-down menu: Rockwood Clinical Frailty Scale (CFS) Identification of Senior at Risk (ISAR) Silver code Prisma-7 Edmonton Frail Scale Locally agreed frailty tool Frailsafe Other	
If other, please indicate		Narrative	Please describe which other frailty tool is in use in this setting
For which age group is routine identification of frailty undertaken?		Drop-down menu:- All ages 65+ 70+ 75+ 80+ 85+ Other criteria for frailty identification in place	
If other, please describe		Narrative	
If a frailty tool is in use, is this tool used by the whole MDT or just the medical team?		Drop-down menu:- Whole MDT Medical Team Other	
Is the frailty tool used to identify who requires CGA?		Drop-down menu:- Yes / No	
How many beds does the short term assessment unit have?		Numerical	
Do all admissions of older people go through the short term assessment unit?		Drop-down menu:- Yes No	Answer "No" if direct admissions to wards are allowed from A&E
Who provides clinical leadership of the short term assessment unit?		Drop-down menu:- General Physician Geriatrician GPwSI Advanced Nurse Practitioner Other	
What is the frequency of senior clinical review in the short term assessment unit?		Drop-down menu: Twice per day Once per day Every other day Other	Senior clinical review is Consultant or Speciality Registrar level (not junior doctor) This would also include review by an ANP
Is senior clinical review undertaken at weekends?		Drop-down menu:- Yes/ / No	

Does the short term assessment unit provide an outreach service, working with primary & community care to case find individuals at risk of admission?		Drop-down menu:- Yes No	
Do any other services provide in-reach to the short term assessment unit pulling appropriate patients out/signposting to other services?		Drop-down menu:- Yes No	For example, could be in-reach by Intermediate Care, Mental Health services, therapy teams, social care teams, etc.
If yes, please describe which services		Narrative	
What are the hours of availability of senior medical cover to the short term assessment unit in a 24 hour period?			
During the week		Numerical	Please express as, for example, 8 rather than 9-5
At weekends		Numerical	Please express as, for example, 8 rather than 9-5
How is medical cover provided OOHs to the short term assessment unit?		Drop-down menu:- On-call rota (generic) On-call rota (specialist) Dedicated cover - in house Other	
Is there a dedicated geriatric team located in the short term assessment unit?		Drop-down menu:- Yes / No	Teams may comprise of medical and/or clinical staff dedicated to the
If yes, what are the hours of availability of the dedicated geriatric team located in the short term assessment unit in a 24 hour period?			
During the week		Numerical	Please express as, for example, 8 rather than 9-5
At weekends		Numerical	Please express as, for example, 8 rather than 9-5
Does the Hospital Discharge Team provide dedicated support to the short term assessment unit?		Drop-down menu:- Yes / No	

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Other assessment units

QUESTION	DATA	DATA TYPE	DATA DEFINITION
Other assessment units (between 12 and 72 hours expected length of stay) (answer this section in relation to the whole unit/process for all patients not just older people)			
How many other assessment units are there?		Numerical	
Is routine identification of frailty undertaken on admission / transfer to the other assessment unit(s)?		Yes/No/N/A	Use N/A where an assessment for frailty has been undertaken elsewhere in the system. Routine identification of frailty should be undertaken using a recognised tool
Please indicate which tool is being used		Drop-down menu:- Rockwood Clinical Frailty Scale (CFS) Identification of Senior at Risk (ISAR) Silver code Prisma-7 Edmonton Frail Scale Locally agreed frailty tool Frailsafe Other	
If other, please indicate		Narrative	Please describe which other frailty tool is in use in this setting
For which age group is routine identification of frailty undertaken?		Drop-down menu:- All ages 65+ 70+ 75+ 80+ 85+ Other criteria for frailty identification in place	
If other, please describe		Narrative	
If a frailty tool is in use, is this tool used by the whole MDT or just the medical team?		Drop-down menu:- Whole MDT Medical Team Other	
Is the frailty tool used to identify who requires CGA?		Drop-down menu:- Yes / No	
How many beds do the other assessment units have in total?		Numerical	
What is the expected maximum length of stay on the other assessment units?		Drop-down menu:- 24 hours 48 hours 72 hours	
Do all admissions of older people go through the other assessment unit/s?		Drop-down menu:- Yes / No	Answer "No" if direct admissions to wards are allowed from A&E
Who provides clinical leadership of the other assessment unit?		Drop-down menu:- General Physician Geriatrician GPwSI Advanced Nurse Practitioner Other	

What is the frequency of senior clinical review in the other assessment units?		Drop-down menu: Twice per day Once per day Every other day Other	Senior clinical review is Consultant or Speciality Registrar level (not junior doctor) This would also include review by an ANP
Is senior clinical review undertaken at weekends?		Drop-down menu:- Yes/ / No	
Do the other assessment unit/s provide an outreach service, working with primary & community care to case find individuals at risk of admission?		Drop-down menu:- Yes / No	
Do any other services provide in-reach to the other assessment unit/s pulling appropriate patients out/signposting to other services?		Drop-down menu:- Yes / No	For example, could be in-reach by Intermediate Care, Mental Health services, therapy teams, social care teams, etc.
If yes, please describe which services		Narrative	
What are the hours of availability of senior medical cover to the other assessment unit/s in a 24 hour period?			
During the week		Numerical	Please express as, for example, 8 rather than 9-5
At weekends		Numerical	Please express as, for example, 8 rather than 9-5
How is medical cover provided OOHs to the other unit/s?		Drop-down menu:- on-call rota (generic) on-call rota (specialist) dedicated cover - in house other	
Is there a dedicated geriatric team located in the other assessment unit/s?		Drop-down menu:- Yes / No	Teams may comprise of medical and/or clinical staff dedicated to the care of older people in the other assessment unit
If yes, what are the hours of availability of the dedicated geriatric team located in the other assessment unit/s in a 24 hour period?			
During the week		Numerical	Please express as, for example, 8 rather than 9-5
At weekends		Numerical	Please express as, for example, 8 rather than 9-5
Does the Hospital Discharge Team provide dedicated support to the other assessment unit/s?		Drop-down menu:- Yes / No	

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Assessment of older people

QUESTION	DATA	DATA TYPE	DATA DEFINITION
Frailty assessment			
If a frailty identification tool is in use, how is this used throughout the acute pathway?		Narrative	Include how the frailty identification tool may be used to flag at risk patients. In other sections of the collection you will be asked to provide which frailty identification tool is in use and if patients are routinely assessed.
Once frailty assessment has been undertaken and frailty identified, what action is then undertaken by the Trust/UHB/Hospital site? (answer only if you undertake frailty assessment)			
Referral to an acute frailty service		Drop-down menu:- Yes / No	
Referral to a frailty unit		Drop-down menu:- Yes / No	
Management by the medical team		Drop-down menu:- Yes / No	
Other		Drop-down menu:- Yes / No	
If other, please describe		Narrative	
Is the frailty score added to the patient's hospital record?		Drop-down menu:- Yes / No	
Comprehensive Geriatric Assessment			
CGA is a multi-dimensional, multi-disciplinary process which identifies medical, social and functional needs, and the development of an integrated/co-ordinated care plan to meet those needs. Further information on CGA can be found here - https://www.bgs.org.uk/resources/managing-frailty			
Does CGA take place in the frailty unit? (Answer only if you have a frailty unit)		Drop-down menu:- Yes / No	
Does CGA take place in the short term assessment unit? (Answer only if you have a short term assessment unit)		Drop-down menu:- Yes / No	
Does CGA take place in the other assessment unit/s? (Answer only if you have other assessment unit/s)		Drop-down menu:- Yes / No	
Is Comprehensive Geriatric Assessment delivered on Care of Older People wards?		Drop-down menu:- Yes / No	CGA is a multi-dimensional, multi-disciplinary process which identifies medical, social and functional needs, and the development of an integrated/co-ordinated care plan to meet those needs
Is Comprehensive Geriatric Assessment delivered on other specialty wards?		Drop-down menu:- Yes / No	CGA is a multi-dimensional, multi-disciplinary process which identifies medical, social and functional needs, and the development of an integrated/co-ordinated care plan to meet those needs
Is there an MDT response that initiates CGA within the first hour of admission?		Drop-down menu:- Yes / No	
Who is involved in carrying out CGA on the assessment units?			
Consultant		Drop-down menu:- Yes / No	
Other medical staff		Drop-down menu:- Yes / No	
Nurse		Drop-down menu:- Yes / No	
Therapist		Drop-down menu:- Yes / No	
Does the Trust/UHB/Hospital site have an awareness programme for non-geriatricians about frailty and CGA?		Drop-down menu:- Yes / No	
How are patients identified as needing CGA?		Narrative	
Can CGA be accessed in the community?		Drop-down menu:- Yes / No	

Is CGA documented on a single shared assessment document accessible by all MDT members?		Drop-down menu:- Yes / No	
Do CGAs contain a care plan which has been discussed with the patient and/or their carers?		Drop-down menu:- Yes / No	
Has the hospital used the hospital-wide Comprehensive Geriatric Assessment (HoW CGA) self-assessment tool?		Drop-down menu:- Yes / No	wide-comprehensive-geriatric-assessment-how-cga-overview This toolkit is aimed at clinical teams and helps hospitals identify what processes need development, supported by clinical
Are all older people accessing urgent care routinely assessed for the following:- (tick all which apply):-			
Pain		Drop-down menu:- Yes / No	
Depression		Drop-down menu:- Yes / No	
Skin integrity		Drop-down menu:- Yes / No	
Falls and mobility		Drop-down menu:- Yes / No	
Continence		Drop-down menu:- Yes / No	
Safeguarding issues		Drop-down menu:- Yes / No	
Delirium and dementia		Drop-down menu:- Yes / No	
Nutrition and hydration		Drop-down menu:- Yes / No	
Sensory loss		Drop-down menu:- Yes / No	
Activities of daily living		Drop-down menu:- Yes / No	
Vital signs		Drop-down menu:- Yes / No	
End of life care		Drop-down menu:- Yes / No	

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Inpatient care

QUESTION	DATA	DATA TYPE	DATA DEFINITION
Models of care on inpatient older people wards			
Number of designated Care of Older people beds		Numerical	If there are units or wards under the care of older people team but with a different designation (not designated as care of older people beds) these should be included. Do not include stroke beds. Older people wards provide specialist geriatrician-led care to older people with complex needs.
Is routine identification of frailty undertaken on admission/transfer to the older people inpatient wards?		Yes/No/N/A	Use N/A where an assessment for frailty has been undertaken elsewhere in the system. Routine identification of frailty should be undertaken using a recognised tool
If yes, please indicate which tool is being used		Drop-down menu:- Rockwood Clinical Frailty Scale (CFS) Identification of Senior at Risk (ISAR) Silver code Prisma-7 Edmonton Frail Scale Locally agreed frailty tool Frailsafe Other	
If other, please indicate		Narrative	Please describe which other frailty tool is in use in this setting
For which age group is routine identification of frailty undertaken?		Drop-down menu:- All ages 65+ 70+ 75+ 80+ 85+ Other criteria for frailty identification in place	
If other, please describe		Narrative	
Is a nursing self-care model delivered on the inpatient older people wards?		Drop-down menu:- Yes / No	The model of nursing self-care in acute illness has been described to guide nurses in assessing the major issues that influence patients' participation in self-care. Regular assessment of patients' perceptions and circumstances relative to the variables identified by the model will guide nurses in promoting and supporting self-care by acutely ill patients. This works on the theory that patients will want to be as independent as possible and self-care as far as possible. See pdf's for guidance. Older People wards only.
Does a social care worker or generic supported discharge co-ordinator form part of the MDT supporting care of older people wards?		Drop-down menu:- Yes No	
Do the older people wards in the Trust/CHB/Hospital site maintain lists of older people who are no longer benefitting from acute care?		Drop-down menu:- Yes No	From the NAO report 'Discharging older patients from hospital' https://www.nao.org.uk/report/discharging-older-patients-from-hospital/
If yes, are daily progress chasing meetings held?		Drop-down menu:- Yes No	
Models of care on inpatient wards (not designated older people wards)			
Number of medical beds (not designated care of older people beds)		Numerical	Please include stroke beds
Is routine identification of frailty undertaken on admission/transfer to the inpatient wards in older people?		Yes/No/N/A	Use N/A where an assessment for frailty has been undertaken elsewhere in the system. Routine identification of frailty should be undertaken using a recognised tool

If yes, please indicate which tool is being used		Drop-down menu:- Rockwood Clinical Frailty Scale (CFS) Identification of Senior at Risk (ISAR) Silver code Prisma-7 Edmonton Frail Scale Locally agreed frailty tool Frailsafe Other	
If other, please indicate		Narrative	Please describe which other frailty tool is in use in this setting
For which age group is routine identification of frailty undertaken?		Drop-down menu:- All ages 65+ 70+ 75+ 80+ 85+ Other criteria for frailty identification in place	
If other, please describe		Narrative	
Does your Trust/UHB/Hospital site have a specific locally agreed target for reducing length of stay for older people?		Drop-down menu:- Yes / No	This would be an internal target. From the NAO report 'Discharging older patients from hospital' https://www.nao.org.uk/report/discharging-older-patients-from-hospital/
Number of patients under specialty code 430 not in a care of older people bed on 31st March 2019		Numerical	Specialty code 430 is Geriatric Medicine (NHS Data Dictionary). Number of patients with specialty code 430 who were not in a Care of Older People bed on the 31st March 2019

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Discharge process

QUESTION	DATA	DATA TYPE	DATA DEFINITION
Discharge protocols			
Is there a documented supported discharge protocol consistently applied across all wards?		Drop-down menu:- Yes / No	
Is there an up-to-date directory of services available locally?		Drop-down menu:- Yes / No	
Is there a locally agreed protocol for referral to the Housing Department(s)?		Drop-down menu:- Yes / No	
Is there a locally agreed standard time for processing of referrals through the Housing Department?		Drop-down menu:- Yes / No	
Does the Trust/UHB/Hospital site collect the numbers of patients who have lost packages of care due to an acute admission?		Drop-down menu:- Yes / No	
Discharge processes			
Is all discharge information documented in a single "discharge passport" (or equivalent)		Drop-down menu:- Yes / No	
Does the Trust/UHB/Hospital site have an integrated discharge team (IDT) or equivalent?		Drop-down menu:- Yes / No	"Integrated" means both health and social care staff within the team "Discharge team" means any team with a hospital wide remit to deal with complex or supported discharges
Does the Trust/UHB/Hospital site use trusted assessors to carry out a holistic assessment of need to avoid duplication?		Drop-down menu:- Yes / No	A trusted assessor is a person who is competent in performing to an agreed set of nationally recognised competencies. From the NAO report 'Discharging older patients from hospital' https://www.nao.org.uk/report/discharging-older-patients-from-hospital/
Estimate the percentage of supported discharges that have input from the discharge team		Percentage	"Discharge team" means any team with a hospital wide remit to deal with complex or supported discharges
Estimate the percentage of supported discharges that are dealt with by ward staff without the input of the discharge team		Percentage	"Discharge team" means any team with a hospital wide remit to deal with complex or supported discharges
Can the discharge team directly start health care packages?		Drop-down menu:- Yes / No	"directly start a package" means without further assessment from the receiving team
Can the discharge team directly start social care packages?		Drop-down menu:- Yes / No	"directly start a package" means without further assessment from the receiving team
Is there an executive sponsor within the Trust/UHB/Hospital site for the supported discharge process?		Drop-down menu:- Yes / No	
Do the inpatient wards have dedicated ward discharge co-ordinators?		Drop-down menu:- All wards/ some wards/ No	
Does the Trust/UHB/Hospital site operate therapy led discharge?		Drop-down menu:- Yes / No	
Does the Trust/UHB/Hospital site operate nurse led discharge?		Drop-down menu:- Yes / No	
Are Expected Dates of Discharge set within 24 hours of admission?		Drop-down menu:- Yes / No	https://improvement.nhs.uk/documents/629/expected-date-of-discharge-and-clinical-criteria-RIG.pdf
Is the Trust/UHB/Hospital site operating daily board rounds?		Drop-down menu:- Yes / No	https://improvement.nhs.uk/resources/safer-patient-flow-bundle-board-rounds/
If yes, please use this space to indicate the impact of using the daily board round methodology on flow through the acute setting		Narrative	
Does the Trust/UHB/Hospital site operate the Red: Green Bed Day methodology?		Drop-down menu:- Yes / No	https://improvement.nhs.uk/improvement-offers/red2green-campaign
If yes, please use this space to indicate the impact of using the Red: Green Bed day methodology on flow through the acute setting		Narrative	
Do you have access to social care at weekends to facilitate the discharge of patients?		Drop-down menu:- Yes / No	
Other discharge schemes			
Do the IDT or ward staff have access to dedicated Pharmacy advice for supported discharges?		Drop-down menu:- Yes / No	
Does your Trust/UHB/Hospital site have access to specialist transport schemes (other than that provided by Ambulance services) to expedite the discharge of patients from hospital?		Drop-down menu:- Yes / No	
Are any third sector schemes in place which have been commissioned to help with the discharge process from hospital?		Drop-down menu:- Yes / No	

Are there local schemes to expedite the discharge of patients back to care homes?		Drop-down menu:- Yes / No	
If yes, please describe		Narrative	
Delayed transfers of care processes / reporting			
Do you agree your SITREP data with your local authority partners before reporting?		Drop-down menu:- Yes / No	England only From the NAO report 'Discharging older patients from hospital' https://www.nao.org.uk/report/discharging-older-patients-from-hospital/
Did you impose a fine on any of your local authority partners in 2018/19?		Drop-down menu:- Yes / No	England only
Continuing Healthcare (CHC) processes			
Is there a locally agreed standard time for the application of the CHC Checklist Tool		Yes / No	For most people, the first step is to have an assessment with a health or social care professional using a screening tool called the Checklist Tool. This screening may suggest that a patient may be eligible for NHS continuing healthcare.
If yes, give the local standard in days		Numerical	
Is there a locally agreed standard time for the application of CHC Decision Support Tool		Yes / No	If the individual 'screens in' using the Checklist then their needs will be considered in more detail using the Decision Support Tool (DST). This will be done by at least two professionals (from different professional backgrounds) involved in their care who are referred to as the 'multi-disciplinary team' or MDT.
If yes, give the local standard in days		Numerical	
Is there a locally agreed policy for fast-track assessment for CHC?		Yes / No	Fast-track assessment of CHC may be used where health is deteriorating quickly and the patient is nearing end of life. Support and care packages are usually put in place within 48 hours
Where does assessment for CHC occur?			To qualify for CHC the individual has to be assessed and found to have a 'primary health need'. The term 'primary health need' has a very specific meaning, i.e. the patient's day to day nursing/healthcare needs are, taken as whole, beyond local authority powers to meet. This is judged by looking at the nature, intensity, complexity and unpredictability of the patient's needs. Any one, or any combination, of these four characteristics of need might mean that the patient is judged to have a 'primary health need'.
On inpatient ward		Yes / No	
On dedicated assessment ward		Yes / No	
Intermediate care bed based unit		Yes / No	
In "time to think" or transition beds		Yes / No	
At place of care/own home		Yes / No	
Other		Yes / No	
If other, please describe		Narrative	Of particular interest would be insight as to where patients who are occupying an acute bed wait whilst awaiting a CHC assessment. Are the patients receiving any active interventions e.g. to prevent deconditioning, etc.
Who leads the CHC assessment?		**Drop-down menu:-** Integrated discharge team Hospital discharge team (health only) Separate team of CHC nurse assessors Other	
How long does CHC assessment take on average (in days)?		Numerical	Average time in days from when the CHC checklist is applied to panel application
Please use this space for any other information about how the CHC process is managed locally		Narrative	Of particular interest would be insight as to where patients who are occupying an acute bed wait whilst awaiting a CHC assessment
Intermediate care			
Are criteria in place locally outlining which patients might be suitable for intermediate care?		Drop-down menu:- Yes / No	See "Intermediate Care – Halfway Home" updated guidance for the NHS and LAs, July 2009
If a patient is deemed suitable for intermediate care, who carries out intermediate care assessments?		**Drop-down menu (tick all that apply):-** Integrated discharge team Hospital discharge team (health only) Separate intermediate care assessment team based in hospital Inpatient wards Assessment teams from IC providers other	
Who carries out Mental Capacity Act assessments?			

Doctors		**Drop-down menu:-** Often Occasionally Never	
Nurses		**Drop-down menu:-** Often Occasionally Never	
Mental health liaison		**Drop-down menu:-** Often Occasionally Never	
Psychiatrist		**Drop-down menu:-** Often Occasionally Never	
Therapist		**Drop-down menu:-** Often Occasionally Never	
Social workers		**Drop-down menu:-** Often Occasionally Never	
Shared patient records			
Can social workers access patient records?		Yes / No	
Can social workers document their notes in patient records?		Yes / No	
Can community services access secondary care / acute services patient records?		Yes / No	
Can community services document their notes in secondary care / acute services patient records?		Yes / No	
Aids and adaptations			
Is there a locally agreed standard for the time taken for aids and adaptations to be fitted to a service user's home		Yes / No	
If yes, give the standard for aids and adaptations (days)		Numerical	Give waiting time from referral to fitting in days

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Discharge to assess

QUESTION	DATA	DATA TYPE	DATA DEFINITION
Discharge to Assess (D2A)			
Which discipline within your organisation clinically leads the discharge to assess service?		Drop-down menu:- Medical Therapy Nursing Social Care Other	
If other, please describe here		Narrative	
Where a discharge to assess model is in operation, what is the percentage of supported discharges where assessments are carried out in the patient's own home?		Percentage	From the NAO report 'Discharging older patients from hospital' https://www.nao.org.uk/report/discharging-older-patients-from-hospital/ If an exact figure is not available, please provide an estimate.
Is there a locally agreed standard for the time taken to assess a person in their own home under the discharge to assess model?		Drop-down menu:- Yes / No	
If yes, what is this standard in hours?		Numerical	
On average, how long does it take for a person to be assessed in their own home in hours?		Numerical	Waiting time for assessment in hours. It is likely that the organisation responding to this question will only know this if the Discharge to Assess scheme is run and managed by the same organisation.
Please use this space to describe your local discharge to assess model		Narrative	If known, describe which organisation manages the service, how this links with local acute, community and social care services, the composition of the workforce delivering the service, etc. It would be useful to know the impact of having a local Discharge to Assess scheme on flow through the acute setting.

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Activity

QUESTION						DEFINITION
Total and age profile of Trust/UHB/Hospital site patient activity 2018/19						
Emergency Department activity (type 1) - Please note Trust total is the total of all ages for your Trust, not a summation of the over 65 age groups.						
	0-64	**65-74**	**75-84**	**85+**	**Trust total (auto sum)**	
A&E attendances						See NHS data dictionary
Unplanned re-attendances at A&E within 7 days						
Disposal method from Emergency Department:						
Admitted						Code 01
Discharged						Codes 02,03
Referred						Codes 04,05,06,11
Transferred to another hospital						Code 07
Died						Code 10
Left department						Codes 12,13
Other						Code 14
Assessment units activity (this section should be completed for all assessment units (frailty units, short term and other assessment units) assessing patients within a 72 hour stay). Exclude maternity, paediatric and surgical units.						
	0-64	**65-74**	**75-84**	**85+**	**Trust total (auto sum)**	
Admissions to assessment units						
Admissions to assessment units by source:						
GP						
A&E						
Outpatients						
Other						
Disposal method from assessment units:						
Admitted/transfer to inpatient care						
Discharged						
Left/self-discharged						
Died						
Average time before a patient is assessed by a senior clinician in hours						Numerical
Percentage of patients admitted through an assessment unit who received CGA						Numerical. From the NAO report 'Discharging older patients from hospital' https://www.nao.org.uk/report/discharging-older-patients-from-hospital/
Average length of stay in assessment unit in hours						Numerical

Inpatient activity						
Emergency admissions should include those patients initially admitted to the assessment unit						
	0-64	**65-74**	**75-84**	**85+**	**Trust total (auto sum)**	
Elective admissions						Elective admissions - see NHS Data Dictionary
Emergency admissions						Emergency admissions - see NHS Data Dictionary. Include activity related to admission methods 21-28, exclude admission methods 31-32 and 2C (maternity) and 81-82 (other admissions). Emergency admissions should include those patients initially admitted to the assessment unit
Emergency re-admissions within 30 days						Re-admission rates can indicate the success of the NHS in helping people to recover effectively from illnesses or injuries. Re-admissions can occur for a number of reasons and are not always preventable, but can serve as a warning indicator that local practices may not be providing the required quality of acute care and discharge planning, particularly when re-admissions are increasing
Average length of stay in days for emergency admissions						
Number of emergency admissions to inpatient wards who were discharged:						From the NAO report 'Discharging older patients from hospital' https://www.nao.org.uk/report/discharging-older-patients-from-hospital/
On the same day						
The following day						
Number of spells (emergency admissions) with length of stay of 0 - 6 days						
Number of spells (emergency admissions) with length of stay of 7 - 20 days						
Number of spells (emergency admissions) with length of stay of 21 days or more						
Number of occupied bed days for spells (emergency admissions) with length of stay of 0 - 6 days						Inpatient care only. Please exclude assessment units.
Number of occupied bed days for spells (emergency admissions) with length of stay of 7 - 20 days						Inpatient care only. Please exclude assessment units.
Number of occupied bed days for spells (emergency admissions) with length of stay of 21 days or more						Inpatient care only. Please exclude assessment units.
Total number of occupied bed days in Trust 2018/19						Inpatient care only. Please exclude assessment units.
Average % bed occupancy over 12 month period	**Trust Total 2018/19**					Average % bed occupancy is calculated as occupied bed days (see previous question) divided by available bed days in the period (as a percentage). Use the General and Acute category as per the KH03 returns definitions.
Discharge activity						
	0-64	**65-74**	**75-84**	**85+**	**Trust total (auto sum)**	
Total number of discharges						
Total number of supported discharges						Discharges processed by the supported/integrated discharge team (or equivalent)
Number of patients returning to usual place of residence following discharge from hospital						
Admissions directly to long-term care from hospital						If a service user was admitted from long term care, please exclude.

Delayed transfers of care (DTOC)						
	0-64	65-74	75-84	85+	Trust total (auto sum)	
Total delayed transfers of care (total for 2018/19 from SITREP) in bed days						NHS England November 2018 guidance on SITREP reporting. If this information is collected by the Northern Ireland HSCTs or the Welsh University Health Boards, please still provide.
Total delayed transfers of care (total for 2018/19 from SITREP) in bed days which are due to NHS delays						NHS England November 2018 guidance on SITREP reporting. If this information is collected by the Northern Ireland HSCTs or the Welsh University Health Boards, please still provide.
Total delayed transfers of care (total for 2018/19 from SITREP) in bed days which are due to Social Care delays						NHS England November 2018 guidance on SITREP reporting. If this information is collected by the Northern Ireland HSCTs or the Welsh University Health Boards, please still provide.
Total delayed transfers of care (total for 2018/19 from SITREP) in bed days which are due to both NHS and Social Care delays						NHS England November 2018 guidance on SITREP reporting. If this information is collected by the Northern Ireland HSCTs or the Welsh University Health Boards, please still provide.
Reasons for delayed transfers for care (2018/19 from SITREP) - Trust/UHB/Hospital site						
Awaiting completion of assessment						NHS England November 2018 guidance on SITREP reporting. If this information is collected by the Northern Ireland HSCTs or the Welsh University Health Boards, please still provide.
Awaiting public funding/CHC						NHS England November 2018 guidance on SITREP reporting. If this information is collected by the Northern Ireland HSCTs or the Welsh University Health Boards, please still provide.
Awaiting further non acute hospital care						NHS England November 2018 guidance on SITREP reporting. If this information is collected by the Northern Ireland HSCTs or the Welsh University Health Boards, please still provide.
Awaiting care home placement						NHS England November 2018 guidance on SITREP reporting. If this information is collected by the Northern Ireland HSCTs or the Welsh University Health Boards, please still provide.
Awaiting care package in own home						NHS England November 2018 guidance on SITREP reporting. If this information is collected by the Northern Ireland HSCTs or the Welsh University Health Boards, please still provide.
Awaiting community equipment & adaptations						NHS England November 2018 guidance on SITREP reporting. If this information is collected by the Northern Ireland HSCTs or the Welsh University Health Boards, please still provide.
Awaiting family choice						NHS England November 2018 guidance on SITREP reporting. If this information is collected by the Northern Ireland HSCTs or the Welsh University Health Boards, please still provide.
Disputes						NHS England November 2018 guidance on SITREP reporting. If this information is collected by the Northern Ireland HSCTs or the Welsh University Health Boards, please still provide.
Housing						NHS England November 2018 guidance on SITREP reporting. If this information is collected by the Northern Ireland HSCTs or the Welsh University Health Boards, please still provide.
Other						NHS England November 2018 guidance on SITREP reporting. If this information is collected by the Northern Ireland HSCTs or the Welsh University Health Boards, please still provide.

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Benchmarking Network

British Geriatrics Society
Improving healthcare for older people

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Finance

Please include here the costs of teams identified under Workforce section. Please ensure consistency e.g. where staff are apportioned across teams, apportion budgets accordingly.
Include the cost of social care colleagues where this has been included in the Workforce section (even if not paid by the Trust/UHB)
You are asked to provide the total costs/workforce of the short term assessment unit and supported discharge teams on the basis that these areas will largely be dealing with older people but it is not feasible to attribute cost/workforce to the older people cohort only.
The bank, agency and overtime spend should be included in total pay costs column and then extracted for the bank, agency & overtime data fields below.

QUESTION					DATA DEFINITION
Cost of teams	**Pay costs £**	**Non pay costs £**	**Indirect costs/overhead allocations £**	**Total costs £**	Use outturn 2018/19
Acute frailty team (resource allocated to A&E)					Include dedicated geriatric team and any other dedicated admission avoidance resource such as therapists and social workers This team may be located in A&E or in an assessment unit
Assessment units (all costs of the units)					Exclude maternity, paediatric and surgical units.
Care of older people medical team					Exclude staff time included in dedicated geriatric A &E team or short term assessment team
Care of older people wards (all non-medical staff on wards)					If care of older people is under general medicine, provide the data for your general medicine wards
Supported discharge team (all costs of the team)					

CIP/CRES target as % of budget	Percentage
Acute frailty service in A&E department CIP %	
Assessment units CIP %	
Care of older people medical team CIP %	
Care of older people wards CIP %	
Supported discharge team CIP %	

CIP as % of total budget 2018/19

Bank, agency & overtime expenditure 2018/19	
Bank spend	
Agency spend	
Overtime spend	

To include all bank/agency staff including medical and nursing
To note that this should be an extract of finance data supplied above

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Workforce

All figures should be for the year 2018/19 WTE in establishment
You are asked to provide the total costs/workforce of the short term assessment unit and supported discharge teams on the basis that these areas will largely be dealing with older people but it is not feasible to attribute cost/workforce to the older people cohort only.
Please note, the template should be completed on the basis of the employed job ROLE rather than professional background
Please do not double-count employees if they have, for example, a managerial role but a clinical role also; time should be apportioned accordingly.

Medical staffing

*other Medical staff would include Associate Specialists, Staff Grade doctors, Trust Grades, Specialty Doctors

WTE	Consultant funded establishment	Other Medical (non-Consultant or other trainee WTE - not FY1/2) funded establishment	Trainees - FY 1 funded establishment	Trainees - FY 2 funded establishment	Locums
Acute frailty team (resource allocated to A&E)					
Assessment units all medical staff (exclude maternity, paediatrics and surgical units)					
Care of older people medical team (not included in above teams)					

Nurse and HCA staffing

WTE	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c and above
Acute frailty team (resource allocated to A&E)									
Assessment units									
Care of older people wards									
Supported discharge team									

Allied Health Professionals:

Please note, where staff work across functions, please apportion wte input to the teams listed

WTE	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c and above
Acute frailty team (resource allocated to A&E)									
Assessment units									
Care of older people wards									
Supported discharge team									

Social Care Professionals:

Please note, where staff work across, functions, please try to apportion wte input to the teams listed

For social care professionals, please include wte worked across the 4 areas of the acute pathway, regardless of whether the employing organisation is the trust or by the Local Authority

Social care professionals deliver social work, personal care, protection or social support services with needs arising from old age, illness, disability or poverty

WTE	WTE
Acute frailty team (resource allocated to A&E)	
Assessment units	
Care of older people wards	
Supported discharge team	

Management and administrative & clerical

WTE	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c and above
Acute frailty team (resource allocated to A&E)									
Assessment units									
Care of older people team (medical secretaries)									
Care of older people wards									
Supported discharge team									

Overall workforce metrics:	Vacancy rate %	Staff sickness rate %	Staff turnover rate %
Acute frailty team (resource allocated to A&E)			
Assessment units			
Care of older people medical team			
Care of older people wards			
Supported discharge team			

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Additional workforce

QUESTION	DATA	DATA TYPE	DATA DEFINITION
Does the Trust/UHB/Hospital site have Advanced Nurse Practitioners (ANP) in older people's care?		Drop-down menu:- Yes / No	
Does every care of older people ward in your Trust/UHB/Hospital site have access to an ANP in older people's care?		Drop-down menu:- Yes / No	
Do ANPs provide advice and support wider than the older people wards?		Drop-down menu:- Yes / No	
Do the ANPs in older people's care link directly with community services?		Drop-down menu:- Yes / No	E.g. working with community matrons / care coordinators in the community to step service users up and down to/from secondary care
If yes, please describe how this linkage works		Narrative	
Does the Trust/UHB/Hospital site participate in a consultant practitioner trainee programme?		Drop-down menu:- Yes / No	Developing clinical leaders to work with vulnerable older people
Does the Trust/UHB/Hospital site have specific dementia training for all staff?		Drop-down menu:- Yes / No	
Does the Trust/UHB/Hospital site provide any training on frailty specifically for the surgical specialties?		Drop-down menu:- Yes / No	
If yes, please describe		Narrative	
% of dedicated care of older people workforce who have completed local mandatory training requirements		Percentage	% of staff that have completed local mandatory training requirements during the year 2018/19 calculated as: Numerator: WTE completing mandatory training requirements in the year; divided by Denominator: Average WTE staff in post in the year eligible to complete mandatory training requirements multiplied by 100 to give a % rate
% of dedicated care of older people workforce who have had an annual appraisal		Percentage	% of staff that have an annual appraisal completed during the year 2018/19 calculated as: Numerator: WTE having had an annual appraisal in the year; divided by Denominator: Average WTE staff in post in the year eligible for annual appraisal multiplied by 100 to give a % rate

Does the Trust/UHB/Hospital site provide a frailty identification/awareness training programme		Drop-down menu:- Yes / No	This would include why it is important to identify frailty, why it is important, the frailty syndromes, etc
Please indicate which staff receive frailty identification / awareness training			
Geriatricians		Drop-down menu:- Yes / No	
Other speciality medics		Drop-down menu:- Yes / No	
Nursing staff		Drop-down menu:- Yes / No	
Therapy staff		Drop-down menu:- Yes / No	
Please outline any other staff that receive frailty identification / awareness training		Narrative	
Is this training mandatory?		Drop-down menu:- Yes / No	
Is training available for non-core staff?		Drop-down menu:- Yes / No	Non core refers to non geriatric/frailty specialist trained staff
Does the Trust/UHB/Hospital site provide training on how to identify/screen for people living with frailty?		Drop-down menu:- Yes / No	
Is this training mandatory?		Drop-down menu:- Yes / No	
Does the Trust/UHB/Hospital site provide training on how to assess and manage people living with frailty?		Drop-down menu:- Yes / No	
Is this training mandatory?		Drop-down menu:- Yes / No	
Please describe any initiatives in place to help with the recruitment or retention of staff		Narrative	

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Quality & outcomes

QUESTION	DATA	DATA TYPE	DATA DEFINITION
Key indicators for care of older people wards			
Do the Care of Older People wards routinely collect Patient Reported Experience Measures?		Drop-down menu:- Yes / No	Patient Reported Experience Measures which are routinely collected following intervention (rather than an annual patient satisfaction survey). PREMs assess the experience of care delivered to patients from the patient perspective
Do the Care of Older People wards routinely collect Patient Reported Outcome Measures?		Drop-down menu:- Yes / No	Patient Reported Outcome Measures which are routinely collected following intervention (rather than an annual patient satisfaction survey). PROMs assess the quality of care delivered to patients from the patient perspective
Friends and Family Test - percentage of patients who would recommend the service		Percentage	Include those 'extremely likely' or 'likely' to recommend the service. Not applicable to Wales and Northern Ireland
Number of formal complaints - Care of Older People wards during 2018/19		Numerical	
Number of Serious Incidents - Care of Older People wards during 2018/19		Numerical	Number of serious incidents recorded (for Older People's services) by the organisation in 2018/19
Percentage of SIs fully investigated and completed within 60 working days during 2018/19 for Care of Older People wards		Percentage	Numerator: The number of older people SIs fully investigated and completed in 2018/19 within 60 working days; divided by Denominator: The total number of Older People SIs fully investigated and completed in the year; multiplied by 100 to give the percentage rate. If there were no reported serious incidents, please leave blank.
Number of 'never events' recorded during 2018/19 for Care of Older People wards		Numerical	

Number of safeguarding incidents reported 2018/19 for Care of Older People wards		Numerical	Include safeguarding alerts to adult social care
Number of whistle blowing incidents reported to the Trust/UHB Board in 2018/19 for Care of Older People wards		Numerical	
Number of medication errors on Care of Older People wards 2018/19		Numerical	
Does the Care of Older People service routinely carry out satisfaction surveys with service users/carers?		Drop-down menu:- Yes / No	At least an annual satisfaction survey for Older People's services users/carers
Harm free care (Patient Safety Thermometer)			
Number of incidences of falls (with harm) of patients whilst on the Care of Older People wards 2018/19		Numerical	see http://www.safetythermometer.nhs.uk/ for further information. Take the average of the 12 monthly scores for 2018/19.
Number of incidents of pressure ulcers whilst on the Care of Older People wards 2018/19		Numerical	see http://www.safetythermometer.nhs.uk/ for further information. Take the average of the 12 monthly scores for 2018/19.
Number of occurrences of UTIs of patients with catheterisation whilst on the Care of Older People wards 2018/19		Numerical	see http://www.safetythermometer.nhs.uk/ for further information. Take the average of the 12 monthly scores for 2018/19.
Number of patients catheterised on Care of Older People wards 2018/19		Numerical	Number of patients newly catheterised on care of older people wards in 2018/19. Take the average of the 12 monthly scores for 2018/19.
Number of incidences of newly acquired VTEs whilst on the Care of Older People wards 2018/19		Numerical	see http://www.safetythermometer.nhs.uk/ for further information. Take the average of the 12 monthly scores for 2018/19.
Number of occurrences of C. Diff on the Care of Older People wards 2018/19		Numerical	The number of occurrences of hospital acquired clostridium difficile infection on care of older people wards in 2018/19
Number of occurrences of hospital acquired pneumonia on the Care of Older People wards 2018/19		Numerical	The number of occurrences of hospital acquired pneumonia on care of older people wards in 2018/19
Number of occurrences of MRSA on the Care of Older People wards 2018/19		Numerical	The number of occurrences of MRSA on care of older people wards in 2018/19

Trust/UHB/Hospital site wide indicators			
Does the Trust/UHB/Hospital site have a process in place for disseminating NICE quality standards?		Drop-down menu:- Yes / No	
Number of incidences of falls (with harm) in the Trust/UHB/Hospital site in 2018/19		Numerical	see http://www.safetythermometer.nhs.uk/ for further information
NHS Staff Survey results % feeling satisfied with the quality of work and patient care they are able to deliver (Trust/UHB/Hospital site)		Percentage	Latest survey results from NHS staff survey (use 2019 results if available). Is only available at whole organisational level and does not apply to Wales
Is the Trust/UHB/Hospital site taking part in any local CQUIN schemes related to the care of older people?		Yes/No	Welsh UHBs and NI HSCTs should respond yes to this question if any locally agreed quality improvement schemes are in operation locally (as Wales and NI don't operate CQUIN schemes in the same way as England)
If yes, please provide details		Narrative	
Is the Trust/UHB/Hospital site taking part in any local CQUIN schemes related to the management of frailty in the acute setting?		Yes/No	Welsh UHBs and NI HSCTs should respond yes to this question if any locally agreed quality improvement schemes are in operation locally (as Wales and NI don't operate CQUIN schemes in the same way as England)
If yes, please provide details		Narrative	
Please describe any good practice in the services covered by this survey which is occurring in your Trust/UHB/Hospital site		Narrative	
Please briefly describe any examples of how your organisation has used previous iterations of the benchmarking project to support service improvement		Narrative	

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Intergrated Care Systems Project and Consent

The NHS Benchmarking Network is developing a new Integrated Care Systems product to support strategic planning at the whole system level.
The product will use selected data from NHSBN projects alongside national data sets.
To ensure this tool is as complete and useful as possible, we are seeking consent to use the following data submitted as part of this collection (2018/19 data) and the previous collection (2017/18 data) on a named basis.

Only the following data would be used for this purpose, and no other data already submitted.
Please review the data below, answer the two consent questions, and click 'Save'.

QUESTION	DATA	DATA TYPE	DATA DEFINITION
Is routine identification of frailty undertaken on entry to the accident and emergency department in older people?		Drop-down menu:- Yes / No	Routine identification of frailty should be undertaken using a recognised tool

Does your Trust/UHB/Hospital site have a frailty unit?		Drop-down menu:- Yes / No	"Acute frailty service" includes geriatric liaison, and dedicated geriatric teams
Is Comprehensive Geriatric Assessment delivered on Care of Older People wards?		Drop-down menu:- Yes / No	CGA is a multi-dimensional, multi-disciplinary process which identifies medical, social and functional needs, and the development of an integrated/co-ordinated care plan to meet those needs
Does your Trust/UHB/Hospital site operate a "Discharge to Assess" model?		Drop-down menu:- Yes / No	"Discharge to assess" schemes commonly operate as soon as the patient is clinically optimised ie the point at which care and assessment can safely be continued in a non-acute setting. The dischage to assess schemes will work with the patient/their carers to plan post-acute care in the person's own home or another community setting. This is in relation to immediate post-acute care & support needs and not the assessment for long-term care.
Does the Trust/UHB/Hospital site have an awareness programme for non-geriatricians about frailty and CGA?		Drop-down menu:- Yes / No	
How long does CHC assessment take on average (in days)?		Numerical	Average time in days from when the CHC checklist is applied to panel application
Number of designated Care of Older people beds		Numerical	If there are units or wards under the care of older people team but with a different designation (not designated as care of older people beds) these should be included. Do not include stroke beds. Older people wards provide specialist geriatrician-led care to older people with complex needs.
Total delayed transfers of care (total for 2018/19 from SITREP) in bed days:		Drop-down menu:	NHS England November 2018 guidance on SITREP reporting. If this information is collected by the Northern Ireland HSCTs or the Welsh University Health Boards, please still provide.
0-64		Numerical	
65-74		Numerical	
75-84		Numerical	
85+		Numerical	
Trust Total (Auto-Sum)	0	Auto-sum	
Trust/UHB/Hospital site WTE Geriatricians employed		Numerical	WTE Geriatricians employed at year end 2018/19 (all staff)
Overall Workforce Metrics (vacancy/sickness/turnover)			
Care of older medical team			
Vacancy rate		Percentage	
Sickness rate		Percentage	
Turnover rate		Percentage	
Care of older people wards			
Vacancy rate		Percentage	
Sickness rate		Percentage	
Turnover rate		Percentage	
Number of medical beds (not designated Care of Older people beds)		Numerical	Please include stroke beds

Total number of occupied bed days in Trust 2018/19			
0-64		Numerical	Inpatient care only. Please exclude assessment units.
65-74		Numerical	Inpatient care only. Please exclude assessment units.
75-84		Numerical	Inpatient care only. Please exclude assessment units.
85+		Numerical	Inpatient care only. Please exclude assessment units.
Trust Total (Auto-sum)	0	Auto-sum	
Trust/UHB/Hospital site WTE consultants employed		Numeric	WTE consultants employed at year end 2018/19 (all staff)

Consent

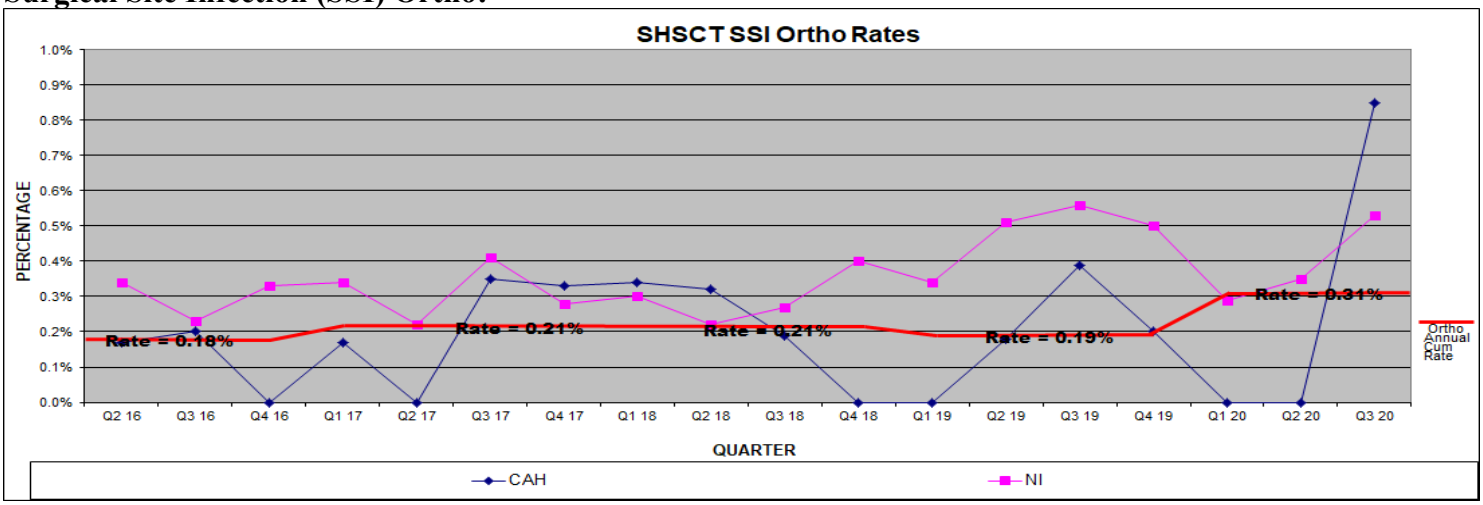
QUESTION	DATA	DATA TYPE	DATA DEFINITION
I/we consent to the above data for the **current collect (2018/19 data)** being used on a named basis for the ICS Project		Drop-down menu:- Yes, I/We consent No, I/We do not consent	
I/we consent to the above data for the **previous collection (2017/18 data)** being used on a named basis for the ICS Project		Drop-down menu:- Yes, I/We consent No, I/We do not consent	

Location of Paper Death Certificate Book – 28.3.2020

Directorate	Site	Location
Acute	CAH Main Hospital	Patient Flow – Bleep [redacted] to request death certificate book
	Daisy Hill Hospital	Patient Flow – Bleep [redacted] to request death certificate book
	Acute Care at Home	AC@H Office - Lurgan Office
CYP	CAH Blossom Ward	Black Box, Sister's Office
	CAH Neo-Natal	Store Room Cabinet
	DHH Paediatric Ward	Patient Flow – Bleep [redacted] to request death certificate book
MHLD	CAH Bluestone Unit	Contact Patient Flow CAH
	Gillis Ward, St Luke's Hospital	Ward Safe
OPPC	Lurgan Hospital	Ward 1 – Paper Death Certificate Book kept beside the Mortuary Book (Nurses Station front wing) Ward 2 – Paper Death Certificate Book in black box in Sister's Office Ward 3 – To borrow from Ward 1 or Ward 2
	South Tyrone Hospital	Dr P Stinson's Office – Clip on drawer but not locked

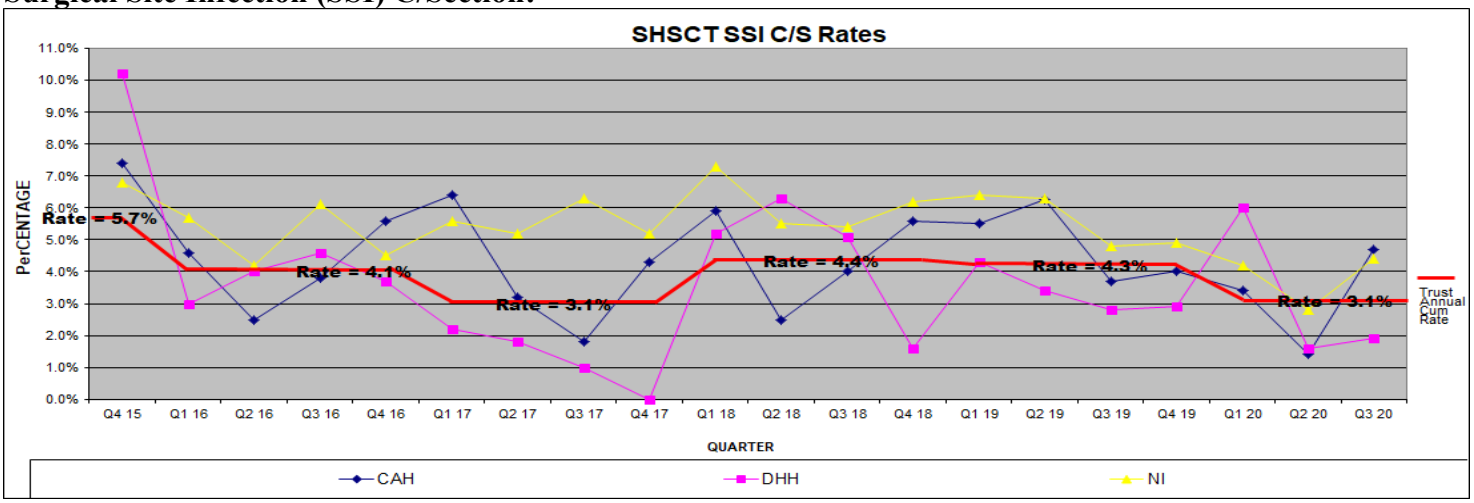
Patient Safety Report for Acute Governance Meeting April 2021

Surgical Site Infection (SSI) Ortho:



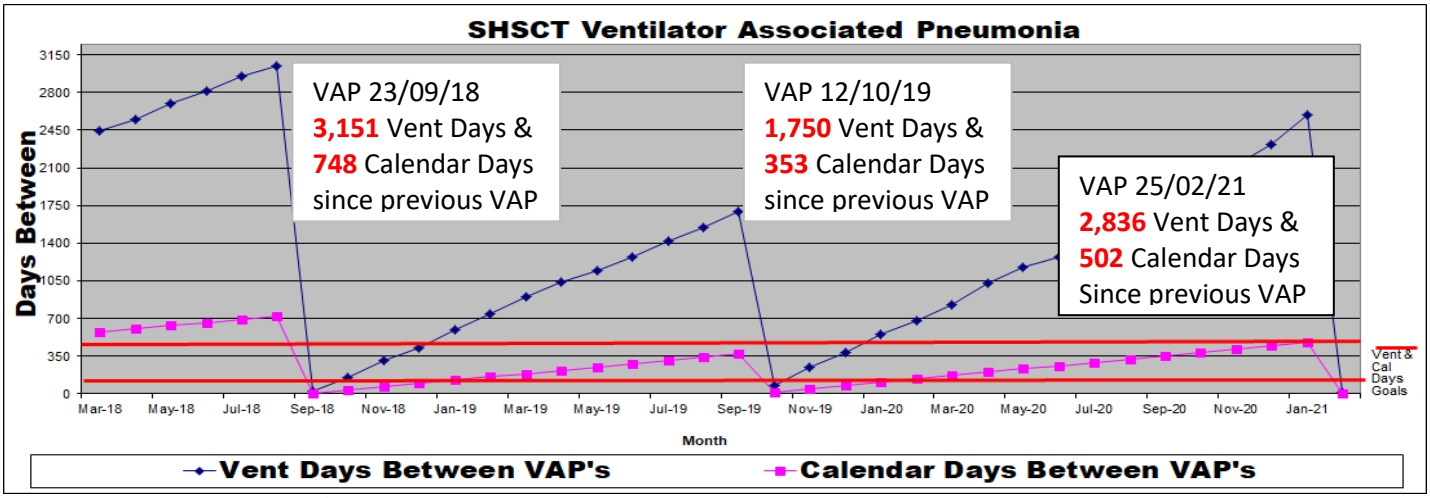
- Next update when Q4 2020 SSI Rates released by PHA

Surgical Site Infection (SSI) C/Section:



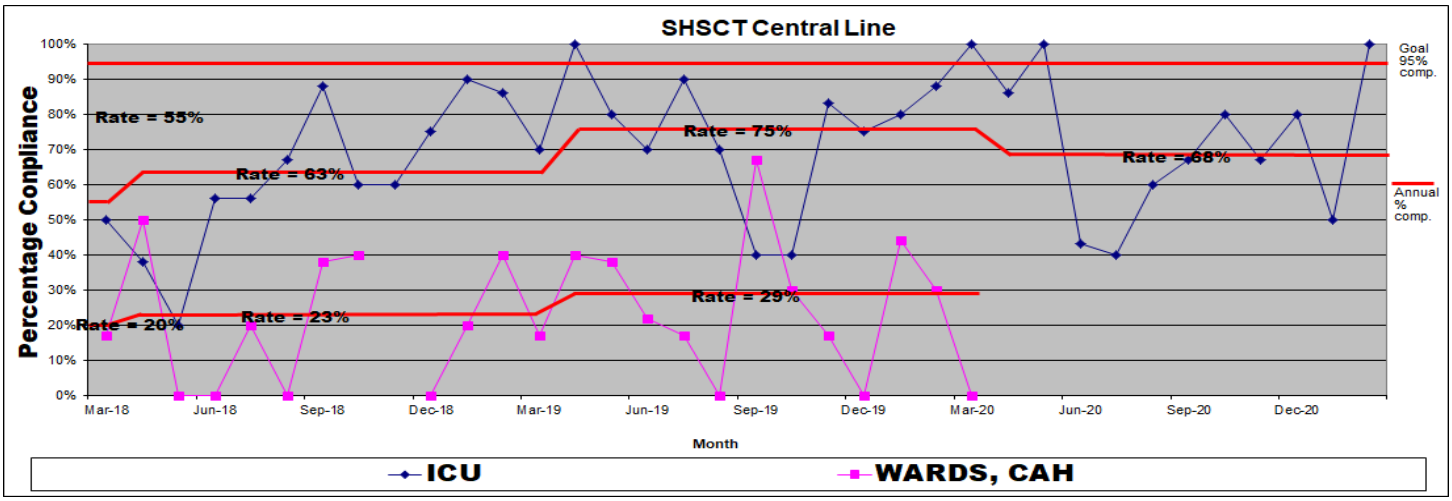
- The quarterly C/S Audits takes place in March 2021 with results reported in May 21

Ventilator Associated Pneumonia (VAP):



- VAP reported 25th Feb 21. Period of **2,836** Vent Days/**502** Calendar Days since previous VAP 12th Oct 19
- Vent Days Between VAP's **19** (26th February 21 → 28th February 21)
- Calendar Days Between VAP's **3** (26th February 21 → 28th February 21)

Central Line:



Overall Bundle Compliance Feb 21, ICU **100%** (5/5 cases audited), up from **50%** (1/2 cases audited) in Jan 21

- The Audit on the Wards has been suspended until further notice due to Covid-19
- Results shared with Lead Clinician & Lead Nurse for this QI work to address areas of non-compliance

NEWS:

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q3 20/21	Q2 20/21	Q1 20/21	Q4 19/20
ACUTE	94% (422/451)	92% (428/463)	Audit cancelled due to Covid-19	88% (346/392)
TRUST	93% (554/596)	93% (541/584)		90% (442/492)

- NB: Q4 19/20 data is for Jan & Feb 20 only. March audits not undertaken due to Covid-19
- Q1 20/21 Audit was cancelled by the PHA due to Covid-19

MUST (Malnutrition Universal Screening Tool):

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q3 20/21	Q2 20/21	Q1 20/21	Q4 19/20
ACUTE	90% (365/406)	88% (404/458)	Audit cancelled due to Covid-19	90% (353/392)
TRUST	92% (502/548)	90% (521/578)		92% (451/492)

- NB: Q4 19/20 data is for Jan & Feb 20 only. March audits not undertaken due to Covid-19
- Q1 20/21 Audit was cancelled by the PHA due to Covid-19

Critical Medicines Omitted:

The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q3 20/21	Q2 20/21	Q1 20/21	Q4 19/20
ACUTE	1 (405)	2 (461)	Audit cancelled due to Covid-19	1 (392)
TRUST	4 (549)	2 (582)		1 (492)

- NB: Q4 19/20 data is for Jan & Feb 20 only. March audits not undertaken due to Covid-19
- Q1 20/21 Audit was cancelled by the PHA due to Covid-19

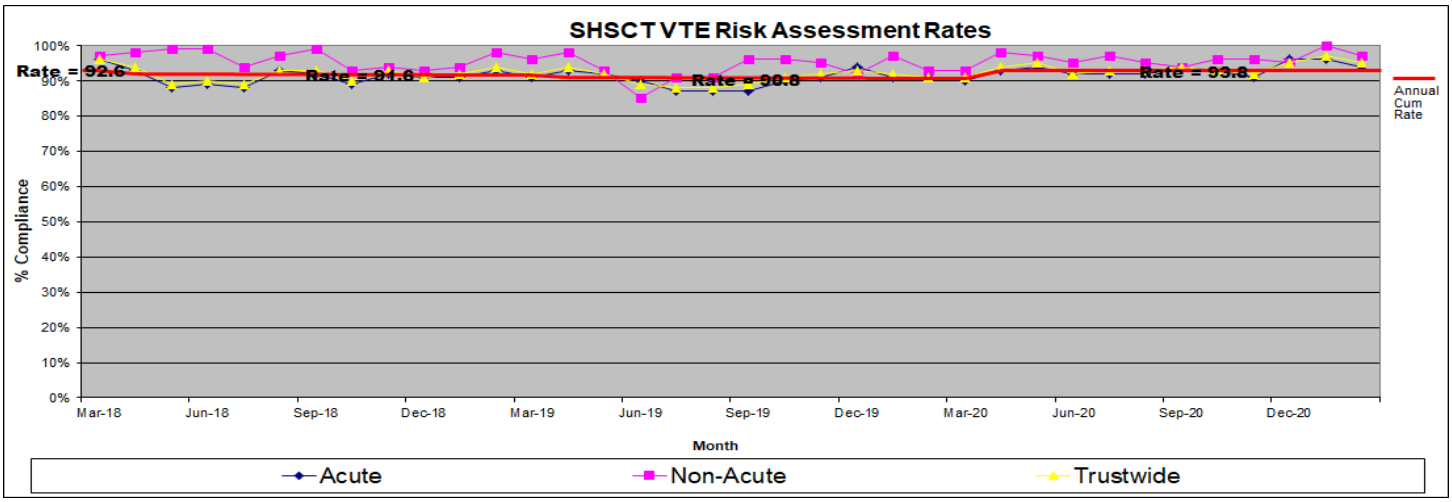
VTE:

Feb 21 (Week Commencing 01/02/21 → Week Commencing 22/02/21)							
Division	Site	Ward	Number of Weekly Audits not done	Charts with Fully Completed VTE Risk Assessment	Number of Charts Audited	Monthly Percentage Compliance	Quarter 3 20/21 Percentage Compliance
S&EC	CAH	3 South	0	11	15	73% ↓	76% ↓
		4 North CESW	0	18	20	90% ↓	100% ↑
		4 South	1	14	14	100% ↔	98% ↑
		Elective Adm.	0	12	16	75% ↓	77% ↑
		Orthopaedic	0	17	17	100% ↔	100% ↔
		Trauma	4	N/A	N/A	N/A	100% ↔
	DHH	F/male Surg.	0	18	19	95% ↓	94% ↓
		MSW/HDU	N/A	N/A	N/A	N/A	N/A
M&UC	CAH	1 South	1	15	15	100% ↑	93% ↓
		1 North	0	16	19	84% ↓	81% ↓
		2 North Resp.	0	20	20	100% ↔	94% ↑
		Haematology	0	8	8	100% ↑	100% ↑
		3 North	0	18	18	100% ↔	100% ↔
		2 North Med	0	18	19	95% ↓	89% ↓
		AMU	2	7	10	70% ↓	97% ↓
		Frailty Ward	0	14	15	93% ↓	N/A
	DHH	F/male Med.	0	20	20	100% ↑	97% ↑
		CCC/MMW	0	19	19	100% ↔	98% ↑
		Stroke/Rehab	0	19	19	100% ↑	99% ↑
		Respiratory L3	0	19	19	100% ↔	99%
IMWH	CAH	Gynae	1	7	7	100 % ↑	89% ↓
TOTAL			9 ↓ (19)	290	309	93.9% ↓	93.1% ↑

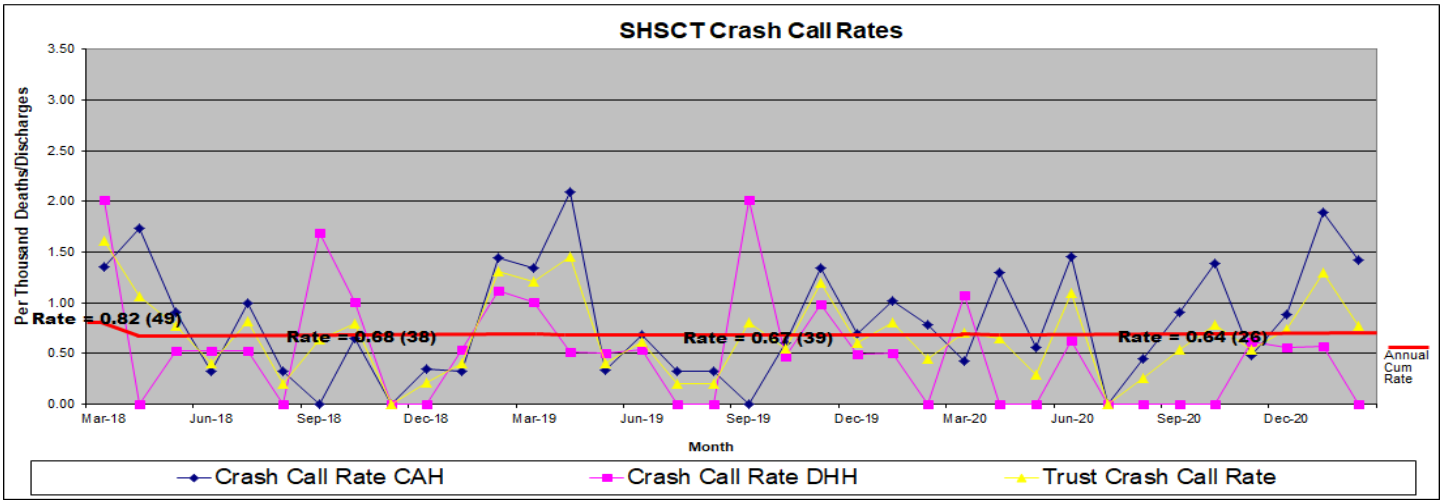
Key: Red – Under 85% compliance, Amber – Compliance between 85% & 94%, Green – Above 95% (Reg. target)

- In summary Overall Compliance with fully completed Risk Assessment on the Acute Wards was **93.9%** (290/309 charts audited) down from **96.2%** (251/261 charts audited) in Jan 21
- Total number of weekly audits not completed in Feb 21 was **9** down from **19** in Jan 21

- The Run Chart below shows compliance against the Commissioning Plan target of **95%** compliance. The Trust Compliance includes the Non-Acute Wards & therefore their compliance has been included also for comparison. Trust Overall Compliance in Feb 21 was **95%** (364/385), down from **97%** in Jan 21



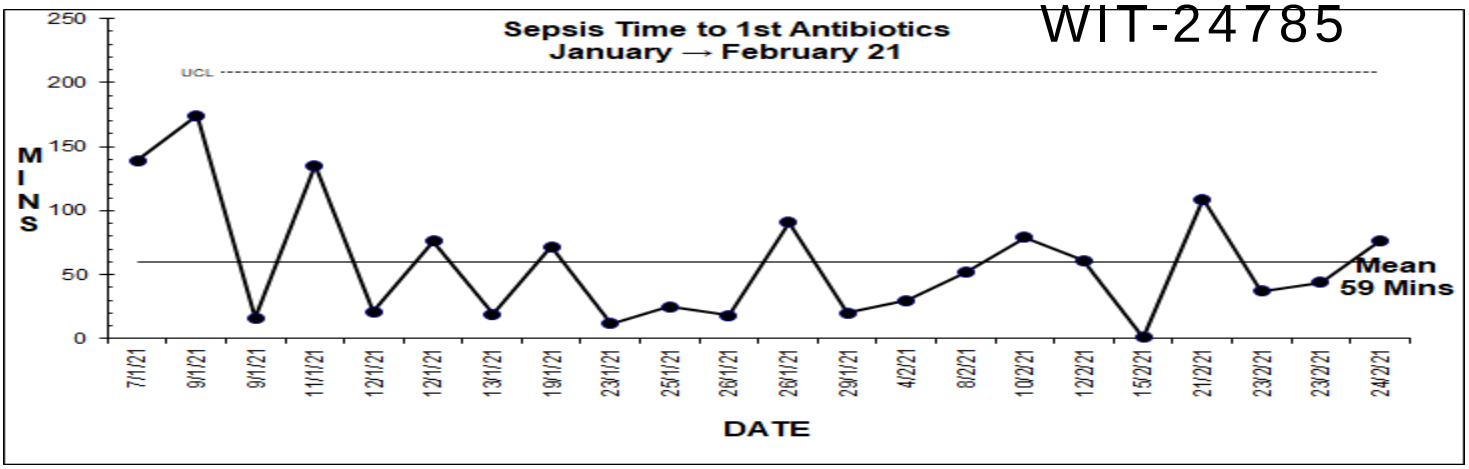
Crash Calls:



- CAH Rate **1.42** per 1,000 deaths/discharges (**3** Crash Calls) down from **1.89** (**4** Crash Calls) in Jan 21
- DHH Rate **0** per 1,000 deaths/discharges (**0** Crash Calls) down from **0.55** (**1** Crash Call) in Jan 21
- Trust Rate **0.77** per 1,000 deaths/discharges (**3** Crash Calls) down from **1.30** (**5** Crash Calls) in Jan 21
- Trust cumulative Crash Call Rate for 20/21 stands at **0.64 (26)** per 1,000 deaths/discharges, down from **0.67 (39)** in 19/20

Emergency Care QI Work: Sepsis 6 CAH & DHH:

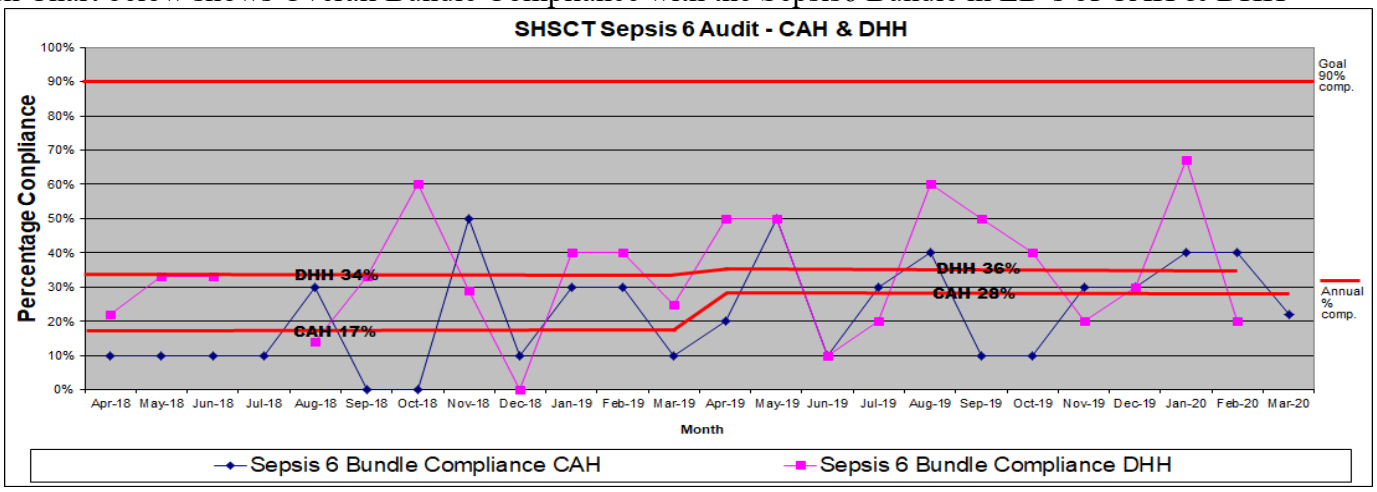
- The new Regional Sepsis QI initiative has been ongoing from Oct 19. The Regional Agreed aim is to improve the time to 1st antibiotics "In Hours" i.e. Mon → Fri 9:00am → 5:00pm. Work is underway in 3 Pilot Areas ED, CAH, (Oct 19 – Dr. Suzie Budd, Clinical Lead), AMU, CAH (Dec 19 – Dr. Emily Hannah, Clinical Lead) & ED, DHH (14th Jan 20 – Dr. Laura Lavery, Clinical Lead). In the ED's of CAH & DHH it was decided to measure compliance 24/7. The Run Chart below shows progress made in ED, CAH. Data from the other Pilot Areas will be shared in due course



- Feb 21 compliance in-hours was **75%** (3/4 cases audited), up from **33%** (2/6 cases audited) in Jan 21. Case outside target timeframe was 61 mins.
- Feb 21 compliance out-of-hours was **40%** (2/5 cases audited), down from **71%** (5/7 cases audited). Cases outside target timeframe ranged between 76 & 109 mins.
- Mean Time Jan 21 → Feb 21 = **59** mins, within Regional target timeframe of 60 minutes.
- In 2020 Mean Time = **76** minutes

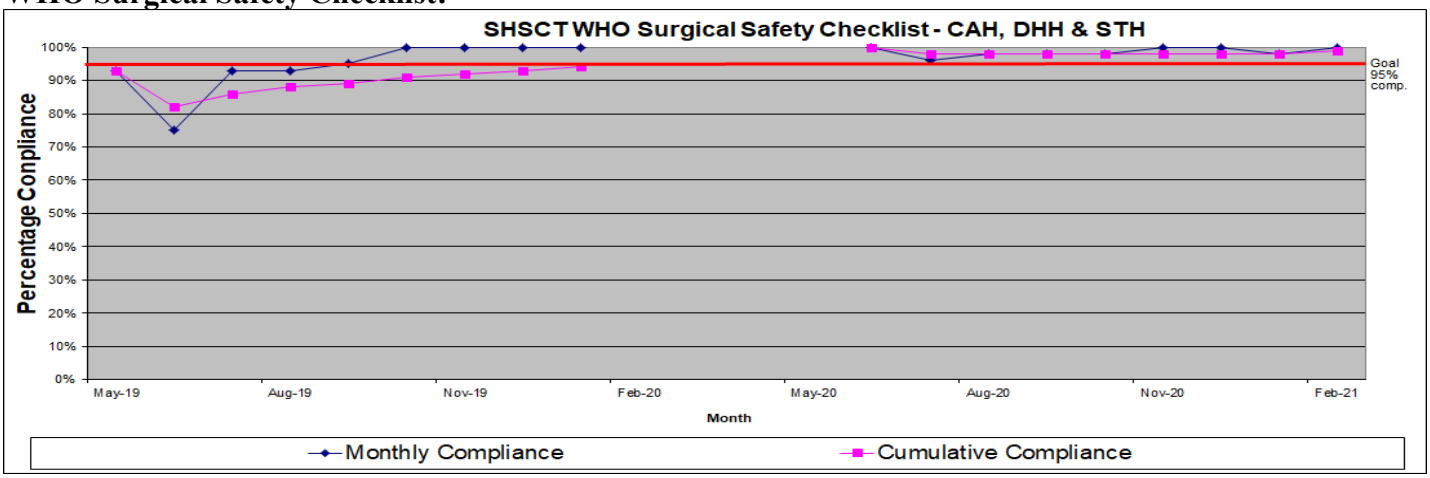
- Auditing in ED, DHH & AMU have been suspended due to Covid-19

The Run Chart below shows Overall Bundle Compliance with the Sepsis6 Bundle in ED's of CAH & DHH



- Auditing has been suspended due to Covid-19

WHO Surgical Safety Checklist:



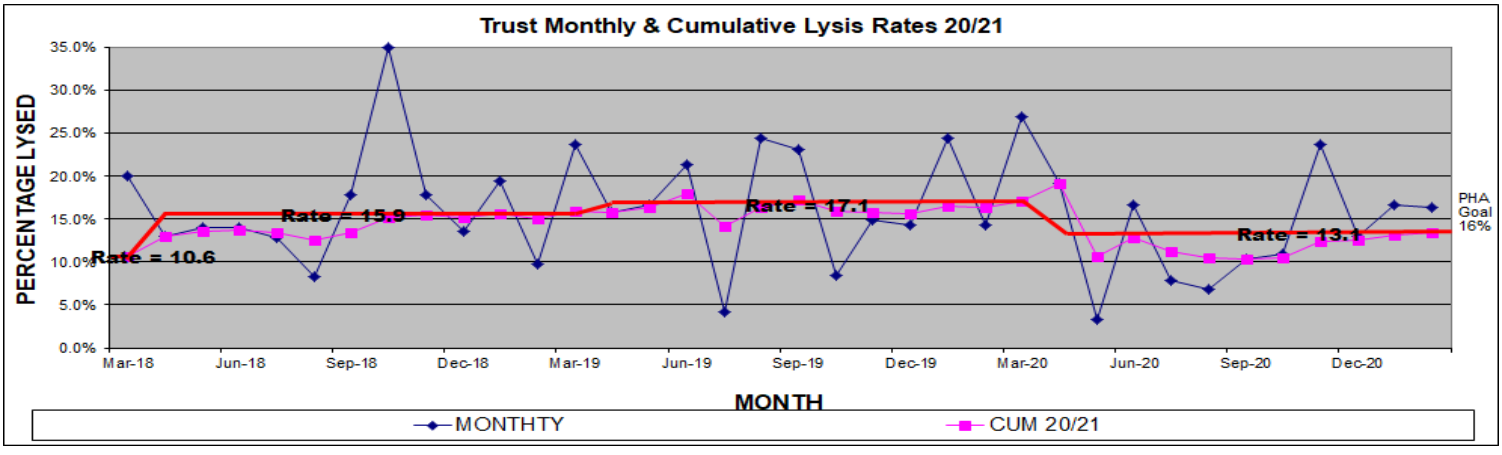
- The Monthly Audits were reinstated in May 19 & were suspended Feb → May 20 due to Covid-19
- Feb 21 Compliance **100%** (50/50) up from **98%** (49/50) in Jan 21, Cumulative Compliance 20/21 **99%**

Stroke Collaborative:

- Regional agreement to collect data on the following, however only Lysis Data will be reported to the PHA/DHSSPS on a quarterly basis:

	CAH		DHH		TRUST		
Measure		Feb 21		Feb 21		Feb 21	Commentary Feb 21
Patients who are potentially eligible for thrombolysis are assessed by Acute Stroke Team within 30 minutes of arrival	18/19 99% 19/20 99%	100% (35/35)	18/19 99% 19/20 99%	100% (19/19)	18/19 99% 19/20 99%	100% (54/54)	-
Patients who are potentially eligible for thrombolysis receive CT scan within 45 minutes	18/19 99% 19/20 99%	100% (22/22)	18/19 98% 19/20 98%	100% (13/13)	18/19 99% 19/20 99%	100% (35/35)	-
Patients deemed suitable for thrombolysis receive first bolus within 60 minutes	18/19 90% 19/20 78%	83% (5/6)	18/19 75% 19/20 75%	100% (1/1)	18/19 86% 19/20 77%	86% (6/7)	CAH – Patients presented in-hours. Outside timeframe by 11. Delay due to language barrier
Patients transferred to Hyper Acute Stroke Unit (or appropriate environment) within 90 mins	18/19 94% 19/20 98%	100% (6/6)	18/19 89% 19/20 96%	100% (1/1)	18/19 93% 19/20 98%	100% (7/7)	-

	CAH		DHH		TRUST		AIM 20/21 (Based on Commissioning Plan) To ensure that the proportion of thrombolysis administration Target 16%
Outcome Measure	2019/20	Feb 21	2019/20	Feb 21	2019/20	Feb 21	
Monthly Thrombolysis Rate		23.1% (6/26)		5.9% (1/17)		16.3% (7/43)	
Thrombolysis Rate (Yearly)	17.6% (58/329)	13.3% (45/338)	16.1% (28/174)	13.8% (9/65)	15.9% (69/435)	13.4% (54/403)	



The above is "Real Time" data, which is subject to change. The Directorate of Performance & Reform is responsible for reporting to the RHSCB. From the above table only the lysis rates are reported. Furthermore their report is 3 months in arrears to allow Clinical Coding to reach an acceptable level.

SKIN Care (Pressure Ulcer):

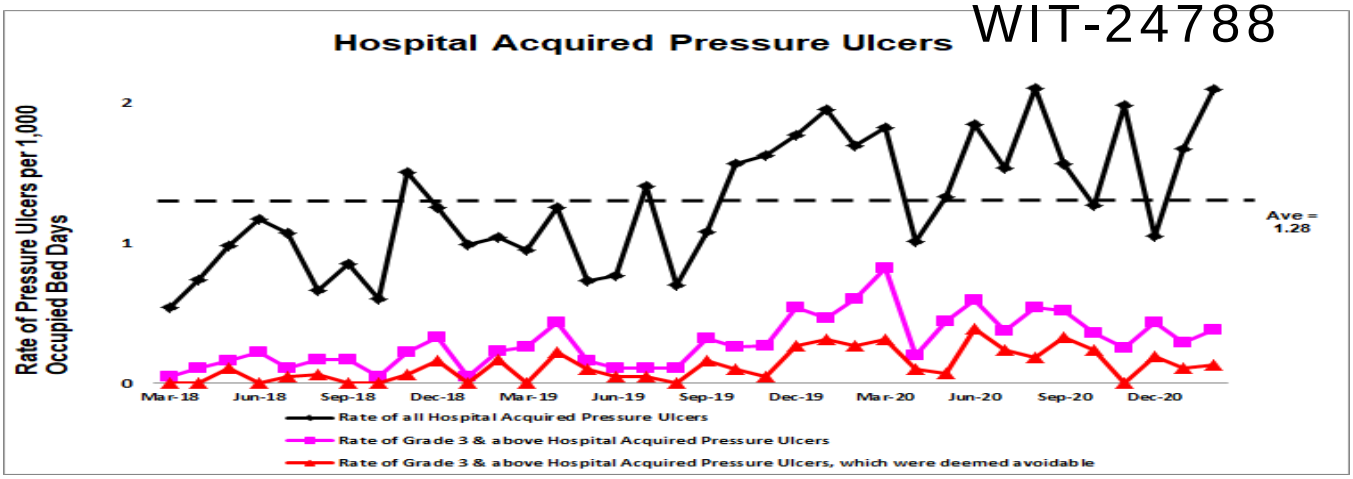
- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q3 20/21	Q2 20/21	Q1 20/21	Q4 19/20
ACUTE	88% (224/256)	84% (262/311)	Audit cancelled due to Covid-19	76% (178/233)
TRUST	89% (324/366)	85% (331/389)		81% (264/325)

- NB: Q4 19/20 data is for Jan & Feb 20 only. March audits not undertaken due to Covid-19
- Q1 20/21 Audit was cancelled by the PHA due to Covid-19
- There were **33** Hospital Acquired Pressure Ulcers reported in Feb 21. Of these, **6** were deep wounds i.e. Grade 3/4 U or DTI's, (2 South Med, 3 South (2), 3 North Med, & ED, CAH & Male Medical, DHH).
- In 20/21 Post Incident Reviews have been carried out on **68** cases to date with **31** deemed to have been avoidable. This represents **11%** of all Ward Acquired Pressure Ulcers reported in 20/21. The outstanding Post Incident Reviews (**3**) will be carried out in due course.

Ward Acquired Pressure Ulcers & Rate per 1,000 Occupied Bed Days 2020/21:

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL	Rate 20/21	Rate & No 19/20
CAH															
Ward 4 South	3	0	0	1	0	0	1	0	0	3	0		8	1.16	1.94 (25) ↓
Ward 4 North	0	1	0	0	1	1	0	1	1	0	1		6	0.78	0.89 (10) ↓
Ward 3 South	1	2	4	4	8	2	5	0	0	3	2		31	3.77	1.24 (14) ↑
Trauma Ward	1	2	2	0	0	1	1	0	2	2	0		11	1.65	4.64 (41) ↓
Orthopaedic Ward	0	0	2	1	0	1	0	3	0	3	2		12	2.82	0.62 (2) ↑
Gynae Ward	N/A	N/A	N/A	0	0	1	0	2	1	0	1		5	2.03	0.30 (1) ↑
ICU	2	2	2	3	0	4	2	4	2	6	12		39	15.71	12.12(28)↓
Ward 3 North Medicine	1	1	4	3	4	2	1	4	0	1	2		23	4.90	2.75 (17) ↑
Ward 3 North Stroke	0	1	1	0	0	0	0	0	0	2	0		4	0.84	1.49 (9) ↓
Ward 2 North	0	1	2	2	0	0	2	0	3	1	1		12	1.34	1.39 (17) ↓
Ward 5 Haematology	1	0	2	1	1	N/A	N/A	0	0	0	0		5	2.24	1.36 (6) ↑
Ward 1 South	0	0	1	3	3	0	2	1	1	0	1		12	1.22	2.01 (26) ↓
Ward 1 North	0	0	1	0	1	2	0	1	0	0	1		6	0.69	0.70 (8) ↓
AMU	1	1	0	1	3	2	1	1	0	0	0		10	1.17	1.52 (18) ↓
2 South Medical	0	2	2	1	3	3	1	5	0	0	2		19	1.97	2.10 (14) ↓
CEAW	0	0	0	0	0	0	0	1	0	0	1		2	1.09	N/A
Emergency Department	0	0	2	1	4	0	0	3	2	1	2		15	N/A	N/A
Ramone 4	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	1	1		2	1.00	N/A
Other Areas e.g. Recovery	0	1	0	1	0	1	2	2	1	0	0		8	N/A	N/A
DHH															
Male Surgical/DEAW/Resp.	0	0	0	0	0	0	0	0	0	1	1		2	0.69	0.65 (4) ↑
Female Surg/Gynae	0	1	1	0	0	0	1	0	0	0	1		4	0.74	0.51 (5) ↑
HDU	0	0	0	1	0	1	0	0	0	0	0		2	1.07	1.70 (5) ↓
Stroke/Rehab	0	0	0	0	1	1	0	1	0	1	0		4	0.48	0.28 (3) ↑
Male Med/CCU	0	0	0	1	0	0	1	0	0	0	1		3	0.34	0 (0) ↑
Female Medical	0	2	0	0	1	2	0	0	2	0	1		8	0.81	0.74 (9) ↑
Emergency Department	0	0	0	0	0	0	0	0	1	0	0		1	N/A	N/A
Lurgan															
Ward 1	0	0	0	0	3	0	0	0	0	0	0		3	0.84	0.65 (4) ↑
Ward 2 Stroke	0	0	1	0	1	0	0	1	0	0	0		3	0.67	1.26 (7) ↓
Ward 3	0	0	0	0	0	0	1	1	1	0	0		3	0.78	0.85 (5) ↓
STH															
Ward 1 STH	0	0	0	0	1	0	0	0	0	2	0		3	0.67	1.12 (7) ↓
Ward 2 STH	0	N/A	0	0	N/A	N/A	0	1	0	0	0		1	0.51	0.65 (4) ↓
MHLD															
Gillis	0	1	1	1	0	0	0	0	0	2	0		5	0.96	0.51 (3) ↑
Willows	0	0	0	0	0	0	0	0	0	0	0		0	0	0 (0) ↔
TOTAL	10	18	28	25	35	24	21	32	17	29	33		272		
RATE	1.01	1.33	1.84	1.53	2.10	1.56	1.27	1.98	1.05	1.67	2.09			1.61	1.36(301)↑



- The Trust's Monthly Hospital Acquired Pressure Ulcer Rate for Feb 21, based on **30** Wards was **2.09** (**33**/15,764) per 1,000 Occupied Bed Days up from **1.67** (**29**/17,413) per 1,000 Occupied Bed Days in Jan21
- **There was a significant rise in cases in ICU in Feb 21. The vast majority of these cases were in ICU2 & were Covid-19 related**
- The Trust's 20/21 Hospital Acquired Pressure Ulcer Rate, based on **30** Wards stands at **1.61 (272)** per 1,000 Bed Days, up from **1.36 (301)** in 2019/20.

Regional Delirium Audit:

The table below shows compliance against the 3 Measures of the Delirium Bundle, for the Acute Wards, where auditing is underway. All 5 Non-Acute Wards also undertake a monthly audit.

Ward/Measure	At risk patients who have a SQiD carried out (single question in delirium)	Patients with a 4AT completed (tool to assess for delirium)	Patients with an Investigations & Management Plan completed
Trauma (Aug 20)	95% (19/20)	83% (5/6)	60% (3/5)
1 North (Feb 21)	100% (20/20)	100% (1/1)	N/A (0/0)
3 North Med (Feb 21)	100% (20/20)	94% (16/17)	100% (14/14)
3 South (Dec 20)	100% (5/5)	100% (1/1)	N/A (0/0)
4 North (Oct 20)	90% (18/20)	100% (1/1)	N/A (0/0)
4 South (Sept 20)	100% (14/14)	100% (3/3)	100% (3/3)
Stroke/Rehab (Jan21)	100% (20/20)	100% (4/4)	0% (0/1)
Female Surg. (Feb 21)	100% (20/20)	100% (3/3)	100% (3/3)
Ramone 4 (Feb 21)	87% (13/15)	100% (4/4)	100% (4/4)

- Ward's in black audits suspended due to Covid-19

Patient Falls:

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q3 20/21	Q2 20/21	Q1 20/21	Q4 19/20
Acute Bundle A Compliance	79% (321/405)	86% (401/467)	Audit cancelled due to Covid-19	79% (310/392)
Trust Bundle A Compliance	81% (445/550)	87% (512/587)		82% (402/492)

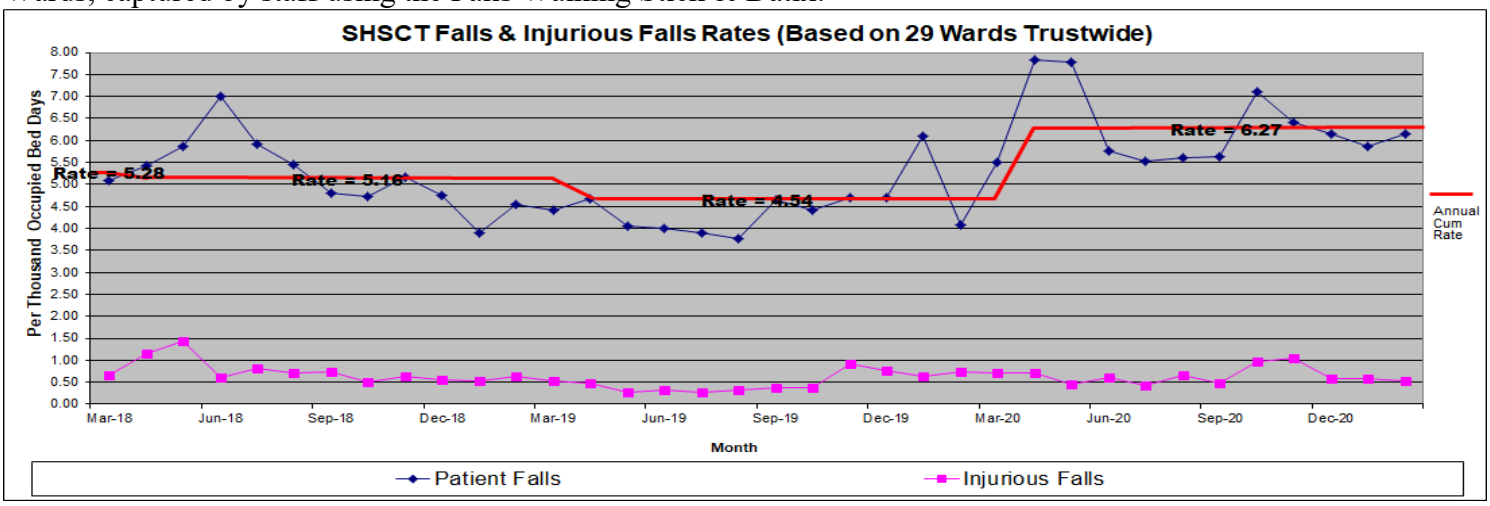
Quarter	Q3 20/21	Q2 20/21	Q1 20/21	Q4 19/20
Acute Bundle B Compliance	82% (289/352)	83% (340/411)	Audit cancelled due to Covid-19	77% (249/323)
Trust Bundle B Compliance	83% (412/495)	84% (444/526)		81% (341/421)

- NB: Q4 19/20 data is for Jan & Feb 20 only. March audits not undertaken due to Covid-19
- Q1 20/21 Audit was cancelled by the PHA due to Covid-19

The table below gives details of individual Ward's Falls Numbers & Falls Rate 20/21

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL	Rate 20/21	Rate 19/20
CAH															
Ward 4 South	2	0	0	3	2	2	2	2	1	3	1		18	2.61	2.88 (37) ↓
Ward 4 North	3	3	3	4	7	5	2	1	3	2	5		38	4.97	2.22 (25) ↑
Ward 3 South	10	5	7	8	3	7	6	6	1	7	5		65	7.90	3.73 (42) ↑
Trauma Ward	4	4	3	4	8	3	0	10	5	5	7		53	7.93	5.77 (51) ↑
Orthopaedic Ward	4	5	1	5	0	0	8	3	5	8	8		47	11.06	3.08 (10) ↑
Gynae Ward	N/A	N/A	N/A	0	0	1	2	2	0	2	1		8	3.25	1.79 (6) ↑
Ward 3 North Medicine	2	5	4	4	7	4	5	3	6	4	3		47	10.01	8.26 (51) ↑
Ward 3 North Stroke	1	3	5	6	1	1	4	4	5	4	2		36	7.57	6.94 (42) ↑
Ward 2 North	4	7	3	2	3	5	1	2	6	3	2		38	4.25	3.36 (41) ↑
Haematology Ward	1	0	0	1	0	N/A	N/A	0	1	0	1		4	1.80	4.75 (21) ↓
Ward 1 South	5	9	4	2	3	4	11	4	3	5	6		56	5.69	3.55 (46) ↑
Ward 1 North	1	2	1	2	6	3	3	5	2	0	0		25	2.89	3.59 (41) ↓
AMU	2	5	9	8	3	6	16	7	13	12	10		91	10.65	9.40 (111) ↑
2 South Medicine	0	3	10	2	3	12	8	6	2	2	6		54	5.60	3.91 (26) ↑
CEAW	N/A	N/A	0	0	0	0	0	0	0	1	0		1	0.54	N/A
Ramone 4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2	1	5	4		12	5.98	N/A
DHH															
Male Surgical/Resp	3	0	0	0	0	0	0	1	2	2	0		8	2.78	2.76 (17) ↑
Female Surg/Gynae	0	0	0	2	0	2	2	0	0	3	1		10	1.85	2.67 (26) ↓
HDU	0	0	1	0	0	0	0	0	0	0	1		2	1.07	2.72 (8) ↓
Stroke/Rehab	4	2	6	5	2	3	5	7	1	3	3		41	4.89	4.73 (50) ↑
Male Med/CCU	4	16	11	12	8	3	4	2	3	5	9		77	8.67	4.76 (56) ↑
Female Medical	2	7	6	3	7	8	7	7	7	6	4		64	6.44	4.34 (53) ↑
Lurgan															
Ward 1	0	6	2	3	3	2	3	7	5	1	2		34	9.54	3.08 (19) ↑
Ward 2 Stroke	3	3	2	0	0	3	1	1	4	2	3		22	4.91	3.61 (20) ↑
Ward 3	3	2	1	1	0	1	2	1	2	0	2		15	3.89	3.57 (21) ↑
STH															
Ward 1 STH	2	0	1	1	3	1	1	0	1	2	2		14	3.13	1.44 (9) ↑
Ward 2 STH	0	N/A	0	0	N/A	N/A	0	1	0	5	1		7	3.54	2.28 (14) ↑
MHLD															
Gillis	12	4	2	6	7	5	12	8	13	4	2		75	14.33	14.24 (83) ↑
Willows	4	13	5	5	16	3	5	5	5	3	3		67	10.08	9.47 (69) ↑
TOTAL	76	104	87	89	92	84	110	97	97	99	94		1029		
RATE	7.84	7.77	5.77	5.52	5.61	5.64	7.12	6.42	6.16	5.86	6.14			6.27	4.54 (995) ↑

The Run Chart below shows Patient Falls & Injurious Falls Rates per 1,000 Occupied Bed Days based on 28 Wards, captured by staff using the Falls Walking Stick & Datix.



- Falls Rate **6.14** (**94**/15,317 Occupied Bed Days) up from **5.86** (**99**/16,908) in Jan 21
- Injurious Falls Rate **0.52** (**8**/15,317 Occupied Bed Days) down from **0.59** (**10**/16,908) in Jan 21
- Cumulative Falls Rate for 20/21 stands at **6.27**, compared to **4.54** in 19/20

Acute SMT Report on Patient Experience and Adverse Incidents

Introduction

The attached report looks at complaints, compliments and adverse incidents for the month of February 2021 in Acute Services.

Key Messages

Complaints

- There were 23 formal complaints received in February 2021.
- The 2 day acknowledgement target has been met at 100% for January complaints. With the ongoing 3th Surge the target of the 20 day response time has been 27% in February 2021. Some of the complaints are very overdue and would need further escalation for responses. Reminders have been sent from Governance Office and ongoing meetings are happening to try and facilitate a more timely response time.
- The top subjects of complaint for February 2021 were Quality of Treatment and Care with 9 and Staff Attitude with 9 also.
- At year to date the top subject of complaint is Quality of Treatment and Care with 109 formal complaints to date with Staff Attitude sitting at 90.
- Currently we have 4 new reopened complaints for February 2021. There has been an upturn in reopened complaints due to further issues more than incomplete first responses.

Compliments

There were compliments 34 recorded for the month February 2021. It is up to the Ward Managers/ staff to log any compliments received through the compliments portal on the intranet.

Incidents

- There was an decrease in incidents recorded in February 2021 to 600
- Patient Falls/ Accidents is the top incident for the period April 2020 to January 2021 contributing to 1159 incidents recorded. Behaviour including violence and aggression second with 1139 incidents.
- There were 95 in patient falls in the month of February on the Wards a decrease from January 2021.

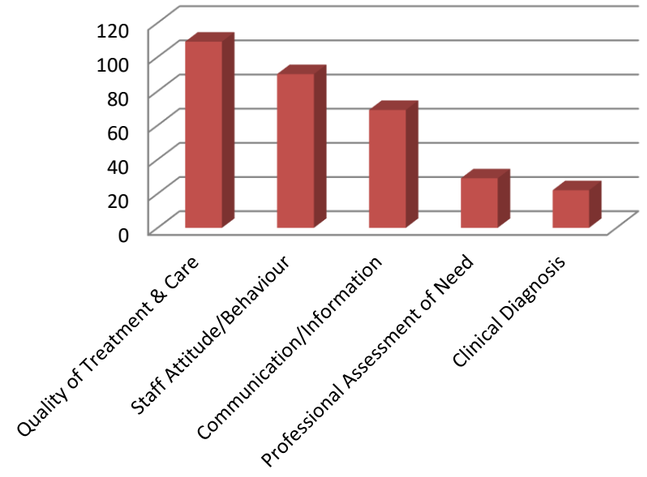
PATIENT EXPERIENCE (Complaints and Compliments)

Complaint Statistics

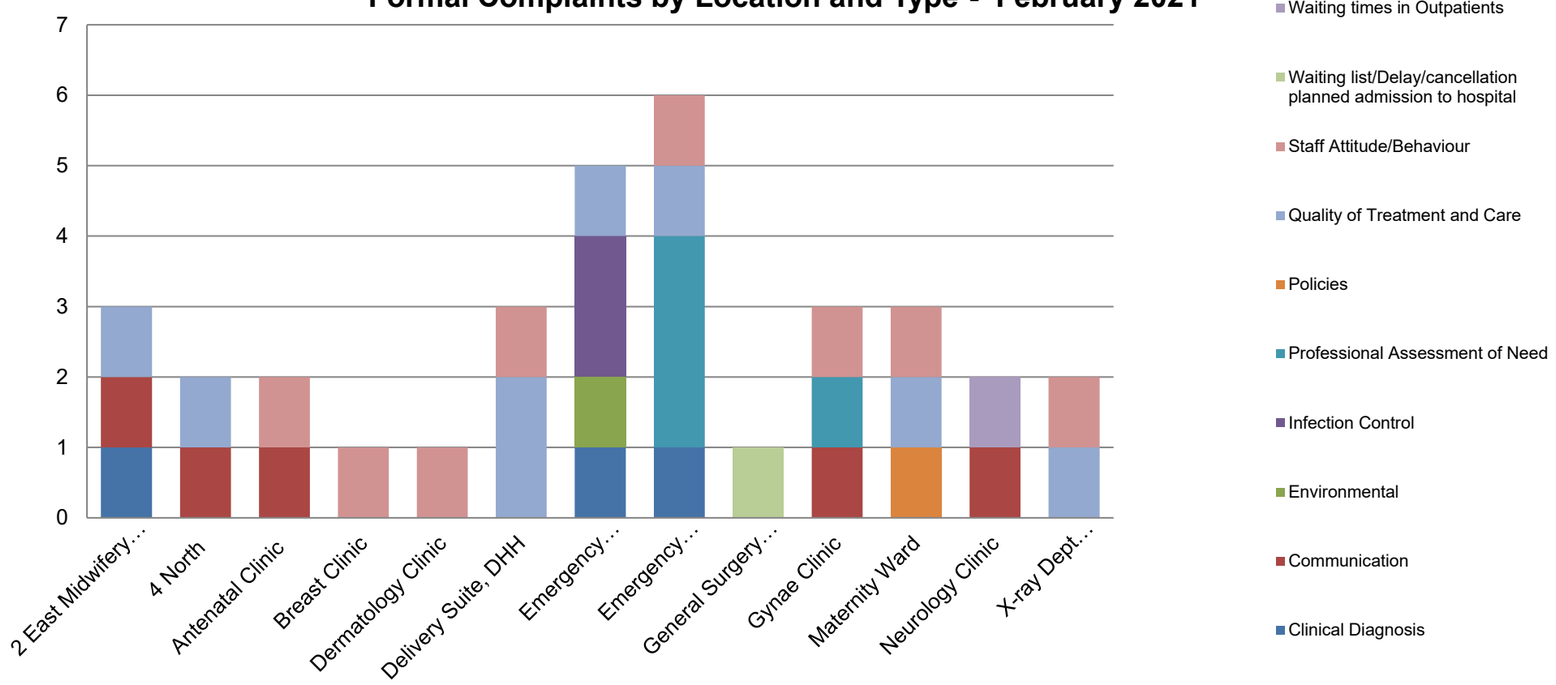
Top 5 Complaints for February 2021

	Formal Complaints	Informal Complaints	MLA Enquiries	Re-Opened Complaints	Awaiting Consent	Ombudsman*
Jan-20	29	4	20	1	1	1
Feb-20	38	11	17	0	7	1
Mar-20	23	4	16	5	3	1
Apr-20	9	6	20	0	2	1
May-20	8	5	12	1	2	3
Jun-20	20	6	9	2	5	0
Jul-20	34	2	29	1	7	0
Aug-20	35	3	27	1	3	1
Sep-20	26	3	34	7	6	0
Oct-20	30	2	15	6	4	2
Nov-20	34	3	30	6	0	0
Dec-20	25	4	25	6	1	0
Jan-21	30	4	32	3	1	1
Feb-21	23	4	22	4	3	1
Total	**364**	**61**	**308**	**43**	**45**	**10**

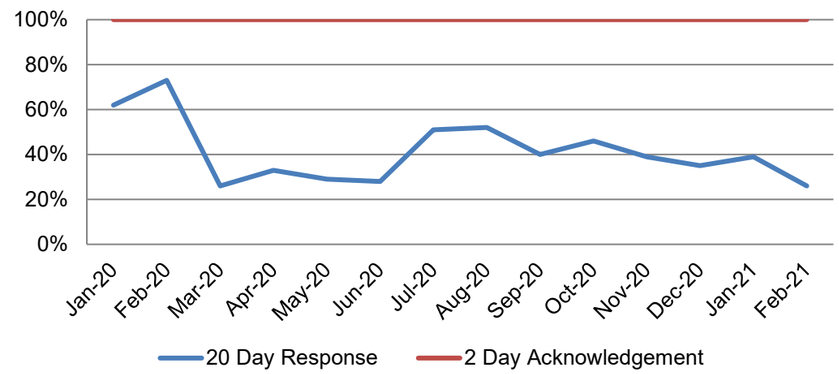
Top 5 Subjects of Complaints Total Year to Date (April 2020- February 2021)



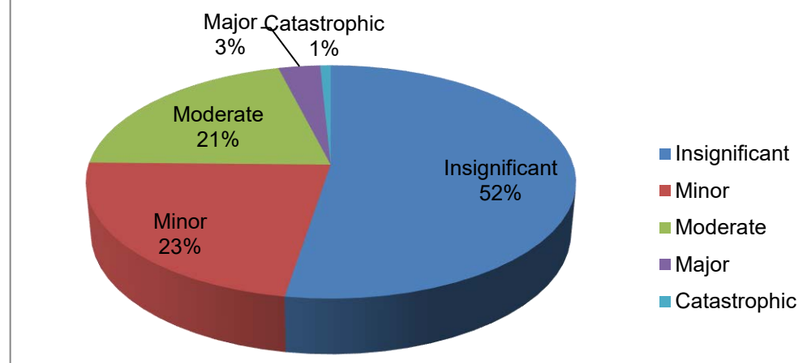
Formal Complaints by Location and Type - February 2021



Complaint Response Times



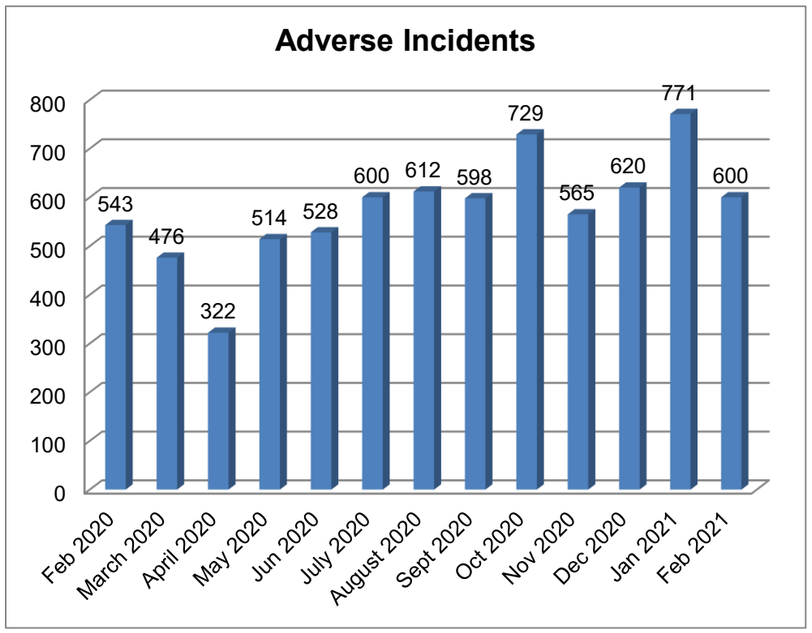
Complaints by Severity April 20 to Feb 2021

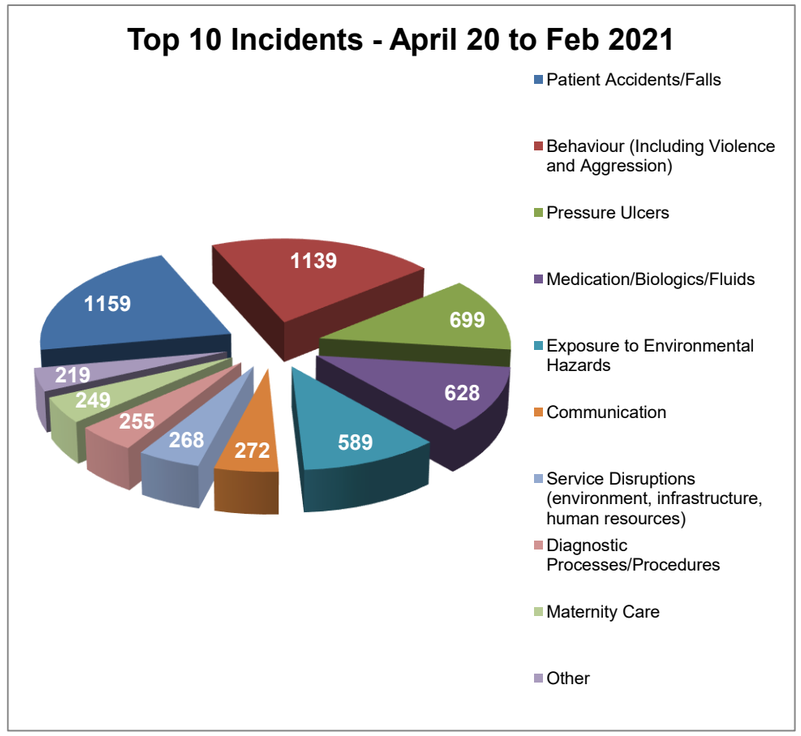


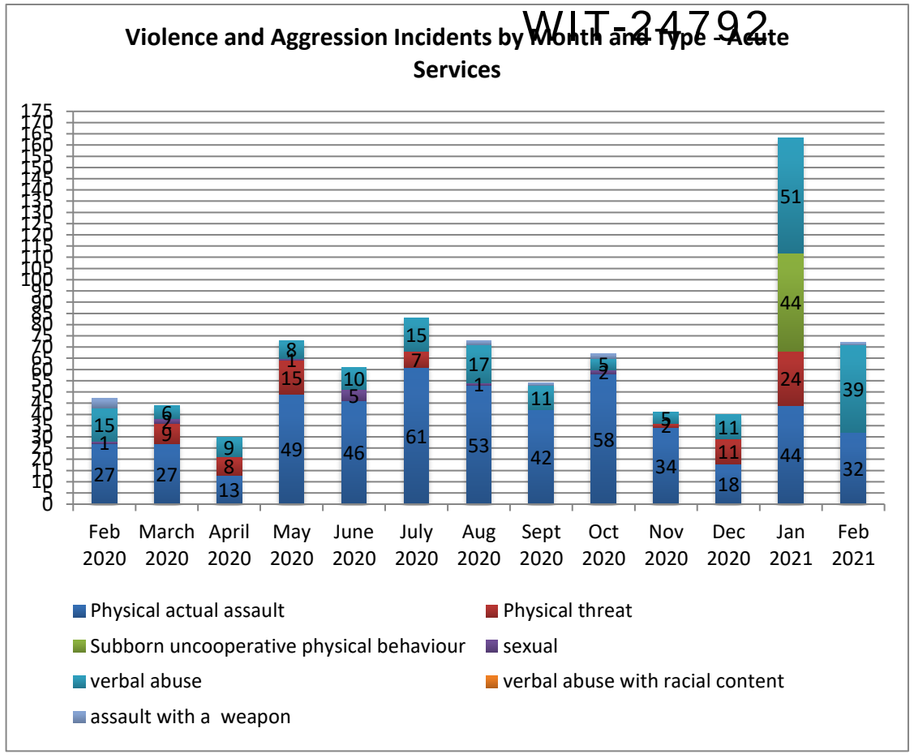
Complaints by Division and Date Received Feb 20 to Feb 21

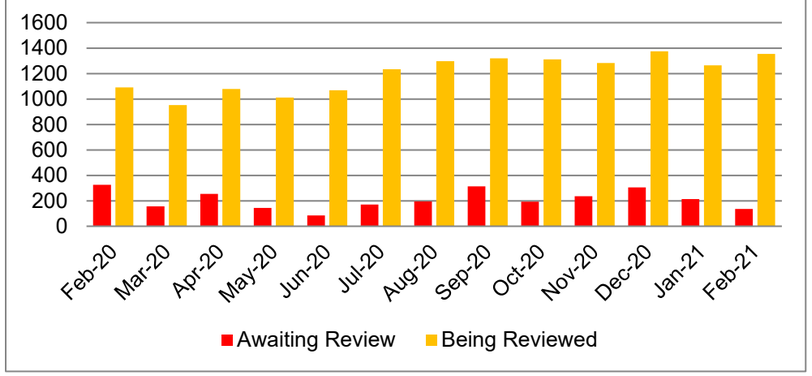
	Feb 20	Mar 20	Apr 20	May 20	Jun 20	July 20	Aug 20	Sept 20	Oct 20	Nov 20	Dec 20	Jan 2021	Feb 2021	Total
IMWH / CCS	16	7	5	0	10	7	7	5	8	13	14	6	17	115
FSS	6	3	0	1	0	1	1	6	0	2	1	1	0	22
MUC	21	18	6	3	11	10	19	23	34	22	44	37	15	263
PHARMACY	1	1	0	0	0	0	0	0	0	0	0	1	0	3
SEC	15	7	2	2	1	5	6	8	8	11	0	14	5	84

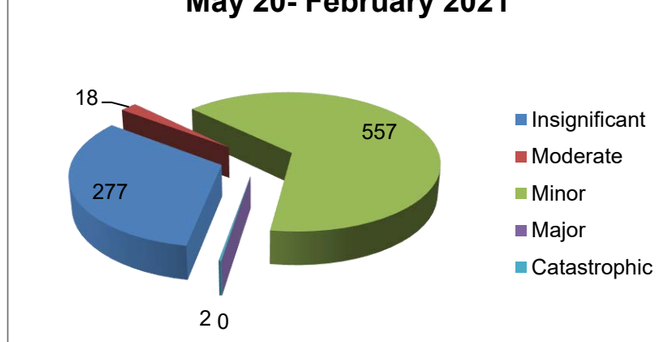
ADVERSE INCIDENTS

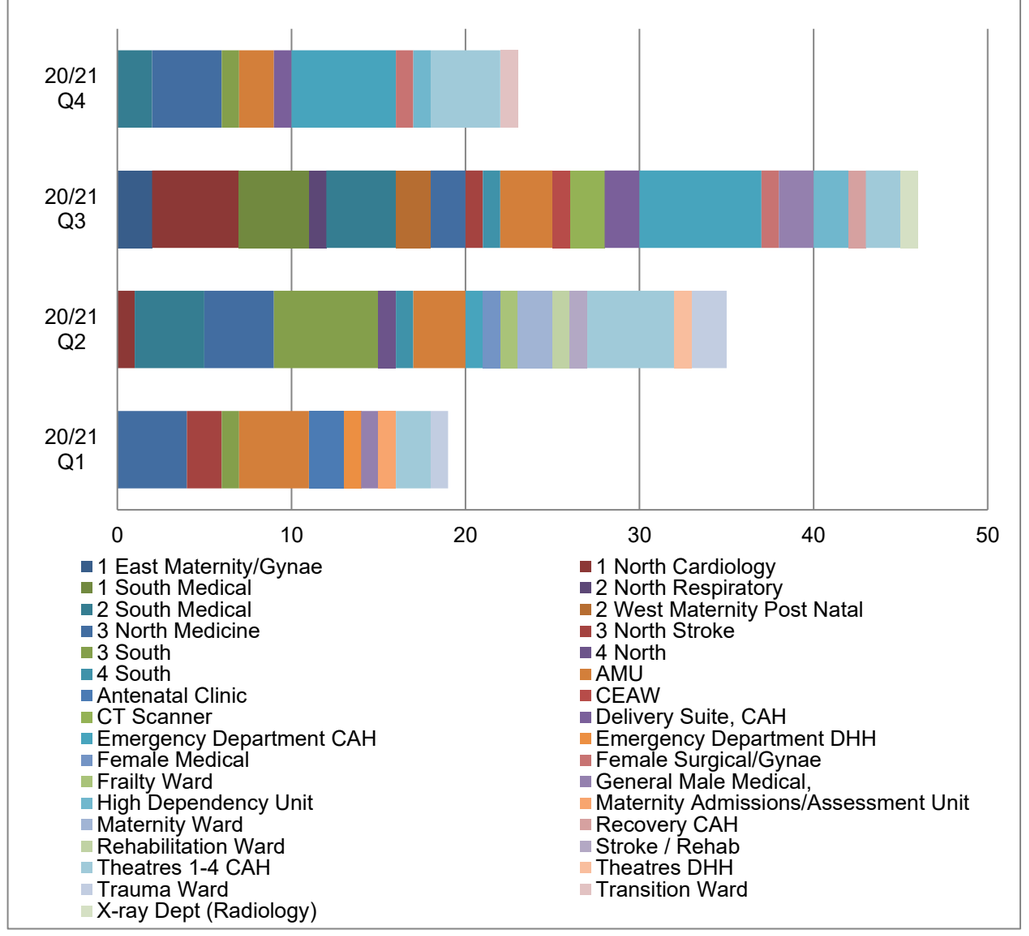


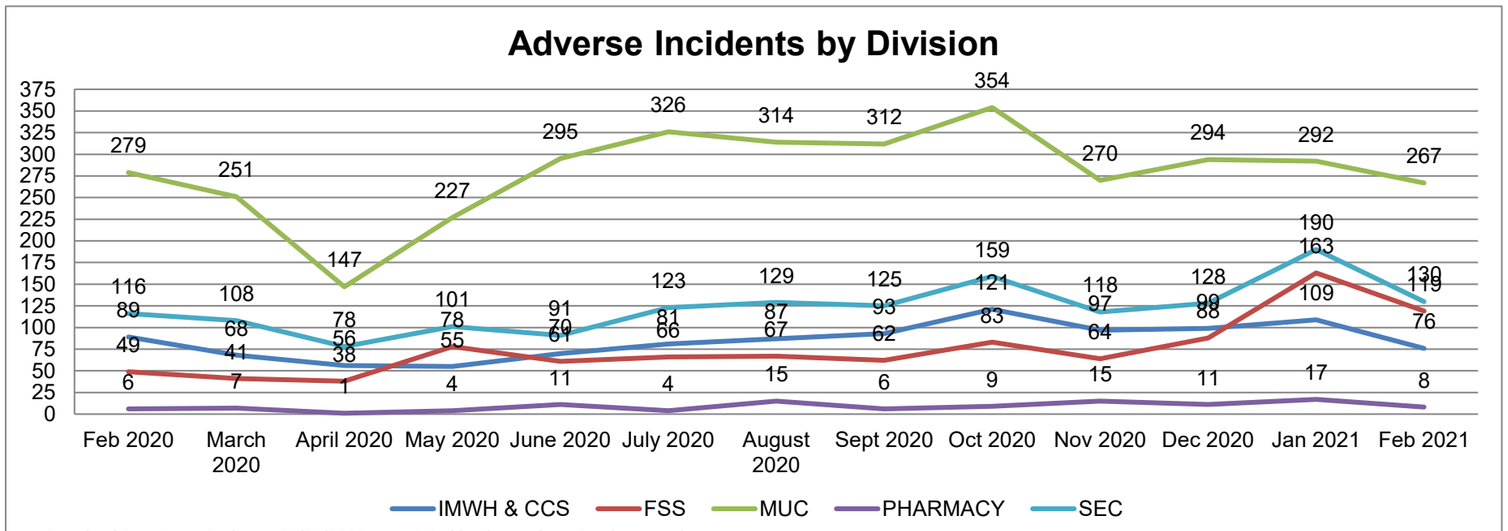


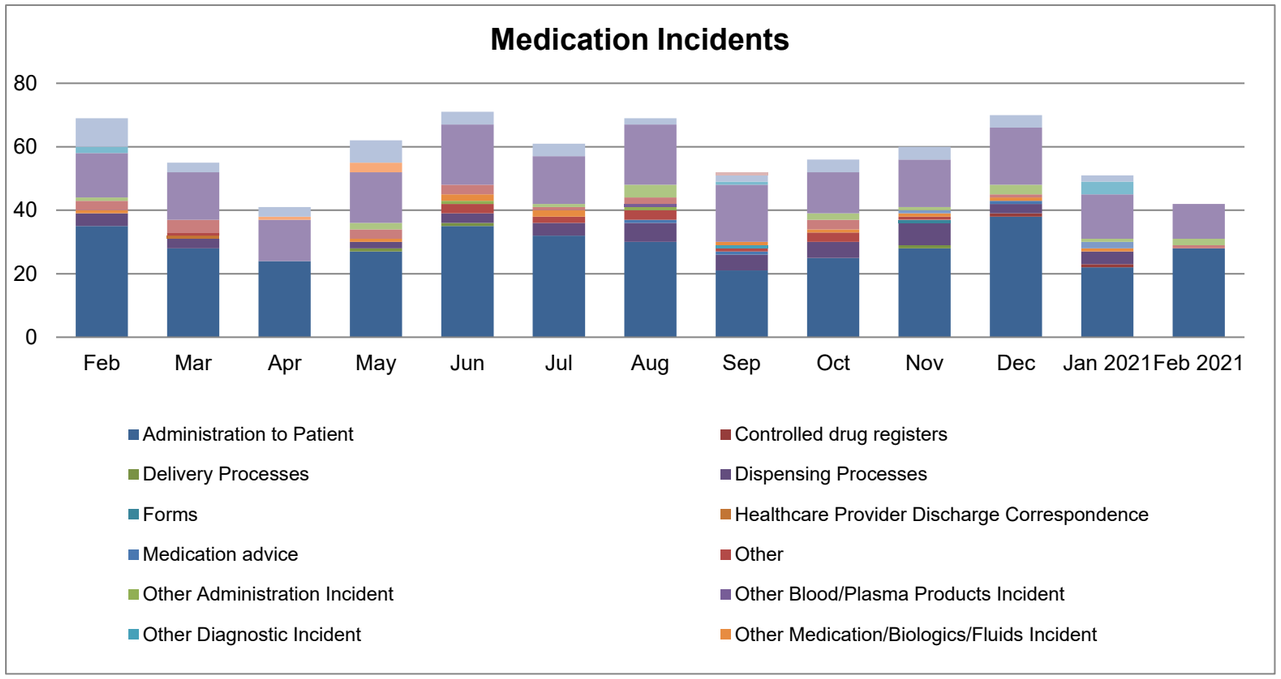


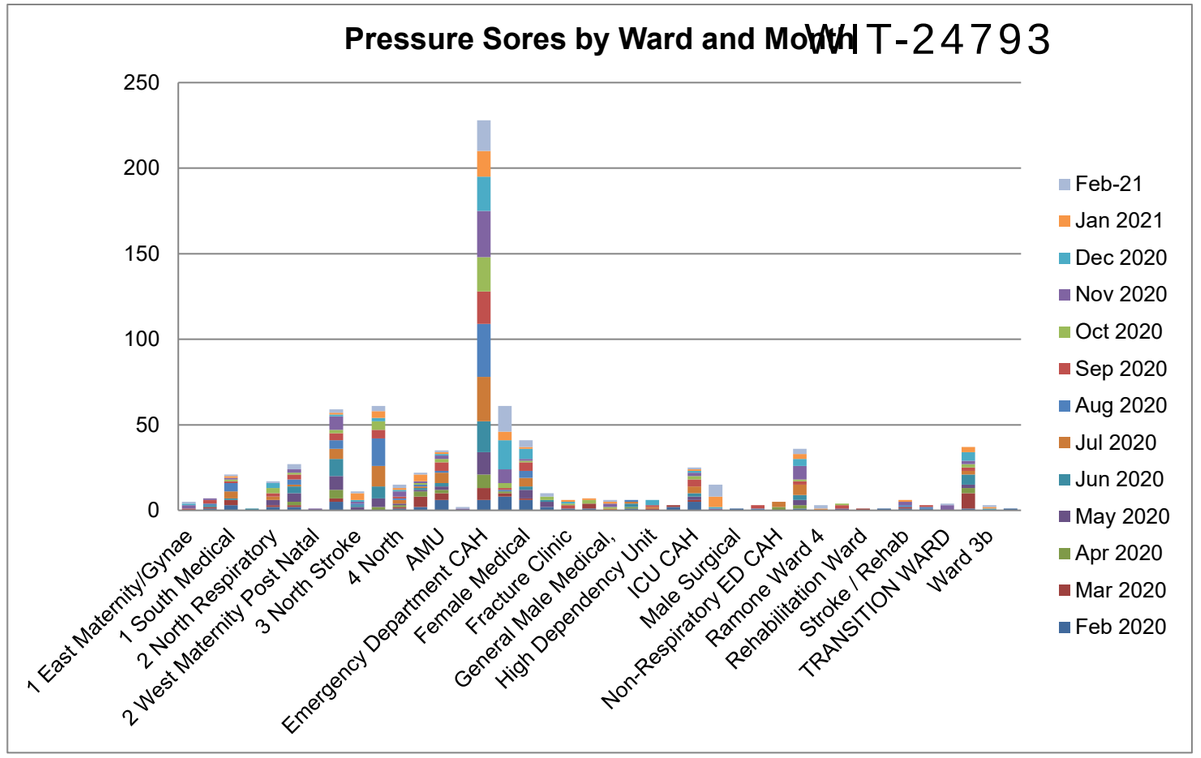


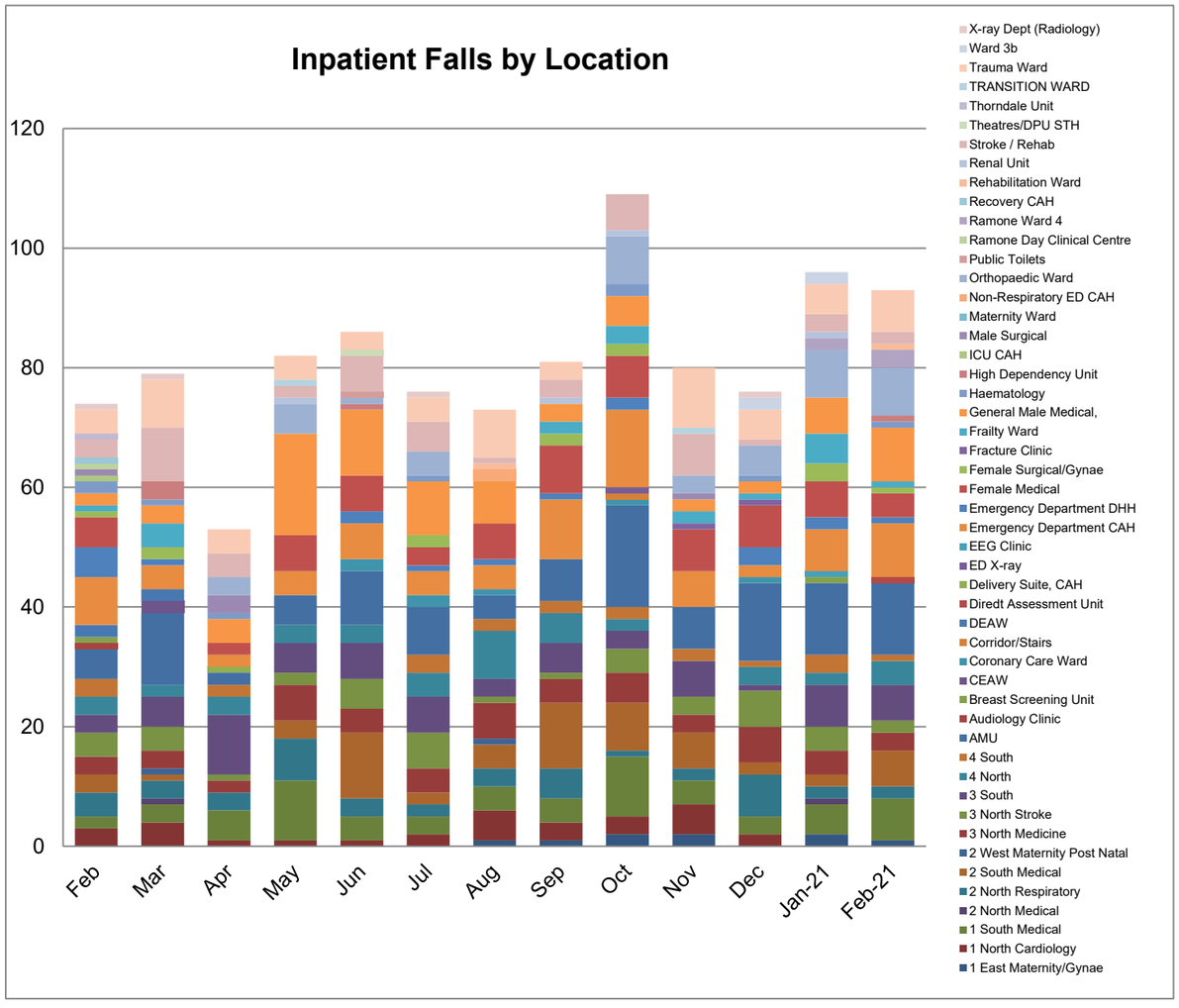












Absconding Patients

	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Total
1 East Maternity/Gynae	0	0	0	0	1	0	0	0	0	0	**1**
1 North Cardiology	0	1	0	1	0	0	0	0	0	0	**2**
1 South Medical	0	0	1	0	0	0	0	0	0	0	**1**
2 South Medical	0	1	0	0	0	0	0	0	0	0	**1**
2 West Maternity Post Natal	0	0	0	0	0	1	0	0	0	0	**1**
3 South	0	0	0	0	0	0	0	1	0	0	**1**
4 North	0	0	0	0	0	0	1	0	1	1	**2**
4 South	0	0	0	0	0	0	0	1	0	0	**1**
AMU	4	0	2	0	0	0	0	0	6	2	**12**
Car Park/Grounds	0	0	1	0	0	0	0	0	0	1	**1**
Direct Assessment Unit	0	0	0	0	0	0	0	0	0	1	**1**
Emergency Department CAH	6	7	11	13	9	15	11	11	17	19	**119**
Emergency Department DHH	0	0	5	2	6	3	5	10	15	11	**57**
Entrance/Exit	0	1	0	0	0	0	0	0	0	0	**1**
Female Medical	0	1	1	3	0	0	1	2	0	0	**8**
Female Surgical/Gynae	0	0	0	0	0	0	0	0	1	0	**1**
Frailty Ward	0	0	0	0	0	0	0	0	2	0	**2**
General Male Medical,	5	6	3	1	1	4	0	0	2	0	**22**
Non-Respiratory ED CAH	1	1	0	1	2	1	0	0	0	0	**6**
Reception/Waiting Area	0	0	0	0	0	0	0	0	1	0	**1**
Rosebrook	0	0	0	0	0	0	0	0	1	0	**1**
Stroke / Rehab	0	1	0	0	1	0	1	0	0	1	**4**
Theatres DHH	0	0	0	1	0	0	0	0	0	0	**1**
TRANSITION WARD	0	0	0	0	0	1	0	0	0	0	**1**
Trauma Ward	0	1	0	0	0	0	0	0	0	0	**1**
Total	**16**	**20**	**24**	**22**	**20**	**25**	**19**	**25**	**46**	**36**	**253**

DIRECTORATE OF ACUTE SERVICES										
Ref	Record name	Div	Loc (Exact)	Date Received	Investigation due	Reply due	Sent to….	Reminders Sent	Last Holding	Comments
Personal Information redacted by the USI		SEC	Urology	16/12/2019	02/01/2020	16/01/2020	Mark Haynes, Martina Corrigan	14/02/2020 22/06/2020	23/03/2020	**(PCC Bronte Mayo)** Mark Haynes has requested time off clinical duties to carry out investigation before he can issue response. Martina Corrigan advised this time off could not yet be given. - Sent to Ronan Carroll 05.02.2021
		MUC	MMW DHH	05/10/2020	19/10/2020	02/11/2020	Kay Carroll - Annette O'Hara	09/11/2020, 06/12/2020, 11/12/2020		Anne McVey obtaining clarification of dates
		MUC	ED DHH	24/12/2020	12/01/2021	26/01/2021	Kay Carroll - Laura McAuliffe	16/02/2021 &19/03/2021		Sent to Kay Carroll / Laura McAuliffe for Medical input 16/02/2021. Screening for SAI
		SEC	ED CAH	05/01/2021	19/01/2021	02/02/2021	Erskine Holmes	18/02/2021 & 19/03/2021	03/02/2021	ED section completed and approved, T&O response got await physio. - email to Teresa Ross 19/03
		MUC	2 South/2 North	12/01/2021	26/01/2021	09/02/2021	Patricia Loughan	22/02/2021 & 19/03/2021	22/02/2021	file with P Lougan for further investigation 30/03
		SEC	Booking Centre	15/01/2021	02/02/2021	16/02/2021	Amie Nelson	22/02/2021 & 19/03/2021	23/03/2021	Query FSS - Booking centre sent to Amie - email to Amie to confirm she can take for investigation
		SEC	Urology	21/01/2021	04/02/2021	18/02/2021	Wendy Clayton, John O'Donoghue, Dorothy Sharpe	19/02/2021	19/02/2021	For drafting wendy clayton email to ronon for concideration 02/03/2021
		SEC	SEC	02/02/2021	17/02/2021	03/03/2021	Aimee Nelson Ronan Carroll	23/03/2021	23/03/2021	Investigation email sent out 05/02 - AN to send to EE and 352
		SEC	General Surgery	18/02/2021	04/03/2021	19/03/2021	Aimee Nelson Ronan Carroll	23/03/2021	23/03/2021	Reminder to Amie Nelson
		CCS	STH Physio	08/10/2020	22/10/2020	05/11/2020	Teresa Ross	05/02/2021	02/11/2020	Barry Conway OK - do not send until OPPC approval received still needs Melanie approval
		SEC	ED	21/01/2021	03/02/2021	17/02/2021	Amie N, Gerarld McArdle	19/02/2021	19/02/2021	SEC part to be drafted
		IMWH	DHH Mathernity	03/02/2021	17/02/2021	03/03/2021	Wendy Clarke, Mary Dawson, Mr Wheeler, Dr Kamath		23/03/2021	Wendy Clarke to approve draft response

Report on Re-Opened Complaints

Ref	Record name	AD	Div	Loc (Exact)	Re-Opened	Last Updated	Progress
Personal Information redacted by the USI		Ronan Carroll	SEC	4 South	06/12/2019	13/10/2020	Mr Hewitt/Amie Nelson/Ronan Carroll. Amie to come back re plan of action/ Pull out old sent received emails from CMCC/Acute - AN awaitng RC response - ? Offer meeting AN to ask GRH to facilitate a zoom meeting 19.02.2021
		Ronan Carroll	SEC	Surgical Assessment Unit	20/01/2020	02/06/2020	June 2020 further reminder. Reminder to Amie Nelson (10/03/20) for timeline requested by solicito. Reimdinder to Amie 31st July 2020. Reminder to Amie 17/12/2020 - AN to review Med Notes and come back to gov 19.02.2021
		Barry Conway	IMWH	Maternity / Delivery Suite	14/02/2020	24/08/2020	**Meeting cancelled by family due to COVID**. Second response requested. Reminder to Mary and Wendy regarding drafting of this response. 15/6/2020 Further reminder sent to Mary / Wendy. Letter sent to patient to contaxt Governance Team 04/03/2021
		Barry Conway	IMWH	Maternity / Delivery Suite	22/07/2020	23/07/2020	**PCC Nicola Marcantonio** Patient contacted governance to advise that she would like a further meeting. Suggested dated 30/07/2020 AM Email sent to Wendy Clarke and Mary Dawson
		Anne McVey	MUC	DHH Female Medical	10/08/2020	04/03/2021	Kay Carroll, Anne McVey, Gamal Ahmed - **Meeting suggested 27/01/2021 - Meeting declined. Awaiting response from Kay.**
		Mary Burke	MUC	X-Ray / MIU	02/09/2020	04/03/2021	Radiography response received. Awaiting MIU - Reminder email to Sharon Holmes
		Anne McVey	MUC	Cath Lab	09/09/2020	04/03/2021	Meeting to be set up - Kay to advise of dates.
		Barry Conway	IMWH	Maternity / Delivery Suite	16/09/2020	07/10/2020	Mary Dawson suggesting meeting. Suitable dates requested from Mary Mary contacted again.
		Mary Burke	MUC	ED	06/10/2020	04/03/2021	Awaiting response from Erskine Holmes
		Barry Conway	CCS	Physio	12/10/2020	13/10/2020	With Melanie for signing
		Anne McVey	MUC	DHH Male Medical	12/10/2020	04/03/2021	Laura McAuliffe obtaining notes to answer questions.
		Barry Conway	IMWH	Delivery Suite CAH	14/10/2020	14/01/2020	Sent to Mary Dawson, Wendy Clarke & Barry Conway Need GP response before drafting
		Barry Conway	IMWH	Gynae Ward	07/12/2020	08/12/2020	Sent to Wendy Clarke, Michelle Portis 07/12/2020
		Anne McVey	MUC	2 South	11/12/2020	04/03/2021	Meeting to be set up with Anne McVey, Phillip Murphy & Family - awaiting response re dates from family.
		Anne McVey	MUC	ED	21/12/2020	23/02/2021	WITH Melanie for signing 22/03/2021
		Ronan Carroll	SEC	Surgery	22/12/2020	07/01/2021	Sent to Wendy Clayton, Trudi Kelly, Sarah Ward - Meeting suggested PCC declined on patients behalf stating they are still awaiting written response to initial complaint.

Report on Re-Opened Complaints							
Ref	**Record name**	**AD**	**Div**	**Loc (Exact)**	**Re-Opened**	**Last Updated**	**Progress**
Personal Information redacted by the USI		Anne McVey	MUC	3 North			
		Ronan Carroll	SEC	4 North			Meeting held 23/10/19 - Action Plan Prepared - still need done. Further investigation regarding transfer to LH is to be completed and findings fed back to patient's family - Email to sent to Information Governance check if copy notes sent to wife 2019 - AN to contact AN/MYO/KME re review of treatment plan
		Barry Conway	IMWH	CDS/1 East/MLU	05.02.2021	04/03/2021	Re-draft sent to Wendy Clarke/Mary Dawson for approval email to Edward Smith re Diabeties
		Barry Conway	IMWH	Delivery Suite CAH	10/02/2021	04/03/2021	Meeting to be arranged Wendy and Michelle
		Ronan Carroll	SEC	General Surgery CAH			Invesitgation email out to Aimee Nelson
		Barry Conway	IMWH	MATERNITY CAH	05/03/2021	04/03/2021	Patient wants a meeting with the Anaesthetic, Sarah emialed Laurie Martin re meeting
		Anne McVey	MUC	AMU / Social Work	29/03/2021	29/03/2021	Complainant states information provided in response is incorrect. Sharon Holmes / Sister Cullen / Flo Fegan emailed.

Ombudsman at 11.03.2021

Trust Ref	NIPSO Ref	Patient	Div	Ombudsman Date	Progress
Personal Information redacted by the USI			SEC/MUC/Radiology	10.03.2020	Further response to the ombudsman. OPPC have received further correspondence on 12.02.2021 which they will answer
			SEC	25.01.2021	6 month recommendations to be carried out bu June 2021
			SEC	10.12.2020	evidence of recommendation to be forwarded in 6 months by June 2021
			SEC	15.08.19	initial investigation with Ombudsman
			MUSC	14.03.2020	Repsonse with the Ombudsman
			SEC	05.05.20	Accepted by the Ombudsman for investigation 24/02/.2021
			MUSC	10.12.2020	Further medical records requested and sent 11..03.2021
			SEC	12.02.2021	Further records sent to Corporate to be forwarded to NIPSO completed by acute on 12.02.2021
			IMWH	Feb-21	Accepted by t he Ombudsman
			Gastro	Mar-21	initial investigation response required by 14th April 2021

Personal Information redacted by the USI third party notes

Medication incidents CCS2

ID	Incident date	Directorate	Division	Site	Loc (Exact)	Description	Drug administered	Correct drug	Action taken	Consequence	Incident affecting	Incident type tier one	Incident type tier two	Incident type tier three	DHSSPS impact	DHSSPS potential	DHSSPS likelihood	DHSSPS risk rating
Personal Information	20/02/2021	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Emergency Department CAH	pt prescribed doxycycline 200mg orally @2200, same given. Pt ?allergic to tetracyclines pt denied allergies at time of administration to same. only realized same upon checking over notes at 22:55 (Adverse reaction to tetracyclines recorded on NIECR)	Doxycycline	Doxycycline	person in charge and medical dr informed		Patient Incidents	Medication/Biologics/Fluids	Administration to Patient	Contraindication due to history of allergy	insignifica	catastrop	possible	extreme
Personal Information	19/02/2021	Acute Services	Surgery and Elective Care	Daisy Hill Hospital	DEAW	LOH checked PARIS for referral - no referral made. LOH checked NICER to see abtain information of continuing daily injection on discharge and inf regarding discharging ward/hosp. Daily injection to be continued Pt discharged on 17/02/21. LOH contacted GP spoke with DR T L informed of discharge and no referral to District nursing by the discharging ward. Offered to administer injection by evening staff. Dr L informed me that the pt was on injection for a PE 9 months ago and the Pt would be ok to continue with prescribed injection on 20/02/21. LOH contacted the Pt and advised her of the details regarding no referral.I asked her if she had DN contact sheet to contact Personal Information redacted by the USI District Nurses. She was aware of how to contact District Nursing. She informed me that she felt too weak following her discharge to phone so her cousin who lives in Personal Information contacted Personal Information HC for her. LOH District Sister contacted at 16.50 on 19th Feb 2021 by CR admin staff in Personal Information to inform District nursing the Personal (Patient) was home from hospital a few days and need a call to administer her daily injection. (Enoxaparin for previous PEs - on long term) LOH was aware that Pt was in hosp and awaiting referral to recommence daily injection.	Enoxaparin	Enoxaparin	Pt informed that LOH spoke with the GP and he advised that the District Nurse was to resume injections Sat 20th. Pt appeared to understand all	Minor	Patient Incidents	Medication/Biologics/Fluids	Administration to Patient	Failure to administer	insignifica	major	possible	high
Personal Information	22/02/2021	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	Trauma Ward	IV hydrocortisone reducing dose regime prescribed in 'Once only' medications section on back of Kardex by Anesthetist. 4 doses missed by 3 different staff nurses.	Hydrocortisone	Hydrocortisone	Doctor KK informed and reviewed patient. Nil harm to them, nil else to follow up. missed by x2 nurses permanent staff on ward and x1 ortho staff bank shift. Ortho SR Personal informed and to discuss with this staff member	Insignificant	Patient Incidents	Medication/Biologics/Fluids	Administration to Patient	Failure to administer	insignifica	major	possible	high

Personal Information	20/02/2021	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	3 North Medicine	Datix completed as requested by Medical team. Incident today regarding Patient being found with levitracetam epilepsy tablets in their hand. It was unclear whether or not the patient had taken any. Patient stated they did not take any but noted to not have capacity as confused currently. FY1 was contacted regarding this by the day shift and they would attend the ward but to go ahead and administer 2200 medications as normal. Medications withheld until this review as nil documented. FY1 did attend and after lengthy discussions and registrar input it was decided to give medications as per Kardex and monitor for signs of overdose/shallow breathing/ unresponsiveness. Registrar had said it was unlikely the patient had taken the tablets.	Levetiracetam		Medical review medical decision documented Medications given as per Kardex Patient monitored for signs of overdose	Moderate	Patient Incidents	Medication/ Biologics/Fluids	Storage Processes (in pharmacy or on unit)	Incorrect storage environment	minor	major	possible	high
Personal Information	24/02/2021	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	1 North Cardiology	A new patient was admitted to the ward at 15:45 on 23/02/21 and clerked in by the day team doctors. Upon checking Kardex during 0200 observations, noticed Epilim (critical anti-epileptic medication) had been prescribed wrong. Medication frequency was BD, only time prescribed was 10:00 therefore missing a 2200 dose. This was not noticed by nurse during 20:00 observations and medications round.	Sodium Valproate	Sodium Valproate	Spoke to nurse in charge. Contacted Clinical Co-Ordinator Judy and explained what had happened. Advised she would send up an FY1 to prescribe a stat. Stat dose prescribed and given.		Patient Incidents	Medication/ Biologics/Fluids	Prescribing Processes	Incorrect frequency of dose	insignifica	moderate	possible	medium
Personal Information	27/02/2021	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	Female Medical	Patient's IV drip pump bleeping overnight reading end of infusion. Patient buzzed to alert staff. Staff nurse from another area of ward attended as patient's own nurse on break. Patient told nurse "that should have been through hours ago". Amount left to infuse reading "0.0" but appeared to be approx. 40-50mls left in bag. Cannula flushed with saline as also positionally occluded. Nurse programmed into pump volume 50mls and ran at 100ml/hr, presuming it was IV antibiotic, however it was 24hr IV furosemide infusion. Infusion ran to completion ie infused too quickly. (approx 100mg/30minutes)	Furosemide	Furosemide	Medical team informed - advised to continue to monitor clinical observations (remain stable) and delay putting up further IV furosemide infusion until 24hrs after first one commenced.	Minor	Patient Incidents	Medication/ Biologics/Fluids	Administration to Patient	Incorrect rate of administration	minor	moderate	possible	medium

Personal Information	16/02/2021	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	4 North	patient day 0 post mastectomy - T1DM - fasting protocol taken down post surgery - with no follow up insulin prescribed. Patient normally on basal bolus regime with novorapid and lantus. Patient did not have insulin in her system since over night. CBG monitored this am and 27. Ketones then monitored = 4.7. DKA developed post surgery.	Insulins	Insulins	DKA identified during diabetes ward round. DKA protocol written up. Fluids prescribed and staff nurse to alert surgeons to carry out post op review and to contact F1 to carry out ABGs and U+Es and monitor patient. For patient to	Moderate	Patient Incidents	Medication/ Biologics/Fluids	Prescribing Processes	Medication not prescribed	moderate	moderate	possible	medium
Personal Information	22/02/2021	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	AMU	As handed over patient receiving both warfarin and clexane until patient INR was >2.5. When doing patient medications I noticed 3 doses of clexane had been missed, which was highlighted to consultant on the ward round - who indicated a IR1 to be completed as missing these doses with patients condition could have serious implications.	Enoxaparin		Patient aware. Consultant made ware. Ward manager made aware.	Minor	Patient Incidents	Medication/ Biologics/Fluids	Administration to Patient	Incorrect frequency of dose (omitted dose)	insignifica	moderate	possible	medium
Personal Information	19/02/2021	Acute Services	Pharmacy	Daisy Hill Hospital	Pharmacy Dispensary	When dispensing a dossette it was noticed that a pack of Bisoprolol 1.25mg tabs was found to contain Digoxin 125 microgram tablets.	Bisoprolol	Digoxin	A new pack of Bisoprolol was removed from the shelf and used to dispense the dossette. The broken packs for both items were checked to ensure no other errors were identified.	Minor	Patient Incidents	Medication/ Biologics/Fluids	Storage Processes (in pharmacy or on unit)	Incorrect storage environment	insignifica	moderate	possible	medium
Personal Information	06/02/2021	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	1 South Medical	Discharge prescription arrived in pharmacy with patient Kardex. 4 drugs were identified on the Kardex as new - doxycycline, carbocisteine 375mg, gliclazide tablets 30mg, furosemide 40mg. Patient had received these on the ward. Pharmacist queried with nurse on ward if gliclazide and furosemide were to be reviewed by GP as no information in letter. Also dose of gliclazide was unusual- 30mg twice daily. 30mg dose is only available as a modified release tablet and usually given once daily. Nurse had no information. Pharmacist telephoned house officer who had written the discharge script but house officer was unable to help and advised pharmacist to telephone Reg. Reg on call was able to confirm that patient should not be on carbocisteine, gliclazide or furosemide as patient was a re-admission with post-covid syndrome and had only been on these temporarily during last admission because also on dexamethasone and blood sugars elevated. Dose of gliclazide was incorrect. 30mg twice daily of the modified release tablet is equivalent to 160mg of standard formulation of gliclazide.	Gliclazide	none	Advice was sought from the Reg on and the three drugs were taken off the discharge prescription. Only the antibiotic, doxycycline was dispensed.		Patient Incidents	Medication/ Biologics/Fluids	Prescribing Processes	Incorrect medication/fluid	insignifica	moderate	possible	medium

Personal Information	09/02/2021	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	Emergency Department DHH	Patient admitted to Daisy Hill Hospital from Personal Information re. MAR chart sent with patient. Documented on front of Kardex that tramadol, amitriptyline, isosorbide mononitrate, chlorphenamine and omeprazole stopped whilst in Personal Information redacted by the USI by MOOP. Isosorbide mononitrate had not been stopped, tramadol and amitriptyline doses had been reduced but not stopped and omeprazole had been changed back to esomeprazole.	Isosorbide Mononitrate		Incident discovered 9/2/2021. Patient has been without these medications from 20/1/2021 with no ill effect. Isosorbide mononitrate restarted. GP pharmacist informed for medicines reconciliation.		Patient Incidents	Medication/ Biologics/Fluids	Prescribing Processes	Not prescribed required medication (reconciliation error)	insignifica	moderate	possible	medium
Personal Information	09/02/2021	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	Direct Assessment Unit	Patient came to the DAU ward in DHH on 9/2/21 due to a GP referral for query DVT as they were complaining of left ankle swelling & left leg pain. The doctor looking after the patient took bloods, d-dimer and doppler. They documented that the doppler report showed evidence of a DVT in the left femoral vein. At this point the doctor approached me as the ward pharmacist to discuss prescription of apixaban to treat the DVT. I checked the patient's blood results, weight and calculated their creatinine clearance to confirm if apixaban would be a suitable treatment option. A prescription was then written for apixaban for treatment of a DVT (10mg BD for 7 days followed by 5mg BD for 6 months). After the prescription was dispensed and checked, I sent a referral through as normal for any new patients being started on a DOAC to the anticoagulation pharmacy team. On 11/2/21, when one the of anticoagulation pharmacists was processing the referral and uploading details onto DAWN she checked the doppler scan from 9/2/21 as this is part of DAWN criteria. When she read the report it said there was no evidence of DVT. They contacted me to highlight this.	Apixaban		I immediately spoke to the ward consultant to highlight and discuss the error. The patient's notes and scan were checked which confirmed that a serious mistake had been made. The ward consultant contacted the nursing home and advised them to stop apixaban. The nurse from the NH informed him that the patient was well. The consultant tried to ring the NOK to inform them as well. The NOK did not answer but a message was left on 11/2/21 to make them aware of the incident. The consultant also spoke to a GP practice nurse who rang to know about the apixaban dose. He informed them to stop apixaban and the nurse will confirm with the nursing home as well. He also spoke to the Dr (prescriber) involved about the mistake, action taken and the learning points from the incident. The cause of this error, is that the doctor was looking at the patient's scan from 2018 which did show a DVT rather than the scan from 9/2/21.		Patient Incidents	Medication/ Biologics/Fluids	Prescribing Processes	Incorrect medication/fluid	insignifica	moderate	possible	medium
Personal Information	23/02/2021	Acute Services	Surgery and Elective Care	Daisy Hill Hospital	High Dependency Unit	Patient prescribed Bisoprolol 10mg OD, preadmission medication, prescribed correctly on Kardex each morning. Staff nurse made an error and placed signature in 10pm box, scribbled it out and wrote error. 2 nights later agency nurse looking after patient administered 10mg at night time, after patient already receiving morning dose - therefore received a double daily dose	Bisoprolol	Bisoprolol	Care taken over by S/N the following day found patients blood pressure to be low. Doctor informed, patient placed on bed rest, bisoprolol held for 24 hours.	Insignificant	Patient Incidents	Medication/ Biologics/Fluids	Administration to Patient	Incorrect frequency of dose (extra dose)	insignifica	moderate	possible	medium

Personal Information	13/02/2021	Acute Services	Medicine and Unscheduled Care	Community	Cloughreagh House, Bessbrook	SU admitted via ICS for 2/52 rehab at 18.30 hours on the 12.02.2021. Initially referral stated that the SU required 24 hour oxygen due to post Covid pneumonia. D2A referral stated that physio would order an oxygen concentrator which would be in place on SU's arrival. The senior staff member on duty received a verbal handover from the ward, she was advised that the SU no longer required oxygen as her SATS were 94, this was documented on the discharge letter. On admission clinical obs indicated that the SU's oxygen levels were 90. SU advised to rest, she was observed closely. When the rehab staff were carrying out their assessments SU's SATS dropped to 82 on exertion and 86 on rest. SU did not present with SOB.	Oxygen *		Senior staff on duty contacted OOH, the doctor advised that the SU required oxygen therapy as a matter of urgency. Same sourced from a local pharmacy. The doctor advised staff to contact OOH if they had any further concerns about this SU. ICS staff have requested an urgent review with the respiratory team on Monday. Staff also advised by the doctor to check SU's both calves for swelling, ?? pulmonary embolism Same observed no swelling, redness or pain. Staff updated on changes and advised to report and record any changes or decline in breathing.	Minor	Patient Incidents	Medical Gases /Oxygen	Prescribing Processes	Incorrect duration of treatment	minor	moderate	possible	medium
Personal Information	17/02/2021	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	1 South Medical	This incident occurred at ward level on 1 south. The Doctor prescribed contrast to the patient. This is a radiological procedure which requires accurate timings and contrast must be given in the x-ray department - no exceptions. X-ray did not know what contrast was given - is it radiopaque? They did not know the type or volume given to the patient. A contrast safety questionnaire was not filled out. The patient was a female of child bearing age which could become a serious radiation incident if the incorrect contrast was given and the patient xrayed.	contrast media		Spoke to radiologist in charge. Ward was contracted and spoke to the nurse who administered the contrast for more information.		Patient Incidents	Medication/ Biologics/Fluids	Prescribing Processes	Prescription illegible	insignifica	moderate	possible	medium
Personal Information	06/02/2021	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	Female Medical	Patient on Edoxaban for AF. Was discharged 6/2/21 from DHH, but no Edoxaban on D/C letter (Kardex check only). Readmitted on 14/2/21 to CAH, admitting Doctor noted patient was previously on Edoxaban for AF but that it wasn't on d/c letter? No obvious reason as to why. Assumed mistake and continued during admission. DHH notes came to ward, and checked old Kardex to make sure it wasn't stopped. During DHH admission, dose had actually been reduced due to renal function. Dose subsequently reduced in CAH (due to renal function). (Patient continued to take edoxaban from own supply following discharge on 6/2/21, missed one dose on admission to CAH Isolation ward before confirmed still on edoxaban)	edoxaban		See above.		Patient Incidents	Medication/ Biologics/Fluids	Prescribing Processes	Not prescribed required medication (reconciliation error)	insignifica	moderate	possible	medium

Personal Information	08/02/2021	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	Orthopaedic Ward	On admission to recovery it was noted that critical medications (Madopar)that were prescribed for 1200 had not be administered prior to transfer to theatre. Student nurse was sent to ortho ward to collect critical medications. Staff on ward stated they had not been sent by care home and no stock on the ward. SN Personal Information contacted ward and spoke to nurse caring for patient involved. Nurse stated on phone that do to quick admission and being sent to theatre there was no time to source medication and administer it.	Co-Beneldopa	Co-Beneldopa	Recovery staff attended MAU for the critical medication. (one of the 3 wards mentioned in critical medications policy). 1500 dose given as quickly and safely as possible following general anesthetic. Anesthetist Dr. Gupta was informed of missed dose.	Minor	Patient Incidents	Medication/ Biologics/Fluids	Administration to Patient	Failure to administer	minor	moderate	possible	medium
Personal Information	14/02/2021	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	3 South	Patient was prescribed for morphine sulphate 2.5mg - 5mg IM/PO and received MST (continuous) 5mg	Morphine	Morphine	Drs informed, bloods checked.	Minor	Patient Incidents	Medication/ Biologics/Fluids	Administration to Patient	Formulation of medicine was wrong	insignifica	minor	possible	low
Personal Information	05/02/2021	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	Female Medical	Patient A was admitted in FMW on the 5/02/21 at night time coming from ED.Staff Nurse reviewed the plan of care and medical team stated on the plan that he is for IV Gentamicin.It was prescribed in the medical Kardex,and stated see chart but no Gentamicin chart handed over. Contacted ED to check if there's a chart left in their ward. But nothing was found. Could not confirm whether patient A had it or not because there's nothing documented on ED notes. When the staff nurse looking after him checked his armband to give his prescribed medications, she noticed that the patient name was different. Incident was reported to the bed manager. Upon further investigation by bed manager, the name in patient A armband was patient B who was admitted as well last night in male medical. Patient B came in with UTI and was prescribed with IV Gentamicin as well. In view this, datix completed. (Gentamicin sample 08.30 5/2/21 2.22mg/l however ED advised gentamicin was administered in AC@H and no indication any dose administered in ED)	Gentamicin		Bed manager informed and correct name band applied to patient A. Doctor to review whether patient needs Gentamicin prescribed as already on IV tazocin.	Insignificant	Patient Incidents	Medication/ Biologics/Fluids	Administration to Patient	Incorrect patient	insignifica	minor	possible	low
Personal Information	19/02/2021	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	4 North	Missed dose of enoxaparin this am.	Enoxaparin	Enoxaparin	doctor informed, patient informed, recorded in notes	Insignificant	Patient Incidents	Medication/ Biologics/Fluids	Administration to Patient	Incorrect frequency of dose (omitted dose)	insignifica	minor	possible	low

Personal Information	10/02/2021	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	Ward 3b	(IANTUS) INSULIN MISSED DOSE	Insulins	Insulins	DOCTOR INFORMED PATIENT INFORMED CONSULTANT INFORMED BLOOD GLUCOSE CHECKED 11.8 DATIX	Moderate	Patient Incidents	Medication/ Biologics/Fluids	Administration to Patient	Failure to administer	minor	minor	possible	low
Personal Information	17/02/2021	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	3 South	SLT was contacted by patients daughter 17/02/21 to report that her mother was discharged home 16/02/21 with no supply of thickening powder from the ward and the family were unable to thicken drinks to IDDSI Level 3 as per SLT recommendations. Other medications including supplement drinks had been received	Nutilis Clear		SLT contacted 3 South and spoke with clinical sister Personal Information redacted by the USI and Pharmacist Personal Information. Ward staff were unaware of the issue. Pharmacist checked drug Kardex and Nutilis Clear was appropriately documented however she reported it was documented as being a pre-admission medication and therefore was not included on discharge letter or dispensed. This was not the case as Nutilis clear was a new medication for this patient during current hospital admission. Pharmacist agreed to rectify the error and ward sister contacted patients NOK and requested they come to CAH to receive a supply of thickener	Minor	Patient Incidents	Medication/ Biologics/Fluids	Dispensing Processes	Incorrect medication/fluid	insignifica	minor	possible	low
Personal Information	14/02/2021	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	3 North Medicine	Critical medication missed on following days and times: Metformin MR 1.5G 12/2/21 @6PM Metformin MR 1.5G 14/2/21 @6PM Glicazide 80MG 12/2/21 @6PM Glicazide 80MG 13/2/21 @6PM Glicazide 80MG 14/2/21 @6PM	Gliclazide		Blood sugar checked (4.2mmol) Clinical coordinator made aware - nil ordered Handover to day team in the am Critical meds written on handover		Patient Incidents	Medication/ Biologics/Fluids	Administration to Patient	Failure to administer	minor	minor	possible	low
Personal Information	27/02/2021	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	Stroke / Rehab	AM correction dose of insulin not given. Noticed by another member of staff when checking lunch time BM. Lunch time BM increased to 20.3. Insulin was not prescribed properly- insulin name not written on prescription. Nurse that morning had noticed error in prescription but forgot to follow it up.	Insulins	Insulins	DR was made aware. Correction dose of insulin prescribed and given when noticed and blood sugar monitored.	Minor	Patient Incidents	Medication/ Biologics/Fluids	Administration to Patient	Failure to administer	minor	minor	possible	low
Personal Information	10/02/2021	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Emergency Department CAH	independent pt in waiting room waiting to be seen did not take evening dose of insulin (T2DM on Novorapid/Tresiba)	Insulins	Insulins	ensured pt took night time insulin. informed NIC Personal Informati	Insignificant	Patient Incidents	Medication/ Biologics/Fluids	Administration to Patient	Inappropriate /incorrect Self Administration	insignifica	minor	possible	low

Personal Information	22/02/2021	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	Ward 3b	patient missed 4 doses of carbimazole on 4 consecutive nights. documented as '6' ie drug not available on Kardex **please note : patient in MSW DHH not HDU but no MSW on dropdown menu **	Carbimazole		Spoke to Dr FY1 on ward (Personal Information) and ward sister (Personal Information redacted by the USI) regarding missing doses. Did confirm impications of same with Medicines Information and agreed to recheck Thyroid function tests. Since done on admission and normal, GP was informed of missed doses on discharge letter and requested GP to recheck same.	Insignificant	Patient Incidents	Medication/ Biologics/Fluids	Administration to Patient	Incorrect frequency of dose (omitted dose)	minor	minor	possible	low
Personal Information	21/02/2021	Acute Services	IMWH - Cancer and Clinical Services	Craigavon Area Hospital	2 West Maternity Post Natal	Delay in medication given previous morning.	Gentamicin		When reviewing infants notes I noted gentamicin had not been given the previous morning. Informed the Paediatrician	Insignificant	Patient Incidents	Medication/ Biologics/Fluids	Administration to Patient	Failure to administer	insignifica	minor	possible	low
Personal Information	26/02/2021	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Frailty Ward	medication incident. Patient took medication off a table belonging to another patient as it was handed to the patient by other staff member. The medication was not the patient meds. subsequently patient took medication not prescribed to them. they received thiamine, Olanzapine, Metformin and Gliclizide.	Gliclazide	Paracetamol	Doctor informed immediately. patient was informed, patient did not wish to inform family. Nurse in charge informed. Incident recorded in patient notes. Drs in attendance by Rhem when incident occurred and they reported that they had gave the patient the medication off the table. The table was moved to the opposite patients bed space which caused the confusion in medication.	Minor	Patient Incidents	Medication/ Biologics/Fluids	Administration to Patient	Incorrect patient	minor	minor	possible	low
Personal Information	15/02/2021	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	3 North Medicine	On checking Kardex's at 6pm medicines round. It was apparent 1400 IV amoxicillin was missed on the 1400 medicine round on the ward.	Amoxicillin	Amoxicillin	Nurse in charge informed. Medical staff informed. No action, usual 2200 dose to go ahead.	Insignificant	Patient Incidents	Medication/ Biologics/Fluids	Administration to Patient	Incorrect frequency of dose (omitted dose)	insignifica	minor	possible	low

Personal Information	25/02/2021	Acute Services	Pharmacy	Lurgan Hospital	Ward 3, Assessment and Rehabilitation	Patient DC from LGN hospital to Crozier house DC letter had several mistakes: azopt stopped on letter but brinzolamide continued in preadmission section (patient had been generically switched to brinzolamide preadmission from GP) Directions on lansoprazole detail - into both eyes (this however was correctly labelled) Latanoprost had no directions as to which eye to instill drops into - must be stated for care home staff as unable to administer unless appropriately labelled medications remain free typed and not added to ECM stopped medication section (Further information: Pharmacist endorsed directions 'for both eyes' on entry for lansoprazole instead of on entry for latanoprost eye drops which was row above lansoprazole. Azopt had correctly been entered as stopped in Section 'Further information for GP' and generic brinzolamide continued)	Lansoprazole	Latanoprost	spoke with ward pharmacist - Personal Information ensured medications received labelled correctly spoke with lead Personal Information redacted by the USI re way to ensure meds that are stopped recorded correctly on DC letters moving forward spoke with patients rep to ensure eye drops would be instilled into correct eye endorsed label and MAR accordingly		Patient Incidents	Medication/Biologics/Fluids	Dispensing Process es	Incorrect route	insignifica	insignifica	possible	low
Personal Information	17/02/2021	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Haematology	Forgot to send patient home with their CD medication as once checked locked it into the CD Cupboard because patient was awaiting transport	Oxycodone	Oxycodone	Patient contacted ward regarding missing medication, took phonecall - checked CD cupboard told them it was still here. Asked if happy to come and collect and family was, therefore medication returned and family understood. Rechecked medication before giving to family.	Minor	Patient Incidents	Medication/Biologics/Fluids	Administration to Patient	Failure to administer	insignifica	minor	possible	low
Personal Information	04/02/2021	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	3 North Medicine	Insulin Dose not prescribed for 2200. Staff nurse did not realise patient was on Insulin at night. patient did not inform staff nurse he was on insulin. (NIECR checked - patient prescribed NovoMix 30 insulin morning and teatime and liraglutide at night, not insulin)	liraglutide	Insulins	F1 informed. Datix completed.	Insignificant	Patient Incidents	Administrative Processes (Excluding Documentation)	Other Administration Incident	Other administration incident	insignifica	insignifica	possible	low
Personal Information	22/02/2021	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	3 South	Pt medication kardex-medication for 22/02/21 all medication including crital medications had been signed and dated.			F1 contacted new medication kardex prescribed for todays date, staff on 4 north informed of findings.	Moderate	Patient Incidents	Documentation	Other Documentation Incident	Other documentation incident	insignifica	minor	possible	low

Personal Information	22/02/2021	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Emergency Department CAH	patient given paracetamol iv, checks complete patient asked if had taken paracetamol and stated no. deemed to have capacity., post administration patient had been given po paracetamol 1 hour prior.	Paracetamol	Paracetamol	medics bleeped. patient observed. nighty staff advised. datix complete	Minor	Patient Incidents	Medication/Biologics/Fluids	Administration to Patient	Incorrect frequency of dose (extra dose)	insignifica	minor	possible	low
Personal Information	10/02/2021	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	3 North Stroke	critical med missed dose - warfarin	Warfain	Warfain	Noticed missed dose following day. Nurse will be contacted when next on shift to make aware	Insignificant	Patient Incidents	Medication/Biologics/Fluids	Administration to Patient	Failure to administer	insignifica	minor	possible	low
Personal Information	26/02/2021	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Frailty Ward	patients medication for 2pm was dispensed but patients medication was not given at the time. He was transferred to SoUTH Tyrone and at that time medication appeared to have been taken. At approx. 3.30pm it became apparent that the patient had not taken the medication and that it was taken by the patient in the bed space opposite instead. Patient medication that was not given was metformin, delayed Gliclizide (as wasn't available for 10am dose) thiamine and Olanzapine	Gliclazide		lOANE house contacted and no nurses able to take the call. Resident pharmacist was given the hand over regarding the medication omission and to observe blood sugars on arrival to Loane House.	Minor	Patient Incidents	Medication/Biologics/Fluids	Administration to Patient	Failure to administer	minor	minor	possible	low
Personal Information	14/02/2021	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	3 South	Patient received 6g of IV paracetamol within a 24 hour period Patient was unable wo get IV paracetamol all day even with a high temperature.	Paracetamol	Paracetamol	Dr's informed, bloods and NEWS checked	Moderate	Patient Incidents	Medication/Biologics/Fluids	Administration to Patient	Incorrect frequency of dose (extra dose)	minor	minor	possible	low
Personal Information	18/02/2021	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	Direct Assessment Unit	Patient cared for in DAU under CDU (A&E) care. Patient arrived to A&E with chest pain. Patient had known cardiac HX - (3x stents). Patients TROP level checked x3 and continued to rise. A&E Doctor made aware of high TROP levels and to review patient. On reviewing patient he prescribed Aspirin 300mg and ticagrelor and patient for admission. Medication given via DAU staff nurse on A&E blue flimsy were prescribed. When completing nursing documentation, it was noticed on the front of the flimsy written on, that the patient had taken Aspirin 300mg in the am before arrival to A&E. This had not been handed over to any staff nurses in DAU that the patient had taken Aspirin and it was not prescribed that the patient had self admitted medication before attendance.	Aspirin	Aspirin	I informed 2 ED Doctors and one came over and prescribed lansoprazole for this patient. NIC made aware in A&E. Nursing documentation updated. Patient was on cardiac monitor and for admission to the ward.		Patient Incidents	Medication/Biologics/Fluids	Prescribing Processes	Incorrect frequency of dose	insignifica	minor	possible	low

Personal Information	24/02/2021	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	Recovery CAH	Patient out of theatre @ 1850hrs following Subtotal Colectomy. IT Diamorphine/ Ketamine/ fentanyl in theatre and 20ml each rectus sheath catheter(2) prior to arrival recovery. AVPU- grunting on arrival to pain stimulus. 1930hrs became unresponsive after rolling and skin check, breathing became shallow and tachy 111bpm- sign of LAST. On call Anaethetist bleeped to review and jaw thrust performed. Rectus sheath infusion (intermittent 0mls since started administered) stopped.			1935hrs- sh[redacted] jaw thrusting patient when Dr Ferguson arrived. Requested further bloodgas. 1950hrs- bloodgas worsening patient very acidotic pc02 17.0, pH 6.9, Bicarb 16.4, B.ex -6.3 Naloxone 0.4mg administered, nil effect. GCS 3/15, Pupils size 5 sluggish both. 1955hrs- Intralipid protocol commenced. Dr Ferguson worked out dosage as per patient weight- 103ml Bolus from 500ml bag, then rest of Intralipid bag administered over 30minutes. Further Naloxone 0.4mg IV administered @ 1955hrs- nil effect. Dr McClelland contacted on call anaethetist Dr Winter. Capnograph commenced c02 5.2 2005hrs- mapleson 15L/min commenced to help blow off C02, ECG carried out ST 129. C02 now 6.9 2015hrs- BP down 90's systolic for 5 minutes. Another Bloodgas obtained. pC02 12.0, pH 7.05, Bicarb 18.2, B.ex -5.6. Little change from intralipid	Minor	Patient Incidents	Anaesthesia Care	Post-anaesthesia Recovery/Monitoring	Unplanned elevation of care to intensive care setting	TBC			
Personal Information	16/02/2021	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Emergency Department CAH	patient was nursed in amber resus, received x1 unit of FFP - no issues regarding same commences x1 unit of PRC, within 15minutes of transfusion patient had taken a reaction. Complained of itchy skin and widespread rash	blood		blood was stopped immediately and disconnected, surgeons were contacted ed dr was in attendance in resus and she commenced the anaphalyic pack observations were recorded and updated patients blood pressure did drop, but came up with some fluid replacement following reaction	Minor	Patient Incidents	Blood/Plasma Products	Product Administration to Patient	Product contraindicated for patient	Blood product incident			
134278	24/02/2021	Acute Services	Pharmacy	Community	South Lakes Leisure Centre	Nurse vaccinator at South Lakes Leisure Centre reported that the covid-19 mRNA vaccine vial she was using was leaking and that there was insufficient left in the vial for a sixth dose. covid vaccine	covid vaccine	Pfizer covid vaccine	The vial was left with the pharmacist to bring back to Aseptics so that this could be examined and reported upon. Batch number EN1185 expiry 05/2021.		Organisational Incidents	Medication/Biologics/Fluids	Procurement/Supplier Processes	Damaged/contaminated product	defective medicine			

Personal Information	04/02/2021	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	Coronary Care Ward	Patient presented to DHH with atypical/non-cardiac chest pain. Found to have subtheraputic INR of 1,5. Patient has a history of AVR with mechanical aortic valve fitted in 2015. ECHO revealed significant gradient through mechanical valve suggestive of obstruction. Flouroscopy showed evidence of partial blockage of the valve prosthesis. This has been confirmed by TOE which showed large thrombus attached to the valve and blocking it. Patient stated on Thursday 4.02.2021, that she had an issue with GP declining to prescribe Warfarin. This apparently was raised with GP few times (since 2015) but she continued to struggle getting her prescription for Warfarin. As per patient: GP was prescribing Warfarin every month supplying for 28 days only.	Warfain		Patient had to be transferred to RVH having life threatening condition likely caused by subtheraputic INR. She is likely to need cardiac surgery to replace her aortic valve.		Patient Incidents	Medication/ Biologics/Fluids	Prescribing Processes	Medication not prescribed	GP incident		
Irrelevant info	22/02/2021	Acute Services	Surgery and Elective Care	Daisy Hill Hospital	High Dependency Unit	linked Datix Incident Report Number Irrelevant information redacted by t This datix is in relation to the new trilogy ventilators - obtained to support the 3 V60S in use in our HDU during the pandemic This is the 2nd case noted (initial case datixed late 2020 and actioned) where high pressure settings >20 with bipap therapy does not appear to be delivered to the patient - this is evidenced by rising C02/Ph against what is clinically expected Again in this instance - when put back onto the V60 ventilator at same settings - Ph normalised If Bipap settings >~20 required triology ventilators should not be used and should be reserved for CPAP therapy only in hypoxic respiratory failure On discussion with colleague ST7 in south of Ireland -they have discovered this in small case series with similar / smaller NIPPY/NIV machines and as a result they now reserve their V60S/larger machines for these more unwell patients requiring higher levels of pressure support In this small case series down south they also felt that these smaller machines could also not deliver >50%	Oxygen *		As above It is not a FAULT with the machine - we are discovering along with colleagues down south that this is a consequence of them being smaller and weaker machines - concerns over it demonstrating on screen it is delivering these pressures and 02 settings when it doesn't appear to translate into patient's clinical picture so ALL users need to be aware of this	Minor	Patient Incidents	Medical Devices, Equipment, Supplies	Instructions/User Guidance	Lack of appropriate training	medical device		

ID	Incident date	Time	Site	Division	Service Area	Speciality	Loc (Exact)	Severity	Description	Action taken	Lessons learned	Approval status	Closed
Irrelevant	01/03/2021	08:15	Community	Pharmacy	PHARM	PHASEP	South Lakes Leisure Centre	Insignificant	Pfizer Biontech COVID vaccine diluted and on inspection, small floating fragment noted in solution BN: EN1185 EXP: 05/2021 Thaw expiry: 11.55 03/03/21	Vial quarantined for return to pharmacy for onward reporting.		In holding area, awaiting review	
Personal	01/03/2021	06:30	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Patient presented to ED and has a grade 2 pressure sore, in from own home	Nursed in cub 12 and transferred on hospital bed	Early recognition and intervention of pressure areas essential. Ensure skin check and risk assessment carried out within 6 hrs of arrival. Patients should be transferred from trolley to a bed as early as possible.	Final approval	06/03/2021
Personal	01/03/2021	16:40	Craigavon Area Hospital	Surgery and Elective Care	ATICS	ICU	ICU CAH	Minor	Grade 2 on patients Left buttock first noticed on 26/02/21 on return from ICU. Staff unsure if same grade 2 or moisture lesion. Reviewed by TVN on 01/03 and same graded as grade 2 pressure ulcer x2 sites, ?SRC related as linear	Patient informed. Nurse in charge informed. Dressing applied as per TVN. Pressure reliving cushion given. On repositioning chart. no longer has src insitu	as above	Being reviewed	
Personal	01/03/2021	17:15	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Minor	pt attended ED with long standing issues with diabetic foot ulcers - increased pain, on oral antibiotic with no effect (GRADE 4).	feet assessed by doctor ? osteomyelitis. being admitted to medical ward. body map done, PACE documentation and Datix completed. feet dressed.	pre-existing foot ulcers	Final approval	06/03/2021
Personal	01/03/2021	18:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	1 North Cardiology	Minor	Reablement support worker (RSW) Personal went to client's house for teacall. Team OT Personal had been advised by hospital staff that client was returning home after attendance to ED this morning and for Reablement to restart his service at teacall. On Perso 's arrival to the house at 6pm client was not home.	Perso made contact with OT oncall Person Personal and informed her of same. Whilst OT was checking details with hospital, client then arrived at home via Red Cross ambulance. It was then noted that client had no key to get into his home. His NOK - Son, who lives next door was also in hospital and unable to speak. Red Cross staff unable to stay due to other duties and RSW to remain with client until family could be sourced to provide entry. RSW checked son's car in driveway and it was open - put hat and coat on client as he came home in nightwear. He then sat in car to await access to home. RSW was able to get phone number for grandson from client and made contact with him. He had not been informed for client's discharge home this evening. He agreed to come over and provide entry into house. Grandson arrived and provided entry - no further issues. OT oncall Personal informed of outcome and she provided feedback to hospital staff (SW) of incident.		In holding area, awaiting review	
Personal	01/03/2021	21:30	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Moderate	on completing skin check with pt noted g2 to right hip.	first aid, dressing applied to pt. pt informed of same, nurse in charge informed, body map completed, pt placed on hospital bed for comfort.		Being reviewed	
Personal	01/03/2021	10:30	Community	IMWH - Cancer and Clinical Services	MIDWIF	COMM	Home of client	Insignificant	Newborn bloodspot screening sample deemed inadequate.	Mother informed this sample may have to be repeated as although baby bled easily the blood was not absorbed to back of sample card.		Being reviewed	
Personal	01/03/2021	16:30	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	Emergency Department CAH	Insignificant	Security requested by ED sister to attend the Blue Area as a male patient was being verbally aggressive towards another patient.	Security arrived to the Blue Area and separated the two patients making them sit at either end of the corridor. The aggressor Pe Personal kept being verbally abusive towards staff and acting in a threatening manner. Screens were put up to separate the two patients. The doctor then attended to asses the patient who then decide he was ok for discharge, Security escorted the patient off the premises and were then stood down.	None	Final approval	
Personal	01/03/2021	13:09	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Insignificant	Security bleeped to attend AMU as a male patient was wondering about the ward trying to leave against medical advice.	Security arrived to AMU and witnessed the male patient walking about the ward. Security along with nursing staff managed t talk him into staying and he returned to his bed. Security were then stood down.	none	Final approval	
Personal	01/03/2021	01:19	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Insignificant	Security called to AMU to assist with male patient o several occasions. on one occasion when walking back to his bed the patient had a piece of metal in his had and was trying to smash window.	Security spoke to patient and got him calmed down and to go back to his bed and leave metal object down. PSNI arrived and security was stood down	None	Final approval	
Personal	01/03/2021	16:00	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, CAH	Minor	patient had caesarean section at 9cm difficulty delivering baby attempted to disimpact by reg Attempted breech delivery. Uterus clamped down round baby with legs delivered consultant contacted patient required inverted T on uterus to deliver baby. Blood loss 1500mls	baby delivered by consultant minimal resuscitation required. pH normal uterus and abdominal wall repaired		Being reviewed	

Personal	01/03/2021	18:20	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Patient absconded before triage. Booked on to reception with low mood.	Absconding protocol carried out. NOK informed. Patient returned by himself but then absconded again after seeing triage nurse. PSNI contacted again & updated.		Being reviewed	
Personal	01/03/2021	20:27	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	3 North Medicine	Minor	Security bleeped to attend 3 North as a female patient had become aggressive towards nursing staff.	Security arrived to 3 North and witnessed a female patient hitting out at staff with here walking aid. Security managed to take the walking aid away from the patient and assisted her onto her bed. The patient then became more aggressive trying to spit bite and hit out at Security staff. Security had to restrain the patient on the bed until medical staff could administer medication. Once the medication was administered Security stepped back and observed for a short time until the patient was calm enough for security to be stood down.	None	Final approval	
Personal	01/03/2021	11:00	Craigavon Area Hospital	Surgery and Elective Care	ATICS	THEAT	Theatres 1-4 CAH	Minor	I was acting as scrub nurse and handed the surgeon a retracting rake which caught my hand as it was being handed over. The site was examined by the surgeons and myself and no obvious hole was seen in the glove or pain/ bleeding at the sight noted. The surgeon took the instrument and continued with surgery. Approximately 5 minutes later I noticed that there was a 1 cm diameter spot of blood on the scrub wristband under the glove where the instrument had caught my hand. Surgery was halted and the instrument removed from use. First aid was undertaken as per protocol immediately. A small puncture/scratch was noted when removing the glove at the sight.	I immediately de-scrubbed, washed the sight and occupational health was notified.	Any suspected breakage of a glove should involve rescrubbing & affected instrument removed from sterile field. Sharp retractors should be handed over to surgeon in a receiver & vice versa the same as any sharp instrument, to be discussed at staff meeting. SMA	Final approval	08/03/2021
Personal	01/03/2021	01:00	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, CAH	Minor	shoulder dystocia	McRoberts, internal manoeuvers by s/m Per unsuccessful, followed by internal manouvres by s/m Personal patient debriefed, information leaflet given.	To ensure RCOG leaflet is given for information to the mother following delivery and to document in the notes.	Final approval	29/03/2021
Personal	01/03/2021	16:10	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	2 West Maternity Post Natal	Minor	day 9 post NVD (20/2/21) IOL at 38+2 due to PIH Discharged home 20/2/21 bp recordings prior to delivery 143/87 and 126/79 recorded BP reading in community 21/2 118/72 and 140/78 on 23/2/21. Presented to assessment unit 1/3/21 referred by GP as hx headaches. on admission BP 188/99. also feeling shivery - temp 38.4	admitted to ward IVAB antihypertensives PET bloods	18/03/2021: Person , readmitted, managed appropriately as inpatient, discharged home to community midwife.	Final approval	18/03/2021
Personal	01/03/2021	10:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	1 North Cardiology	Minor	Patient was started on a high risk medicine and this was not reviewed by pharmacy in a timely manner. Patient was admitted to CAH on 4/2/21. Drug history and medicines reconciliation carried out on 5/2/21. Patient was commenced on Apixaban on 16/2/21. Between 5/2/21 and 1/3/21 NO pharmacy review of prescribed medications was carried out (including reviewing Kardex rewrite). Patients weight is 38kg. Apixaban is not recommended for use in patients weighing <40kg.	Kardex reviewed ad rewrite checked by ward pharmacist on 1/3/21. Potential issue with Apixaban detected. Anticoagulant pharmacist contacted for advice. She will discuss patient with one of the Consultant Haematologists for further advice.		In holding area, awaiting review	
Personal	01/03/2021	15:46	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	2 South Medical	Minor	I am a community staff nurse and whilst visiting the patient mentioned who is for historic leg dressings I noticed that he had two cannulas insitu (one in both arms). I asked him who inserted these and he said they never took them out when he left CAH. To be sure I went back to the office to make sure ACAH where not attending him which they are not. I then took the too cannulas out on my second visit. No signs of clinical infection in both sites and Patient feeling well otherwise.	District Nursing Sister, NOK, Ward; 2 South CAH	new proforma for discharge has now been instigated and is attached to the front of nursing notes. all staff made aware of same via safety brief and email advised to ensure arms are visibly checked for cannulas prior to discharge	Final approval	23/03/2021

Personal	01/03/2021	15:55	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	Patient brought to department @ 11:59. Skin check completed @ 15:55. Grade 2 pressure damage to left buttock. Transferred onto hospital bed. Care provider informed & asked to clarify same.	Air mattress ordered	pre-existing pressure ulcer	Final approval	06/03/2021
Personal	01/03/2021	23:50	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Female Medical	Insignificant	called to female medical patient was pacing up an down ward,staff said he was aggressive an throwing stuff about we talked him back to bed. called a while later where we found him on stairwell on level 3 walked him back using low level mapa he was verbally abusive but went to bed an settled down. o100 to 0120 hours	none	none	Final approval	03/03/2021
Personal	01/03/2021	21:45	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Female Medical	Insignificant	security was called to female medical patient trying to leave ward he was confused looking to go home we spoke to him an he went back to bed where nursing staff give him medication	none	none	Final approval	03/03/2021
Personal	01/03/2021	08:30	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	Ramone Ward 4	Insignificant	During breakfast service, Catering assistant asked one of the patients what would they like to eat as there was no diet sheet. Patient asked for tea and toast. Patient was on soft diet and when trying to eat toast, started to choke. Nurse who was in the room at the time was able to help the patient.	Incident was reported to sister in charge of the ward.	Ensure that all domestics are aware to refer to the diet sheet or the board above their beds which states their diet. if unsure always ask a nurse for advise. Ensure accurate and up to date information is on all whiteboards reflecting each patients IDDSI levels	Final approval	08/03/2021
Personal	01/03/2021	14:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	TRAUSU	Trauma Ward	Insignificant	grade 2 found on top of tail bone when repositioning patient. UPDATE- 8.3.2021- nil damage noted on review. Nil need for datix	when grade discovered patient was cleaned, repositioned, barrier cream used, aria mattress insitu, pressure sore pathway updated and braden updated, repositioning schedule 4 to 6 hourly, nursed from side to side, tvn referral to be made, dietician referral to be made, safety brief updated and staff informed	as above	Final approval	08/03/2021
Irrelevant	01/03/2021	23:30	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Female Medical	Minor	Curtain rail fell and hit member of staff on arm. Patient was not injured. Staff member stated no pain / injury was caused.	Datix completed Bed manager informed Patient was reassured Curtain rail fixed by member of staff from maintenance services	on ongoing piece of work with estates and FSS to find a long term solution.	Final approval	08/03/2021
Personal	01/03/2021	10:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Minor	Patient admitted to hospital and written up for pre-admission medication. This included their Flixotide 100microgram accuhaler. This was ordered by ward staff and subsequently Flixotide 500microgram accuhaler was ordered in error (high dose steroid inhaler). This was then administered by the patient twice daily for 5 days. I was completing a medication history on the patient and checking the patient's own drugs when I recognized the incorrect strength of accuhaler in the patients locker. I asked nursing staff if they knew whether the accuhaler was ordered from pharmacy whilst the patient was an inpatient which staff nurse confirmed it was supplied by hospital pharmacy and was ordered late last week.	I informed the patient that the wrong strength of accuhaler was ordered. I asked if the patient had suffered any side effects as a result (eg oral thrush)which the patient denied. I told them that I ordered the correct strength from pharmacy. I alerted the ward sister to this.	see above	Final approval	15/03/2021
Irrelevant	01/03/2021	12:40	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Major	no one to take bloods for three south. leading to delays in discharges. And patient safety issue as bloods need to be handed over to night team.	datix and escalated to sister in charge	If no medical assistant cover, try to allocate ward staff to complete early morning bloods if ward acuity permits.	Final approval	15/03/2021
Personal	02/03/2021	04:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	GENSUR	4 South	Insignificant	Patient admitted to 4 South with a pre-exsisting pressure ulcer - G2 to R buttock. Bruising to Left Hip.	Documentation completed. Braden 19 Must 0 Mattress ordered.	As above.	Final approval	05/03/2021
Personal	02/03/2021	09:15	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	RENAL	Renal Unit	Minor	The student nurse was administering aranesp into the dialysis machine under direct supervision from the staff nurse. The needle usually re-sheaths when clicked hard enough but in this incident, the needle did not re-sheath and she pricked her finger accidentally.	Bled out the needlestick injury and ran under cold water. Nurse in charge informed of same and needlestick injury policy followed. Occupational health contacted.	none	Final approval	12/03/2021
Personal	02/03/2021	18:00	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	Emergency Department CAH	Minor	Security requested by ED Green Area to look for female missing patient.	Security searched the area and found the patient out the front of ED smoking. Security asked the patient to return to the ward, Instead the patient walked into the ED waiting room. The female patient started causing disruption so security got a wheel chair and assisted her onto it using a low level MAPA hold. The patient was then brought back to ED Green area cubical 5 where a doctor arrived to talk to here. Security were then stood down.	None	Final approval	
Personal	02/03/2021	10:05	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	ENT	3 South	Insignificant	Patient sitting on chair, lent over to pick something off the floor and fell on to left side	medical team informed observations checked GCS obs recorded NOK informed falls prevention updated	ensure patients are sitting within reach of their buzzers	Final approval	04/03/2021

Personal	02/03/2021	00:10	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Minor	THE PATIENT BECAME AGGRESSIVE WHEN HE WAS NOT ALLOWED TO LEAVE THE WARD.HE ENTERED A PATIENT AREA AT C BAY WHEN HE WAS DIRECTED DOWN FROM THE DOOR AREA BY THE SECURITY STAFF.HE BEGAN TO HIT OUT WHEN DIRECTED AWAY FROM THAT AREA	THE PATIENT WAS RESTRAINED BY SECURITY STAFF AND ESCORTED TO HIS BEDSIDE WHERE HE BECAME MUCH MORE AGGRESIVE.HE STARTED TO ATTACK SECURITY STAFF AND WAS PUT TO THE GROUND WHERE HE WAS RESTRAINED USING MAPPA HOLDS.LORAZEPAM 4MG WAS GIVEN IM. PSNI WERE CONTACTED AND ATTENDED AND HANDCUFFED THE PATIENT AND RESTRAINED THE PATIENTS FEET WITH STRAPS.THE DR WAS CALLED AND THE PATEINT WAS GIVEN HALOPERIDOL 2.5MG IM AT 0030 HRS OLANZAPINE WAS PRESCRIBED BY THE DR IN LINE WITH THE RAPID TRANQUILIZATION PROTOCOL.THE PATIENT SETTLED TO SLEEP AND WAS NOT GIVEN THE OLANZAPINE. THE PSNI LEFT AND A MEMBER OF SECURITY STAYED ON THE WARD PATIENT	To ensure Rapid Tranquilization drugs prescribed prior to night duty.	Final approval	
Personal	02/03/2021	00:13	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Minor	Whilst Security was on one to one detail in AMU with male patient Personal he became unsettled and headed towards the exit. Security were alerted to the incident to prevent him from leaving.	Once Security arrived to AMU we started to walk the male patient back to his bed space in F Bay, whilst doing so the patient entered C Bay and started disturbing other patients by pulling the privacy curtains open. Security made the decision to restrain the patient using a medium level MAPA hold and walk him back to his bed. Once he arrived back to his bed he was placed on his seat, Moments later he lunged towards security staff in a violent manner where he was then retrained to the floor. whilst this was ongoing 999 was called requesting Police assistance. Security continued retaining the patient who was struggling aggressively until the police arrived and took over. The police then handcuffed the patient and used leg restraints to bring the situation under control. Sedation was then administered by medical staff. Security were asked by the ward to provide 2 Security staff due to how aggressive the patient was. Security agreed.	None	Final approval	
Personal	02/03/2021	14:05	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Insignificant	Security requested to AMU as a male patient had become aggressive towards staff.	Security arrived to AMU and were informed by another member of Security staff that Personal had got up into a nurses face in a threatening manor and was threatening to leave the ward. Once all members of Security were present the male patient walked back to his bed where a doctor then came to speak to him, Security were then stood down.	None	Final approval	
Personal	02/03/2021	10:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	ORTHSU	Orthopaedic Ward	Minor	Critical drug missed being administered	reported to medical staff and patient informed	Always complete a full front to back check of Kardex. Medications not due on daily basis should be highlighted in the kardex	Final approval	08/03/2021
Personal	02/03/2021	10:15	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Insignificant	Patient having ongoing behavior problems detained on ward and needing 1-1 supervision. At present due to demands in other areas and covid outbreaks 1-1 was not covered. Staff on ward attempting to keep close supervision however ward was busy and staff were called away. As staff member approached the side room the patient was sliding off the chair. Falls protocol commenced as staff member came in as it slip was occurring. Medical team aware and no further investigations were requested. Oral medications changed and staff to observe for effects of same. No injuries evident and patient assisted back to bed safely.	Falls protocol medical team aware sister in charge aware medications reviewed need for 1-1 supervision escalated	1-1 supervision escalated medications reviewed and record outcome of same Liaise with MDT, nursing staff, medics, and family regarding plan for discharge. Importance of communicating all patients at risk of aggression/falls at ward safety brief to all staff members	Final approval	08/03/2021
Personal	02/03/2021	14:55	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	patient attended ED at approx. 14:05, skin checked @ 14:55. grade 2 PU to left buttock noted	c/o PACE document pressure area care given Air Mattress ordered	none	Final approval	06/03/2021
Personal	02/03/2021	12:00	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	GYNAE	Gynae Clinic	Moderate	differentiated VIN added to waiting list for surgery 22/10/2020 Given date or 31/12/2020 then list reallocated to another specialty admitted 27/01/2021 for procedure - cancelled due to difficult first case and theatre over-run admitted to Kingsbridge for surgery. Histology - cancer - 2 mm deep therefore will require lymph node dissection	apologized to patient		Being reviewed	
Personal	02/03/2021	17:53	Daisy Hill Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, DHH	Minor	Patient had a post partum haemorrhage	appropriate post partum haemorrhage treatment commenced		Being reviewed	

Personal	02/03/2021	20:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Minor	g2 pressure sore noted on upper left buttocks. nil documented on admission	tvn referral, photographs taken	To ensure Braden Score is dated and timed. Some gaps in repositioning schedule noted - to be aware of same and make effort to improve.	Final approval	07/03/2021
Personal	02/03/2021	16:00	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Antenatal Clinic	Minor	positive booking urine sample, women contacted and asymptomatic. As per SOP to provide second sample within 72 hrs, no second sample provided, 19 days later	Women contacted to attend with second sample 3/3/21 I will follow up second sample on 4/3/21. asymptomatic Bacteraemia diary reinstated, email to staff, discussed with SR Person , lead midwife advised, SOP amended to reflect change in diary to asymptomatic bacteraemia for recording same	03/03/2021: Revised SOP attached.	Final approval	03/03/2021
Personal	02/03/2021	12:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	3 North Medicine	Insignificant	2/3/21 SLT Dysphagia Review: I noted SLT yellow bedside sign re. swallow recommendations (as issued 24/2/21)not in place at the bedside. I noted "Level 1"; and "Level 5" handwritten on a laminated sign (format recently introduced by nursing team) on patient's side room door. This did not match SLT recommendations (as per 24/2/21, which were for Level 2 drinks & Level 5 foods. I also noted that patient's nursing notes indicated oral intake of ice cream on 28/2/21 (a food texture outside of SLT recommendations). I understand that this patient moved from Sideroom 5 to Sideroom 4 during the period between 24/2/21 & 2/3/21.	I spoke with S/N, and Ward Manager and advised them of the above errors. I removed the errorful information on the patient's laminated sign on the door. I proceeded with dysphagia review as planned; issued a new SLT yellow bedside sign detailing recommendations; updated M/N and N/N; and provided verbal update to S/N.	Ensure SLT yellow bedside signs remain on display at patient's bedside until withdrawn by SLT, or removed at the direction of the medical team. Where SLT bedside signs are accidentally damaged/ lost; nursing staff contact SLT to seek replacement ASAP. Where patients have been issued with SLT swallow recommendations (& yellow bedside sign) by the Acute SLT team, staff should avoid displaying other handwritten information re. the patient's swallowing recommendations, other than to state "see SLT advice". Ensure that patients are not offered food or drinks outside of SLT swallow recommendations, (unless with acknowledged risk & associated consents & documentation).	Final approval	
Personal	02/03/2021	08:15	South Tyrone Hospital	Surgery and Elective Care	ATICS	DPU	Theatres/DPU STH	Insignificant	On admission to DPU for procedure patient temperature checked on arrival. Temperature 38.3, rechecked further on 3 different monitors and temperature 37.9, 39.3 and 39.1. Patient denies and shortness of breath/cough. COVID swab from 27/2/21 Negative. Has seen doctor about issues with tongue recently but states no procedure was preformed.	Patient kept in reception away from other patients. Manager informed and decision taken to cancel patient. Patient and NOK son informed of decision to cancel due to temperature. Advised to liaise with GP and book further COVID swab if required and to take paracetamol when eating to reduce temperature.	none	Final approval	
Personal	02/03/2021	12:00	Craigavon Area Hospital	Surgery and Elective Care	ATICS	ICU	ICU CAH	Minor	Right sided neck sprain/strain immediate on-set at start of normal exercise routine/following sufficient warm-up 02/03/2021 (outside of working hours. I have been working in ICU since November 2020 to present (both covid + non-covid ICU. I am not a re-deployed member of staff) Potential contributing work-related factors to neck pain - increase in workload/manual handling being carried out secondary to increased amount of patients between both ICUs - increase in amount of re-deployed staff who have less experience of manual handling with critical care patients, in turn increasing responsibility with current staff members to carry out manual handling tasks - fatigue more easily in red PPE	Unable to do clinical duties in ICU today as neck too painful. Put on non-clinical duties today and rest of week 05/02/2021.		Being reviewed	
Personal	02/03/2021	20:45	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	CEAW	Minor	came on duty at 20:00, attended to patient and noted iv medication that was given to patient was not as prescribed in the drug Kardex. paracetamol iv was signed by 2x staff nurses for that time but the drug attached was iv metronidazole which is not prescribed in patient's drug Kardex. IV metronidazole immediately stopped and disconnected from patient.	bed manager informed Doctor informed for assessment of patient Staff members involved notified checked vital signs regularly, closely monitored overnight	as above	Final approval	08/03/2021
Personal	02/03/2021	02:30	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Patient who took overdose and had thoughts of life not worth living absconded from department at 02:30. Staff and security where with patient at the time however patient refused to stay. PSNI informed. Patient returned to department at 04:00, PSNI with patient.	Security called. PSNI contacted. Patient returned to department.	Keep patients at risk of absconding in area visible to staff.	Being reviewed	
Personal	02/03/2021	17:55	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Emergency Department DHH	Insignificant	security called to emergency ,dept patient had seen by a doctor began to argue aggressively with staff,who informed us he had been discharged security spoke to patient who agreed to leave he was escorted of the premises	none		Being reviewed	

Personal	02/03/2021	18:30	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	Pressure/ leg ulcer r leg x2 lower limb and heel, 1x l leg, dressed regularly by district nurses	pressure relieving care, pressure relief matress	Early recognition and intervention of pressure damage However most likely leg/heel ulcers	Final approval	24/03/2021
Personal	02/03/2021	15:45	Daisy Hill Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Antenatal Clinic	Minor	Anti-D appointment due at 28-30 weeks of pregnancy was "missed". The woman had children previously and was aware she needed to have it, so she rang DHH to book it herself. The lady also did not receive appointments for antenatal follow up appointments.	N/A		Being reviewed	
Personal	02/03/2021	14:45	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	CT Scanner	Minor	from the maternity ward clerk 02/03/21 @ 14:45. She was asked to get an "emergency barcode" for a user as nobody at that time yesterday had access to the glucometer device and we were told an urgent blood glucose sample was required for a baby. When asked for staff details it became clear that the staff requiring access at that time had access to the device but it had since expired in 2020. Per took the call as I was in ED, Per is fairly new and felt under pressure to give access to an expired user due to the concern for patient safety. The person whose training had expired was given access to the device for 1 month. Currently we have received no results generated by this user? I am concerned for a few reasons: 1. Firstly patient safety – if this happened OOH POCT would not be available for help. 2. An "emergency barcode" is not something that is available to staff as there is a frequent training programme in place. 3. POCT staff should not be put under	Pers felt forced into breaking the POCT policies and had to give access to a staff member whose training had expired as she felt concerned for patient safety.		Being reviewed	
Personal	02/03/2021	09:00	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Emergency Department DHH	Insignificant	got a call from E\dept staff who said a patient had gone missing looked round shop area an also out side no sign reported this back to staff in E \dept	none	none	Final approval	03/03/2021
Personal	02/03/2021	14:30	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	MRI Unit	Moderate	PT HAS PACEMAKER INSITU. This was not documented on safety section of referral and is therefore counted as a near miss.	Referral cancelled. Ward informed to ask DR to send new referral with correct safety info documented.	Pers	Being reviewed	
Personal	03/03/2021	03:15	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	2 East Midwifery Led Unit	Minor	Shoulder Dystocia Head delivered 03:15 Shoulder Dystocia suspected 03:18 Birth of live infant girl @ 03:19, cried at birth. Apgars 8 and 9. Paed SHO asked to review.	McRoberts and Suprapubic pressure		Being reviewed	
Personal	03/03/2021	12:25	Daisy Hill Hospital	IMWH - Cancer and Clinical Services	MIDWIF	MEDGYN	Antenatal Clinic	Minor	MID-STREAM URINE RESULT DOCUMENTED ON NIMATS BOOKING 'INVESTIGATIONS REPORT' AS 'NAD' HOWEVER, MSSU BOOKING URINE RESULT 26/1/21 - ECOLI PRESENT!!!!! PATIENT TREATED FOR SAME AND REPEAT MSSU 16/2/21 - NAD.	MSSU ALERT STICKERS FILED IN MHHR FOR URINE SAMPLE TO BE SENT AT EVERY ANTENATAL APPOINTMENT AS PER HOSPITAL POLICY. PATIENT INFORMED OF SAME AND HAD ANTIBIOTICS		Being reviewed	
Personal	03/03/2021	16:00	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	2 West Maternity Post Natal	Minor	Twin 1 35+2 2750g weeks gestation transferred to NNU fron 2 west on day two following emergency section. Transferred due to poor feeding and deranged bloods.	paediatric team involved. Mother informed of plan of care. midwife in charge of ward aware of transfer		Being reviewed	
Personal	03/03/2021	16:00	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	2 West Maternity Post Natal	Minor	Twin 2 35+2 weeks gestation 1995g transferred to NNU from 2 west on day 2 following emergency section. Transferred for deranged bloods and poor feeding.	paediatric team involved. Mother made aware of plan of care		Being reviewed	
Personal	03/03/2021	14:30	Craigavon Area Hospital	Pharmacy	PHARM	PHCLIN	1 South Medical	Moderate	medications wrongly entered in clerk in - apixaban, propranolol spironolactone and metformin, lansoprazole prescribed, not on preadmission -wrong dose furosemide rx -vte risk ass not filled in given dose of propranolol which could have reduced heart rate	spoke with ward SHO and FY1 and rectified Kardex nursing staff reported drop in heart rate - patient given bed rest and ECG(background of hyperkalemia)		Being reviewed	
Personal	03/03/2021	14:00	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Minor	I was involoved to oxygentate a patient with air gas from gas port in AE resus instead of oxygen mistakenly	I immediately removed the air port and switched to oxygen as soon as I discovered that	Importance of ensuring correct connection is used.	Being reviewed	

Personal	03/03/2021	18:30	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Minor	patient got delivered a bag of sweets on ward. suspect small white paper bag noticed in the bag of sweets, same had a hole on the back. patient has history of drug abuse	pharmacy made aware of above. bed manager and ward manager aware. sho Person contacted and happy with psni getting involved, to recontact her if any clinical concerns re patient. psni contacted as per advice of bed manager. asked to leave bag in reception of hospital and they will collect it, form for removal of suspect drugs completed, asked reception to get it signed by psni and delivered back on ward datix completed	To alert staff to incident via safety briefing in case patient admitted in the future.	Final approval	06/03/2021
Personal	03/03/2021	12:30	Craigavon Area Hospital	Surgery and Elective Care	ATICS	ICU	ICU CAH	Major	A DNAR form was completed on patient on 12/10/20 in ICU signed by Dr Personal Personal. This was not communicated to patient or his family at any stage.Patient's son contacted a member of our team after finding ambulance copy of DNAR form recently and was clearly distressed that they were not involved in this decision and neither informed regarding this. Patient has been in and out of hospital several times in last few months.	Phoned son, apologized and informed that we will inform the relevant team and complete and incident form as an educational opportunity to stop similar incidents happening in future.		Being reviewed	
Personal	03/03/2021	14:15	South Tyrone Hospital	Surgery and Elective Care	ATICS	DPU	Theatres/DPU STH	Insignificant	Patient admitted for planned and consented OGD clinical observations on admission recorded and stable, Monitors in Endoscopy room attached prior to procedure and Heart Rate recorded 186bpm, Nurse Endoscopist decision to abandon procedure due to Heart rate remaining tachycardic 10minutes later, 12 lead ecg carried out, consultant informed and reviewed ECG and decision made to transfer patient to A and E, Family informed and ambulance contacted	Nurse in charge of department informed Lead nurse informed 12 lead ecg carried out consultant reviewed ecg transfer policy followed Family informed ambulance contacted all transfer documentation completed A and E contacted to inform of transfer datix complete		Being reviewed	
Personal	03/03/2021	11:40	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, CAH	Minor	*BIRTH TRAUMA* Patient reviewed at debrief clinic and is suffering from birth trauma Datix submitted in view of this	datix rev notes		Being reviewed	
Personal	03/03/2021	20:13	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, CAH	Moderate	LIVEBORN MALE DELIVERED BY KIWI AND BNF. APGARS 2,2,2 CORD PH ART 7.042 BE -15.8 VEN 7.124 BE -14.2 TRANFERED TO NNU	INFANT TRANSFERED TO NNU		Being reviewed	
Personal	03/03/2021	01:42	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, CAH	Minor	during a normal vaginal delivery a shoulder dystocia occurred which was rectified by carrying out McRoberts.	the woman was placed into the McRoberts position and baby was born		Being reviewed	
Personal	03/03/2021	14:00	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	DIAGNO	IMAOTH	X-ray Dept (Radiology)	Insignificant	Her GP requested the wrong side for xray. The left side was requested when it was her right side	GP informed and a new request was made	Duplicate Datix see Personal	Final approval	
Personal	03/03/2021	14:00	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	DIAGNO	IMAOTH	X-ray Dept (Radiology)	Insignificant	The patient Personal was referred by their GP for a left knee x-ray. During the start of the examination an AP of the right leg was taken by mistake (likely because that's the side the patient pointed to and that's the side they had the limp, but ultimately it just wasn't checked by me). So I then took an AP of the left side and afterwards the patient told me that's the wrong side and it's the right side that's giving her pain. So the GP had requested the wrong side. We were able to contact them to send in a new request for the right knee and the patient was imaged under a new, correct request.	New request was made and the correct images taken		Being reviewed	
Personal	03/03/2021	14:00	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Major	Resus Patient, GCS 7, unclear history, seizures. Pre intubation check by consultant, Desat during intubation. Following intubation noted that C-Circuit attached to Medical Air, not O2 supply. Medical air flow-meter has flap covering Christmas tree nozzle and was functioning.	Patient placed on O2		Being reviewed	
Personal	03/03/2021	14:26	Daisy Hill Hospital	Surgery and Elective Care	ATICS	ANAES	Emergency Department DHH	Minor	Critically ill patient brought in by ambulance to DHH ED. ED staff requested emergency anaesthetic team to attend due to low level of consciousness and seizures. Patient with severe metabolic disturbance (Na 111, low chloride and low potassium). Patient required emergency airway management (RSI) and intra-hospital transfer to CT scanner. No trained skilled assistant (anaesthetic nurse) available to attend ED department.	This unfortunately is a recurring issue in DHH in that the emergency anaesthetic team do not have a dedicated/guaranteed trained and skilled anaesthetic assistant to deliver care to critically ill patients throughout the hospital. When theatre nurses can help, this is greatly appreciated by the anaesthetic staff and it is understood they are going above and beyond the terms of their jobplan.	None	Final approval	12/03/2021

Personal Informatio	03/03/2021	18:45	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	TRAUSU	Trauma Ward	Minor	Critical medication Epilim 12.5mls not administered at 1400hrs 03/03/2021 on ward prior to surgery	Not noticed until Staff nurse Personal in recovery ward was checking patient drug kardex at 18.45hrs and getting patient ready for transfer back to ward. Dr Harte CT2 made aware of same- ensure patient gets next dose at 2200hrs. Patient made aware of missed dose.	Advised the nurse to always double check her work and ensure that all medications are given especially critical medicines. It is on the safety brief so that staff are aware of the critical medicine and it will be added to the handover the specific times.	Final approval	08/03/2021
Personal Information	03/03/2021	20:30	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Insignificant	patient walking up corridor, bended over pushing shower chair. declined to use Zimmer frame. 1:1 and other staff with patient as aggressive and agitated. patient knee buckled and patient went down and sat on her knees on the floor	staff aware FY1 contracted basic first aid carried out	liaise with MDT liaise with pysch observe medication therapy Communication all patients at risk of aggression/falls to all staff members at ward safety brief Importance of having up to date and accurate risk assessments for moving and handling, fall safe and bed rails on admission and post fall incident.	Final approval	04/03/2021
Personal Information	03/03/2021	12:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	3 North Medicine	Insignificant	Patient in side room 6 became agitated and aggressive very suddenly around 12pm. no trigger warnings. attempting to leave ward and go outside. requires ax1-2 for mobilizing but fighting against staff to help, was hitting staff with zimmer frame. kicking, hitting, attempting to bite all named staff as well as being verbally aggressive.	PRN lorazepam given to deescalate situation- nil effect further stat dose haloperidol given which worked for short period. 2nd dose lorazepam given around 3.30. attempted multiple times to deescalate situation but managed to control same with ward staff nursing and doctors. spoke to NOK and updated and allowed patient to speak to them which settled the patient for short period.	escalate need for 1-1 review meds liaise with pysch liaise with MDT Importance of communicating all patients with risk of aggression with all ward staff at ward safety brief.	Final approval	08/03/2021
Personal Informatio	03/03/2021	13:20	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	2 East Midwifery Led Unit	Minor	NVD in MLU. im syntometrine given. signs of separation. cord separated and retained placenta.	in/out SRC. out to toilet. Reg to ward- attempted removal. for theatre for MROP under spinal.		Being reviewed	
Personal Information	03/03/2021	11:00	Daisy Hill Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, DHH	Minor	The person affected was a student midwife working in Delivery Suite DHH on 03/03/2021. She was assisting a patient out to the toilet in Room 2 when the toilet door snapped closed, shutting her finger in it. She sustained a laceration to the top of her finger, went to ED where they applied paper stitches.	To ED, steristrips applied.		Being reviewed	
Personal Information	03/03/2021	09:00	Daisy Hill Hospital	Functional Support Services	LOCNE	PORNE	Entrance/Exit	Insignificant	At Approx 0900 I came across a woman patient sitting on the floor by the front doors, the lady seemed to slip off the chair. I informed the bed manager and we assisted the lady onto a chair. The Lady was taken to DCC level 5 for her appointment.	none	none	Final approval	08/03/2021
Personal Information	03/03/2021	02:15	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Female Medical	Insignificant	Staff nurse sitting at nurses station. Patient very unsettled throughout Night duty. Approx @2.15 PT was found to be in possession of X4 25,00 Unit Creon capsules in a medicine cup. No Creon due with night duty staff. He withdrew them from his left breast pocket and managed to ingest x1 capsule before I was able to obtain x3 remaining tablets with much difficulty. Uncertain as to how he required these medications s kept safe in locked drawer at beside.	Immediately reported this To FY1 I. Davies incase of any contraindications. No concerns by medical team of creon having been taken Nurse in-charge informed. Patient flow Nelly informed that this patient in need of 1-1 supervision at all times due to abusive behavior to staff and wondering around the ward.	Discussed with staff at PSB to ensure that all medications given to patients are taken.	Final approval	
Personal Information	03/03/2021	01:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Female Medical	Minor	Cardiac arrest, needle stick obtained while attempting femoral stab.	Bled and washed	The importance of adhering to P&P in relation to the safe use of sharps and wearing appropriate PPE.	Final approval	11/03/2021
Personal Information	03/03/2021	23:30	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Female Medical	Minor	Patient states that , after coming from smoke he tripped and fell , no witness for this incident .Noticed Lacceration on forhead	Porter brought him up by wheelchair , didn't allow to check full body , Mobilizing well no c/o pain noted .	Nil	Final approval	24/03/2021
Personal Information	03/03/2021	11:30	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Female Medical	Insignificant	patient was at reception he became un well so we got him in to a wheelchair an took him back to female medical told staff he was unsteady on his feet	none	none	Final approval	08/03/2021
Personal Information	03/03/2021	18:18	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Insignificant	Security bleeped by 3 South as a male patient had managed to leave the ward and was outside 3 North refusing to come back.	Security arrived to level 3 and met the patient along with nursing staff outside 3 north. Security tried talking to the patient asking him to return to the ward. After no compliance from the patient Security made the decision to escort the patient back onto the ward using a low level MAPA hold. The male patient was brought back to the nursing station and sat along side a member of nursing staff. Nursing staff were satisfied that Security could be stood down.	nil	Final approval	08/03/2021
Personal Information	03/03/2021	17:21	Daisy Hill Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, DHH	Minor	PPH following NVD of 1500mls due to uterine atony.	Initial brisk loss at delivery which settled. then further brisk loss - uterine atony. Consultant in labour ward and into room - 2nd syntometrine and IV syntocinon given. Settled quickly. Repair of perineum by Mr Wheeler.		Being reviewed	

Personal Information	03/03/2021	17:05	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	1 South Medical	Minor	Resident arrived at Roxborough House at 17.05 with no discharge letter and no medication, including: Bendroflumethiazide, Methyldopa, Ramipril, Simvastatin, Co-codamol, Flucloxacillin, Bendroflumethiazide.	Ambulance crew stated they were informed that the family would be taking medication over in 1.5 hours time. We rang family, they were not aware of this. Hospital contacted again, was informed there were 2 critical medications that had to be given. Medication was eventually found in 1 South and arrived at Roxborough at 23.40pm and resident awakened to be given medication.	in review	Being reviewed	
Personal Information	03/03/2021	14:30	South Tyrone Hospital	Surgery and Elective Care	OUTPAT	OUTPAT	Entrance/Exit	Minor	Patient was approaching front door of hospital. She was being linked by her husband. She fell outside hospital door.	Patient presented in waiting room of eye clinic. She was holding a tissue to her right knee. On questioning by myself, patient stated she fell coming into the hospital. Patient was examined by myself and found to have an open wound on right knee. Patient was shaken and in shock. Patient stated she was on a blood thinning agent. Patient was taken straight to minor injuries unit within the hospital.		Final approval	
Personal Information	03/03/2021	19:30	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Minor	Patient has grade 1 pressure sore on presentation to ED	recorded on documentation and personal care carried out	none	Final approval	06/03/2021
Personal Information	03/03/2021	20:45	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Minor	Patient found sitting on the floor at the bedside by domestic staff at approximately 20:45. Nursing staff and domestic staff assisted patient x onto their feet and onto the chair at the bedside.	Patient X assisted onto the chair at bedside from floor by nursing staff and domestic staff. Nurse in charge aware of same. Clinical observations checked at the time, GCS observations checked at the time and FY1 contacted immediately who reviewed patient and advised to monitor patient's clinical observations and if any change to recontact them as patient may need a CT brain. Falls protocol commenced. Next of kin to be informed of same tomorrow by day staff.	Falls protocol commenced and risk assessment in place patient advised and appears aware of the risks of moving without assistance. Staff aware to increase supervision.	Final approval	08/03/2021
Personal Information	03/03/2021	18:00	Craigavon Area Hospital	Pharmacy	PHARM	PHDISP	Pharmacy Dispensary	Minor	[redacted] house residential facility for 2 weeks rehab. DC prescription - full 28 days of all medicines supplied. Amiodarone label details incorrect; not detected at labelling stage, dispensing or final check. Medication sent with patient to crozier house and transcribed onto MAR according to DC letter from CAH; take last BD dose on 3/3/21 then reduce to once daily from 4/3/21 - however label was incorrect detailing that reduced dose following titration was due to commence on 4/4/21. Patient DID receive once daily dose whilst in crozier house however - patient DC to home on 17/03/21 without pharmacy being made aware lady was going home. Medication returned to the lady was that which had been labelled incorrectly from CAH. Patient did not take any amiodarone on her return home for 6 days - from 18/3/21 - 23/3/21. ICS pharmacist made a house call to follow the lady up as greencard had not been sent with patient and wanted to ensure no queries with medications as prolonged hospital stay and wanted to remain independent with	Patient was advised or the error. Contact Personal SHO 1 N to confirm if Dr Tweedie happy to resume once daily dose or if retitration wanted (given patients complex admission to RVH and CAH) Contacted dispensary manager to follow up with dispensary team as this was dispensed during extended hours. Spoke with home manager to crozier - medication labels should have been checked on admission and DC for any errors and this had not been identified. Called the patient back at 6pm 23/03/21 to advise to restart 24/03/21 at 1 x 200mg tablets amiodarone after discussion with reg on ward.	t	Being reviewed	
Personal Informatio	03/03/2021	17:40	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	4 North	Minor	patient found on floor beside bed, incident unwitnessed. patient stated that he slipped	Limbs checked ,no obvious injuries , no complaints of pain anywhere , no bleeding . Clinical observations-News 1 Spo2 95% GCS 15/15 , Pupils R size 5 , L size 4 , doctors informed C.T. brain ordered. Family contacted and informed	ensure patients are wearing correct foortwear	Final approval	05/03/2021
Personal Information	03/03/2021	17:05	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	CANCER	ONCOLO	Oncology Clinic, Mandeville Unit	Insignificant	At 17:05 SN noted on checking RISOH protocols while completing documentation, blood forms that the above patient treatment of Durvalumab should have been administered using a 0.22micron in-line filter giving set but had been erected using a standard giving set.	Infusion of stopped, explanation given to patient. Giving set changed as half of drug still remaining in bag. Clinical observations recorded-no change on baseline. No Doctor in Unit to inform . Cytotoxic pharmacy no staff available . Contacted main pharmacy to ascertain if any chemo pharmacists available. Spoke with on-call pharmacists advised she would try and find some information and then phone back. Patient kept in Unit for 30 mins after infusion with advice to phone helpline if any problems overnight. Unit Manager informed today 4.3.21 Cytotoxic Pharmacy informed 4.3.21		In holding area, awaiting review	
Personal Information	04/03/2021	15:15	Lurgan Hospital	Functional Support Services	LOCCB	DOMSCB	Corridor/Stairs	Insignificant	Staff member was using the buffer - lead caught underneath buffer and she fell on her back	First aid - but no apparent injuries - not hurt and didn't want to go to A&E	None	Final approval	15/03/2021

Personal Information	04/03/2021	07:39	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Insignificant	Security bleeped to attend ED CDU as a male patient had become aggressive.	Security arrived to CDU where they witnessed a male patient with police in handcuffs. Police talked to the patient where he then settled and security were stood down.		Being reviewed	
Personal Information	04/03/2021	18:25	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	2 West Maternity Post Natal	Minor	ELECTIVE C/S 4/3/21 AT 09:36 unknown posterior placenta previa, MBL 2000mls Bakri balloon inserted. Nursed in delivery suite recovery until 1825hrs. however transferred to 2west at 1825hrs with Bakri balloon still insitu	reviewed by night obstetric team on ward, enoxaparin withheld. for review by consultant on ward round 5/3/21		Being reviewed	
Personal Information	04/03/2021	09:44	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, CAH	Moderate	MBL >1500ML @C/S FOR PLACENTA PRAEVIA Personal Information	BARKI BALLOON INSERTED. DRAIN INSITU		Being reviewed	
Personal Informatio	04/03/2021	00:23	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC		1 South Medical	Insignificant	Security was called to 1south. On arrival security observed a patient who was confused, agitated and wanting to leave the ward.	Security tried to talk to the patient into returning to his bedside, however he became more aggressive and verbally abusive to staff. He attempted to strike out at security and low level Mapa was used to escort the patient back to his bed. Whilst in his bed to continually attempted to get back up and restrictive intervention was required to keep him in bed. The patient was given oral medication to calm down. Every time security went away from the bed the patient repeatedly attempted to get out off bed and had to be restrained. He continued to be verbally aggressive during this time and was given additional medication via injection. Eventually the patient settle and security was stood down.		Being reviewed	
Personal Information	04/03/2021	10:36	Craigavon Area Hospital	Surgery and Elective Care	ATICS	DPU	Day Surgery Unit CAH	Minor	HCA Pers admitted to ED via Ambulance this morning with shortness of breath and 1 day history of sore throat & head, stiff neck, persistent cough and wheeze. On Admission to ED initial Covid test came back positive, awaiting result of Covid PCR swab.	All staff who had worked with HCA Pers on Tuesday 02nd March spoken with and all have given assurances that they where wearing masks and/or socially distancing at all times.	All staff in department adhere to Covid regulations within the trust	Being reviewed	
Personal Informatio	04/03/2021	17:00	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Minor	Patient attended ED today at 1312. Suicidal with alcohol on board. Noticed to have absconded at 1630.	Absconding protocol commenced.	managed appropriately	Final approval	24/03/2021
Personal Information	04/03/2021	14:10	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Emergency Department DHH	Insignificant	called down to emergency dept,patient laying on the floor at the toilets helped on to a wheelchair an left in waiting area	none		Being reviewed	
Personal I	04/03/2021	08:30	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	1 South Medical	Insignificant	Three clean fire sheets sent up to ward and each had a strap missing so the fire sheet could not be applied to beds. These three fire sheets do not comply with health and safety regulations.	Removed the fire sheets with straps missing so they can be sent to the appropriate department for further examination. Reported the incident to nurse in charge of ward.	importance of inspecting equipment to ensure it is fit for purpose.	Final approval	08/03/2021
Personal Information	04/03/2021	17:30	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Female Medical	Minor	Nurse assisting patient to commode in bay, behind screens. Another patient deliberately pulled the curtains, causing the magnetic curtain rail to detach from its holding and fall down, hitting the nurse on the head.	Other staff attended to hold up rails/curtains until patient on commode could be attended to and assisted back to bed. Patient who had pulled curtain rails down moved to area closer to nurses' station for observation. Estates contacted to reinstall rails. Apologies made to patient who had been on commode at time. Staff nurse declined any treatment for head injury although painful and bruised.	Nil	Final approval	08/03/2021
Personal Information	04/03/2021	20:00	Craigavon Area Hospital	Surgery and Elective Care	ATICS	THEAT	Theatres 1-4 CAH	Minor	Patient in theatre 1 for torsion, emergency laparotomy from ICU needing to come to theatre 2. Two theatres required.	Second emergency theatre opened, nurse in charge informed.	None - common event in dealing with emergency cases	Final approval	05/03/2021
Personal Information	04/03/2021	15:30	Daisy Hill Hospital	Surgery and Elective Care	GENSUR	GENSUR	High Dependency Unit	Minor	When repositioning the client I checked his skin and discovered a grade 2 pressure ulcer on his left heel with a pinpoint blackened area to same.	dressing applied. documented in nursing notes. wound chart completed. referral made to TVN. heels elevated to ensure zero pressure.	0	Final approval	21/03/2021
Personal Informatio	04/03/2021	01:56	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Coronary Care Ward	Insignificant	security called to male medical to a female patient who was confused and aggressive toward s staff on ward an security staff also got patient back to bed, restrictive intervention used until patient settled down	none	none	Final approval	08/03/2021
Personal Information	04/03/2021	12:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	2 South Medical	Minor	Patient discharged home on Wednesday 3rd March from CAH. District nurse called out to house on Thursday 4th March. Carried out skin check and on examination a grade 2 pressure ulcer was discovered on patients left buttock. There was a dry dressing on same. Patient complaining of pain and discomfort from buttock. District nursing team not informed of pressure ulcer on discharge.	BESSOP completed on wound. DNS informed. Wound cleansed and redressed.		Being reviewed	

Personal	04/03/2021	11:25	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Female Medical	Insignificant	patient was walking about the ward area we got him back to bed . awhile later we got called back walking about again,nursing staff give him medication he settled down we used low level mapa to walk him to his bed. time called again 1240 to 1400 hours	none	none	Final approval	08/03/2021
Personal	04/03/2021	11:40	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	Personal attended ed 4/3/21 with a necrotic ulcer to his 3rd L toe.	informed nurse in charge	pre-existing ulcer	Final approval	06/03/2021
Personal	04/03/2021	00:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	GENSUR	4 North	Major	Hospital Acquired Covid19 in surgical unit	transfer to 2N - died	case to be reviewed as part of the SHSCT COVID outbreak cases review and learning to be shared post.	Final approval	05/03/2021
Personal	04/03/2021	13:40	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Insignificant	Security called to attend 3 South as a male patient had managed to leave the ward and was refusing to come back.	Security arrived to level 3 and witnessed a male patient Personal standing outside 3 North refusing to go back to the ward. Security tried asking the patient to return to the ward and in turn he become aggressive towards Security. Security made the decision to escort the patient back onto the ward using MAPA the patient was placed on his bed where he then received sedation by the nursing staff. Once the patient began to settle Security were then stood down.	nil	Final approval	08/03/2021
Personal	04/03/2021	00:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	GENSUR	4 North	Major	Hospital Acquired Covid19 in Surgical Unit	Transfer to 4S & then 2north for CPAP	case to be reviewed as part of the SHSCT COVID outbreak cases review and learning to be shared post.	Final approval	05/03/2021
Personal	04/03/2021	12:30	Daisy Hill Hospital	Surgery and Elective Care	ATICS	THEAT	Theatres DHH	Insignificant	goods and service employee putting away stores and lifted her head up struck her head on x-ray machine	asked if she felt sick, dizzy, or had alternation in vision.none. declined ED attendance. went for break	NA	Being reviewed	
Personal	04/03/2021	10:30	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	GENSUR	4 North	Insignificant	Phsyiotherapist was supervising patient mobilizing towards chair. Patient decided they wanted to go back to bed. Began to swear at Physio and stated he was going to collapse if not going into bed. Physio advised to mobilise to bed and turn so bottom was closer to bed. Nil signs of physical distress and patient was steady on feet using delta rolator at this time. Mobilise to bedside and when advised to turn bottom towards bed, put hands out and threw self onto bed sideways. Did not report any pain and was assisted ax3 to get legs into bed and was then able to reposition self up bed independently with nil pain reported.	Nursing staff witnessed and assisted with completing transfer t bed. Recorded events in medical notes.	To Encourage Zero Tolerance.	Final approval	04/03/2021
Personal	04/03/2021	09:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	General Male Medical,	Moderate	This gentleman was referred for an ERCP for a CBD stone in irrelevant inform Unfortunately, due to our significant backlog of OP ERCP's, this did not occur in a timely manner. This gentleman was readmitted with cholangitis while awaiting an OP ERCP in irrele irrelev, nearly 1 year and 7 months after his initial referral, albeit with COVID affecting OP provisions through 2020. He has had a very stormy course with post ERCP pancreatitis and pseudocyst formation, likely due to an inflammatory CBD stricture he had developed from his initial MRCP in 2019 to his repeat MRCP in 2021. He was admitted on irrelevant info and is still an inpatient. Main question is if he had been ERCP'ed in 2019, if this current situation could have been avoided.	To be actioned	Increase in capacity required focus on getting funding to implement works	Final approval	29/03/2021

Personal	04/03/2021	12:00	Craigavon Area Hospital	Medicine and Unscheduled Care	CSMUC	CARDIO	Cardiac Catheterisation Lab	Insignificant	5.3.21 Inter Trust incident from BHSCT Patient admitted to ward 4F 3.3.21 with Chronis SDH. H/O PCI to LAD 8.2.21. Discharge letter on ECR 8.2.21 available for info, however, no mention of discontinuation of anti-anginal medications post-op. Medication list on ECR suggested certain medications (that 4F pharmacist thought should have been stopped) are to continue. 4F pharmacist asked patient for further info and patient thought some medications were stopped. Pharmacist contacted patients GP surgery and spoke with practice pharmacist. He was able to tell that along with the electronic letter dated 8.2.21 on ECR, a hand written note from the cath-labs (procedure performed CAH) accompanied it. Detailing certain changes to medications post-op. Changes that included the cessation of some medication, changing from an ACEi to an ARB, reducing the dose of a beta-blocker and changing from one statin to another. This hand written note contained important information, information that was unavailable on ECR.	9.3.21 Response to BHSCT attached	nil	Final approval	09/03/2021
Personal	04/03/2021	16:00	South Tyrone Hospital	Surgery and Elective Care	ATICS	DPU	Theatres/DPU STH	Insignificant	[redacted] the daughter of a patient due to attend CAH 06/03/2021 for covid swab 72 hrs prior to BCS colonoscopy as per Trust policy. Relative explained that her mother had recently been admitted to CAH with acute epistaxis, and as a result her family were unhappy with their mother receiving a swab to nasal passage. Explained to relative that STH is designated 'clean' Trust site, and policy remains that all patients attending must have negative swab result. Relative became increasingly distressed and irate, demanding that her mother would NOT receive a swab. Relative advised that as these were unique circumstances, perhaps we should discuss postponing procedure until a Consultant's advice could be sought, or indeed for more recovery time of nasal passages. Relative insisted that I was withholding treatment from her mother, was increasingly distressed and irate and culminated in her demands for staff full name to be repeated in order that her formal complaint be forwarded. Relative abruptly hung up phone ending any further communication.	Line manager informed. Datex completed. Patient herself contacted to more fully explain Trust policy and reasons for same. Patient and I discussed prudence of postponing procedure to allow nasal passages to heal and for further advice from Consultant. Patient assured that under no circumstances was her treatment being withheld. Patient verbalized her appreciation for my phone call, and verbalized her gratitude at the opportunity to postpone procedure for 1 month as discussed with her personally.		Being reviewed	
Personal	04/03/2021	19:45	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	TRAUSU	Trauma Ward	Minor	A discrepancy was noted in our control book where there was supposed to be 280mls liquid shortec in the cupboard. While myself and another SN on the ward were administering a 5mg/5ml dose of liquid shortec it was noted that the open bottle had only 5mls left which meant there was a 30ml discrepancy. This left a full bottle of 250mls in the cupboard.	Myself and another SN checked through the CD book to ensure there were no missed calculation to which we couldn't find any, I checked with the other nurses on shift were there any doses given today that had not been entered into the book to which there wasn't. The box and bottle did not appear to be sticky and no spillages noted inside the cupboard. On call pharmacist informed. Bed manager informed Datix completed Handed over in safety brief. On call pharmacist assured ward pharmacist would follow up tomorrow.	Staff to be more vigilant when dealing with CD's and ensuring that they are not starting new pages unnecessarily.	Final approval	08/03/2021
Personal	05/03/2021	10:00	Daisy Hill Hospital	IMWH - Cancer and Clinical Services	MIDWIF	GYNAE	Gynae Clinic	Major	H&C [redacted] was seen by a consultant at ANC/GOPD ON 05/03/21 ?ectopic pregnancy Pregnancy test using clinitek machine number 295478 was negative Serun HCG taken Result 126	Due to concern re possibility of ectopic pregnancy HCG had been taken 10/03/21 Machine sent to lab for investigation		Being reviewed	
Personal	05/03/2021	10:45	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	GENSUR	4 North	Minor	medication error 5/3/21 patient meant to get longtec 5 mg as prescribed on the kardex and on a reducing dose from longtec 20mg which was given as it was still prescribed on the Kardex and was not scribbled out.	Patient informed. NIC [redacted] informed. SN [redacted] aware. Doctor on ward informed. Pain nurse informed.	Ensure whoever stops a drug needs to ensure stop date is signed to avoid confusion and clearly draws a line through drug on Kardex to show it has been stopped.	Final approval	05/03/2021

Personal	05/03/2021	00:15	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	General Male Medical,	Insignificant	The patient found on floor near bedside by 12.25 by Staff nurse and HCA. His head was resting over his clothes bag . They both helped him back to the bed .Patient initially agitated and trying to get out of bed and settled after few minutes. Also on examination no obvious sign of head injury seen Patient didn't complain any pain over extremities or hip..	Falls protocol in place. Neuro obs done 15/15. News checked and recorded. Medics reviewed and advised to continue Neuro Obs and contact if any deterioration . Also bloods send to the lab .1:1 supervision provided	to reiterate the use of call bell and ensure it is in reach of patient at all times. to continue to identify those who are falls risk on admission and speak to nurse in charge if they could be put into an observation bay. also the importance of risk assessments for identifying those at risk on the ward. to ensure all family is informed about falls in hospital - if fall out of hours to ensure handover given to contact family	Final approval	24/03/2021
Personal	05/03/2021	11:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	TRAUSU	Trauma Ward	Insignificant	Patient came down to theatre 5 from trauma ward for operation. after check in when in theatre it was noticed that the wrong patient's medical notes had been brought down with Mrs Personal	Trauma Ward rang and the nurse that had brought the patient down to theatre was spoken to and made aware of the error and asked to bring Mrs Personal 's medical notes down to theatre and retrieve and bring back to the ward the wrong patient's medical notes.	To continue to be vigilant when checking patient for theatre that all documents are labelled correctly and belong to the correct patient to avoid errors TRAUMA INVESTIGTION 15/3/21-To be more vigilant with notes ad ensure correct ones are brought to theatre. Ensure NIC aware of issue.	Final approval	15/03/2021
Personal	05/03/2021	14:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Insignificant	Patient transferred to Transition Ward from ED at 1:30pm. No Novorapid insulin prescribed for lunch-time dose. BMs 9.3. Dr bleeped but ?unable to come. Dose prescribed as normal for tea & night-time. (T2DM)	Dep sister on Transition Ward spoke to Sister of ED to inform them.	Follow trust medication policy. Insulin is a critical medication ensure staff awareness of same. Avoid transfer at meal times for insulin dependent diabetics. Appropriate handover between teams	Being reviewed	
Personal	05/03/2021	10:30	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Personal Information redacted by the USI	Patient absconded from department @ 10:25, attempts made to discuss the importance of remaining in the department. A friend was with patient. Patient left through ambulance doors, security contacted to ensure patients movements. left hospital grounds heading to ?portadown direction. PSNI 101 number contacted and patient details handed over plus description. Appendix C completed. reference number Personal	Keep patients at risk of absconding in area visible to staff.	Being reviewed	
Personal	05/03/2021	23:00	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Minor	Security carried out one to one security duties with a male patient in AMU from llpm to 7am.	The patient was settled most of the night apart from one occasion from 1am till 2am patient began to get unsettled and verbally aggressive towards staff Security managed to deescalate the situation. the patient received medication and then settled again. There was nothing else to report.	None	Final approval	
Personal	05/03/2021	11:00	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	2 West Maternity Post Natal	Moderate	pt underwent complex caesarean section for placenta praevia MBL 2000mls mobilized slowly day 1 fell whilst going to toilet fractured clavicle	attended fracture clinic		Being reviewed	
Personal	05/03/2021	11:18	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	2 West Maternity Post Natal	Minor	D1 POST ELEC C/S (MBL 2000MLS) BAKRI BALLOON REMOVED FOLLOWING WARD ROUND ON 2 WEST 5/3/21 OUT TO BATHROOM WITH ASSISTANCE OF STAFF. WHILE OUT AT TOILET, FAINTED AND FELL OFF TOILET AND HIT RIGHT SHOULDER AGAINST WALL	BUZZER PULLED HELP SUMMONED OBSERVATIONS RECORDED - HYOPTENSIVE ASSISTED ONTO CHAIR AND BACK INTO BED WARD ATTENDED BY F2, SPR AND CONSULTANT BLOODS OBTAINED, ORDERED FOR SHOULDER XRAY WHEN CLINICALLY FIT ONLY TO MOBILISE WITH CHAIR FOR REMAINDER OF DAY LLIF FORM COMPLETE AND SENT TO RISK MIDWIFE		Being reviewed	
Personal	05/03/2021	05:09	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, CAH	Minor	5/3/21 Pers attended MAAU in early labour - sent home to await events. Phoned MAAU again following her attendance to report that she had SROM and was feeling pressure. She dialed 999 and had a BBA at home at 05.09 today 5/3/21. She attended CAH Delivery Suite and her placenta was delivered here in hospital. All well with both mother and baby.	Datix complete	To ensure that women are assessed properly before sending home.?/ keep for a bit longer to assess contractions in the A&A unit.	Final approval	31/03/2021
Personal	05/03/2021	23:59	Daisy Hill Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, DHH	Minor	CAT II Emergency C/Section Baby transferred to SCBU Apgars 3@1 5@5 9@10	called 2222 Baby to SCBU Sr in charge aware		Being reviewed	
Personal	05/03/2021	08:30	Daisy Hill Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, DHH	Minor	Baby delivered via NVD @ 0736hrs 05/03/2021, gestation 38+3. Developed low saturations and grunting at approx. 1 hr old. Taken to SCBU after paediatric SHO and REG review.	Clinical observations completed when grunting developed, low saturations noted intermittently. Paediatrician bleeped to review. Paediatric SHO and then REG reviewed baby - taken to SCBU.		Being reviewed	

Personal	05/03/2021	13:30	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	General Male Medical,	Moderate	Patient with cognitive impairment got up without asking assistance from the staff, patient was confused and unsteady on his feet even with the rollator and requires close supervision. He went to the toilet on his own and had a fall. Staff heard noises in the toilet and he was found sitting on the floor. He claims he did not hit his head. Medics assessed patient.	Patient was assisted back to bed, NEWS: 0, Falls protocol commenced. GCS: 14/15 due to confusion. Assessed by medics and advised not requiring any scan at present. NOK informed. patient clinically stable.	none	Final approval	10/03/2021
Personal	05/03/2021	16:30	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	STROKE	3 North Stroke	Insignificant	Patient admitted to 3 North Stroke with a healing Grade 2 pressure sore to their right heel.	Nurse in charge informed, pressure prevention pathway in place and duo mattress ordered for patient.	nil	Final approval	08/03/2021
Personal	05/03/2021	20:30	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Insignificant	Only one health care assistant on night duty on the 4th and 5th of March. Therefore very difficult for staff to maintain enhanced supervision on patient while repositioning other patients prior to settling. Patient has a high falls risk and is aggressive towards staff, requiring assistance of at least x 3 members of staff when they had been aggressive towards staff on previous shifts.	Bed managers contacted and advised of same.	nil	Final approval	08/03/2021
Personal	05/03/2021	12:15	Daisy Hill Hospital	Surgery and Elective Care	GENSUR	GENSUR	Female Surgical/Gynae	Insignificant	Staff Nurse[irrel] came to office to inform Sister that she had made a drug error 2 days prior (03/03/2021) when preparing a syringe driver, and realized today when she was doing the same driver that it was a different amount being administered than she worked out with Staff nurse[irrel] 2 days ago. The patient had received less than prescribed of alfentanil. (prescribed 1.5mg, received 0.75mg)	[irrel]was open and honest about this and brought it to Sisters attention & informed ward pharmacist & medical team immediately. Patient reviewed & no concerns. Pain well managed at time and dose reduced on 04/03/2012 before we were aware of error therefor patient suffered no ill effect from lower dose. Pharmacist reviewed & datix to be completed as per policy.	Importance of independent checks when a double nurse check required.	Final approval	21/03/2021
Personal	05/03/2021	00:25	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Moderate	Patient from PNH, has G2 pressure sore to right inner buttock, dressing insitu from nursing home, no documentation about same from nursing home. For regular rounding to maintain skin integrity. Surrounding sacrum area blanching but intact.	NIC informed, new dressing applied, for regular turns to maintain skin.		Being reviewed	
Personal	05/03/2021	12:50	Daisy Hill Hospital	Surgery and Elective Care	GENSUR	GENSUR	High Dependency Unit	Insignificant	Patient had a witnessed fall, due to a seizure with HCA in her room. Had stood at side of bed and fell onto her bottom, threw her head back, banging it on the floor.	SR in charge informed by doctor, doctor present after seizure commenced and reviewed patient at the time. Father updated. No ctb required.	,	Final approval	08/03/2021
Personal	05/03/2021	17:00	Craigavon Area Hospital	Surgery and Elective Care	ATICS	THEAT	Theatres 1-4 CAH	Minor	2 theatres running simultaneously OOH - Theatre 6 overran, patient bleeding - case finished at 20:07. 3 staff stayed late to cover theatre 6. Urgent Laparotomy needed to be sent for in theatre 1 at 17:00 - case in theatre until 22:37 Both patients requiring ICU postop	NIC aware, Three staff members stayed late to finish case in theatre 6 and emergency team OOH covering theatre 1.	none as the elective list was not planned to over run but they ran into difficulties & needed a lot of blood transfusions. Emergency theatre also needed to go ahead with a sick laparotomy.	Final approval	08/03/2021
Personal	05/03/2021	12:00	Community	IMWH - Cancer and Clinical Services	MIDWIF	COMM	Home of client	Moderate	Day 12 post Barnes Neville Forceps Birth of Baby Girl, discharged home initially [releva]. 2021 with haemoglobin 78g/l, however required readmission where she was transfused. During admission required psychiatric review due to behavior's on the ward discharged home with daily input from Home treatment Team, medication and constant adult supervision.	Today[relevant inform],following home visit from Home Treatment Team the mother was found to be very unsettled and labile in presentation and despite medication was still unable to rest to allow health to improve thus requiring admission to[relevant informatio].		Being reviewed	
Personal	05/03/2021	11:00	Community	IMWH - Cancer and Clinical Services	MIDWIF	COMM	Home of client	Minor	insufficient Heal prick sample	repeat sample obtained	Staff aware of need to obtain sufficient amount of blood as required to facilitate screening process.	Final approval	10/03/2021
Personal	05/03/2021	22:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	Female Medical	Minor	Patient admitted to female medical ward skin inspected on arrival G2 to scram daughter states this is not new and district nurse had been out yesterday	dressing applied wound charts commenced spoke with daughter aware of same nurse in charge informed braden 20 - c/o repositioning chart to monitor skin	Nil	Final approval	08/03/2021
Personal	05/03/2021	01:30	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	[Persona] came from ED to 2 south, and when skin check done, noted her Left heel has a pressure ulcer which is purple and black in colour approximately 5cm big. Deep tissue injury.[Person] has learning difficulties. Informed nurse in charge.	zero pressure to heel and Primo mattress ordered, informed nurse in charge.		Being reviewed	
Personal	05/03/2021	09:45	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	3 South	Minor	Pt was found after having an unwitnessed fall in side room 5, she stated she fell over her feet, denied dizziness.hit her head on the cupboard and has encurred a small bump to the ride side and a small graze to left underforarm.	Ward manager and sister aware, doctors informed and falls protocol followed.	ensure patients have their call bells within reach. Nil else as the lady is orientated and is aware of her own limiatations.	Final approval	07/03/2021

Personal	05/03/2021	17:38	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	DEAW	Insignificant	security called to elective ward level 4 patient sitting on the side of the bed shouting out he was confused he started to hit out we restrained him using low level mapa while doctor's, got a line in to him to give him medication we where stood down after this .	none	none	Final approval	08/03/2021
Personal	05/03/2021	16:30	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Female Medical	Minor	Patient lifted walking stick nd began hitting himself over the head. When prompted to stop the patient began to hit stick out at staff. When stick was removed from patient he picked up a trainer and began hitting himself on the face, trainer was recovered from patient. Urged to sit down for a cup of tea. Patient poured tea all over his head. He then began to use the key secured onto a zipper on his body warmer to attempt to slice his neck. When dinner arrived he refused the meal put picked up the knife and made attempts to slice his neck. Knife was then recovered from patient. Security were called and sedation was administered	Security called, psych called and sedation administered.	Discussed with staff at PSB to be aware that he can be physically and verbally abusive towards staff.	Final approval	23/03/2021
134728	05/03/2021	07:30	Craigavon Area Hospital	Functional Support Services	LOCCB	CATCB	Kitchen	Minor	Failure of gas in main kitchen for 4 hours resulting in delay of production and reduced menu choices for patients	Reported to engineer on call	none	Final approval	
Personal	05/03/2021	04:55	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	General Male Medical,	Moderate	had clinical observation checked. i heard knocking on the door.Personal was sitting on the ground. He stated that he could not control rollator and it run away on him	Clinical observation recorded. full body check carried out. Fi contacted. falls protocol followed.		Being reviewed	
Personal	05/03/2021	18:00	Daisy Hill Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, DHH	Minor	S/M Personal tripped over CTG leads in room 4 on the 5/03/21 and injured her left arm.Attended ED on the 6th March and given a sling to immobilize the arm,?soft tissue damage or rotation cuff ligament injury.	Advised to go off sick for 1 to 2 weeks.		Being reviewed	
Personal	05/03/2021	15:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	3 North Medicine	Minor	Patient who is currently being reviewed and assessed by speech and language therapists due to recent stroke. Had previously been recommended for level 3 fluids and level 4 puree diet but downgraded on 3/3/21 (1545)to 5 teaspoons only of level 3 fluids as caution warranted, and will RV. the nursing staff noted at 1600 that patient sounded chesty and rattly and doctor was informed with plan in place. verbally, it was said to put patient nil by mouth which was documented by nursing staff but not medical staff. the sign above the bed space indicating SALT recommendations had not been removed at this time. on 4/4/21, HCA gave patient 5 teaspoons of level 4 puree meal, despite the yellow recommendations being above bed which stated level 3 fluids only. - ??this should have been reviewed as patient was still NBM until reviewed again and isn't documented in medical notes to continue NBM or trial oral teaspoons, only to recommence feeding and meds via NG tube. As per HCA, handed over by night duty staff nurse that patient was NBM but could have 5 teaspoons of level 3 fluids which is also incorrect.	spoke to staff members involved re giving more than recommended level 3 fluids. staff advised when patient becomes NMB that handover to be changed and yellow sheet to be taken down from bedside. clear information to be handed over at shift change.	HCA further training on SALT guidelines and recommended levels of food and drink and what these mean. Communication needs improved throughout the team to ensure safe patient care.	Final approval	06/03/2021
Personal	06/03/2021	17:40	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	2 NIAS STAFF MEMBERS ENTERED A RED AREA WITH A COVID POSITIVE PATIENT ONGOING AN AEROSOL GENERATED PROCEDURE WITHOUT THE APPROPRIATE RED PPE. THE 2 NIAS STAFF MEMBERS WERE BRINGING A NEW PATIENT INTO THE RED RESUS AREA TO BE ASSESSED. THE STAFF WERE BEGINNING TO GIVE HANDOVER, WHEN THEY WERE TOLD BY A DOCTOR THAT RED PPE WAS REQUIRED.	2 NIAS STAFF MEMBERS ALERTED THE HALO (NIAS STAFF) WHO WAS PRESENT IN THE DEPARTMENT AND ADVISED TO ISOLATE.	alert to be put outside red resus doors - NIAS to be advised of proper PPE for Red resus	Final approval	08/03/2021
Personal	06/03/2021	09:45	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	GENSUR	4 North	Insignificant	HCA, when on enhanced nursing support with patient a in CAH was using mobile phone to make contact with the ward as patient was unsettled. patient a stated to HCA 'are you recording me'. This was witnessed by SN[redacted] who can confirm that HCA was not recording her.	patient reassured that staff was not recording her incident report completed Nurse in charge informed	Staff providing 2:1 supervision should come to door of side room or use call bell to alert staff of patient becoming agitated. If no staff about and need assistance immediately can use emergency call bell.	Final approval	08/03/2021
Personal	06/03/2021	10:45	Craigavon Area Hospital	Functional Support Services	LOCCB	DOMSCB	Corridor/Stairs	Minor	when the member of staff was returning from her break she went to the donning area and sanitized her hands using the 5lt liquid hand sanitizer. She put on her face mask, sanitized her hands again and when putting on her goggles some of the residue sanitizer splashed into her left eye.	staff member rinsed her eye and it continued to burn so she went to ED. ED treated the staff member and gave her eye ointment.	NA	Final approval	16/03/2021

Personal	06/03/2021	23:00	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Minor	Security carried out One to one duties from 11pm to 7am with a male patient in AMU Back wing as he was very aggressive and unpredictable.	Throughout the night the male patient slept and Security had no dealings with the patient.	None	Final approval	
Personal	06/03/2021	23:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Minor	Patient very agitated on ward, security 1:1 present. hit Spo2 probe against wall and smashed. shouting on ward. trying to leave on several occasions. MAPA used to get patient back to his bed on several occasions. additional security called x4 times	rapid tranquilization utilized. 1:1 HCA and 1:1 security remain. close observation of patient as also threatening to kill self.	Managed appropriately by security and medical staff	Final approval	07/03/2021
Personal	06/03/2021	14:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Minor	PAtient became agitated and verbally aggressive looking to leave ward - to be detained as per medics. Security Porters in attendance, patient asked to return to bedside refused and then set fire alarm off.	Escorted back to bedside and Olanzapine 10mg given. medics aware. Patient flow are. Switchboard aware of false alarm.	NONE	Being reviewed	
Personal	06/03/2021	20:30	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Minor	Security called to AMU at 2030 to assist with an aggressive male patient. Patient wanted a cigarette and when he could not get one he said he was leaving the ward to go and get one. He then tried to push his way past security and became aggressive. Patient tried to head butt a security porter and then tried to wrap his legs around another security porters neck. Patient was restrained to the bed and held. Patient was given an injection held until he calmed down. Security left ward at approx. 2130 and left 1 security porter to continue 1 2 1 with the patient.	security called	None	Final approval	
Personal	06/03/2021	14:30	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Minor	unwitnessed fall from chair. found lying on floor by staff. patient confused at present	staff informed drs informed for r/v family informed	Importance of communicating all patients at risk of falls to all staff members at ward safety brief. Importance of having acute and up to date risk assessments for moving and handling, bed rails and fall safe, updated post change in condition or fall incident.	Final approval	10/03/2021
Personal	06/03/2021	10:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	Emergency Department CAH	Moderate	patient prescribed and administered enoxaparin 90mg and apixaban 10mg and clopidogrel 75mg once daily on 6/3/21 at 10am on AMU ward CAH. Initially had been prescribed enoxaparin 90mg BD for PE, then switched to apixaban 10mg BD for one week on 6/3/21. However enoxaparin was not stopped on prescribing apixaban.	I spoke to F1 Dr Caoimhe O'neill, SHO DR Ahern and ward manager. Dr Ahern contacted haematology consultant. Advised for patient to be monitored overnight and to contact stroke re clopidogrel if it is to be held whilst on apixaban or continued.		Being reviewed	
Personal	06/03/2021	22:02	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Coronary Care Ward	Insignificant	security called by reception that a patient had absconded from the ward looked round the front of the hospital on the way back saw patient at reception area she ran to donning area we got her into a wheel chair took back to ward to her bed she started to struggle with us and fight us staff give her two injection's she settled down we left soon after .	none	none	Final approval	08/03/2021
Personal	06/03/2021	08:45	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Donning and Doffing DHH	Insignificant	called by a member of staff to assist with a patient who was in an agitated state member of staff from doffing give help in getting patient in a wheel chair at temporary entrance taken back to male medical given injection by nursing staff we then left	none	none	Final approval	08/03/2021
Personal	06/03/2021	20:30	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Minor	unknown substances and syringes found in patients ripped coat lining	doctor informed, night co-ordinater informed. PSNI informed clinical obervations stable	Second similar incident this week in AMU, ? whether there is a need for search policy of patient's belongings coming onto the ward similar to Bluestone Unit.	Final approval	07/03/2021
Personal	06/03/2021	22:00	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, CAH	Minor	PATIENT GIVEN 2X DOSES OF CYCLIZINE WITHIN 8 HOURS	REGISTRAR, PATIENT AND SISTER INFORMED		Being reviewed	
Personal	06/03/2021	09:10	Craigavon Area Hospital	Medicine and Unscheduled Care	CSMUC	HAEMAT	Haematology	Minor	When entering sideroom, coffee was all over the floor spilled. Personal I informed me that he got up onto his feet to pick up his coffee and he fell. Stated he bumped the back of his head.	Assisted back to bed. Falls protocol commenced and JHO called to review patient. For CT Brain due to unwitnessed fall.	Moved to side room in front of nurses station so he can be monitored.	Final approval	15/03/2021
Personal	06/03/2021	02:15	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	2 South Medical	Insignificant	Patient (Personal -SR1) found on the floor, unwitnessed fall, she stated that- hit her back of head. Personal	informed to the clinical coordinator, post fall assessment done, GCS-15/15, NEWS-3,INFORMED TO THE DOCTOR	ensure patients that are high risk of falls have close supervision in place at all times.	Final approval	09/03/2021

Personal	06/03/2021	10:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	General Male Medical,	Minor	During administration of night medications it was noted on kardex that the above named patient had missed 3 doses of IV Terlipressin on 06/03/2021. The patient was under the care on this day of the above named nurse, who had recorded in nursing notes the medication was discontinued. It was recorded in the medical notes that the patient was to receive a total of 15 days of this medication, completing the course on 09/03/2021. This was also marked on the kardex. The missed medication times was reported to the doctor who advised to continue with 22:00 dose, same administered. Nurse in charge informed.	Doctor Informed Nurse in charge informed.		In holding area, awaiting review	
Irrelevant	06/03/2021	10:30	Craigavon Area Hospital	Functional Support Services	LOCCB	CATCB	Kitchen	Minor	Member of the staff were cleaning the hot plate and Bain Marie in the staff dining room .while cleaning staff member had set the stainless steel lids on the hot plate which was ON .she had lifted stainless steel lid from hot plate which was hot and this caused a burn to the palm side and thumb of her right hand.	Member of the staff immediately kept her hand under cold running water, later attended to A & E, staff member continued to work until end of her shift.	None	Final approval	10/03/2021
Personal	06/03/2021	09:25	Craigavon Area Hospital	Surgery and Elective Care	ATICS	DPU	Day Surgery Unit CAH	Minor	Patient had an appointment at DSU for OGD He is an insulin/ medication dependent diabetic Arrived and patient stated he had taken 40units of his insulin and his medication States he was gave no instructions regarding his diabetes during his telephone call re:diabetes letter stated for patients to ring DSU if diabetic, pt did not see this. initial BM Checked- 3.8. Dr informed and glucogel gave. Rechecked then reading 4.3. During endo check in patient became drowsy and unresponsive	When patient became unresponsive O2 applied, suction gave and jaw thrust- no response Approx 3mins unresponsive Ambulance called @9.40, arrived at 10.25am Dr Malik present throughout IV Cannula inserted BM continuously checked Pt gave tea and toast once alert and responsive DR liased with A&E doctors re:events all explained Pt does not know N.O.K telephone number. NOK son in Personal	Diabetic patients need to have a pre endo assessment to ensure they have good understanding about their medication pre-procedure. UG 08/03/2021	Final approval	09/03/2021
Personal	07/03/2021	15:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Moderate	Patient in cub 7 in green transferred out to x-ray, was brought back from x-ray by two radiographers. Noted by nursing staff skin tear to back of (R) hand. When patient questioned she stated "her hand hit of door on way back from xray" Pace and body map completed prior to transfer and no injury noted to hand patient no history of confusion and coherent	spoke with radiographer and advised him on what patient stated, denied any injury happening wound care and Steri-strips applied	Safe transportation of patients whilst in trolleys. Limbs not to outside of trolley. Body map complete ion early essential	Being reviewed	
Personal	07/03/2021	12:00	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Minor	Security called to AMU as a male patient had managed to leave the ward through the back fire exit in F Bay.	Security arrived to AMU and witnessed male patient Personal Inform outside in the courtyard outside F Bay. Security along with an HCA managed to talk the patient back onto the ward where he returned to his bed. Medication was being prepared by medical staff to be administered. Once the medication was ready Perso managed to grab the syringe and took the safety cap off he was threatening to inject himself. Nursing staff managed to retrieve the needle from the patient where he then agreed for it to be administered. Once the injection was given Security were then stood down.	None	Final approval	
Personal	07/03/2021	16:00	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Minor	A male patient in AMU managed to leave the ward via the back fire exit in F Bay.	Security followed the patient and managed to talk him back onto the ward. once the patient arrived back inside two more members of Security arrived Perso began to become more aggressive and was pushing past Security shouting 'I'm going to kill you' along with rude comments towards the nursing staff. Security had to restrain the patient on the bed for about 5 minutes until he settled. Security were stood down and two members of the security team remained on a one to one roll.	None	Final approval	

Personal	07/03/2021	11:40	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Minor	Security called to AMU back wing as a male patient had become aggressive towards staff and was trying to leave the ward.	Security arrived to AMU and witnessed the male patient punching the nursing station and shouting bad language at staff. The patient then clenched his fist and raised it at a member of security staff. At this point Security made the decision to restrain the patient using MAPA the patient was restrained to the floor and after a very short time he settled and agreed to go back to his bed where he then received medication via injection. Security then left one member as a one to one and the rest were stood down.	None	Final approval	
Personal	07/03/2021	18:25	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Minor	Security required in AMU as a male patient had become violent towards Security staff whilst on one to one duties.	The male patient Pers said he was going to fight with security staff. After saying that, Pers charged towards Security where he was then restrained to the ground as per MAPA. The police where phoned using 999. Security continued to restrain the male patient until the police arrived and took over. Security stepped back and was there for assistance if required.	None	Final approval	
Personal	07/03/2021	18:40	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Minor	patient becoming physically and verbally aggressive to staff. attempted to fight with portering staff and clinical hold to ground. psni contacted to help manage situation as patient was unmanageable.	psni contacted. medical sho contacted mental health team to help with sedation and management of care	TO ENUSURE APPRORITATE SEDATION IS PRESCRIED FOR AGIGATARTED PATIENTS	Final approval	18/03/2021
Personal	07/03/2021	12:20	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Insignificant	Patient became physically aggressive attempting to hit out at one of the security porters.	Clinical Hold applied by security porters and sedation given.	NONE	Being reviewed	
Personal	07/03/2021	16:30	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	2 West Maternity Post Natal	Minor	infant born 6/3/21 @0206hrs via emergency c/s @ term hx PROM >46hrs Bandals ring also noted at c/s as well as foul smelling liquor. Infant transferred to NNU from 2west on 7/3/21 @1630hrs due to increased respiratory rate and poor feeding	transferred to NNU		Being reviewed	
Personal	07/03/2021	03:20	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	2 North Respiratory	Minor	Personal HAD AN UNWITNESSED FALL IN HIS ROOM (SIDE ROOM ONE) AT 03:20AM ON 07/03/21. HEALTH CARE ASSISTANT ENTERED ROOM AND Personal In WAS SITTING ON FLOOR AT BOTTOM OF HIS BED, WITH HIS BACK LEANING AGAINST THE WALL. Personal BEDSIDES WERE UP WHIKST HE WAS IN BED. Personal REPORTS HE 'SLIPPED'. NO OBVIOUS INJURY NOTED. BODY CHECKED AND NO NEW MARKS VISIBLE ON HIS BODY.	Personal GCS 14/15. CLINICAL OBSERVATIONS RECORDED- NEWS 6. ASSISTED BACK TO BED WITH HELP FROM 3 STAFF. SISTER PRESENT DURING SHIFT INFORMED. F1 INFORMED FOLLOWING INCIDENT.	continued awareness of all aspects of falls protocol.	Final approval	22/03/2021
Personal	07/03/2021	18:00	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Minor	Patient attended ED, Skin check complete, 0.5cm x 0.5cm G2.	Patient placed on hospital bed, regular pressure area care provided, protective dressing in situ.	Managed appropriately Early recognition and intervention for pressure damage in community	Final approval	24/03/2021
Personal	07/03/2021	10:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	2 South Medical	Insignificant	UNWITNESSED FALL	COMMEMCED NEURO OBERVATIONS AS PER PROTOCOL BLEEPED FY1 ON CALL TO REVIEW PATIENT, CLINICAL SISTER AWARE OF INCIDENT CT BRAIN SCAN REQUESTED FAMILY INFORMED 1:1 MONITORING FOR THE DAY DATIX COMPLETED	ensure patients high risk o falls/ previous falls always has supervision	Final approval	23/03/2021
Personal	07/03/2021	20:30	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	2 South Medical	Minor	Patient admitted on the 7/3/21 at 0410am noted on the admission that patient was a type 2 diabetic but no blood sugars had been documented from admission until I took over shift 7/3/21 at 2030hrs. Blood sugar noted to be 27.6mmol ketones 0.1 (T2DM Humalog Mix 50 - doses in Nov 20 62units am and 58units PM)	Clinical coordinator contacted and medical SHO reviewed patient whom was then put on an insulin infusion at algorithm 2. Insulin prescribed for morning. Patient on BD insulin.	ensure all diabetic patient have a blue b chart in place on admission and bms are checked as per protocol. ensure green clerk in is read thoroughly by admitting nurse to alleviate incidents like this one	Being reviewed	
Personal	07/03/2021	22:40	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	Emergency Department CAH	Minor	Security requested by ED Amber Resus as a male patient had become aggressive towards the nursing staff.	Security arrived to ED Resus and witnessed several nursing staff restraining a male patient on an ED Trolley. Security immediately intervened and took over from nursing staff and continued to restrain the patient as he was being very aggressive, During this time the patient received several injections which finally started to take affect around 2 hours later. Once the patient eventually settled Security were then stood down. Security were with this patient for over 3 Hours.	None	Final approval	
Personal	07/03/2021	19:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	STROKE	3 North Stroke	Insignificant	patient states bottom dentures missing	bedside and surrounding area checked		Being reviewed	
Personal	07/03/2021	06:15	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Female Medical	Insignificant	called to female medical,patient was confused an wandering about we approached him an told him he needed to go back to bed,he agreed so we stayed for a while then left.stood down at 06.30	none	none	Final approval	08/03/2021

Personal	07/03/2021	18:45	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Emergency Department DHH	Insignificant	Security called to ED on arrival security informed a friend of a patient was being very aggressive towards staff. Nursing staff had words with person and informed PSNI were going to be called. The friend contacted a family member and calmed down, security stood down 1855.	nnoe	none	Final approval	08/03/2021
Personal	07/03/2021	12:40	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	Patient had been prescribed IV vancomycin. Iv Cannula inserted by ED Dr approx. 40mins into infusion patient reported pain at infusion site. Site noted to be swollen.	IV infusion stopped Drug disconnected, line aspirated 1.5mls out Iv cannula removed Dr Mawhinney informed cold compress applied and elevation of limb Iv cannula re sited to other arm for completion of treatment Patient admitted medically for 24hr observation of site.	check patency of line prior to drug administration	Final approval	24/03/2021
Personal	08/03/2021	16:30	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	MEDGYN	Antenatal Clinic	Minor	Personal HCN Personal Person Personal rang to say she had been looking through her Green Maternity notes and found another service users radiology report in the growth chart section of the antenatal section. Radiology report from another service user: Personal Information redacted by the USI Personal	Personal HCN Personal) Person advised to come and get same removed from her chart. Same removed 8-3-2021 by myself.		Being reviewed	
Personal I	08/03/2021	09:15	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Car Park/Grounds	Insignificant	At 0915 switchboard informed security of a fire alarm sounding in clanrye house. Perso Personal Information redacted by the USI responded, on arrival we evacuated the building of workmen. There was construction work taking place in the building and alarm was set off accidentally, Fire service arrived we met them at the front doors of clanrye house. Checks carried out we were stood down, all clear.	Electrical alarm fault	none	Final approval	08/03/2021
Personal	08/03/2021	08:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	GENSUR	4 South	Minor	deep tissue injury noted on patients left heel while attending to his hygiene needs verified by TVN 8/3/21 as ungradable eschar plaque on left lower Achilles area	zero pressure to L heel	importance of visual inspection and documentation of all potential pressure ulcer sites, refusals. written leaflet and verbal related education handover so patient knows the risk of not moving or offloading pressure and aware of consequences of his own actions.	Final approval	10/03/2021
Personal	08/03/2021	14:00	Daisy Hill Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Antenatal Clinic	Minor	NIMATS investigation report for Patient Personal was printed and placed in the chart of Personal . This is a data protection breech	The incorrect NIMATS investigation report was removed from the chart, Lead MW and Manager of ANOPD in DHH informed. DATIX completed		Being reviewed	
Personal	08/03/2021	11:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Minor	patient very physically aggressive to staff and portering security. stated that he was going to kill them.	psni contacted. mental health team on the ward at that time. sedation given.	Several Datix completed for this patient as he was very unsettled since admission. Managed apprpriately	Final approval	11/03/2021
Personal	08/03/2021	23:00	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	Patient inappropriately transferred from A&E to female surgical ward. transferred at same time as two others admissions from A&E. only one staff nurse present on ward at this time. concerns raised as to safety of patients. Bed manager was not made aware of this patients transfer. no armband on patient, no Kardex written for patient. handed over that patient was for IV fluids as per plan no canula in situ. fluids not commenced in A&E as per plan. poor handover. Patient was not ready for transfer to ward	Bed manager informed Phone call received from sister Person in A&E at later stage - my concern expressed of inappropriate transfer and poor care	clear communication between teams essential armbands to be placed on all admissions prior to transfer to be shared at safety briefing w/c 22/03/2021	Being reviewed	
Personal	08/03/2021	03:30	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Female Medical	Insignificant	Security called to female medical at 0330, on arrival security informed that a patient was being very aggressive towards staff. Nurse informed security that patient had head butted the nursing station and punched his own face claiming that nurses had done it. security approached patient and he was very aggressive towards us making numerous threats, patient spat at one of security guards in the face. Patient took his walking stick and started to hit himself on the head and on the legs claiming that security had assaulted him. Security removed stick from patient, and used low level MAPA techniques to restrict the patient. Doctor arrived and asked security to manage patient whilst medication administered, security stood down a short time later. Security called back at 0545, patient trying to leave the ward. security managed to talk him back to his bed and were stood down a short time later.	none	none	Final approval	10/03/2021

Personal	08/03/2021	00:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	ORTHSU	Orthopaedic Ward	Minor	On looking after this patient today it was handed over to review wound. patient also requested this today as she was worried about it. when changing wound dressing, found that skin was broken with superficial wound to buttock area and grade 1 / dry blanching area to left buttock. patient stated this had started at home as she was very unwell last week and was unable to move very much and was in bed most of time. she also stated as she had lost weight it was sore since lying on it. however she said she was aware of pressure relief measures to take and was trying to lie on left hip to relieve pressure to sacrum/buttocks. initial time of incident unknown for sure. patient remains independent and regularly repositioning. braden on 6/03/2021 = 20	wound dressed and cleansed. repositioning chart insitu. duo mattress ordered and put onto bed.	as above Mobile young patients that have been unwell at home for a period of time are at risk of skin breakdown. Skin should be inspected thoroughly on all patients and clear documentation if there is rationale for this not being done	Final approval	11/03/2021
Personal	08/03/2021	18:10	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	STROKE	3 North Stroke	Minor	Patient had an unwitnessed fall at 18.10. Fell at bedside.	Checked for injuries, assisted into bed. Falls protocol commenced. Fy1 informed. NOK informed.	Patient was already confused on admission and no safety awareness, was awaiting MRSA results. But could nurse on open bay near sink. same address in patient safety briefing.	Final approval	10/03/2021
Personal	08/03/2021	17:45	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, CAH	Minor	At about 15:45 Dr David Grier was leaving the maternity building and witnessed a man smoking. He asked him to stop and the man went initially to go to the bin. He then became agitated and said that I was abusing him by watching him going to put the cigarette out. He then refused to put it out and acting aggressively by shouting and then blowing smoke at me. Name of patient Personal Information Personal	Dr Grier identified that he was the partner of a patient in labour ward and spoke to the Sister. She advised speaking to the Lead Midwife who advised contacting Security.	For all staff to ensure that they challenge members of the public re smoking.	Final approval	31/03/2021
Personal	08/03/2021	03:30	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	2 South Medical	Insignificant	Male patient heard shouting, on checking, found sitting on the floor besides his bed	Head to Toe examination carried out - No obvious injuries, patient denied hitting his head on floor, denies pain. Assisted to bed by two staff, patient during transfer bore his weight. Repeat Toe to head again repeated - no obvious injuries. Neuro observations and NEWs reviews commenced as per NHS Policy. Co Ordinator and Doctor informed. Patient has since been seen by Doctor, and has been for CT Brain and CXR Pending. Sedative medication and Apixaban on Hold	ensure patients have close supervision at all times those that are deemed high risk. ensure it is documented on handover and that all staff are aware.	Final approval	09/03/2021
Personal	08/03/2021	05:30	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Insignificant	Aggressive behavior from patient. Hitting out at staff members. hitting walls and bedside.Shouting. Verbally aggressive.	Reassurance Medication	continuous 1-1 supervision monitor effects of medications MDT plan	Final approval	08/03/2021
Personal	08/03/2021	23:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Minor	Patient had unwitnessed fall. Seen by staff on the side of bed claiming having the fall after attempting to mobilize out of bed to get a smoke. He claimed he did not hit his head and claimed he landed on his left shoulder- no pain apparent.	Assisted by 2 staff back to bed. Obs and neuro obs done as per falls protocol. Seen and examined by Fy1 with orders made. transferred to F bay for close monitoring. To inform NOK in AM- handed over to morning shift.	Falls pathway followed No harm to patient	Final approval	09/03/2021
Personal	08/03/2021	19:00	Craigavon Area Hospital	Pharmacy	PHARM	PHDISP	Pharmacy Dispensary	Insignificant	I was on-call Mon 8/3/21. Call from S/N Perso AMU 19:00. Received discharge for Personal for chlordiazepoxide and loperamide, however, no Zopiclone in bag. Patient was on weekly dispensing pre-admission, and had all of his tablets at home, except his Zopiclone. S/N had arranged with Ext Hrs team doing d/c to supply 2/7 Zopiclone until patient collected his weekly on Wed, however, it wasn't in the bag which had just come round with the Porter. Ext Hrs team away. Checked JAC – not labelled. Texted Person (was on ext hrs), she had clinically checked and starred item but must have been missed.	Called S/N back, advised give one dose off ward for that night and I would follow up with community pharmacy in AM. Follow up – called comm. Pharmacy (Personal) on Tues AM and updated them on situation. Suggested possibility of getting weekly early but would need authorised by GP. Persona (pharmacist) kindly agreed to sort out.	t	Being reviewed	
Personal	08/03/2021	04:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Female Medical	Minor	Patient was being assisted back from the toilet. he suddenly became very agitated. He walked towards the desk and purposely banged his head on the desk. He then attempted to hit staff. Security contacted and attended ward. patient spat on one of the security men. He used his walking stick to hit head several times and his right foot. Bedmanger and doctors contacted. Walking stick removed from patient.	Security, bedmanager and medical team informed. Im lorazepam administered. At present patient is refusing to let his head or Rt foot be examined. Extent of injuries to be fully assessed when he is more co-operative.	Discussed with staff at PSB to be aware that he can be physically and verbally aggressive towards staff.	Final approval	24/03/2021
Personal	08/03/2021	11:26	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Antenatal Clinic	Minor	sensitive reaction to monofer infusion TACHYCARDIA,TACHYAPNOEA,NAUSEA,SWEATING ,DIZZY	iv infusion discontinued left lateral position flat clinical obs dr informed SEEN BY DR		Being reviewed	

Personal	08/03/2021	11:30	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Minor	Member of staff as involved in security incident in AMU. during the incident the member of staff injured his right wrist. Patient lunged towards Security and had to be restrained to the floor until the Police arrived. The patient was then handcuffed and managed by Police. He was later transferred to Bluestone.	Member of staff booked into Emergency Department	NA	Final approval	09/03/2021
Personal	08/03/2021	08:30	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Female Medical	Minor	Patient transferred to Cath Lab from DHH Female Medical with No nursing notes, clinical observation chart, previous ECGs. No Cath Lab documentation completed/started for patient.	Ward contacted and nursing notes were transferred over with a patient who transferred from DHH CCU.	Raised with staff at PSB that Angio booklet and nursing documentation must be sent with the patient.	Final approval	09/03/2021
Personal	08/03/2021	11:15	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Moderate	A delirious Insulin Dependent T2DM patient presented to ED on 5/3/21 at 22.10. Admitted medically and clerked in at 01.00 6/3/21, seen on weekend review 7/3/21 and by ward Dr's on the 8/2/21. Pharmacy IP ECR completed on 7/3/21 and documented in medical notes. I took over nursing care of this patient on 8/3/21 at 08.00 and during an independent check of information regarding podiatry for toe ulceration via NIECR, I incidentally discovered that the patient was Insulin dependent and that Novomix '30' BD had not been prescribed from admission. CBG's had been checked QDS by nursing staff and documented as a tablet controlled diabetic on 24 hour nursing admission booklet.	I immediately escalated the findings to the medical team at 11.15, whom had already seen the patient on the ward round that morning, and informed both the ward manager and ward pharmacist.	Prescribing and patient history clarification by medical team	Final approval	15/03/2021
Personal	08/03/2021	20:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Moderate	Took charge of ward to find that no HCA had been booked for 1:1 supervision of an extremely confused and aggressive patient. One HCA had to remain with the patient at all times as has a high risk of falls and is a danger to himself and others (2 security calls were required overnight for this patient) This left only 3 band 5 nurses and 1 band 3 HCA to cover the rest of the ward, which also included 2 other confused patients requiring close supervision. Due to concerns for patient safety, no further admissions could be accepted overnight.	Bed manager contacted to inform of situation at beginning of shift, but no extra staff were available throughout the hospital to help out.	Ongoing staffing review for specials , ensure escalated to site manger overnight.	Final approval	23/03/2021
Personal	08/03/2021	12:00	Community	IMWH - Cancer and Clinical Services	MIDWIF	COMM	John Mitchel Place, HSSC	Minor	Insufficient blood spot	Repeat Sample	Ensure procedure performed as per guidance.	Final approval	14/03/2021
Personal	08/03/2021	19:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Insignificant	Witnessed fall at ambulance triage, alcohol on board.	Assessed by Ed doctor - no intervention Clinical observations carried out	PACE documentation for all patients. Update moving and handling risk assessment if need supervision when mobilizing to prevent further falls. ensure all staff aware falls risk.	Being reviewed	
Personal	08/03/2021	12:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Female Medical	Insignificant	Patient admitted via ED with Grade 2 pressure sore on sacrum. Known to DN for dressing of same.	nil	Nil	Final approval	23/03/2021
Personal	08/03/2021	23:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Emergency Department DHH	Insignificant	Pt transferred from A&E on IV Fluids. no fluid balance chart with patient. Unable to recommence fluids on admission to ward. A&E department had to be phoned to locate patients fluid balance chart.	A&E phoned to locate PTs fluid balance chart	All relevant documentation to be transfer to the ward with the patient. to be shared at safety briefing week commencing 08/03/2021	Final approval	24/03/2021
Personal	08/03/2021	12:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Insignificant	3 north medical was staffed with X3 staff nurses and X2 first year student nurses on this day With nine patients this was manageable but as the ward re-opened to admissions/transfers pressures on staff mounted. The ward had no 1:1 cover for an unsettled patient, a 2nd patient sustained an unwitnessed fall and student nurses were compelled to act as additional bodies - providing 1:1 supervision for patients with a high risk of falls.	Shifts had been out to agency/bank and not picked up, management and bed managers aware. Advised to seek assistance from 3 north stroke. Staff from stroke side were able to help out for a short time late afternoon.	additional HCA support provided by lead nurse to facilitate transfers. Patient flow staggered admissions to facilitate ward staffing.	Final approval	09/03/2021
Personal	08/03/2021	12:20	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	General Male Medical,	Minor	Patient transferred over to Cath Lab from DHH MMW without his continuation of Nursing Notes	DHH MMW contacted and the nursing documentation was scanned and sent by email.	the importance and safety aspect of other departments needing notes and why they need to be sent	Final approval	10/03/2021
Personal	08/03/2021	13:00	Daisy Hill Hospital	Medicine and Unscheduled Care	CSMUC	CARDIO	Coronary Care Ward	Minor	Patient required pre and post hydration fluids. Pre hydration fluids given in DHH. On checking fluid balance for post hydration fluids no addressographs or patient details on Fluid balance chart	New fluid balance chart commenced with patient details and post hydration fluids prescribed and administered.		In holding area, awaiting review	
Personal	08/03/2021	11:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Minor	patient was found sitting on the floor at the front of his chair. patient had last been sat in said chair	Already attempting to get to his feet, patient x was assisted to stand and into bed X3 staff. FY1 attended, falls protocol commenced, risk assessments updated, nurse in charge informed	Importance of communicating all patients at risk of falls to all staff members at ward safety brief. Importance of having accurate and up o date risk assessments for moving and handling, falls and bed rails.	Final approval	10/03/2021
Personal	08/03/2021	08:10	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	GYNAE	1 East Maternity/Gynae	Minor	Unwitnessed fall.Personal out from the toilet with small bloods in the mouth and stated that the she fell.	Checked the mouth and cleansed. OBS taken and GCS as pathway Dr. Rait Informed and assessed. Husband informed		Being reviewed	

Personal	09/03/2021	14:00	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	GYNAE	Gynae Clinic	Minor	on 9/3/21 an endometrial pipelle sample was received from the gynae OPD clinic in CAH. The patient details on the request form and the specimen container did not match. Personal on the form and Personal on container)	GOPD were contacted and asked to attend the lab to confirm which details were correct, and to correctly label the specimen container/form so they matched. The details were logged into the lab QMS Q-Pulse- see Personal		Being reviewed	
Personal	09/03/2021	15:18	Community	Pharmacy	PHARM	PHASEP	South Lakes Leisure Centre	Insignificant	pfizer covid vaccine had black particle floating in it after reconstitution.	vial not used		In holding area, awaiting review	
Personal	09/03/2021	21:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Moderate	Patient had unwitnessed fall at beside. Loud noise heard and patient found on floor, fell out of chair and chair was on top of patient. Bleeding heavily from nose - found face down. Patient admitted to AMU on 07/03/21 at 04:30am and had 1:1 from PNH in attendance since then. since 20:00 on 09/03/21 no 1:1 provided. contacted PNH regarding same and they stated that they had informed social worker LH that they would no longer be providing staff for 1:1 and it was now up to the trust. same information not relayed.	Stopped bleeding from patients nose. Assisted off floor and into bed. NEWS and GCS recorded as per falls protocol. Medics informed. patients nose looks displaced - contacted PNH to ask if this is how it looked previously or not. IV analgesia given as nose appears to look broken.	Essential that 1:1 is requested for patients at increased risk of falls. On this occasion there was a breakdown in communication between care home and ward staff.	Being reviewed	
Personal	09/03/2021	00:30	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Female Medical	Minor	Patient found on floor beside bedside, no witness for this fall, full body checked no injury noticed, no bleeding from any where on the body orifices patient is full conscious and alert, patient remains confused.	assisted back into bed, NEWS stable, GCS - 14/15 (confused) informed medical team, both upper and lower extremities normal. falls pathway followed.	Nil	Final approval	09/03/2021
Personal	09/03/2021	07:30	Craigavon Area Hospital	Functional Support Services	LOCCB	DOMSCB	Domestic Services	Moderate	Infection attributable to specified work (schedule 3 No.27) tested positive Covid19	Reported to OH Tested at Kernan Testing station Isolating	covid19	Final approval	16/03/2021
Personal	09/03/2021	23:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Patient was clerked by medical doctor. Medical clerk in and Kardex had been completed, signed and dated. 10pm medication drug round had been completed by myself, medications given to pt which included Temazepam and Mirtazapine. On administering and completing checks I had talked pt through the medications he was being given and pt was happy with same. Patient later become drowsy, clammy and sweating.	Clinical obs checked, BM checked, GCS completed and asked pt had he any chest pain which he replied no. Rang medical doctor to inform him of same and also informed of pt getting night time medications which had been prescribed. Doctor stated he forgot to hold numerous medications as pt had told him he did not take these any longer. Medic came to r/v pt. ECG carried out and stated to monitor resps and o2 saturations closely.		Being reviewed	
Personal	09/03/2021	15:00	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	GYNAE	Gynae Clinic	Moderate	Personal old lady with gelhorn pessary in situ from july 2019. It is not embedded and unable to be removed. clinic appointment at 4 months post insertion did not happen	d/w next of kin, happy for it to stay and understand risks		Being reviewed	
Personal	09/03/2021	10:00	Daisy Hill Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, DHH	Minor	bloods in theatre taken not labelled	repeat bloods organized and explanation with apology given to mother		Being reviewed	
Personal	09/03/2021	23:15	Craigavon Area Hospital	Surgery and Elective Care	ATICS	THEAT	Theatres 1-4 CAH	Minor	Urology Consultant requested a second theatre open as a general case already in theatre1.	Nurse in charge informed and rest of team informed	None - nature of emergency access.	Final approval	12/03/2021
Personal	09/03/2021	17:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Minor	Medical Out of Hours F1 - handed over by SHO working on front of ward 3s - as bloods were not taken and sent on the ward until late (did not state when exactly). The SHO proceeded to state they needed to leave this ward at their scheduled finish time - 1700. OOH F1 requested a list of patients who needed bloods chased. On arrival to the ward, OOH F1 discovered that the list of bloods only had 7 names. On further investigation, the entire ward had blood results to be chased. This represented roughly 20 individual patients. As it transpired, the SHO working on the backside never contacted the OOH F1 to hand over their workload of bloods. This included patients who had not had their bloods taken.	OOH F1 chased up the roughly 20 individual's blood results and acted on them appropriately.		Being reviewed	
Personal	09/03/2021	11:00	Craigavon Area Hospital	Functional Support Services	LOCCB	DOMSCB	Domestic Services	Moderate	Infection attributable to specified work (Schedule 3 No 27) Tested positive for Covid19	Referred to Occupational health Staff member isolating	covid19	Final approval	18/03/2021
Personal	09/03/2021	16:00	Craigavon Area Hospital	Pharmacy	PHARM	PHDISP	AMU	Minor	One Butrans 10mcg patch was ordered from pharmacy this morning. Four patches were dispensed, instead of one, and sent to ward.	Pharmacy reception had phoned myself prior to dispensing, checking it was definitely only one patch we required. Ward pharmacy informed at time of incident.		Being reviewed	

Personal	09/03/2021	10:30	Craigavon Area Hospital	Surgery and Elective Care	OUTPAT	OUTPAT	Thorndale Unit	Minor	Patient was referred in as red flag by GP with description of "penile ulcer 14/52". In the comment section of referral- reference is made to a name not that of the patient referred. Patient was subsequently triaged and booked to a red flag new clinic in Urology CAH. On attending today patient did not know why he was here and discovery of wrong referral was made. Patient was spoken to by Urology consultant.	GP surgery contacted to see if patient had any need to be referred to urology- also to bring to their attention a patient may have been missed.	When letter was received the name difference on the content of the letter and that of the patient should have been picked up.	Final approval	09/03/2021
Personal	09/03/2021	02:20	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	GENSUR	4 South	Minor	Patient received dose of Teicoplanin at 02.00, eight hours after previous dose instead of 18.00. Patient should have received IV Meropenem at 02.00 instead.	Clinical obs checked on realization of error. FY1 informed. Reviewed by FY1 - nil ordered.	as above	Final approval	16/03/2021
Personal	09/03/2021	02:40	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	3 South	Insignificant	Security bleeped to attend 3 South as a male patient was agitated and trying to leave the ward.	Security arrived to 3 South and witnessed male patient Personal trying to get out of bed. Security spoke to the patient and managed to convince him to stay in bed. Security were then stood down.	to escalate daily to ensure this man has a 1-1 carer/HCA to look after him and keep him safe.	Final approval	
Personal	09/03/2021	07:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Moderate	pressure damage noted on right ear and right elbow, both grade 2. patient is known to district nurses and is receiving treatment for same.	encouraging pressure alleviating care where possible and assisting patient with mobilization.	Good practice of skin check on admission and documentation of same but ED Skin intervention chart must be completed in ED to document what interventions have been put in place to prevent further prevention/ deterioration. ? braden score ?TVN referral or DN care plan in community. Lesson to always document an action, regular prevention might have bee done but needs to be documented to ensure continuity of care.	Being reviewed	
Personal	09/03/2021	10:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	X-ray Dept (Radiology)	Moderate	[redacted] HDU Initially had a CT abdomen reported out of hours reported by everlight radiology system: Conclusion; The main findings consist of pancreatic swelling associated with oedematous changes and peripancreatic infiltration in favour of signs of acute pancreatitis. The patient was very unwell. Surgeons had felt initially was not acute pancreatitis as amylase normal. As clinical picture didn't fit our team re-approached the surgeons who discussed the images (48hours after admission) with our DHH radiology team at X-ray meeting and reviewed by consultant radiologist and initial radiology report amended: The case was discussed at surgical meeting. There is also a residual collection in left paracolic gutter measuring 3.6 cm in transverse diameter and 12 cm craniocaudally . There has been significant interval change in density of hepatic parenchyma since previous CT dated 21st January202 consistent with	Surgical/medical and radiology teams aware As discussed I advised I would complete a datix to raise awareness of significant error made by this everlight radiology reporting system missing this significant collection		in holding area, awaiting review	
Personal	09/03/2021	11:30	Daisy Hill Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Antenatal Clinic	Minor	patient presented at ANC today 9-3-21 was seen by Dr Chinnadurai at 25/40 gestation there was no booking blood reports in the file the lady stated she had telephone call with midwife at start of jan 2021 but no bloods were discussed and date only of anomaly scan given no time letter was to follow but subsequently didn't. The lady had contacted ANC to receive the time of anomaly herself and also had contacted myself regarding a consultant appointment. She had been EITP/MLC up until this point and she had had no further communication from them. However in the notes there was only the secretaries bloods report no individual lab reports from booking, no 16week BR proforma. This lady was very upset regarding the care she had receive up to date.	appointment was made for consultant today booking bloods where recorded rubella non-immune leaflet given p/n notes updated Rh Positive. Sr Person was made aware by consultant at clinic	Inconsistencies identified, plan made to rectify situation following meeting on 16/03/2021.	Final approval	23/03/2021
Personal	09/03/2021	14:00	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, CAH	Insignificant	x3 minor with errors in pre-transfusion samples within a 3-month period received in Blood Bank from the same sample taker.	Samples rejected & sample taker informed after each error. The Trust Transfusion Team recommend that the sample taker is issued with a temporary desist notice. This means that they should desist pre-transfusion sampling until they have been successfully re-assessed in NPSA competency 1: obtaining pre-transfusion samples.		Being reviewed	

Personal	09/03/2021	07:30	Craigavon Area Hospital	Functional Support Services	LOCCB	DOMSCB	Domestic Services	Moderate	Infection attributable to specified work (schedule 3 No 27) tested positive Covid19	Referred to OH Tested at Kernan testing station Isolating	Covid19	Final approval	16/03/2021
Personal	09/03/2021	07:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	2 South Medical	Moderate	patient admitted to 2 south. on skin check noted extensive bruising, g2 to right buttock, dti to sacrum/buttocks. yellow bruising to upper body. abdo folds red and raw. ? ungradable pressure ulcer to right calf area. extend of skin breakdown not detailed form ed nurse handover. see current body map for more details.	full head to toe examination sr to refer to TVN barrier cream applied to skin where appropriate, await mattress upgrade. ? need for vulnerable adults form, ward manager aware and clinical sister. Not handed over that same was completed in ED	ensure staff continue to review skin on admission.	Being reviewed	23/03/2021
Personal	09/03/2021	22:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	1 South Medical	Minor	Patient is prescribed Sodium Valproate 2g PO each night. This is a critical medicine. Administration not signed for on 5/3, 6/3 and 9/3. Not given via IV or as stat doses. ?missed doses.	Staff nurse in charge informed.(No sister or ward manager on ward today). Notes checked - no recent seizures. Dr looking after patient informed.	Importance of reviewing Kardex thoroughly at time of medication and also throughout shift to ensure meds not missed or signed for correctly. implement checking Kardex with oncoming shift as part of new ward model	Final approval	12/03/2021
Personal	09/03/2021	20:40	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	Emergency Department CAH	Minor	Security called to ED triage at 2040 to assist with an aggressive male patient. On arrival the male was verbally abusive to staff and squared up to security staff with his fists clenched. Security had to restrain the patient and escorted him to the seating area. He continued to be abusive and then went back and forth for a smoke. Security left at 2100.	security called	None	Final approval	
Personal	10/03/2021	15:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	TRAUSU	Trauma Ward	Minor	used unit of blood was sent from trauma ward and the spigot was not used correctly. the result of this was that the blood bag had leaked and when lifted by a member of staff in blood bank the blood leaked on the staff member.	unit of blood discarded appropriately	To ensure the spigot is inserted as far and as tight as possible before returning the blood product bag to the labs.	Final approval	11/03/2021
Personal	10/03/2021	10:20	Daisy Hill Hospital	IMWH - Cancer and Clinical Services	DIAGNO	IMACT	CT Scanner	Moderate	Patient's CT scan was approved by radiologist and patient was brought for scan, which was performed, however neither the radiologist or radiographers realized the patient had been scanned during the night for the same scan.	Reported to CT Lead, Radiologist, site lead and referring clinician.		Being reviewed	
Personal	10/03/2021	08:30	South Tyrone Hospital	Surgery and Elective Care	SCHED	ENDSCH	Theatres/DPU STH	Minor	Mr[P] arrived in STH for planned Flexible Sigmodoscopy, he stated he had drank bowel preparation and was expecting to have a colonoscopy completed by Mr H. He also stated that he didn't want any trainees or any other Doctor to complete the procedure. I staff nurse[PS] explained as soon as the doctor arrived I would have him speak with him to clarify the situation. Yellow booking form states consultant only, schedulers aware to rebook with Mr H only.	Mr RM was the Doctor completing the list and he went to speak with patient who decided that Mr H was the only person he would accept to do the procedure.	When the booking form states Consultant only it is important for the patient that this is the process within our SHSCT.	Being reviewed	
Personal	10/03/2021	15:00	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Antenatal Clinic	Insignificant	Anti-D not booked from BLR appointment. Potential to be missed. Anti-D was indicated for both patients on the outcome sheet, but this was not booked by admin staff.	Anti-D booked for both patients. Patients informed of appointments. Service administrator informed.	11/03/2021: See above action box.	Final approval	11/03/2021
Personal	10/03/2021	14:05	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Coronary Care Ward	Insignificant	security called to male medical confused patient trying to get out of bed ,nursing staff give him an injection ,he settled down so we left on the word of clinical sister.	none	none	Final approval	15/03/2021
Personal	10/03/2021	19:39	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Insignificant	Security called to AMU at 1939 to assist with a male patient. On arrival patient was on the phone talking to the police. Security staff observed for a short time and were stood down at 1949.	security called	None	Final approval	
Personal	10/03/2021	01:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Female Medical	Insignificant	iv vit k prescribed on 8/10/21@1800 not given for 2 days no contra-indications in edical notes not be given states iv vit k for 3 days no documentation from nursing staff as to why it was not given	stat dose of iv vit k prescribed at 0100 on 10/3/21 and administered after noticing x2 doses not given doctor informed	Discussed with staff to ensure that Kardex's are checked. Medical team reminded to inform staff when added medication are prescribed that they inform the nursing staff.	Final approval	24/03/2021
Personal	10/03/2021	19:50	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Minor	Patient x had an witnessed fall at approximately 18:00hrs, same observed by nursing staff, nursing staff advised that patient had not hit her head. Patient x then found on floor in the middle of bay 2 at approximately 19:50, face and body down flat on the ground with trousers pulled down and patient had urinated on floor.	After witnessed fall patient assisted back onto chair and FY1 reviewed patient - nil ordered at this time as fall witnessed. Patient assisted x2 onto feet after unwitnessed fall, checked patient for facial and head injuries - none evident at present, patient assisted x2 and walked to chair, clinical observations checked, GCS observations checked and FY1 contacted. Falls protocol commenced.		Being reviewed	
Personal	10/03/2021	12:15	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Ramone Ward 4	Insignificant	whole magnetic curtain rail feel in B bay patient 2 bedspace and was caught by HCA and was a near miss to hitting the patient	the rail was moved out of the patients way, the patient was reassured as the bang shocked them. the estates was contacted and maintence logged. put through as urgent as the patient requires assistance and is in need of the curtains	being careful with equipment and not pull too hard on curtains	Final approval	10/03/2021

Personal	10/03/2021	12:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	STROKE	3 North Stroke	Insignificant	SLT noted Level 5 (minced & moist) meal provided to patient for lunch. This was not in compliance with SLT recommendation for Level 4 (puree) foods. SLT also noted SLT yellow bedside sign not in place.	SLT S/W HCA, who removed Level 5 (minced & moist) lunch, and agreed to order replacement Level 4 (puree) lunch. SLT advised S/N of the above incident. S/N advised will raise same at safety briefing. SLT issued replacement yellow bedside sign detailing SLT swallow recommendations.	highlighted near miss at staff in safety briefing. Explained importance of always checking correct diet is being handed out by looking at updated yellow diet sheet. Informed to always rotate sheet if patient is being moved bed spaces.	Being reviewed	
Personal	10/03/2021	12:10	Craigavon Area Hospital	Surgery and Elective Care	ATICS	THEAT	Theatres 1-4 CAH	Insignificant	Patient had to be cancelled from the endoscopy list today 10/03/2021, there was insufficient time remaining due to delays from previous patients.	Theatre manager informed of this decision, Dr Murphy is going to put the patient onto Fridays list but theatre manager and emergency Sr are going to try to organize for the patient to be done tomorrow on the emergency list.	None for ATICS	Final approval	12/03/2021
Personal	10/03/2021	14:15	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Moderate	Grade 2 pressure ulcer on left heel	adhesive foam dressing placed on same heels raised off bed with blanket. Person aware of grade 2, states she has had it but it had been heeled		Being reviewed	
Personal	10/03/2021	18:20	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Insignificant	On return from break at approximately 18:20, patient x noted to be both physically and verbally aggressive with nursing staff on ward. Patient x attempting to hit and kick out at staff. De-escalation techniques unsuccessful.	De-escalation techniques used on patient however unsuccessful. Patient x requiring to be MAPA held (1 staff at each side of patient) by nurse and HCA to administer PRN 1mg Lorazepam. Patient x continuing to hit out at staff after this, security called at approximately 19:00hrs, PRN 500 mcg of haloperidol prescribed by F2 on ward at the time and administered to patient. Security staff then remained on ward the duration of the shift until patient had become more settled.	Importance of highlighting aggressive patients on safety brief and during handovers. Importance of using distraction techniques and completing this is me to ensure all interventions used prior to pharmacological interventions to de escalate behaviors	Final approval	15/03/2021
Personal	10/03/2021	19:07	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	3 North Medicine	Minor	Security called to 3 north at 1907 to assist with an aggressive female patient. On arrival nursing staff were restraining the patient so security took over. Patient was attempting to strike out and spat at staff hitting one security porter on the back of the head. Patient was given an injection and placed into bed. Security stood down at 2005.	security called	none	Final approval	26/03/2021
Personal	10/03/2021	02:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Moderate	Personal gentleman, BIBA following DSH- cuts to wrist and TLNWL. Triaged on arrival. Dr attempted to see patient, no answer when called from waiting room, mobile no. went direct to voicemail, no answer from NOK, security searched premises and not found.	Missing person proforma completed and PSNI made aware.	Early intervention with absconding protocol. Communicating with PSNI and any updates to be documented in patient notes	Being reviewed	
Personal	10/03/2021	23:20	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Lumira buffer sent to the laboratory	Lumira buffer placed in air cabinet. ED telephoned to inform them sample was received and would not be tested.	Lumira buffer not to be sent to laboratory in pod.	Being reviewed	
Personal	10/03/2021	14:30	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Minor	staff had started explaining the process of a covid swab that was due, patient was sitting down on side of bed and reached out and grabbed staff by the right arm with force, was asked to let go and eventually did . 1:1 specialing patient was in the room and witnessed this.	explained to patient this was not acceptable behavior, sister on ward informed and 1:1 special warned to keep a safe distance from patient. same documented in notes	nil	Final approval	16/03/2021
Personal	10/03/2021	22:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Patient was in a bariatric wheelchair in green area she was being assessed by ED doctor, patient attempted to get up and slid to ground. fully assessed by ED DR no injuries apparent. green area cub 9	patient assisted using bariatric hoist onto a bariatric bed once obtained. full assessment by Ed dr no injuries	Bariatric equipment should be used to ensure safe transfer of patients.	Being reviewed	
Personal	10/03/2021	19:45	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	REHAB	Stroke / Rehab	Minor	During handover patient was observed sitting on the floor beside her bed	patient examined no apparent injury hoisted from the floor into her bed unwitnessed falls protocal followed Reviewed by Dr nil new ordered NOK to be informed in AM	none	Final approval	18/03/2021
Personal	10/03/2021	15:00	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Antenatal Clinic	Moderate	Patient came for anti-D appointment but was not on clinic list. Upon investigating it was discovered that patient had been recorded as 'deceased' and all further antenatal appointments had been cancelled as a result.	Medical records contacted and asked to rectify mistake. patient given anti-d and all future appointments reinstated.		Being reviewed	
Personal	10/03/2021	02:10	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	ORTHSU	Orthopaedic Ward	Minor	whilst out to the bathroom under direct supervision x1. Patient holding onto sink and ?weakness/slipped, controlled fall, banged chin on sink basin and bit lip. did not hit head and lowered self onto hands and knees	Assistance x3 given into bed, observations and neuro obs started half hourly. Med FY1 contacted. Family contacted. Attended for CT brain. Lying/standing BP to be done and risk assessment updated. Needs reviewed by physio	as above	Final approval	15/03/2021
Personal	10/03/2021	09:00	Craigavon Area Hospital	Medicine and Unscheduled Care	CSMUC	CARDIO	1 North Cardiology	Minor	7 patient bedside medicine lockers not locked	Locked lockers and informed nurses in charge	The importance of locking lockers therefore ensuring the safe storage of medications.	Final approval	22/03/2021

Personal	10/03/2021	06:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	General Male Medical,	Moderate	CSF samples from Male Medical at DHH taken on consecutive days for two patients listed (Personal and Personal) were not labelled. Unlabelled samples are not normally accepted by the laboratory for analysis. Due to risk of repeat sample of this type samples were analysed and verbal report only issued.	Ward was informed and verbal report was given for immediate management of patient(s). However laboratory will not stand by results and they will not be recorded on LABS or NIECR.		Being reviewed	
Personal	10/03/2021	22:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Patient attended ED department on 10/3/21 ?UTI Patient was on critical medication for his bi-polar which patients wife informed Dr Baird he had not been prescribed at 2200 Medications involved Valproic acid, Lamictal and Respiridone.	Drug Kardex checked and patient has been prescribed for 2200 tonight and she was reassured that he would receive same tonight	Patients waiting to be seen should be aware of own medications. Share when triaging patient so they are aware to inform staff if not received medication	Being reviewed	
Personal	10/03/2021	10:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	3 South	Minor	Patient noticed to have grade2 sore on the natal cleft.	Allevyn dressing applied. Airmattress ordered for him. Datix completed.	Continue to keep risk assessments up to date and adjust according if patients mobility changes.	Final approval	16/03/2021
Personal	10/03/2021	14:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Minor	Patient found on the floor at bedside at approximately 14:00hrs by nursing and medical staff.	Nursing and medical staff informed of same, patient hoisted back into bed. Falls protocol commenced. Patient to have CT brain carried out - same ordered by medical staff. Next of kin informed of same.	x	Being reviewed	
Personal	11/03/2021	08:15	Community	Pharmacy	PHARM	PHASEP	South Lakes Leisure Centre	Insignificant	Pfizer vial reconstituted, BN ER1741 exp 06/21. Floater in vial after recon, full vial wasted	Vial defaced and disposed of.		In holding area, awaiting review	
Personal	11/03/2021	15:20	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	DIAGNO	IMAULT	Portering	Minor	portering issues. patients were 40 minutes + late for their ultrasound appointments due to portering shortage. had to cancel the 4:30pm patient as would not have had time to scan.	scan had to be delayed and cancelled throughout the day.		Being reviewed	
Personal	11/03/2021	15:15	Daisy Hill Hospital	IMWH - Cancer and Clinical Services	DIAGNO	IMAOTH	X-ray Dept (Radiology)	Insignificant	A Personal old female patient came to x-ray dept for an orthopantomogram by referral from their dentist. A 3 point ID was carried out and the OPG was taken. On visualising the image the radiographer sent the patient on as examination was complete, and informed the patient and their parent how to obtain their results. Radiographer went to send the OPG image to PACS, but accidentally hit the discard image button instead of save image button, (the 2 selections are directly beside one another) The image could not be retrieved due to the nature of the equipment so the patient will have to be re-xrayed, therefore is a radiation incident.	The Radiographer phoned the patients mother, apologizing stating the image had been lost and asked were they able to come back in for another x-ray. The patients mother stated she was unable to bring her back in today and the earliest would be Monday morning, and agreed to come in 15.03.21 in the morning.		Being reviewed	
Personal	11/03/2021	00:30	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Insignificant	patient admitted to ward Ed with cellulitis and uses cpap at night time. patient transferred to ward to be admitted to red area in D bay with another patient on CPAP. However when patient arrived she stated that she did not have her machine and therefore there was no bed space available for her. currently being nursed in corridor with screens around patient.	bed manager and medics aware. asked to borrow cpap machine from 2 north however patient unaware of settings and medics unhappy to prescribe same. no family able to bring machine up or know settings. bed manager and medics aware of same asked bed manger to source patient a be as highly inappropriate and unsafe that patient nursed in corridor with no oxygen outlet or space in case of emergency	Insufficient handover between ward staff, Patient flow and ED. Shared with Lead nurses to raise with nursing staff for learning	Final approval	11/03/2021
Personal	11/03/2021	02:43	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	1 East Maternity/Gynae	Insignificant	Security called to ward 5 at 0243 to assist with a male patient. Patient was at the door and wanted to go home. Security staff and the doctor spoke to patient, he received medication and went back into the ward. Security left at 0315.	security called	None	Final approval	
Personal	11/03/2021	09:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	1 South Medical	Minor	Patient was to attend X-ray (current in-patient 1 south) for endoscopic placement of oesophageal stent. Escorted to department with HCA-insulin infusion and IVF in situ-no notes accompanied patient. Patient also did not have identification bracelet. Theater checklist not completed and not dressed in OT gown. Patient assisted to return to ward and ward staff advised re preparation for procedure (Ward had also been contacted night before by X-ray nursing staff and prep advise given).	Patient was returned to ward by X-Ray Nursing staff, who advised ward staff to appropriate procedural prep. Manager aware of above incident. Procedure was delayed but completed.	Importance of patients having 2 x armband insitu to ensure safe and accurate patient identification can be made Importance of a nurse transfer for procedures to ensure effective information transfer of all necessary information. Importance of effective communication surrounding patients attending for procedures during handovers Importance of completing of a robust handover process including all specific checklists, notes and gowns	Final approval	16/03/2021

Personal	11/03/2021	20:20	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	2 South Medical	Insignificant	Female patient informed HCA who had found pill box on patient's table whilst doing NEWS Reviews of patient, that she had taken 4 tablets as per her routine at home. On immediate follow up patient confirmed taking 4 tablets for her liver disease as per her home routine ie 2 tablets in the morning and 2 in the evening. The pill box was not labelled but patient described the tablets as being white, oval in shape	1. Patient advised that while in Hospital she should only take tablets prescribed by Dr and administered by a Nurse. 2. Pill box locked away in patient's Pod with her permission 3. 22 hours medication withheld and reason explained to patient 4. Coordinator and Dr informed - Plan withhold 22hrs medicine, Bloods for liver function, UEs, FBC ESR, CRP to be taken in the morning	staff to ensure that they question all patients on admission in regards to own medications brought into hospital.	Final approval	12/03/2021
Personal	11/03/2021	09:30	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	TRANSITION WARD	Minor	Patient with a history of seizures brought to transition ward. Patient initially well on arrival. Patient went into TC seizure on ward. Staff immediately attended patient. Doctor asked for Lorazepam - none available on ward. Staff member had to run to ED to get some. In interim seizing spontaneously stopped but patient dropped GCS to 3/15 and lost her airway. Crash trolley called for and 02 applied. Airway asked for. Staff unable to get into crash trolley to get airway. Suction asked for. Suction point not available above bedside. Crash team called for assistance and staff member ran to get another crash trolley. Patients airway held open manually with head tilt and chin lift. Patients GCS improved to the point she could maintain own airway and was nursed in recovery position. Crash team stood down on arrival.	Lorazepam immediately ordered for ward. Staff members familiarized themselves with crash trolley. Patient moved to bed space were suction was available. Senior medical and nursing teams updated re incident.	Ensuring that all staff are aware of how to open crash trolley, especially new staff coming from other areas. Ensuring that patients are appropriately placed within the ward.	Final approval	18/03/2021
Personal	11/03/2021	13:20	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	patient came in from home with grade 2 pressure sore on buttock, buttocks extremely red and blanching. first contact with patient at 13:10 skin checked at13:20 .	pressure area care given. informed nurse in charge. hospital bed ordered regular pressure area care given	Early recognition and intervention for pressure damage essential in the Emergency Department	Being reviewed	
Personal	11/03/2021	20:40	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Moderate	Needlestick injury while disposing of arterial line (hollow) needle used on patient. Wearing gloves.	First aid Patient risk assessed by another colleague Blood taken for storage		Being reviewed	
Personal	11/03/2021	11:00	South Tyrone Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Ramone Day Clinical Centre	Minor	Patient attended DCC for IV Infliximab infusion. Had an immediate reaction to the drug as soon as the infusion was started. Became cyanosed and complained of chest tightness and shortness of breath. Became hypotensive and sweaty.	Infusion immediately stopped. Clinical observations checked. Oxygen 15l/min administered. Doctor and colleagues/team informed and attended to the patient. Treated with Hydrocortisone, Chlorpenamine, Salbutamol nebs,IVF 500 NACL,IV paracetamol all given with good results.Transfered to CAH ED Via NIAS.		In holding area, awaiting review	
Personal	11/03/2021	15:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Minor	Patient was being wheeled back from scan by porter. When entering AMU, the dinner trolley's had arrived. The porter tried moving he trolley's and when doing this, the porter had pulled the wheelchair back quite quickly to prevent the patient getting hit. During this time, the patient complained of neck and back pain.	Patient was able to transfer back to bed independently. SHO was informed. CT scan was arranged to exclude any fractures	All actions appropriate.	Final approval	11/03/2021
Personal	11/03/2021	14:30	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Minor	Patient admitted to AMU from transition ward at approx. 14:30. Patient had an IV perfusor pump connected with unknown substance. No labels or stickers on the syringe, running at 40mls/hour.	Transition ward informed. Datix completed.	Staff must follow correct procedures for the administration of medications.	Final approval	18/03/2021
Personal	11/03/2021	10:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	ORTHSU	Orthopaedic Ward	Minor	Nurse in charge of patient not ordering medications to be administered to patient. Beclometasone 100micrograms/dose breath actuated inhaler - brand ideally should have also have been specifically prescribed, prescribed as two puffs twice daily. Patient was admitted to the ward on 11/03/2021 and all doses for 11th and 12th marked as medication not available on the Kardex. This could have been ordered through pharmacy by the named nurse.	I informed the patient that this hadn't been administered, she was aware of this and on discharge planned to take this immediately when she gets home today. She was happy with this outcome.	always order drugs if not available on the ward	Final approval	15/03/2021
Personal	11/03/2021	18:00	Daisy Hill Hospital	Functional Support Services	LOCNE	CATNE	Kitchen	Minor	B was taking a patient trolley to be plugged in, B needed to manoeuvre the trolley into the provided space which caused her to bang her wrist on the guard surrounding the emergency stop button.	On Friday morning B complained about her wrist being sore from the previous nights accident, I advised B to attend A&E to get her wrist checked.	none	Final approval	16/03/2021
Personal	11/03/2021	08:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	CEAW	Minor	patient was coming to 1 west for a procedure lift became out of order even though it was reported to lift company day previous and problem was sorted	ward clerk informed housekeeper who rang estates straight away and filled in a request on portal. estates contacted lift company as a matter of urgency. Porter had to bring patients trough 1 north(which is a breach of protocol)	same was reported to lift company as urgent	Final approval	11/03/2021

Personal	11/03/2021	12:00	Craigavon Area Hospital	Medicine and Unscheduled Care	CSMUC	CARDIO	Cardiac Catheterisation Lab	Insignificant	Midazolam 7mgs given for sedation instead of the safe sedaton policy amount which is 5mg.	ward manager informed. no adverse effect but goes against our policy of safe sedation. To be reviewed with the anaesthetic team.	none Procedure carried out safely, no adverse reaction to the medication. No issues post procedure, patient discharged home as per protocol	Final approval	
Personal	11/03/2021	10:00	Craigavon Area Hospital	Medicine and Unscheduled Care	CSMUC	CARDIO	1 North Cardiology	Minor	8 patient medication lockers opened when check was carried out this morning. All lockers in Bay 3 East side, side rooms 3,4 and 5 and bay 2 bed 3 on the east side also.	Lockers locked	Staff informed about the importance of safe storage of medication	Final approval	22/03/2021
Personal	11/03/2021	19:00	Daisy Hill Hospital	Surgery and Elective Care	GENSUR	GENSUR	High Dependency Unit	Insignificant	Patient stated to the physio he fell on the evening of 11th march 2021. the patient did not tell any staff at the time of the incident and this was an unwitnessed fall. The patient states he stumbled getting into bed and fell on his right knee. The patient states he got up quickly and got into bed . The patient states he did not hurt himself.	The patient was asked about the incident, the patient states he stumbled getting into bed and fell on his right knee same examined no obvious injury noted patient states he did not hurt himself and was able to get into self he did not inform staff. Patient advised to use call buzzer system as he requires supervision for mobilizing. Falls assessment reassessed and bed rails assessment completed. At risk of falls sign on patients door. Patient advised to call for help when needed.	none	Final approval	21/03/2021
Personal	11/03/2021	02:00	Daisy Hill Hospital	Surgery and Elective Care	GENSUR	GENSUR	Female Surgical/Gynae	Insignificant	Patient called disabled toilet call buzzer. toilet door locked from inside. pt had mobilized to toilet independently. door unlocked from outside. pt found kneeling on floor, head at toilet level. pt voiced he was kneeling down to clean toilet after opening his bowels	observations checked, GCS commenced, bed manager bleeped to inform doctor, visual check for any injuries, pt assisted into chair, brought back to bed, examined by doctor 1/2 hourly observations + GCS carried out as per FY1	0	Final approval	21/03/2021
Personal	11/03/2021	07:10	Daisy Hill Hospital	Surgery and Elective Care	GENSUR	GENSUR	Female Surgical/Gynae	Insignificant	while attending a patient with the DR Pt was squeezing staff hand felt faint collapsed	Dr Bara F2 checked staff member no neuro defect BS news Neuro obs checked	0	Final approval	21/03/2021
Personal	11/03/2021	15:20	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	TRANSITION WARD	Minor	This is a case of a Personal -old female who was admitted due to confusion and a recent d/c on 25/2/21. She is confused however very settled. At around 1520, she hit her right lower leg(shin) on the side rail and created a skin break approximately 3cmx3cm. Prior to the skin break, there was already bruise-like that looks very fragile.	The incident was known to the medical and nursing team. The doctor made aware and agreed to apply a foam non-adhesive dressing over the skin tear. Thus, dressings applied aseptically with no active bleeding. Patient remains pain-free with no signs of discomfort. Nevertheless, skin check was done and no further breaks noted.	Risk of unsettled patients causing damage to themselves while in bed due to their frail skin must be recorded in patient notes	Final approval	15/03/2021
Personal	11/03/2021	08:30	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Insignificant	Lockers left unlocked with medications inside 3 North Med bay 2 bed 4 sr5 3 North Stroke bay 1 bed 2	lockers closed or for those where nurse didn't have fob that worked with locker. Medications removed into pharmacy room cupboard that locked	Importance of ensuring equipment is working. Importance of highlighting issues such as this during the safety briefing to ensure all staff are aware.	Final approval	15/03/2021
Personal	11/03/2021	08:30	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Insignificant	LOCKER UNLOCKED 3 SOUTH BACK BAY 1 BED 2 BAY 2 BED 1 BAY 2 BED 4 FRONT BAY 2 BED 3 BAY 2 BED 4 ROOM 4	WARD SISTERS INFORMED LOCKERS LOCKED BY MYSELF	Always keep medication locked	Final approval	16/03/2021
Personal	12/03/2021	11:45	Community	Pharmacy	PHARM	PHASEP	South Lakes Leisure Centre	Insignificant	Full covid vaccine vial discarded (six doses) as grey particle seen floating in the liquid.	Vial quarantined and datix submitted		In holding area, awaiting review	
Personal	12/03/2021	09:05	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	CANCER	HAEMNU	Pharmacy Aseptic Unit	Minor	Medication sent to incorrect patient address. The patient moved from Personal , Personal to Personal Information redacted by which was updated on ECR. The patients prescription chart for the oral chemotherapy, Ibrutinib had the incorrect address and therefore a taxi was ordered for delivery to this address on 12/3/21. The patient contacted the aseptic pharmacy department to inform us she had not received the expected delivery of medication and wondered what address we had sent it to. On reviewing the taxi request sent, it was confirmed that the medication was delivered to the incorrect address.	Transport was contacted to visit 3 Fairview Park and retrieve the medication. The medication was delivered back to aseptic pharmacy department to check no medication had been taken. On confirmation of this the medication was then delivered to the correct location.		In holding area, awaiting review	
Personal	12/03/2021	11:30	Craigavon Area Hospital	Medicine and Unscheduled Care	CSMUC	CARDIO	1 North Cardiology	Minor	1 patient medicine locker unlocked at 11.30 am it was Bay 1 Bed 1 East side	Locked patients medicine locker	The importance of locking lockers, for safe medication storage.	Final approval	22/03/2021
Personal	12/03/2021	12:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Ward 3b	Minor	Per admitted with DTI24/5/21.Very dry scaly shin on legs and feet Dry cracked skin noted on heels. Dry skin washed with dermol, Dual star mattress, repositioned chart 12/3/21 Dry skin revealed a grade (2) 2cmx1cm clean and dry dressed with urgo clean. NOK informed	Dressed daily and condition reported Pervious pressure ulcer on right heel District nurse calling for skin checks in the community	importance of skin check	Final approval	24/03/2021
Personal	12/03/2021	13:10	Daisy Hill Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, DHH	Minor	Patient had a normal delivery of a stillborn infant at 24 weeks of a known Turners Syndrome infant, with associated Hydrops and cardiac abnormalities	Patient received all the care required, and appropriate documentation was completed.		Being reviewed	

Personal	12/03/2021	14:15	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	small Grade 4 on sacrum. Patient states they sit long periods of time on a chair at home.	Grade 4 cleansed and dressed. Nurse in charge informed.	Recommendations; Elevate heels. TVN referral. ? if patient being seen in community for wound care,as has carers into home should've been escalated in community.	Being reviewed	
Personal	12/03/2021	11:50	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Coronary Care Ward	Insignificant	Security called to male medical, on arrival a patient was trying to leave the ward. The patient started acting aggressively towards nursing staff, security went to medium level MAPA holds escorting the patient back to his bed. Security staff continued to hold the patient whilst medication was administered, security stood down at 1215.	none	none	Final approval	15/03/2021
Personal	12/03/2021	14:25	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Coronary Care Ward	Insignificant	Security called to male medical patient was confused and aggressive trying to hit out at nursing staff, medication was administered. MAPA holds in place whilst medication given. Security stood down at 1615. Security called again at 1635 to 1655	none	none	Final approval	15/03/2021
Personal	12/03/2021	16:15	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, CAH	Insignificant	Caesarian section set no 039757 returned from delivery suite cah. when ATO KC was checking tray in SSD Wash area she observed a small yellow sharps box containing 2 green sheathed needles,2 blades,4 curved needles, 1 straight needle & 1 diathermy blade left on tray	SATO SW Disposed of all sharps in sharps box . near miss incident	To ensure that all CSSD trays are sent back fully checked and with no additional items such as sharps boxes on the tray.	Final approval	22/03/2021
Personal	12/03/2021	00:40	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	Emergency Department CAH	Minor	Security informed by ED Yellow area that a patient of theirs had absconded.	Security checked all areas as per our SOPs and did not manage to locate the male patient. Security reported back to ED Yellow area who then told Security that he was located and found in Banbridge.	None	Final approval	
Personal	12/03/2021	00:20	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	pt left department before treatment completed. Alcohol level high and had CT brain. Report awaited.	absconding protocol commenced. PSNI contacted. NOK contacted. ED dr spoke with pt's girlfriend. Ed dr happy pt did not need to return to ED as he was with a responsible adult. CT brain NAD. PSNI updated.	Keep patients at risk of absconding in area visible to staff.	Being reviewed	
Personal	12/03/2021	04:02	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, CAH	Minor	Shoulder dystocia delivery of a live male infant at 0402hrs.	Ward activity very high at present, datix completed as per handover. At 0345hrs- client bradycardia noted and Registrar Dr Ali and sister Person attended. At 0350hrs - Legs into stirups and full dilatation confirmed. Preparations for instrumental delivery commenced for instance instrumental trolley brought into the room and Peads bleeped at 0355hrs. 0400hrs - Head delivered spontaneously with legs in McRoberts position, shoulder dystocia noted. 0401hrs - Suprapubic pressure applied by sister Person and posterior shoulder applied by Dr Ali. 0402hrs - Vaginal delivery of a lie male infant with apgar scores of 8 at 1, 9 at 5 mins. PHs: A - 7.252, BE: - 4.6 and V: 7.335; BE: -5.5.		Being reviewed	
Personal	12/03/2021	05:32	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Patient detained under mental health act by approved social worker & out of hour GP. Patient booked a bed in bluestone unit cloughmore ward. Despite being told multiple times by nursing staff that we book ambulances for patients to transfer to bluestone due to risk of absconding; approved social worker insisted on walking patient to bluestone with herself and her mum. Social worker informed staff that she always walks detained patients across to bluestone. During their walk to bluestone patient absconded and social worker arrived back to A&E to advise us of same and we would need to activate our absconding protocol.	Absconding protocol commenced 05:32am. whilst on the phone to PSNI call handler ED reception staff informed us that the patient had arrived back to emergency department reception. PSNI informed that patient had returned safely to emergency department. Nurse in charge informed. Approved social worker went to reception to speak to patient and left the department again to walk patient to bluestone.	Ensure correct protocol for transfer of a detained patient is adhered to and escalate if any issues occur to prevent this happening. To be discussed at ED safety brief.	Being reviewed	
Personal	12/03/2021	00:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	Ramone Ward 4	Insignificant	pharmacist carried out a drug history and med rec on patient when she was admitted to Frailty Ward, CAH. The times of her Metformin were 1000 and 2200 - Pharmacist amended these on the Kardex to be with meals as per pre-admission, so 1000, 1800. Pharmacist had crossed out the 2200 time and put a line through, while also circling the 1800 time. Unfortunately, the patient did not receive their Metformin at 1800 for 4 days (this was noticed at discharge).	On checking her BMs for the past 4 days, they were actually at the lower end of the range (4-6) so it was decided to keep her at a dose of Metformin once a day and for GP to monitor BMs post-discharge.	ensure that all medication that needs amended is rewritten in future.	Final approval	26/03/2021

Personal	12/03/2021	00:04	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	ICU CAH	Minor	Security's pager went of for ICU.	Security attended and were then informed that the panic button was hit by accident. Security were then stood down.	None	Final approval	
Personal	12/03/2021	04:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	STROKE	3 North Stroke	Minor	Loud thud heard from nurses station, on investigation patient found lying on floor at base of bed, IPC stocking still in place and bed sides up. Buzzer in side room not working.	Nursing assessment completed, normal power to all limbs no complaints of pain small bruise noted to top of head on left side close to hair line, skin tear noted to right wrist beside cannula site. Assisted back to bed and clinical observations completed and normal.	post fall pathway not completed, discussed with staff in patient safety briefing.	Being reviewed	
Personal	12/03/2021	19:20	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	ORTHSU	Orthopaedic Ward	Minor	Patient had NG tube inserted 12/3/21. Due for NG feed at 1900. PH checked at 1915 = 7.0 Feed commenced at 1920 and ran overnight for 12 hours. Ph should have been 5.5 or below. Error noticed on night shift 13/3/21.	Patient informed	Always follow guidelines. Ongoing training for refreshment as staff have not had NG feeding consistently on the ward	Final approval	16/03/2021
Personal	12/03/2021	10:30	Craigavon Area Hospital	Surgery and Elective Care	ATICS	ANAES	Theatres 5-8 CAH	Moderate	Fixation of shoulder injury on Trauma List. PMH Hypertension GORD DH Irbesartan Omeprazole Previous gynae surgery No History of Allergy Had awake interscalene block then modified RSI. Increasing airway pressures 30 mins into case Patient draped and in deck chair position Concerns regarding tube position investigated and satisfactory Unsatisfactory capnograph trace. Concern over mechanical obstruction of airway. second dose of rocuronium given Increasing bronchospasm reduced lung compliance on manual ventilation with ambu bag bradycardia then 20-30 seconds asystole adrenaline given improvement in ventilation adrenaline infusion commenced remaining drugs given as per anaphylaxis protocol patient successfully extubated but requiring ongoing adrenaline infusion	patient referred to ICU for follow up and moved to recovery on adrenaline No ICU bed available ICU agree to review	To continue to be prepared for anesthetic complication and to adhere to protocol for management of same.	Being reviewed	
Personal	12/03/2021	09:34	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, CAH	Minor	Infant born GA section for brow presentation, admitted to NNU with same and tachypnea	Admitted to NNU		Being reviewed	
Personal	12/03/2021	21:15	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	3 North Medicine	Insignificant	Security fast bleeped to attend 3 North as a female patient had become aggressive towards staff and was refusing to return to her bed.	Security arrived to 3 North and witnessed a confused female patient refusing to return to her bed. Security tried talking to the patient asking her to walk back to her bed, at this point the female began to strike out with her fists so Security escorted her back to bed using MAPA. whilst doing so the female patient continued to attempt to punch kick and bite staff. Once the patient was back to her bed she received medication which was administered by the nursing staff. She then began to settle and security were then stood down.	Importance of highlighting aggressive patients on safety brief and during handover. Importance of using 'this is me' and discussing with family the patient's preferences and if there are any effective distraction therapies we could use to de escalate behaviors.	Final approval	
Personal	12/03/2021	21:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Insignificant	Patient becoming very agitated and aggressive raising zimmer frame to the staff. Security called site coordinator present lorazepam 1mg given s/c. with settling effect.	The site coordinator was called and presnt	Importance of highlighting patients who have potential of aggression on safety brief. Importance of regular medic review to ensure medication used is appropriate and effective. Importance of delirium pathway, de escalation therapies and using this is me to prevent agitation and aggression	Final approval	15/03/2021
Personal	12/03/2021	05:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	IBD Nurses	Minor	whist giving an IM injection patient moved and received an needle stick injury	First aid, needle stick injury protocol followed		In holding area, awaiting review	
Personal	12/03/2021	12:00	Craigavon Area Hospital	Medicine and Unscheduled Care	CSMUC	CARDIO	Cardiac Catheterisation Lab	Minor	Midazolam which was supposed to be disposed of found in side room 1 day after procedure carried out. The Doctor was supposed to have disposed of the remaining unused vial. This was signed in the cd book by two doctors that they had disposed of it..	Another consultant approached me that 3mls of Midazolam was sitting in the side room. I escalated this to the sister on the ward. I locked away this amount until the consultant involved was contacted. This was then disposed of and signed by the consultant involved.	proper checking and disposal should be maintianed at all times	Final approval	24/03/2021
Personal	12/03/2021	22:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	ORTHSU	Orthopaedic Ward	Minor	when I was administering clexane patient was confused that time attempted to push my hand away and the needle slipped and went into my index finger	bed manager and clinical coordinator informed FY1 done the risk assessment,patient informed and consent obtained blood taken from patient and mine occupational health to contact on monday	if patient confused bring second member of staff to ensure needle stick doesn't occur.	Final approval	15/03/2021
Personal	12/03/2021	23:35	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, CAH	Minor	during a normal vaginal delivery the patient sustained a 3rd degree tear at birth of baby	the patient was taken to theatre for repair	Repair as per procedure . No debrief or RCOG leaflet given	Final approval	31/03/2021

Personal	12/03/2021	18:40	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	2 South Medical	Insignificant	DRUG ERROR. DISCREPINCENY NOTED IN CD BOOK. APPEARS PATIENT HAS HAD DOUBLE DOSE OF ORMORPH ON 11/03/2021 22:00. PATIENT PRESCRIBED 2MG = TO 1ML, AVAILABLE STRENGHT 10MG IN 5MLS.ON THE DOES GIVEN AT THIS TIME IT HAS BEEN NOTED THAT 2MLS WHERE REMOVED FROM BOTTLE.	ON NOTICING DISCREPIENCY, ON CALL PHARMISIST CONTACTED. SPOKE WITH Personal ADVISED TO NOT AMMEND BOOK (I WAS NOT GOING TO), TO COMPLETE DATIX, TO IMFORM STAFF COMING ON SHIFT TO BE VIDULANT OF DOSAGE. Personal INFORMED ME HE WOULD INFORM OUR WARD PHARMISIST Personal OF THIS ON MONDAY SO SHE CAN MEASURE OUR CONTENCE TO CHECK. I AM NOT AWARE OF ANY OTHER DISCREPENCIES		Being reviewed	
Personal	12/03/2021	04:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	ENT	3 South	Minor	patient is known 1:1 physically aggressive to two HCA's grabbed both their arms on two separate occasion. one of the HCA's has a evident purple bruise on her upper right arm	report to nurse looking after the patient will notify Ward Manager in am	nil	Final approval	16/03/2021
Personal	12/03/2021	18:45	Community	IMWH - Cancer and Clinical Services	MIDWIF	COMM	Home of client	Moderate	BABY VISITED ON DAY 3 AT HOME AND NOTED TO HAVE MARK ON OUTER LEFT LOWER LEG, WHICH [AS WELL AS BIRTH MARK ON NAPE OF NECK AND SPOT ON INNER CORNER OF LEFT EYE],WAS NOT RECORDED IN RED BOOK. BRUISING OF BABY PROTOCOL INITIATED. PHOTOGRAPHS THEN SUBMITTED BY PARENTS, AND VIEWED AND ACCEPTED BY CONSULTANT.	LINE MANAGER INFORMED PAEDIATRIC REGISTRAR INFORMED		Being reviewed	
Personal	12/03/2021	10:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Ward 3b	Insignificant	Personal got up from chair to see her notes at the end of her bed, over balanced and fell back onto her. witnessed fall at bedside by nursing staff.	Assessed for injury, no evidence of injury, assisted into bed. Dr S Nixon informed, assessed in bed. falls pathway commenced. able to recall events. no head injury- no need for CT head. impression loss of equilibrium. plan followed as per Dr Nixon. post fall nurse/doctor document completed. nursing assessments updated. family updated by SN Per.	importance of minimizing falls risk as history of falls.	Final approval	24/03/2021
Personal	12/03/2021	09:59	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	3 South	Moderate	Medicine written as Valproic Acid on Kardex but Sodium Valproate (Epilim/Chrono) given tiotropium 10mcg inhaler given, should have been 2.5mg but medic had not stated dose Budesonide inhaler no dose so was not given Transtec patch had no dose so not given Vit b co Rxd, should have been Vit B Co Strong	Ward Manager and Pharmacist informed correct medicines supplied and Kardex endorsed to make it clear the correct med was given	medics to ensure all elements of prescription are complete. Nurses to ensure any missing elements are escalated.	Final approval	13/03/2021
Personal	12/03/2021	10:30	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	GENSUR	4 North	Minor	Medicine trolley closed on finger of staff causing a laceration, swelling and bruising. Staff member then felt faint.	First aid given. Staff assisted to lie down due to feeling faint.	as above	Final approval	15/03/2021
Personal	12/03/2021	09:35	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	Patient sent to ward with no COVID swab. Handed over to nursing staff swab negative. While check-listing this patient for theatre and attempting to print out COVID result, no result on either LABS or NIECR.	would check Lumera list and get back to me. Re-contacted ward mobile @ 10.15 to inform there was no swab ever done in ED. I escalated my concerns regarding this as on multiple occasions this week I have had to ring down to ED to query swab results as they are not coming up on LABS/NIECR and there is no result print out in patients notes on admission so we are only going off a handover which is unacceptable. Advised by ED NIC it is the responsibility of the bed manager to ensure the patient has a negative swab prior to admission to the ward not ED staff. At this time consultant had called me away to have difficult conversation with patient. Advised nursing staff to pull curtains & ask patient to wear mask until I could plan. Patient is distanced from other patients in bay. Contacted bed manager @ 11.15 to inform of issue with this swab. Bed manager contacted ED NIC who declined allowing a Lumera swab to be completed as this patient was no longer in ED.	0	Being reviewed	26/03/2021
Personal	12/03/2021	02:30	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	Patient taken overdose of prescription medication and feeling suicidal absconded from ED	NIC aware, Security contacted and hospital grounds searched, Patient contacted via mobile - (no answer), reported to the police. ED protocol followed and documented in patients notes	nil	Being reviewed	
Personal	12/03/2021	14:30	Craigavon Area Hospital	Surgery and Elective Care	ATICS	THEAT	Theatres 1-4 CAH	Minor	Theatre 1 busy with ongoing emergency case.	2nd theatre opened for bleeding evacuation of uterus.	This is the nature of the Emergency theatre	Final approval	29/03/2021
Personal	12/03/2021	10:50	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	2 West Maternity Post Natal	Minor	sustained needle stick injury whilst taking patient blood	first aid, bled site and run under water. blood taken from staff member and patient as per guidelines OH informed	To ensure own personal safety when taking bloods and adhere to policy and good technique.	Final approval	22/03/2021

Personal	13/03/2021	09:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Entrance/Exit	Minor	a copy of the medical 'on take' handover sheets for 12.03.21 were found sitting on reception in the foyer. this included confidential patient information. It was found by a member of ED staff as they walked by	handover sheet stored in ed office Datix completed		In holding area, awaiting review	
Personal	13/03/2021	01:43	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Presented to emergency department having TLNWL & alcohol onboard. Seen by ED doctor and referred to learning disability crisis team. Left department prior to being seen as they only see patients in the morning and not out of hours.	Absconding protocol commenced as per policy.	Keep patients at risk of absconding in area visible to staff.	Being reviewed	
Personal	13/03/2021	11:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Ward 3b	Minor	G2 noted on R heel. Patient already on pressure relieving mattress and repositioned 4-6 hourly.	Patient aware of pressure damage and states will inform NOK. Band 6 sister of ward/NIC also informed of same.	this IS THE SAME INCIDENT AS Personal and being investigated	Final approval	24/03/2021
Personal	13/03/2021	01:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Female Medical	Minor	Found by staff confused and climbed out of bed. Assisted slid off the bed with staff.	Assessed and no injury noted. Re-assurance given to patient. Medical doctor informed	Nil	Final approval	18/03/2021
Personal	13/03/2021	20:25	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Coronary Care Ward	Insignificant	Security called to male medical for patient kicking out at staff, low level MAPA restrictions used to control patients movements. Patient settled down A short time later and security stood down at 2055	none	none	Final approval	15/03/2021
Personal	13/03/2021	15:55	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	GYNAE	1 East Maternity/Gynae	Minor	patient buzzed and student Nurse assisted Personal out of the chair and was going into bed,as Personal sat on the bed she slid off onto the floor slowly. No complaints of any pain. Personal did not hit her head. a witnessed fall.	Assisted off the floor and sat out in the chair . fy 1 bleeped and informed and advised CNS obs until reviewed. b.m checked. Personal daughter informed. reviewed see notes.		Being reviewed	
Personal	13/03/2021	14:20	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Insignificant	Patient under enhanced supervision due to high risk of falls. Patient had trip in bay while staff were supervising, did not hit head, went on to knees and then stood up again. No injury apparent.	Patient was ax into bed as was agitated at time and did not want to sit on chair but was not able to walk around bay due to poor mobility. Enhanced supervision maintained.	Importance of thorough handover, enhanced supervision and investigating any interventions/ distraction techniques that de escalate the patient's distress and agitation	Final approval	15/03/2021
Personal	13/03/2021	00:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	ORTHSU	Orthopaedic Ward	Minor	As handed over by night staff, review wound to sacrum today and redress accordingly. I reviewed this wound today and cleansed with sterile water and redressed with allevyn foam adhesive dressing. this was handed over to be the sacral area, when reviewing it was noted to be on left buttock area rather than sacral. It is evident that a grade 2 wound is visible to this area. this wound appears to be a pressure related wound rather than moisture related. Braden updated = 14. Must= 2. 4hrly repositioning insitu. Aria mattress insitu. unknown exact time of incident but passed over to day staff on morning of 13th march. admitted to ward with G1 to sacrum/buttock area	advised patient of importance of repositioning and encouraged to lie on sides to aid healing of wound.	always complete Repo charts in full.	Final approval	15/03/2021
Personal	13/03/2021	11:35	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	2 South Medical	Insignificant	patient trying to get out of the bed and slipped on to floor on his bottom. was witnessed by another patient who stated he did not hit his head.	patient assisted back to bed. clinical observations carried out, FY1 informed, CTB requested as patient on Apixaban.	Ensure member of staff in bay at all times	Final approval	30/03/2021
Personal	13/03/2021	22:18	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Minor	G2 pressure sore observed on sacrum	NIC informed, spoke to patient regarding relieving the pressure, however he declined to relieve off the side of his pressure sore	early recognition and intervention for pressure damage essential in the Emergency Department	Being reviewed	
Personal	13/03/2021	01:30	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Moderate	Pt arrived to AMU @0120hrs. on admission it was noted that pt did not receive their epilim chrono in ED.	Pt received medication when in amu as it is a critical med		Being reviewed	
Personal	13/03/2021	15:40	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	LABS	MICROB	Microbiology Lab	Insignificant	24.3.2021 Incident from BHSCT Patient attended COVID test at 15:40 on 13.3.21 at CAH prior to admission for elective surgery. No results available on 16.3.21. On 16.3.21 contacted mother of patient to confirm attendance COVID test. Contacted CAH labs and could not confirm any results of patient. Contacted RVH labs and unable to verify any result of the patient system. Contacted virology to confirm rapid COVID swab, mum ver upset 2nd swab needed but reassured by nursing staff on phone. COVID swab completed on arrival in patients car and brought directly to labs by Knox ward and staff.	1.4.2021 response to BHSCT attached		In holding area, awaiting review	01/04/2021
Personal	13/03/2021	03:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Female Medical	Minor	while in sideroom doing clinical observations patient stated that he was waken by a member of staff going thru his belongings with a pen torch in the middle of the night. Person did not state what they where looking and who they were just left the sideward and they did not speak.	nurse in charge informed, bed manager informed and patient ask if he wants to report it to the police. patient decline.	Discussed with staff at PSB that they must introduce themselves to patients when they enter side rooms and they must gain consent before looking and touching their belongings.	Final approval	19/03/2021

Personal	13/03/2021	01:15	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Presented to emergency department having been drinking vodka 1/52 and feeling suicidal today (12/3/21). Attempted to call patient from waiting area but patient had absconded. When patient was contacted on his mobile he returned to department but left soon after. Now unable to contact patients mobile.	Absconding protocol commenced as per policy.	Recommend full patient description write in notes at triage. Think about placement of patient need to be monitored until called into department? keep in triage room until room5 in GA available. Ensure all staff aware of risk. Patient was safe by PSNI in care of relative.	Being reviewed	
Personal	13/03/2021	06:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	General Male Medical,	Insignificant	Unwitnessed patient fall. Denied any head injury. No apparent injury. Assisted to bed. Doctor and nurse in charge made aware. Present on ward.	Clinical obsevrations checked. Checked for any apparent injury. None seen. Assisted into bed. Falls proforma followed. Lying and standing BP checked.NOK informed of fall and nurse in charge on ward aware.	to reiterate to staff the importance of updating risk assessments post fall - applied to safety brief. the importance of the use of monitoring tools i.e GMAWs to monitor patient and to manage medications.	Final approval	24/03/2021
Personal	13/03/2021	21:20	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	GENSUR	4 North	Minor	Bay 3 Bed 4 4 North. FY1 attended patient to re cannulate. Bed rail was left down and Dr left ward. Patient rolled over, and fell from bed to the floor on L side. Witnessed by myself and SN Canning.FY1 informed, Initial observations recorded, CNS observations followed, no obvious injury, all limbs checked, no obvious head injury. DR reviewed patient, CTB ordered. Nil acute.	Daughter contacted and very unhappy, requested to visit mother. Escalated to clinical coordinator, and bed manager, and SHO Jack. Daughter attended ward - where bed manager, clinical coordinator, SHO and myself in attendance held meeting, formal complaints procedure given. Daughter very unhappy with FY1 and wishes to complain.	as above	Final approval	15/03/2021
Personal	13/03/2021	11:45	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Insignificant	Grade 2 pressure sore noticed on patient, between buttocks skin broken on both sides. on further rv moisture lesion not grade 2	patient already on pressure relieving mattress. wound dressing applied to area, wound assessment chart be commenced, TVN referral to be completed. patient to be assessed for a pressure relieving cushion for bedside chart, Nurse in charge informed, patient currently on skin bundle continue to reposition regularly while in bed and ensure pressure in limited in affected area	Importance of correct identification between moisture lesions and pressure damage.	Final approval	15/03/2021
Personal	13/03/2021	06:40	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	patient transferred to amu without a handover and without contacting ward first. Was informed that patient needed telemrty by bed manager patient arrived with no telemetry or handover. A+E staff member stated that sister Perso gave a handover before arrival when she hadn't.	contacted a+e ward to receive handover, contacted bed manager, and datix completed		Being reviewed	
Personal	13/03/2021	01:43	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	Emergency Department CAH	Minor	Security informed by ED Green Area that a female patient had absconded from their ward and were then tasked to search for her.	Security searched all areas as per our SOPs and managed to locate the patient at the roundabout at the main entrance to the hospital. Security informed ED Green area of her whereabouts so they could pass the message on to the Police if needed.	None	Final approval	
Personal	13/03/2021	19:00	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	2 West Maternity Post Natal	Minor	Infant Personal transferred to Neonatal Unit due to poor feeding.	Admitted to neonatal unit and tube fed	appropriate o transfer to the NNU for feeding support.	Final approval	31/03/2021
Personal	13/03/2021	06:15	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Moderate	Person attended CAH ED this morning at 0611 via ambulance after being found by police outside a shop with new self harm marks to arms. Left CAH ED before triage at 0615 and refused to stay.	Police contact & appendix c completed Sister & Doctor incharge informed.	Protocol followed for absconding patient. MHRA completed at triage. Important follow up as high risk mental health patients.	Being reviewed	
Personal	13/03/2021	19:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	Frailty Ward	Minor	MEDICATION BOX CONTAINING 5 TABLETS OF 2.5MG BENDROFLUMETHIAZIDE (FULL BOX OF 28 TABLETS DISPENSED ON 17/2/21)WITH A LABLE ON THE BOX SAYING BISPROLOL 2.5MG TABLETS. PATIENT PRESCRIBED BISOPROLOL 2.5MG, PATIENT HAS OWN MEDS IN HER SUITCASE. WHILST THE PATIENT HAS BEEN AN INPATIENT (12/3/21) THEY HAVE BEEN RECIEVEDING THE CORRECT MEDICAITION BISOPROLOL 2.5MG.	FY1 INFORMED NIL ORDERED AT PRESENT, TO BE DISCUSSED ON MEDICAL WARD ROUND IN AM, PATIENT CURRENTLY BEING TREATED FOR HYPONATRAEMIA ? IF RELATED	good practice shared. Importance of robust review of patients own medication before use in the hospital setting	Final approval	22/03/2021
Personal	13/03/2021	19:32	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	patient was brought in by ambulance following trauma, had fell 8ft off a ladder and car trailer landed on patient's chest. No standby call placed. No attempt to alert staff on arrival by NIAS crew	Patient placed in RESUS 3 Trauma bleep activated PAN scan carried out patient admitted to surgical flow for observation		Being reviewed	
Personal	13/03/2021	18:00	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	MIU	Emergency Department DHH	Minor	Trying to remove thorns from a patients feet with a hypodermic needle and sustained a Needlestick injury to right thumb	immediate first aid at time of incident		Being reviewed	

Personal	13/03/2021	00:33	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	Emergency Department CAH	Minor	Security informed by ED Green Area that a male patient had absconded from their ward and had not been seen for around 15 minutes.	Security searched all areas as per our SOPs and did not manage to located the patient, Security then informed the Green Area that the patient was not found. At 01:25am ED Green Area phoned again about the same patient and informed Security that he was last seen heading towards Bluestone. Security then went up and searched that surrounding area and still did not located the male patient. ED Green Area where informed of the unsuccessful search.	None	Final approval	
Personal	14/03/2021	11:00	Community	IMWH - Cancer and Clinical Services	MIDWIF	COMM	Banbridge HSSC	Minor	Doing BR for Personal found information belonging to Personal in notes which contained sensitive information	Information removed from notes & returned to ANC DHH		Being reviewed	
Personal	14/03/2021	14:15	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Female Medical	Minor	Another patient notified me that patient x had slipped onto the floor. whilst I was participating in a CD administration in the treatment room. Upon returning to the bay patient x was sitting upright on the floor. He stated he had some pain in his back. Ax2 given to get Patient back into bed. Observations taken. Paracetamol administered and doctor notified.	Ax2 given to get patient back into bed. Doctor notified and nurse in charge notified. Paracetamol administered and full bodily skin check observed. Patients next of kin notifed of fall. Patient to be monitored 1-1	Nil	Final approval	23/03/2021
Personal	14/03/2021	06:45	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Stroke	Insignificant	Patient allocated a ward (3 north stroke) by bed management. After numerous phonecalls to hand over the patient to the ward RN then contacted the bed manager to inform 3N were not picking up the phone. When RN finally got through to the ward whomever answered the phone forgot to put the phone on hold, RN overheard them having a conversation about how they have been ignoring phonecalls from ED (therefore ignoring handovers.	RN informed 3N that they had overheard the conversation, RN then informed the bed manager and the nurse in charge. 3N now also not answering phonecalls from bed management.	Previous complaints about lack of phone calls being answered. Staff all informed its everyone's responsibility to answer phones	Being reviewed	
Personal	14/03/2021	05:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Minor	Patient mobilising unaided. When asked what the patient needed they immediately raised their zimmer to hit staff with it. De-escalation techniques attempted but unsuccessful. Patient extremely violent towards staff, hitting, punching and kicking staff. Assisted to chair with AX2 staff, shouting and screaming at top of voice, continues to be aggressive towards staff, continues to kick and punch. Violent behavior towards staff is ongoing and does not appear to be improving, continues to assault staff continually. Extremely high risk of staff injury. Disrupting the entire ward & putting other patients at risk when all staff members required to attend to patient.	De-escalation techniques attempted but unsuccessful. Oral sedation refused. Handover from daystaff was to avoid IM sedation where possible, so have held off presently. Assisted to commode once calmed down. DATIX completed. Nurse in charge to be made aware in am. Needs to be reviewed by medics in the morning due to ongoing assault on staff members. Feel needs to be reviewed urgently by psych.	Importance of highlighting patients who can be aggressive towards staff on safety brief. Importance of 'This is me' being completed, and distraction techniques/ interventions attempted to de-escalate behaviors	Final approval	15/03/2021
Personal	14/03/2021	13:20	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	3 North Stroke	Insignificant	patient stood up to go to the toilet/urinal,HCA went to help. Patient was noted to be incontinent of faeces. HCA pulled the curtain to maintain dignity. Patient went forward and fell to the floor. HCA witnessed the incident.	Ensure environment is safe, assessed for any injury. Able to move upper and lower limbs.Helped/assisted back to bed.Observation and GCS done.Falls protocol observed.Doctor informed and seen the patient.Family informed.	Importance that all staff know the mobility needs of patients within their care. Importance patients risk of falling is communicated to all staff members at ward safety brief and highlighted as a falling staff on the whiteboard posters Its important that staff are aware of patients mobility needs.The importance of highlighting Risk of falls in safety briefing and during handover.Also making the staff aware by putting falling star in the patient's bedside board.	Final approval	19/03/2021
Personal	14/03/2021	22:30	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Insignificant	Patient was found sitting on the floor	assistance of 2 staff required to stand patient and help her to lie on the bed examination done no injuries found observations commenced as per falls protocol	Importance of communicating all patients at high risk of falls at ward safety brief to all staff members	Final approval	22/03/2021
Personal	14/03/2021	23:40	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Female Medical	Insignificant	Security called to female medical ward on arrival security team informed patient had been aggressive towards staff, patient appeared to be confused as to where he was and continued to show aggressive behavior towards security staff. low level MAPA techniques were used to restrain and escort patient back to his bed. Nursing staff were going to administer medication for the patient so security staff continued to restrain the patient using our MAPA techniques, after a while medication took effect and security were stood down at 0115.	none	none	Final approval	15/03/2021

Personal	14/03/2021	14:30	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	presented with pre-existing small areas of grade 2 pressure sores with excoriation	advised position changing frequent personal care as patient incontinent	nil	Being reviewed	
Personal	14/03/2021	02:16	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, CAH	Minor	P1 T+13 Induction of labour Shoulder Dystocia	Staff present 2 midwives, Delivery suite sister and doctor - manouveres as per protocol - legs into McRoberts and suprapubic pressure - delivered within 1 minute.		Being reviewed	
Personal	14/03/2021	09:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	TRAUSU	Trauma Ward	Minor	Patent found on floor by student nurse I can straight away resting hands on head, unwitnessed fall. No obvious signs of injuy. Personal sttes wanted toilet. Did not call staff, buzzer within reach. cot sides up to be used with care.	FY1 rv gcs obs, and news as per protocol. Falls plan updated, next of kin informed transferred lilly to low profile bed and1 to 1 supervision today post fall.	To continue to closely monitor patients that are deemed high risk of falls and to continue to follow falls protocol at all times. Staff made aware of the importance of updating risk assessments post fall.	Final approval	16/03/2021
Personal	14/03/2021	22:00	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	Emergency Department CAH	Minor	Security requested to Ambulance triage as a female patient had become violent towards members of staff.	Security were alerted by a knock on the office door. Security immediately attended Ambulance triage and witnessed a female patient lashing out and being verbally aggressive towards staff. Security intervened and had to restrain the patient on the ED Trolley which was in the triage cubical. Police officers who were already on the premises with another patient attended and tried talking to the patient to calm her down. during this time the police had radioed through for another crew to attend. More police officers arrived about 10 minutes later and took over from Security staff.	None	Final approval	
Personal	14/03/2021	10:50	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	Emergency Department CAH	Insignificant	Security requested to ED Green area as a male patient was trying to leave the ward against medical advice.	Security arrived to the Green Area and were informed by nursing staff that they had taken a bag of pills of the male patient and they had contacted the police so the patient could not leave. Security managed to talk the patient into staying until the police arrived and took over from Security.	None	Final approval	
Personal	14/03/2021	14:15	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Insignificant	Person affected arrived onto AMU at 15:15 pabrinex prescribed not given so went to prepare to administer checked A&E prescription notes states nothing given. Clerking DR present states that patient had pabrinex in A&E contacted department states patient was given pabrinex with them no documentation came from A&E to suggest it was given original telephone handover did not confirm that pabrinex was given either.	telephoned a&e to confirm if given as per clerking DR account.	TO ENSURE ALL MEDICATIONS/STATS ARE GIVEN AND SIGNED FOR AT TIME PERSCRIBED TO ENSURE OF NO MISSES.	Being reviewed	
Personal	15/03/2021	18:45	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Coronary Care Ward	Insignificant	security called to male medical a patient was been aggressive towards nursing staff. we used low level mapa to restrict his movement while staff give him an injection kept a presence on the ward till patient settled down.stood down at 1900 hours	none	none	Final approval	19/03/2021
Personal	15/03/2021	05:40	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Minor	patient admitted to ED with overdose and poisoning. arrived to AMU and extremely unsettled, aggressive and verbally abusive to staff. screaming and shouting about and wanting to leave and go for a smoke. attempting to light cigarette on ward. headbutting and kicking doors and walls to leave. A danger to herself and others	security and PSNI contacted as per medical notes. unable to leave ward until CAMHS assessment. PSNI brought patient out for a smoke and then left the ward however remains unsettled and disruptive to ward	Managed appropriately	Final approval	15/03/2021
Personal	15/03/2021	13:10	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Minor	Patient verbally abusive and towards staff and other patients. Patient attempting to leave ward numerous times. Patient banging her hands off walls, desks etc. PSNI contacted to come to ward for assistance.	PSNI contacted. Doctor informed to review patient.	1:1S NEEDED FOR AGGRESSIVE AND AGIGATATED PATIENTS	Final approval	18/03/2021
Personal	15/03/2021	21:00	Daisy Hill Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Maternity Ward	Minor	Personal DAY 9 POST C/SECTION RE-ADMISSION TO Maternity WOUND INFECTION	seen by Doctor bloods sent+ wound swab commenced IVA		Being reviewed	
Personal	15/03/2021	15:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Minor	Type 7 bowel movements, stool samples sent in ED, came back CDIFF PCR POSTIVE, GDH POSITIVE, BUT TOXIN NEGATIVE. Type 7 stools had been handed over by ED, but were happy for her to go to an open bay as they queried that is was alcohol related. Bed manager and infection control were made aware when patient was admitted to AMU.	Medical team informed of C-diff result, Kardex reviewed, IV Tazocin changes to oral vancomycin, stat does given. Kardex reviewed as per C-Diff bundle. Infection control and bed managers aware of infection status, side room requested. Staff alerted to infection control precautions. Patient informed of C-Diff status and given C-Diff information leaflet and laundry leaflet. Patient happy to inform her family. Second sample for CDiff still to be sent, awaiting sample.		In holding area, awaiting review	

Personal	15/03/2021	18:40	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	2 South Medical	Minor	Patient arrived on ward without clerkin. Had been handed over from ED ?emphysema and new presentation t2dm. was admitted to open bay in 2 south. when clerk in doctor arrived, while looking at chest x ray, felt there where cavitating lesions/abscesses on lungs and stated that it looked like this could be tb. requested 3 afb's and isolation for patient.	swapped pt into side room with patient of lower risk. informed patient of why he was being isolated, informed relevant staff. contacted bed manager Personal , he advised datix completed		Being reviewed	
Personal	15/03/2021	00:00	Craigavon Area Hospital	Pharmacy	PHARM	PHDISP	Pharmacy Dispensary	Insignificant	Patient with end stage COPD commenced on Trimbow inhaler by Respiratory Specialist Nurse on 11/3/21. Ordered from pharmacy on 12/3/21 and 13/3/21 but item never came to ward. Ordered again on 15/3/21 and item then issued to ward and arrived. Inhaler was '6' a total of 9 times before patient received any doses.	Spoke to Stores in pharmacy on 15/3/21 after Doctor on ward noted that patient had still not received any doses. Stock issue with this inhaler and stock came into pharmacy on 15/3/21, they would send inhaler up ASAP. Inhaler came up that afternoon (although still 6 that night!). Patient received doses from 16/3/21 onwards. Not clear whether pharmacy communicated to ward that there was an issue with this inhaler.	All nils should be followed up with ward staff and procurement	Being reviewed	
Personal	15/03/2021	11:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Minor	unwitnessed fall in c bay, F1 first present, claims to have heard patient hit her head, patient states same.	Hoisted from floor to bed with doctor present. attended for CT brain. full body assessment completed by doctor.		Being reviewed	
Personal	15/03/2021	12:00	Craigavon Area Hospital	Medicine and Unscheduled Care	CSMUC	HAEMAT	Haematology	Minor	On Friday 15th March 2021, We checked on LABS system, which confirmed that 1 unit PRC was available for patient named. We sent a porter for the blood unit and when he did not promptly return, we phoned the blood bank who informed us that the unit of blood was not available and that they had failed to update this information on the LABS system. This led to the necessity for a repeat group and crossmatch, and hence a delay in the transfusion process.	Informed haemovigilance practitioner Personal		Being reviewed	
Personal	15/03/2021	15:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	AMU	Minor	admitted to ortho ward today approx. 15:00hours on during admission skin check grade 2 evident on sacral area. alleyn adhesive dressing insitu to sacrum, however handed G1 from AMU	removed this dressing cleansed and two senior nurses reviewed to confirm GD2. assistance of 2 with zimmer frame as per physio, braden 12, repositioning chart in siti commenced on 2-4 hourly repositioning, last skin check 6 hours ago		Being reviewed	
Personal	15/03/2021	00:00	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	PT FOUND HAVING SEIZURE IN BATHROOM. FOUND BY DR,	FIRST AID GIVEN. LASTED APPROX 2 MINS. RESOLVED WITHOUT INTERVENTION REVIEWED BY DR CTB[/]	patient that attend with seizure to be admitted to medical ward	Being reviewed	
Personal	15/03/2021	15:00	Community	IMWH - Cancer and Clinical Services	MIDWIF	COMM	Home of client	Minor	The handover sheet with patient information was left in Personal green chart. She found it when she was at home and looking through the chart.	The handover sheet was taken back to Daisy Hill hospital and given to manager. I informed Personal of the action I would be taking.		Being reviewed	
Personal	15/03/2021	12:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	STROKE	Stroke / Rehab	Minor	While sitting on chair, patient stated she felt faint. Patient lent forward with her full weight transferred onto my lap as she slumped. I caught patient as she had came off the chair. Called for help and with assistance of other members of staff we guided patient to ground in recovery position with pillow to support patients head. BP : 69/46 at time of incident 2mins after BP: increased to 96 sys. Patient alert and able to communicate. No fall No head injury or trauma. Nil loss of conscious. Assisted patient to bed with members of staff BP in bed: 134/83.	Initial ABCDE assessment completed and observations recorded & half hourly there after. GCS assessment completed Reviewed by medical team With assistance supported patient to sit up. With assistance supported patient to mobilise to bed. Bloods taken and BP monitored Patient had full lunch with assistance. Patient alert with on going confusion.		Being reviewed	

Personal	15/03/2021	21:00	Daisy Hill Hospital	Surgery and Elective Care	GENSUR	GENSUR	High Dependency Unit	Insignificant	[illegible] are now corralled in 'HDU2' on level 6 which has 4 beds- currently these 4 beds are occupied by 3 level 1 patients which are all on room air and 1 level 2 patient. Only two of the patients in HDU are confirmed covid positive - neither one of these two patients have covid pneumonia and both are on room air and clinically stable not requiring HDU care. Only 1 unwell level 2 patient who again is only possible/clinical covid I admitted a lady on the medical take on the 15th March with covid pneumonia and hypoxic respiratory failure with a PF ratio of 43. She was suitable to remain in DHH but as a result of there being no beds in the covid ward/the HDU she had to be transferred to CAH. One of the patients in HDU level 2 was medically fit that morning but the Nursing home couldn't facilitate the patient until the following day due to staffing issues- this caused an acute patient to be transferred to CAH as there was no beds left on the covid ward	As above	/	Final approval	26/03/2021
Personal	15/03/2021	16:45	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	STROKE	Rehabilitation Ward	Minor	found on floor by the window in side room 6 by HCA during staff nurse break time.	unknown head injury, hoisted back to bed, clinical observations recorded as per falls protocol, GCS completed and medical staff aware	none	Final approval	18/03/2021
Personal	15/03/2021	12:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Minor	patient was documented to have a 'query DTI' to their left heel beginning 14/03/21. In previous days this has been documented at different times as U (where a dressing was insitu) and B (blanching).	RN forwarded images to TVN today who confirm DTI. Zero pressure boot applied, further TVN advice to follow. Patient informed. Nurse in charge informed. Risk assessments updated.	in review Needs RCA	Being reviewed	
Personal	15/03/2021	19:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	Ramone Ward 4	Insignificant	Patient wondering +++ all day. needed 1:1 no staff to facilitate same. Patient had unwitnessed fall on corridor. No apparent injury at present although on apixaban A/W Fy1 review	Patient able to mobilise ind up onto feet. No obvious signs of injury. news and GCS (falls protocol) started from nurse looking after PT. A/W Fy1 rv who is currently on ward reviewing patient - contact NOK FY1 reviewed patient @ 1950 Family informed of fall that evening	To sure there is adequate staffing levels, however this is not always possible. Importance of communicating all patients at risk of falls to all staff members at ward safety brief Ensure patient with risk of falls is nursed in an observation bay- this was also done, as patient nursed in C bay.	Final approval	22/03/2021
Personal	15/03/2021	00:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	3 North Medicine	Moderate	DTI/ ungradable pressure damage developed on coccyx whilst in ward 3 north	repositioning frequency increased from /..... to ..... Braden reassessed and documented already on dynamic mattress aria when damage occurred datix completed by TVN after confirmed		Being reviewed	
Personal	15/03/2021	12:00	Daisy Hill Hospital	Medicine and Unscheduled Care	CSMUC	CARDIO	Coronary Care Ward	Minor	Patient was transferred from DHH CCU with another patients pathway.	Patient informed, CCU informed and Sister of Cath Lab informed.		In holding area, awaiting review	
Personal	15/03/2021	05:42	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Insignificant	Security requested to ED Green area as a female patient was trying to leave the ward against medical advice and was becoming highly aggressive.	Security arrived o AMU and witnessed a female patient kicking and punching the main security door into AMU. Nursing staff had already contacted the police. Security staff managed to talk the patient back to her bed. Security then stood back and observed until the police arrived and took over. Security were then stood down.	None	Final approval	
Personal	15/03/2021	13:50	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	2 West Maternity Post Natal	Minor	SECONDARY PPH ON WARD 2WEST HAD ELECTIVE C/S AT 0946 AND TRANSFERRED TO WARD AT 1150AM.PAASED A LARGE CLOT AT1350 AND TRANSFERRED TO DELIVERY SUITE AT 1415 MBL 1913MLS.	SHO ON WARD TO BEDSIDE IMMEDIATELY .DR FINNEGAN CONTACTED AND TO WARD AT 1410.SYNTOCINON INFUSION COMMENCED AND BLOODS TAKEN AND TRANSFERRED TO DELIVERY SUITE AR 1415		Being reviewed	
Personal	15/03/2021	01:44	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Insignificant	Security was requested for Broad way at the main entrance.	On arrival security could not find what they were called for until they heard commotion coming from AMU front doors. Security made their way to AMU and witnessed a male patient who had jus discharged himself refusing to leave. Security spoke to the male patient and organized for him to get a taxi. Security walked the male to the front doors where he waited for his taxi. Security were then stood down.	none	Final approval	
Personal	15/03/2021	16:50	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Patient was in Green Area Cubicle 4 Sat on chair and bumped head off wall behind. Small abrasion noted	Minor first aid - dry dressing applied	nil	Being reviewed	
Personal	15/03/2021	13:30	Craigavon Area Hospital	Medicine and Unscheduled Care	CSMUC	HAEMAT	Haematology	Minor	unwitnessed fall. patient states he slipped on a piece of carrot on the floor. No LOC. states he did not hit his head.	Assisted back onto feet and onto chair. post falls protocol followed.	nil	Final approval	15/03/2021

Personal	15/03/2021	16:20	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Minor	Security called to attend AMU as a male patient was walking about the ward in a confused state refusing to return to his bed.	Security arrived to AMU and spoke to the patient asking him to return to his bed which he did. The patient then got up and went outside the back fire exit for a smoke, whilst outside the patient lifted a concrete manhole cover. Security asked the patient to place the object on the floor which he did. The patient returned to his bed space and remained settled so security were then stood down.	None	Final approval	
Personal	15/03/2021	13:55	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Patient absconded from ED Department at 13.55 with IV access insitu. Medical Admission Patient father returned patient to ED Department	Absconding Policy commenced. Medical team informed Sister in charge informed PSNI contacted ref- Personal	Keep patients at risk of absconding in area visible to staff. Ensure Mental Health Risk Assessment and Absconding Policy documented.	Being reviewed	
Personal	16/03/2021	15:15	Community	Pharmacy	PHARM	PHASEP	South Lakes Leisure Centre	Insignificant	small black dot, likely bung floating in pfizer covid vaccine once reconstitued in sllc. bn ER1741. exp 06/21	vial quarentined and reported to s kilpatrick		In holding area, awaiting review	
Personal	16/03/2021	09:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	octaplex box held in emergency department resus area was used. box was not returned to blood bank and paper work was not returned. empty box was discovered on 16/03/2021 and returned to blood bank to be replenished but staff member who contacted blood bank about the box being empty was unable to tell blood bank staff when the octaplex was used or what patient it was given to	haemovigilance contacted to investigate occurrence and determine who received the products		Being reviewed	
Personal	16/03/2021	00:40	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Female Medical	Minor	Found patient sitting on the floor at bedside.	Assessed . No injury noted.	Nil	Final approval	19/03/2021
Personal	16/03/2021	20:35	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	2 West Maternity Post Natal	Minor	Postnatal readmission, raised temp, SOB, Chest/abdo pain, Slightly red wound ??sepsis	Bloods taken, chest x-ray, ivabx, iv fluids, ecg done. OBS SHO reviewed, admitted to ward		Being reviewed	
Personal	16/03/2021	21:55	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	pt absconded from dept	absconding protocol commenced	Managed appropriately.	Being reviewed	
Personal	16/03/2021	16:24	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, CAH	Moderate	Personal lady (speaks and understands little English)arrived at Assessment and admission unit with Perso old daughter(who speaks and understands English) in premature labour at 23+1 by dates though a late booker) and 24+ with USS. Transferred to D/S room 1 at 1625hrs. Obstetric and Paediatric teams present as fetal heart present. Loading dose MgSo4 given followed by maintenance dose. First Betnasol given in A&A unit. Mx discussed with Registrar and 2 Consultants following abdominal USS. Transferred to RJM Hospital leaving CAH at 1750hrs and arriving at RJMH at 1820hrs. Transferred to assessment and admission unit as arranged with Drs.	Transfer fetus in utero to Belfast		Being reviewed	
Personal	16/03/2021	20:00	Craigavon Area Hospital	Surgery and Elective Care	ATICS	THEAT	Theatres 1-4 CAH	Minor	There was already a patient from resus in Th 1,after having had a procedure and was waiting for covid tracheal sputum results in order to be moved to ICU. At approx. 20:00 a 2nd theatre was required for a Personal old who required intubation, ventilation and transfer to Belfast. Another patient also needed to come to theatre urgently as she had a ruptured ectopic.	NIC aware. Staff skill divided between 2 theatres. When the patient in Th 1 went to ICU, the patient with ruptured ectopic came to theatre and the child was still in theatre 2. Therefore 2 theatres ran simultaneously for approx. 3 hours and 30 mins. Some day staff stayed late to assist night staff	Waiting for covid results in a busy emergency theatre is challenging and unable to get a bed to put the patient in, from ICU until the result was back	Final approval	29/03/2021
Personal	16/03/2021	22:15	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	General Male Medical,	Insignificant	The patient has hit the staff while assisting the doctor in putting an IV cannula. The patient also tried to hit the doctor too.	Informed the Hospital at night. Advised the staff to go A & E and see the doctor .		In holding area, awaiting review	
Personal	16/03/2021	10:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	TRAUSU	Trauma Ward	Minor	Patient was admitted with grade 1 pressure sore on sacrum. patient has now developed a grade 2 pressure sore on sacrum. noticed grade 2 whilst repositioning patient.	dressing applied and care plan put in place. Duo mattress insitu. increased repositioning to 4 hourly from 4-6 hourly. TVN referral completed. pressure sore pathway insitu. braden and MUST updated documnteed in nursing notes, handover updated. referral to dietician made, aw review.	Staff to be more vigilant when carrying out skin checks to ensure accurate documentation is maintained.	Final approval	18/03/2021
Personal	16/03/2021	18:00	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	3 North Stroke	Minor	Security needed in 3 North as a female patient was hitting out at staff and was very unsettled.	Security arrived to 3 North and were met with female patient Personal Information banging the rear doors of 3 north. The patient then walked back to her side room with nursing staff. The patient then tried to hit and spit at Security staff and also went to leave the side room. Security staff intervened and escorted the patient back to her seat. the patient continued to try and hit out and spit at staff. Her chair was then moved to the back of the room where she then settled and security were stood down.	Ongoing training with staff to try deescalate behaviors of confused patients if possible before needing security.	Final approval	

Personal	16/03/2021	11:00	Community	Functional Support Services	LOCCB	CATCB	Portadown HSSC	Minor	The member of staff was on break using their own mug, the handle of the mug had broken off causing a cut to the thumb	The member of staff attended the Health Centre treatment room, the treatment room nurse dressed the wound.	None	Final approval	26/03/2021
Personal	16/03/2021	01:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Catastrophic	Pt attended Emergency department on the 16/03/21. PT was assaulted by her female friend whilst at her house. PT has longstanding issues with mental health and addiction.	The Emergency Department completed a UNOCINI in regards to PT's Personal in foster care. On ED flimsy it was noted that an APP1 was not completed as NIC states no need for APP1 as the assault was done by a friend- not family or partner.		Being reviewed	
Personal	16/03/2021	06:30	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	STROKE	Stroke / Rehab	Minor	patient found at bedside following attempt to get out of bed unaided	assessed for injury, hoisted back to bed, clinical observations recorded, GCS recorded, medical team informed	please ensure that NOK contacted at the earliest opportunity-will be raised at PSB.	Final approval	26/03/2021
Personal	16/03/2021	08:20	Craigavon Area Hospital	Functional Support Services	LOCCB	DOMSCB	Corridor/Stairs	Minor	while the ward assistant was removing the buffer lead she tripped over the buffer that was behind her.	reported to supervisor	NA	Final approval	18/03/2021
Personal	16/03/2021	16:30	South Tyrone Hospital	IMWH - Cancer and Clinical Services	MIDWIF	COMM	General OutpatientsTreatment Room	Insignificant	Day 5 newborn screening insufficient sample Personal	Newborn screening was very difficult to complete, baby bled well, sample didn't soak through card well. This was noted n the sample card to the labs. Apologies were made to the mother at the time as I wasn't happy with the sample. Explained at the time the possibility of a repeat	To discuss issues with PKU paper with screening co-Ordinator PHA	Final approval	18/03/2021
Personal	16/03/2021	20:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Patient was transferred to ambulatory after 1700 following CT brain. Noted at 2030 that patients blood sugar was elevated. Patient stated that she is on insulin. Dr contacted and he advised staff for patient to administer same when she arrived home. (T2DM)	Recorded in notes regarding insulin and patient advised that she was to take same when she got home.		Being reviewed	
Personal	16/03/2021	20:30	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Minor	Patient admitted to ward from A&E @ approx 19:40pm . Pt NBM at awaiting theatre. PT T2DM om insulin and had not ate since 7:30am. no insulin infusion in situ although pt had missed more than 2 meals. pt also meant to have IVF as part of her management plan no IVF in situ.	doctors informed- insulin infusion commenced + IVF prescribed A&E sister contacted to inform of same datex completed	surgical team need to consider if an insulin infusion is required and prescribed same if needed	Being reviewed	
Personal	16/03/2021	00:51	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Minor	PATIENT ABSCONDED FROM THE WARD.	STAFF CHECKED THE WARD, SECURITY CALLED AND THEN PSNI INFORMED AS PLAN OF CARE DOCUMENTATED IN THE NURSING PLAN.MOTHER AWARE OF THE SITUATION.BED MANAGER CONTACTED AND CHECKLIST COMPLETED FOR THE PATIENT WITHOUT LEAVE.	AWOL performa initiated and followed	Final approval	18/03/2021
Personal	16/03/2021	00:55	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Minor	Security bleeped to attend AMU as a female patient had absconded from the ward.	Security searched all areas of the hospital as per our SOPs and did not manage to locate the patient. The ward staff were informed and the police were contacted.	Managed appropriately a the time No harm to patient	Final approval	18/03/2021
Personal	16/03/2021	07:00	Craigavon Area Hospital	Surgery and Elective Care	ATICS	ICU	ICU CAH	Minor	Grade 2 noticed to both ears due to friction marks from Oxygen tubing.	Gauze applied to both ears and reported to nurse in charge.	no	Being reviewed	
Personal	16/03/2021	16:45	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	ORTHSU	Orthopaedic Ward	Minor	Patient was found by student nurse, sitting on the floor.	Full ABCDE assessment was carried out, including NEWS and GCS observations. Medical team reviewed the patient and stated they were happy she had came to no harm due to the fall.	The importance of observing our patient's at all times. The importance of Adhering to our Falls protocol as per hospital policy. The importance of updating our post falls pathway. Communicating with family	Final approval	18/03/2021
Personal	16/03/2021	13:00	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	DIAGNO	IMACT	CT Scanner	Minor	patient was given oral contrast to drink by mistake; they were appointed for a CT brain. It is unknown how this mistake occurred; we assume the incorrect labels were printed and put onto the oral contrast form.	none		Being reviewed	
Personal	16/03/2021	23:00	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Insignificant	Security requested to carry out one to one duties due to how unpredictable the male patient in question was.	Security did not have any issues with the male patient from 11pm till 7am he remained settled all night.	None	Final approval	
Personal	17/03/2021	08:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Insignificant	Pt had witnessed fall by HCA at bedside on night duty handover in am. HCA and patient stated at time that he did not hit his head. Pt stats he felt light headed prior to falling. No sign of injury on skin check. Pt complained of slight right sided pain only.	FY1 bleeped and reviewed patient at time. GCS &Obs recorded as per falls protocol. Lying and standing BP obtained- no deficient. NIC informed. Walking stick updated, skin checked, datix completed, NOK informed of incident.	reminding patients to use the buzzer system if they are dizzy for assistance to mobilise. Follow the correct falls protocol	Final approval	18/03/2021
Personal	17/03/2021	19:53	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, CAH	Moderate	hosp no Personal . H AND C NO Personal P1+3 SHOULDER DYSTOCIA anticipated after delivery of head as turtle neck . Sister in charge already in room as decleration previously . Episiotomy , bed flattened ,legs elevated and delivered by one pull axial traction . baby reviewed by paediatrician .parents debriefed .	head delivered at 1953hrs . nvd at 1955 hrs on 17.03/21 . baby wight 3940 gms . had bigger baby previously .		Being reviewed	
Personal	17/03/2021	20:05	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Coronary Care Ward	Insignificant	security called by switchboard to attend male medical , patient was aggressive toward staff in order for to allow a feeding procedure to take place after low level mapa was used, stood down after this as patient settled down.	none	none	Final approval	19/03/2021

Personal	17/03/2021	23:00	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Insignificant	Security were tasked with one to one security with a patient who was previously aggressive and had to be restrained by security staff in ED. The patient was then moved to AMU where a member of security staff sat with him from 11pm to 7am.	Security did not have any issues with the male patient throughout the night he got restless at times but did not require any intervention.	None	Final approval	
Personal	17/03/2021	15:28	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Minor	Security called to AMU to assist with an aggressive agitated male patient. On Arrival the male patient was outside in the courtyard with a healthcare worker. Patient came back tot the ward and seemed settled do security left soon after. Security called back to AMU at approx. 1600 as the patient had been abusive to nursing staff. On arrival the patient said he would hit staff and the left the ward via the fire exit door and then came back into the building via the door beside the courtyard cabin. Security went after him and escorted him back into AMU. Patient became aggressive and tried to strike out at staff so had to be restrained to the floor. Police were called who arrived 10 minutes later and put the patient in hand cuffs and leg restraints. Security staff were able to leave as police stayed with the patient until approx. 2000 when patient had settled a bit and security were able to take over from police. 2 security porters stayed with patient.	Security called	None	Final approval	
Personal	17/03/2021	15:35	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Minor	Patient's behaviour became very aggressive and agitated and disturbed other patients in F3 & F4. Later patient marched up & down the backwing corridor clencing his right fist and stated he was "looking to hit someone. I want out." Patient refused to take lorazepam as "I want something that I can make myself(drugs)	Security were contacted at 15.35hrs & 16.00hrs. Patient flow updated about both incidents. 1:1 staff with patient and patient settled at this time. Patient refused to allow staff to share information ith his father when he rang the AMU. Another patient in F3 CTMA'd as he was frightened by this patient.	Dealt with appropriately.	Being reviewed	
Personal	17/03/2021	17:45	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Minor	patient becoming increasingly aggressive. trying to leave ward and hitting main doors to ward. asked patient what he wanted - he said to he wanted to go home. advised patient that if he came back to his bed we could get a doctor to discuss a CTMA. patient then threatening to hit staff and stated he didn't care about anybody but himself. security called but patient walked back to F bay himself. security remained with patient and he continued to be extremely agitated and verbally aggressive, then pushing porters.	security staff MAPA'd patient to the floor. patient screaming and fighting against staff and very difficult to restrain so PSNI contacted. PSNI onto ward within a few minutes and restraints used on wrists and legs. 1mg IM lorazepam given as per FY1. patient lifted into bed by PSNI and moved on bed to another bay to a more calming environment. PSNI remain with patient.	Dealt with appropriately.	Being reviewed	
Personal	17/03/2021	13:00	Craigavon Area Hospital	Surgery and Elective Care	ATICS	ANAES	Theatres 1-4 CAH	Insignificant	Patient sent for ESP block and waiting in anaesthetic room due to previous case not being finished. Resus call to ward.	Patient sent back to ward and hopefully completed later in day		Being reviewed	
Personal	17/03/2021	13:25	Daisy Hill Hospital	Functional Support Services	LOCNE	DOMNE	Domestic Services	Minor	Persona came into the Domestic Services Store on Lower ground and was talking to me about work. I was in the far end of the store when I heard her fall. I came over and she said she tripped over the first wooden step and fell onto the concrete ground. She graized her right elbow, banged both knees (which become slightly red)and banged her nose. Nose was sore but not bruised or red.	Person sat for few minutes on the ground till she felt ok to get up and came round to the Domestic Services Office. She sat till 13.45 in the Domestic Service office. She was fine on leaving the office but was going to A & E to get a plaster on her Grazed Elbow	None	Final approval	30/03/2021
Personal	17/03/2021	17:30	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Patient helped to commode. Numerous pressure sores noted to sacral area. Two Grade 2, one soft tissue injury and purple non blanching erythema and a non blanching area on sacrum.	Wounds dressed with Adhesive. Patient and NOK infirmed of these. Patient NOK was not aware of the broken skin. Attempted to ring NH numerous times to get information regarding pressure ulcers and whether or not they have been treating them in the nursing home.	Early recognition and intervention of pressure areas essential. Importance of carrying out skin check and risk assessment as early as possible after arrival. Elderly frail patients need moved from trolley to bed promptly.	Being reviewed	

Personal	17/03/2021	18:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Major	PATIENT ATTENED ED FOR THE 2ND TIME 17/03/2, WAS NURSED AT AMULANCE TRIAGE - CLOSED CUBICLE AS NO OTHER APPROPRIATE ROOM FOR PATIENT TO BE NURSED AND OBSERVED HAD ALREADY LEFT DEPARTMENT AND MADE HIS WAY OVER TO BLUESTONE - BEING BROUGHT BACK BY STAFF CONSTANTLY REQURING 1:1 DUE TO WNATING TO LEAVE AND HAD BEEN TAKEN OUT FOR SMOKES ON REGULAR INTERVALS. MENTAL HEALTH TEAM CAME TO ASSES PATIENT, AND WHEN THEY APPROACHED THE ROOM - REALISED THE DOOR WAS LOCKED, I MYSELF WAS COMING OUT OF AMBER RESUS AND NOTICIED THE STAFF TRYING TO GET INTO ROOM. I COULD HEAR PATIENT WRECKING ABOUT ON THE TROLLEY. I ALERTED SECURITY AND THEY WERE ABLE TO OPEN DOOR WITH MASTER KEY PATIENT WAS NOTED TO BE LYING ON HIS LEFT SIDE ON TROLLEY - DID NOT COMMUNICATE WHEN WE OPENED THE DOOR SN Personal APPROACHED Personal TO FIND A SHOE LACE TIED AROUND HIS NECK	SHOE LACE CUT OF Person NECK AND MOVED TO RED RESUS ALARMS PULLED AND EXTRA STAFF ASSISTED		Being reviewed	
Personal	17/03/2021	08:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	3 North Medicine	Insignificant	following confirmation of fractured Left Neck of Femur. Patient has extensive medical history involving 2 x urostomy insitu, ileostomy insitu, PICC Line insitu for TPN in community (can be used for bloods and flush in hospital). Patient mobility restricted due to fracture. when personal care was given this morning by myself and another staff nurse we were shocked at the state of lines. nephrostomy bags had not been changed, the dressing were peeling and strike through was visible. Stoma bag had not been changed or cared, surrounding skin was inflamed. Old stoma site had a dressing insitu that had also not been addressed. Patient PICC Line dressing was also half peeled off site. Patient stated no one had done any care with PICC, only used for bloods and flush however, there is no written confirmation to indicate use on PICC documentation. Patient confirmed all of the above and was visibly upset discussing that none of these had been addressed and was worried that they were only being looked at now from initial admission. While care was being given, we found her sacrum and female areas and been caked in sudocream that had not been cleaned. once	myself and staff nurse addressed all concerns, contacted level 4 to receive correct supplies to change lines. Stoma bag was renewed and documented. nephrostomy (2) dressing were renewed. bags also renewed. PICC line assessed and flushed using ANTT, new PICC dressing and bio connecter applied and documented. For skin issues, Aria mattress insitu, skin cleansed and barrier cream applied, repositioned for comfort and repositioning schedule updated, nursed from side to side to relieve pressure. Foodchart commenced. Dietician referral to be made. All risk assessments and documentation updated.	Poor care identified when reviewing nursing notes. So we are now doing our nursing handovers at bedsides and going through all patient charts to ensure completion and nothings missed. If so then it is highlighted there an then with nurse.	Being reviewed	
Personal	17/03/2021	12:30	Daisy Hill Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, DHH	Moderate	Upon getting a 200mg labetalol tablet from the tablet box it was noted there were different sizes in the container - a mixture of 100mg and 200mg tablets.	Pharmacy advice sought - tablets disposed of and new 200mg box ordered.	JG, 26/03/2021: Cannot ascertain if mix up occurred in pharmacy or at ward level, ward sister asked to remind all staff importance of correct storage of medicines in properly labelled container.	Final approval	26/03/2021
Personal	17/03/2021	12:20	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	GENSUR	CEAW	Moderate	Was contacted by patients sister on the DN out of hours phone who informed me that her sister had been discharged from hospital yesterday evening the 16/3/21 on clexane following surgery. She had been shown how to use the clexane just once and deemed by staff to be competent however when she got home she wasnt sure she was doing it right and instead of administering 1 40mg injection she gave herself 3 in an attempt to ensure it was going in right. Patients sister was advised to phone District Nursing to come out and administer clexane injection today. I advised patients sister that I would like to phoe OOH GP for advice on giving a further injection after she has taken 3 times her dose and advised I would ring back. Patients sister advised OOH were contacted last night and advised she would be ok.	Contacted OOH GP and gave details of incident. OOH GP phoned me back and explained the incident with the patients clexane. GP I spoke with asked that patient be brought into ED to have urgent bloods checked including coag before administering any further clexane. Contacted patients sister and advised that patient needs to go to ED to have her bloods done. She is going to take her now. I advised if clexane to be given for staff in ED to refer to DN regarding this.		Being reviewed	
Personal	17/03/2021	23:20	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	patient attend ED With TLNWL + Alcohol on board. patient absconded from ED.	APPENDIX C completed Psni informed	patients who present with mental health problem to be placed in observation area	Being reviewed	
Personal	17/03/2021	09:30	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	STROKE	Stroke / Rehab	Minor	in retrospect to the date below patient was found sitting on floor at bedside, unwitnessed by staff but patient opposite stated 'tried to get up unaided and lost his footing and slipped onto the floor, he did not hit his head or injure himself'	falls protocol commenced, observations and CNS observations continued half hourly until Dr. review, assessed for injury, assisted back onto chair.	none	Being reviewed	

Personal	17/03/2021	11:20	Craigavon Area Hospital	Medicine and Unscheduled Care	CSMUC	CARDIO	1 North Cardiology	Moderate	Patient had an unwitnessed fall, this morning, a student observed patient already on the floor, she had sound of bang and saw patient laying on the floor.	Observed for any injury and returned to bed: neuro observations done as per protocol, X-ray obtained, doctor's review obtained, patient's son informed.	Email sent to staff for learning -document how the patient was moved -Follow falls pathway -update moving and handling plan post fall -complete falls walking stick	Final approval	24/03/2021
Personal	17/03/2021	15:00	Daisy Hill Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Maternity Ward	Minor	Trigger: postnatal readmission Trigger: return to theatre burst abdomen 1 week following elective c/section (sheath and skin stitches snapped). Readmitted 17/3/21, resutured on 18/3/21. Discharged well on 20/3/21.	resutured in theatre		Being reviewed	
Personal	17/03/2021	13:30	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Personal attended ED on the 17/03/2021. while performing a skin check a grade 3 was noted. patient confirms the dressing which was covering the grade 3 was placed by the district nurse.	dressing was removed wound was cleaned using ANTT, n-a ULTRA on the ulcer using an ALLEVYN classic for protection. moved to hospital bed and patient advised to move around the bed and stay off pressure area.	Early recognition and intervention of pressure areas essential. Importance of carrying out skin checks and moving patients on to bed as early as possible.	Being reviewed	
Personal	17/03/2021	16:30	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Emergency Department DHH	Insignificant	security called to emergency dept on arrival patient was aggressive verbally and physically towards staff mapa was used while medication was given, patient was still trying to punch ,kick out ,settled down after this . stood down after this.	none	none	Final approval	19/03/2021
Personal	17/03/2021	22:10	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Patient admitted for mental health issues, awaiting psych review, patient absconded from A&e,followed by porters who saw patient leaving hospital grounds. 101 called, patient returned to A&e independently within 10 minutes	NIC informed, REG informed, 101 contacted but patient returned to ED	Keep patients at risk of absconding in area visible to staff.	Being reviewed	
Personal	17/03/2021	06:55	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	pt. absconded @ 02:05 but returned to dept, and absconded @ 06:55	absconding protocol commenced	Managed appropriately.	Being reviewed	
Personal	17/03/2021	18:43	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Moderate	18.15 - Integrated Liaison Team paged to ext: Personal request to see Patient A. Collateral obtained before Staff Member B and Staff Member C went to see Patient A. 18.35 - Staff member B and Staff Member C entered Donning area. 18.43 - Staff member B and Staff Member C entered A&E, took brief handover from staff member D. Staff member D approached "ambulance Triage 2" room. The door was locked from the inside. Patient A was inside the room alone. 18:43 to 18:45 no staff members had a key to the door, patient not responding to verbal command. 18:46 door opened by paramedic with a master key. 18:46 Patient found unconscious with shoe lases around his neck. 18:46 alarm raised. Difficulties in finding scissors / ligature cutter. 18:47 ligature removed using scissors. 18:48 Patient A brought to A&E RED resus. 18:50 Patient A was responding to pain.	Raised with sister in charge (staff member E). Patient A on 1:1. Patient A's CRA updated.	Mental health patients should not be placed in rooms with locks. A more suitable pathway for mental health patients should be implemented. We would benefit from a specific security service that can stay with patient to help prevent them from absconding as patient had previously absconded numerous times.	Being reviewed	
Personal	17/03/2021	16:10	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	Emergency Department CAH	Moderate	Security heard shouting banging coming from ambulance triage room beside porters office. Went to check it out and seen a male patient who seemed drunk. Patient wet out for a smoke and then a short time after ED staff informed us he had gone missing. Security went to look for him but never found him. ED staff informed us he had went to Bluestone unit. Nursing staff from Bluestone escorted him back to ED. At approx. 1830 ED staff requested security assist with opening the ambulance triage door and the male patient had locked it from the inside. Door was opened with a master key and when medical staff entered the room the patient had wrapped something around his neck to harm himself. Patient was moved by ED staff to red resus. Security called again for the male patient who had just left ED. Patient walked out the door and down the main road. Nursing staff called the police.	Security called		Being reviewed	
Personal	17/03/2021	19:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	General Male Medical,	Moderate	PATIENT ADMITTED 13/03/21. RIGHT BUTTOCKS INTACT AT TIME OF ADMISSION. GRADE 2 NOTED ON 17/03/21	REPORTED TO DEPUTY SR, DRESSING APPLIED, ZERO PRESSURE TO BUTTOCKS APPLIED, REPOSITIONING CHART MAINTAINED. BODY MAP AND BRADEN IN ADMISSION BOOKLET UPDATED		Being reviewed	
Personal	17/03/2021	21:30	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	2 North Respiratory	Minor	Patient does not have capacity to leave the hospital. verbally aggressive and was trying to leave. Despite encourage, security had to be called.	At the time of incident, encouragement was taken to come back to her room. NOK was informed of incident and spoke to the patient on the phone.	1-1 CARE AT ALL TIMES TO MAINTAIN PATIENT SAFETY.	Final approval	22/03/2021

Personal	18/03/2021	06:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	GENSUR	4 North	Minor	Patient admitted to 4 North from ED following fall. CTB- subdural collection and contusions. Was medically fit for d/c but had increased confusion so refused by Personal. 18/03- Patient found on the floor between the sink and another patient's bed space. Patient had walked from bed space without his slippers on or his walking aid.	Assessed for bleeding, and fractures Physological and neurological observations checked Bleeped FY1 and reviewed patient. Unwitnessed fall protocol followed- GCS 14/15. Patient for R/P CT Brain.	Continue to have patients at risk of falls in observation bays. Encourage to wear slippers when mobilizing and use walking aids.	Final approval	24/03/2021
Personal	18/03/2021	18:35	Craigavon Area Hospital	Surgery and Elective Care	ATICS	RECOVE	Emergency Department CAH	Insignificant	Patient accepted by ICU Consultant as HDU from ED after attempted hanging, x2 prison guards accompanied patient. Patient went for CT and bed was not ready in ICU so patient was brought to trauma recovery. Staff in recovery where not contacted that this was going to happen. Patient arrived in trauma recovery without known covid swab result, where other patient where being cared for and without checking that a bed space was available for the patient. Patient to remain in recovery until ICU space available which will be 3-4 hours as per anesthetist.	Patient arrived to trauma recovery @ 1835hrs with on call anesthetist Dr L. patient accepted by Dr C ICU consultant as HDU as may need a Trache carried out due to compromised airway. Nil communication from ED staff or on call anesthetist's with recovery team or NIC that that a patient was coming to ward, nil check to see if a bed space was available, nil communication of the reason for admission or why they where coming. x2 prison guards accompanied patient, SNP took handover from ED nurse. Nil known result of covid swab result by ED nurse at this time- SnP looked up and PCR covid had just come back s negative. plan was to care for patient hourly observations and GCS until ICU bed available. Observe for deterioration in airway and contact ENT/ ICU team if needed. SnP contacted ICU NIC to get idea of time frame and was told they have 7 patients and need to get 2 out to ward before they can take the patient in recovery. this would take a few hours.		Being reviewed	
Personal	18/03/2021	18:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	1 South Medical	Minor	Flucloxacillin 2g IV Missed at 1200	Informed by nurse looking after patient TO NURSE IN CHARGE. Medical team to be informed in am		In holding area, awaiting review	
Personal	18/03/2021	13:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	grade 2 back right calf grade 1 front right leg	grade 2 covered with N-A ultra, ALLEVYN - and premierpore grade 1 N-A ultra and premierpore	Early recognition and intervention of pressure areas essential. Importance of carrying out skin checks as early as possible after arrival in ED.	Being reviewed	
Personal	18/03/2021	00:24	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	patient arrived to Ed via NIAS. patient was normally mobile and independent. has been drinking a lot 2L of vodka daily and has neglected himself has been sitting in chair in own urine for days. NIAS cleaned patient up. Skin check complete when patient arrived. Garde 2 pressure sore to scrotum, area extremely red and burnt from sitting in urine red area is blanching. inner thighs are burnt and blanching. left elbow extremely red and blanching. back extremely red and blanching. Moisture lesion to left buttocks. grade 1 pressure sore to left buttocks. grade 2 pressure sore to left buttocks. left thigh and calf red and blanching. grade 2/3 pressure sore to right buttocks. skin tear to right buttocks. right buttocks extremely dry and red.	sister in charge informed. pressure area care maintained air matters ordered recorded on skin map		Being reviewed	
Personal	18/03/2021	15:15	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Emergency Department CAH	Minor	NAME GIVEN FROM BED MANAGEMENT FOR TRANSFER TO WARD BUT WERE ADVISED THAT LAMIRA WAS REPEATED. NO KNOWLEDGE OF PCR +. PATIENT TRANSFERRED TO 2 NORTH WITH PORTER AND NO NURSING HANDOVER GIVEN TO WARD STAFF.	WARD MANAGER INFORMED.- SHE CONTACTED ED SR TO INFORM OF INCIDENT. SPOKE TO NURSE CARING FOR PATIENT- HANDOVER PROVIDED.		Being reviewed	
Personal	18/03/2021	08:15	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Emergency Department CAH	Minor	Patient absconded from ED department was admitted for alcohol detox but has left with cannula in arm without forming any medical or nursing staff	Absconding policy completed	Keep patients at risk of absconding in area visible to staff.	Being reviewed	
Personal	18/03/2021	09:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	GENSUR	4 North	Insignificant	Patient given a cup of tea by Domestic Staff which was not thickened to level 3 consistency as clearly stated on notice above bed. Patient took 2 sips of un-thickened tea and immediately developed a coughing episode.	escalated to FY1 NEWS 7 RR40 SPO2 90% RA Nebs administered Oxygen administered to aim SPO2 >94% CXR requested Chest Physio Consultant informed D/W SALT of all food and fluids to be withheld for 24 hours until further assessment Family informed by Consultant	Ensure patient menu sheet is updated daily for Domestic staff and all staff are aware of adhering to signage above patients bed regarding diet and fluids were appropriate.	Final approval	22/03/2021
Personal	18/03/2021	16:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	REHAB	Stroke / Rehab	Minor	PATIENT SLIDDED FROM THE CHAIR TO THE FLOOR, IT WAS WITNESSED BY ANOTHER PATIENT ON THE WARD.	DOCTOR ALREADY IN ATTENDANCE, EXAMINED THE PATIENT AND ADVISED THAT NO INJURIES WERE NOTED. PATIENT WAS HOISTED TO BED AND NOK INFORMED. FALLS PROTOCOL FOLLOWED. CNS OBSERVATIONS CARRIED OUT. FALLS ASSESSMENT UPDATED	None.	Final approval	23/03/2021

Personal	18/03/2021	10:45	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	GENSUR	3 North Medicine	Minor	Patient brought to Recovery following Surgical procedure. Handed over from Anaesthetic nurse that pts skin integrity on arrival was very poor and had queried with ward staff need for Tissue viability input. Patient repositioned, skin at vulval area extremely excoriated, cleansed and cavillon applied to same. Skin at sacral area extremely red/purple, blanching but seeping Grade 1 moisture lesion noted to Right sacral/buttock area with skin fold, cavity type area with yeast like substance again cleansed and cavillon applied to same. No repositioning chart found in patients notes since 16/03 from ward 3North prior to transfer to Trauma ward at midnight that day	Sister Person informed and area rechecked in presence. Skin cleansed and zero pressure applied to Left side. Cavillon cream applied	Sent to 3 north for investigation and for lesson to be addressed	Being reviewed	
Personal	18/03/2021	07:00	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Minor	patient found on floor beside trolley, in which was previously sleeping on. patient roused awake and got up of the floor and back into bed stated that he could not remember falling out of bed. states has hit his head, pt has alcohol on board. observations recorded and medical team bleeped. they will come and review patient	observations recorded. medical team will assess patient.	head injury advised leaflet must be given to all patients that present with head injury shared at safety briefing w/c 22/03/2021	Being reviewed	
Personal	18/03/2021	18:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Minor	patient admitted to amu with faf secondary to alcohol. patient had an amiodarone infusion and another bag of ivf connected on arrival. on looking at fluid balance to continue ivfs, fluid balance noted to not be completed at all throughout the day. no input or output. patient was on cardiac monitor	contacted ED to correct same		Being reviewed	
Personal	18/03/2021	22:17	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Patient attended CAH ED at 22.02 Booked on at front desk with clerical staff - presenting complaint = overdose Called for triage at 22.17 Not in waiting room Did not wait Patient contacted department at approx. 23.00 and informed clerical staff that we was at his mother's and did not want to come back to department. Following discussion with Senior Dr, Non-Emergency 101 Police Service contacted and pt welfare check to be carried out. Police contacted at 23.33. No further contact from PSNI so I contacted for an update at 02.57. PSNI had called at address where Personal was sleeping, mother present to say she would look after him. Discussed same with Senior Dr in charge and happy for patient not to be brought back to department.	101 Non Emergency protocol	Keep patients at risk of absconding in area visible to staff.	Being reviewed	
Personal	18/03/2021	20:55	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	patient ED with intentional self harm to arm with Stanley knife. Patient also had alcohol on board. pt absconded from department.	appendix c completed. psni contacted. psni found patient at home with girlfriend. refusing to return. states to police will return in am to seek medical attention.	missing person procedure commenced	Being reviewed	
Personal	18/03/2021	08:30	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	Emergency Department CAH	Minor	Security requested by ED Yellow area reporting that a patient of theirs had absconded.	Security took the description of the patient and searched all areas as per their SOPs and did not locate the patient. Nursing staff were informed and the police were then contacted.	keep patients at risk of absconding in area visible to staff.	Final approval	
Personal	18/03/2021	09:00	Craigavon Area Hospital	Surgery and Elective Care	ATICS	THEAT	Theatres 1-4 CAH	Minor	Patient had hypoxic cardiac arrest and not ventilating due to laryngeal tumour obstruction. Attempted to intubate with rigid laryngoscope and broke his front upper teeth x3	Informed patient and his wife and will try to get this fixed once he recovers from his laryngeal cancer treatment		Being reviewed	
Personal	18/03/2021	00:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Ramone Ward 4	Minor	SN Personal POD CD missing for patient 18x20mg MST signed into POD register (in MDS) on 1/3/21, but when matching up registered items to what was in cupboard, this MDS was not there.	- Spoke to S/N in charge, didn't remember this patient. - Patient was transferred to DHH Level 4 on 3/3/21, asked pharmacist there to check if POD had moved over with patient but it hadn't. - I informed Senior members of pharmacy staff - Sign added to CD cupboard to remind S/Ns that POD CDs must be signed out again.		Being reviewed	
Personal	18/03/2021	20:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	patient confused and found to have grade 2 on sacrum	dressed by staff	Early recognition and intervention of pressure areas essential. Importance of carrying out skin checks as early as possible following arrival in ED. Elderly frail patients need moved from trolley to bed at earliest opportunity.	Being reviewed	

Personal	18/03/2021	06:45	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Moderate	Patient attended ED following an overdose & stating thoughts of life not worth living. CAMHS referral should have been completed prior to discharge however this was not done. Patient has discharged with no Mental Health assessment and no Mental Health follow up for support.	Notified Sister in ED & Doctor's involved in patient care requesting a CAMHS referral is completed urgently.		Being reviewed	
Personal	19/03/2021	10:30	South Tyrone Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Ramone Day Clinical Centre	Moderate	I sent the syringe driver to EBME DEPT FOR REPAIR, it went via internal post and lost	checked in postal department and EBME department, from last week,		Being reviewed	
Personal	19/03/2021	12:20	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	2 North Respiratory	Moderate	Patient got up to use urinal at side of bed. Lost balance and slid down the wall onto the floor. unwitnessed by staff.	checked for injury, minimal assistance given to stand up, sat back down in chair. News and GCS taken, doctor informed and assessed patient, CT brain already booked from WR- await same. Family to be informed, no answer at present.		Being reviewed	
Personal	19/03/2021	23:00	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	Patient had been victim of domestic violence & sustained head injury. Refused to stay for admission, as no-one at home to monitor HI. left department intoxicated.	security contacted[/] absconding form[/] PSNI informed [/] IR1 [/]	nil	Being reviewed	
Personal	19/03/2021	22:30	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Ward 3b	Insignificant	Pt mobilized to bathroom with supervision. A short time later a 'bang' was heard and pt called 'nurse'. I went into bathroom and pt was found sitting on floor on bum in upright position. States she did not hit her head. No visible injuries noted. Pt stated she had pain left knee but no injury/ bruising/ cuts noted.	Assisted x2 staff from sit to stand position. Mobilized back to bed. News 0. Gcs 15/15. 500mg paracetamol given. Nurse in charge aware. F1 doctor contacted. Falls protocol followed accordingly.	STAFF TO FOLLOW THE FALLS PATHWAY PROCESS TO HIGHLIGHT LEARNING AT ALL SAFETY BRIEFS	Final approval	24/03/2021
Personal	19/03/2021	19:30	Daisy Hill Hospital	Functional Support Services	LOCNE	DOMNE	Surgical Assement Unit	Moderate	DOMESTIC FELL FROM SECOND STEP AS SHE WAS COMING DOWN AFTER HANGING A CURTAIN IN MALE SURGICAL WARD 2 - SHE BANGED HER CHIN ON DOMESTIC WASTE BIN BEFORE SHE FELL ON FLOOR.	DOMESTIC WAS TAKING TO ED FOR TREATMENT BY ANOTHER DOMESTIC ON THE FLOOR.	Going forward all steps to be replaced with suction feet as opposed to steps where brakes need to be manually engaged	Final approval	30/03/2021
Personal	19/03/2021	22:10	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	Ramone Ward 4	Insignificant	@2210hrs found patient lying on the floor at bedside in side room 7, incontinent of urine and floor wet with urine. Remains confused and moving all limbs. no obvious injury.	Hoisted back to bed with help of 4 people. CNS observation done as per falls protocol. Bed manager notified and Hospital at night informed. FY1 reviewed patient post fall	Importance of ensuring adequate supervision for all patients at risk of unpredictable behavior and falling Importance of communicating all patients at risk of falls to all staff members at ward safety brief.	Final approval	22/03/2021
Personal	19/03/2021	15:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	3 North Stroke	Minor	Patient had a scab on back of head which came off resulting in a new grade 2 pressure sore.	Wound was dressed accordingly Wound Management Chart commenced TVN referral sent Skin Bundle updated Braden and Pressure Pathway updated		Being reviewed	
Personal	19/03/2021	17:30	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Patient attended ED @ 14:59, moved to yellow area @1700, patient checked and urine incontinence noted changed, grade 2 noted on sacrum.	grade 2 cleaned and dressed. patient placed on hospital bed and positioned on right side.	Early recognition and intervention of pressure areas essential. Importance of skin checks being carried out as early as possible after arrival and patients moved on to a hospital bed promptly.	Being reviewed	
Personal	19/03/2021	17:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	patient had presented to ED confused and unaware of how they got to ED. when asked they had said they had came from bluestone. pt had left bluestone area. and came to the emergency dep.	bluestone bed manger contacted. sister informed. pt brought back to bluestone.	none	Being reviewed	
Personal	19/03/2021	20:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Insignificant	patient x became increasing verbally and physically aggressive hitting out at staff members attempting to bring him to safety	additional staff attended, security attended, medications reviewed, fy1 contacted	Emphasize in patient safety briefing and hand over of patients who need close supervision. Distraction technique that deescalate the patients distress and agitation. No documentation in nursing notes same informed to in charge and staff who was on duty.	Being reviewed	
Personal	19/03/2021	02:47	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Insignificant	Security requested to AMU as a male patient had become aggressive towards nursing staff. And was refusing to go back to his bed.	Security arrived to AMU and witnessed a male patient at the back nursing station acting aggressively towards nursing staff. Security asked the patient to return to his be to which he complied. Security stayed a short time until the patient settled. and were then stood down.	None	Final approval	
Personal	19/03/2021	20:08	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	3 North Medicine	Minor	At the time stated security was called to 3north on arrival security observed a male patient sitting on his bed. Nursing staff informed security that he was very aggressive towards them and trying to hit out at them.	Security assisted with nursing staff as they give the patient medication to help settle him down but he became more aggressive so security had to restrain patient in low level MAPA hold. Medication was giving by staff and patient settled down and short time later security was stood down and went back to portering duties.	None	Final approval	
Personal	19/03/2021	20:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Insignificant	patient x during a period of outward physical aggression grabbed sn by the arm and squeezed causing a large reddened area to the upper left arm	security contacted, fy1 contacted, additional staff in attendance, medications reviewed, staff member removed from immediate situation, staff member did not wish to attend ED	Emphasize on patient who are 1:1 on safety briefing and hand over. Staff didn't document in nursing notes about the incident same discussed with in charge.	Being reviewed	
Personal	19/03/2021	16:00	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	pt attended ED at 1454 skin checked at 1600 noticed G4/fistula in L inner buttock and old healed pressure sore to top of sacrum. Pt is assistance of 2, wheelchair bound, has careers QID lives in fold. No notes from fold brought in	Datix, patient moved onto hospital bed and ED skin intervention chart started	nil	Being reviewed	

Personal	19/03/2021	11:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Staff member accompanied a high risk of self harm patient to have a smoke outside, which he had done earlier in the morning with staff. Patient proceeded to run from staff member who followed Personal for period of time trying to persuade him to return to emergency department. Patient left hospital grounds.	Porters informed of patient absconding. Staff contacted PSNI 101 to report him missing and state he is high risk of self harm. Description given. Next of Kin informed relative had left department. Psychiatry team informed patient had left department. Appendix C completed. Most senior doctor present informed of incident as well as a sister in the department.	Keep patients at risk of absconding in area visible to staff. Activate Absconding Protocol promptly.	Being reviewed	
Personal	19/03/2021	19:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Patient presented to ED from own home with Grade 3 pressure sore (R) lower leg (injury to leg at home few weeks ago) On oabs with gp for same District nurse dressing same	Patient cared for on hospital bed transferred to 1n Independently mobile	None	Being reviewed	
Personal	20/03/2021	18:40	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	STAFF MEMBER NAMELY MYSELF WAS VERBALLY ABUSED BY A PATIENT WHO ALSO STATED HE DID NOT WANT ME TO CARE FOR THEM IN ANY WAY OR FORM .HE ASKED ME IN A VERY AGGRESSIVE MANNER TO GET OUT OF CUBICLE	I SPOKE with nurse in charge Person and informed her I have been affected mentally by this patients conduct to me . sister Personal also aware of incident		Being reviewed	
Personal	20/03/2021	23:30	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Moderate	Unsettled, agitated and confused. States nursing staff have 'set the hospital on fire', are 'trying to kill her' and we are 'horrible people' Re-orientated to time & place to which she replied 'I know where I am'. De-escalation techniques attempted with no effect. Grabbing staff nurses wrists and digging nails into nurses hands. Refusing to sit down and continues to stand in the middle of the corridor. Whilst staff dealing with acutely unwell patient and another aggressive patient (security called for said patient), Personal left briefly on her own and went into the office and phoned 999. When realized SN Personal spoke to the operator and explained the situation.	Re-orientated patient to time and place - nil effect. De-escalation techniques attempted - nil effect. Reviewed again by medical staff - IM haloperidol given. Assisted to bed with assistance x 2. Sitting on side of bed currently with HCA in attendance. Currently 1 HCA in bay with 2 x 1-1 patients due to high number of 1-1 patients on the ward.		Being reviewed	
Personal	20/03/2021	21:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Moderate	Ambulance arrived to collect patient for transfer. Patient refused to get into chair and be transferred back to nursing home. Very agitated. Phoned daughter to see if she could persuade Person to be transferred. Perso refused to speak to Personal . Phone put on speaker phone & Personal attempted to speak to Perso - Person stated it was not Perso on the phone. Attempted transfer again after phonecall but unsuccessful. Patient continued to be agitated. Locked herself in the bathroom twice and required nursing staff to pick the lock from outside. De-escalation techniques attempted but unsuccessful. Tea and toast offered. Attempted to give oral meds - grabbed tablets out of hands and threw on the floor. Aggressive towards staff - hitting and grabbing at nursing staff wrists. Assisted back to bed with assistance of 2.	Phoned daughter in attempt to settle and be transferred home. De-escalation techniques attempted but unsuccessful. Oral medication offered and refused. Contacted FY1 to review due to aggression. Reviewed and IM lorazepam given as prescribed. Refusing all observation and interventions.		Being reviewed	
Personal	20/03/2021	19:00	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	CANCER	ONCOLO	Oncology Clinic, Mandeville Unit	Minor	Pt commenced on syringe driver for sickness post chemo by Mandeville unit and discharged home19/3/21. No referral made to DN service so unaware of need for call. Marie curie replenished same 20/3/21 and informed DN of need for call 21/3/21	DNS arranged visit for 21/3/21 to replenish driver		Being reviewed	
Personal	20/03/2021	10:50	Craigavon Area Hospital	Medicine and Unscheduled Care	CSMUC	CARDIO	1 North Cardiology	Minor	unwitnessed fall. Personal was looking through his belongings in his locker and fell backwards onto the floor. found on his back. states he never hit his head are had any pain.	Assessed for any injuries before assisting up. Vital signs obtained NEWS 2 due to BP 95/62 asymptomatic, GSC 14/15 due to confusion (baseline from admission), PEARL, normal power to all limbs. Lying and standing BP obtained no significant changes. F1 informed and reviewed. Plan: CT brain, Neuro obs as per protocol.	News not carried out as per protocol escaled to Sn concerned	Final approval	24/03/2021
Personal	20/03/2021	02:15	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Insignificant	Found male patient on the floor at bedside.	Assisted back to bed, Observation taken/GCS. Body checked and Inform the clinical coordinator/FY1	ensure nursing assessments completed on admission and updated when there is a change in cognition.	Final approval	22/03/2021
Personal	20/03/2021	10:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Minor	Patient admitted with grade 2 sore on Rt buttock	Dressing renewed and allevyn dressing applied. Wound careplan initiated. Datix completed.	Through skin inspections to be carried out on admission/ transfer to ward. Assessment of Braden and mobility and determining correct pressure relieving devices are selected.	Final approval	22/03/2021
Personal	20/03/2021	12:20	Daisy Hill Hospital	Surgery and Elective Care	GENSUR	GENSUR	Female Surgical/Gynae	Minor	STAFF MEMBER WAS CARRYING THE MEAL TRAY FROM THE TROLLEY WHEN SHE SLIPPED AND FELL AND HIT HER ELBOW. WATER FROM THE SHOWER HAD LEAKED ONTO THE CORRIDOR	FIRST AID CARE GIVEN, ICE APPLIED TO ELBOW.CONTACTED BEDMANAGER, ADVISED TO GO TO A&E TO GET CHECKED BUT REFUSED TO ATTEND.	0	Final approval	29/03/2021

Personal	20/03/2021	07:00	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	Patient absconded from department under the influence of alcohol against the advice of seeing doctor. Security already in attendance, however patient ran away beyond hospital security jurisdictions	Hospital grounds searched Patient Phoned - no answer Mother (Next of Kin)- no answer Appendix C completed Psni Contacted to perform a welfare check (no mental health issues)	nil	Being reviewed	
Personal	20/03/2021	06:40	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Emergency Department DHH	Insignificant	security called to emergency dept patient would not stay ran out the front doors across the road doctor informed to contact police. left at 06.50 .	none	none	Final approval	22/03/2021
Personal	20/03/2021	11:00	Daisy Hill Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, DHH	Moderate	33+2 week stillbirth	delivered		Being reviewed	
Personal	20/03/2021	08:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	2 South Medical	Insignificant	Patient was found on the floor during handover. Fall protocol completed. Patient assisted off the floo and was seen by the doctor. Nil visible injury. Doctor says patient can eat and drink.	Patient assisted back to bed, clinical obs carried out. Doctor and NOK informed		Being reviewed	
Personal	20/03/2021	22:40	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Insignificant	Patient began to become agitated and verbally threatening towards staff, attempting to leave	po lorazepam given verbal de-escalation used	escalate need for 1-1 review meds liaise with pysch liaise with MDT Importance of communicating all patients with risk of aggression with all ward staff at ward safety brief.	Final approval	22/03/2021
Personal	20/03/2021	23:35	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	3 North Medicine	Insignificant	Security was called to 3north. On arrival nurses were stopping a patient who was using a walking frame from leaving the ward. She was being aggressive and trying to hit out at the staff.	Security talked to the patient and the nurses were able to direct her back to her bed to which she got an injection to help settle her down. Security was stood down short time later.	None	Final approval	
Personal	20/03/2021	23:30	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Insignificant	patient become increasing verbally and physically aggressive towards staff. walking in corridor to de-escalation situation but became increasing aggressive attempting to throw zimmer frame at staff. also proceed to slap staff. unable to control behavior at ward level	security phoned. im haloperidol for intervention	escalate need for 1-1 review meds liaise with pysch liaise with MDT Importance of communicating all patients with risk of aggression with all ward staff at ward safety brief.	Final approval	22/03/2021
Personal	20/03/2021	13:50	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Emergency Department DHH	Insignificant	security called to emergency dept to look for a missing patient had a look out the front of the site no sign reported this back to sister in emergency dept.	none	none	Final approval	22/03/2021
Personal	20/03/2021	19:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	when completing skin check on pt noted G2 to L buttock, G3 & G$ to both legs	skin check complete sister incharge informed dressing applied pt informed of same body map complete DR informed regular repositioning for PT	Early recognition and intervention of pressure areas essential. Importance of carrying out skin checks as early as possible after arrival in ED. Ensure patients are moved off trolley and on to a bed promptly.	Being reviewed	
Personal	20/03/2021	19:50	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	on completing skin check for pt noted G2 to R buttock	first aid dressing applied pt repositioned and pt for regular repositioning sister in charge informed pt information body map complete	Early recognition and intervention of pressure areas essential. Importance of carrying out skin checks as early as possible after arrival and moving patients on to beds promptly.	Being reviewed	
Personal	20/03/2021	08:30	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Minor	Patient had an unwitnessed fall from the chair at 08:30.	Assistance x3 staff given back to chair. F1 contacted to review. NEWS 2- sp02 93%, GCS 14/15 F1 reviewed patient- nil ordered, continue with falls protocol until consultant review.		In holding area, awaiting review	
Personal	20/03/2021	21:30	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Patient attended Ed with hyperglycaemia, diagnosed with DKA, and accepted medically for admission. As pt is Per Blossom accepted pt for admission there as no medical beds available elsewhere in the hospital. After pt transferred to ward, paeds staff got in touch with ED staff re IVF's which transferred with patient. 0.9% sodium chloride with 20 KCL was prescribed correctly on FBC but 5% glucose with 20KCL was what was administered in Ed. Pt received approx <250 mls of same.	fluids were stopped and correct fluids commenced Resus nurse attended blossom ward to discuss	Two person checks for all IV administration. Clear and appropriate storage	Being reviewed	
Personal	20/03/2021	21:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Moderate	Personal old admitted with DKA and commenced on paediatric protocol. Admitted to Blossom Unit under the care of acute medical team as no adult medical beds available. I was contacted by the Paediatric Registrar to inform me that the incorrect bad of fluids had been administered in ED despite appropriate prescription by medical staff. It was noted on the patient's arrival to the ward that 5% Dextrose + 20mmol KCl had been administered (instead of the 0.9% NaCl + 20mmol KCl that had been prescribed) and the batch numbers on the fluid chart and on the fluid bag did not match.	Fluids immediately taken down and appropriate fluids administered. Immediate review by paediatrics registrar and explanation given to family. ED contacted and informed of error	Appropriate checks and trust policy adhered to. Importance of fluid management/	Being reviewed	

Personal	20/03/2021	09:55	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	GENSUR	4 North	Minor	Pers was in side room as had been requiring chest physio. Sitting on chair having breakfast. Staff noticed patient sitting on floor beside chair. No injury apparent. Patient states she tripped on catheter. Assisted patient back to chair. NEWS stable, GCS 15/15.	Unwitnessed fall protocol put in place. Senior review. Patient for CT Brain- improvement of old SAH. Family updated of same. Patient moved into open bay for closer observation. SRC removed to reduce hazards of trips. Falls risk assessment updated	Move patients at risk of falls out of side rooms into observation bays at earliest opportunity when not requiring isolation.	Final approval	22/03/2021
Personal	20/03/2021	17:00	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	DEAW	Minor	Assitsing pt to the commode - noticed 2X grade 2 to sacrum	Informed NIC and will inform NOK		In holding area, awaiting review	
Personal	20/03/2021	21:00	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	2 West Maternity Post Natal	Minor	Postnatnal readmission with DVT	Admitted to 2 West for therapeutic clexane and urgent scan tomorrow.		Being reviewed	
Personal	20/03/2021	07:15	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Patient in ED with mixed OD, unwitnessed fall, has large raised haematoma to forehead.	Doctor present when patient fell, observations including neuro obs carried out, patient advised not to mobilise without assistance. ?? fell over bedrail	Close supervision required for patients at risk of falling. Ensure appropriate placement in safe area.	Being reviewed	
Personal	20/03/2021	09:00	Daisy Hill Hospital	Surgery and Elective Care	GENSUR	GENSUR	High Dependency Unit	Minor	patient was admitted to the unit on 20/03/2021 @0415hrs transfer from home via A/E. it was noted on his skin check that both heels very red and soft to touch C/O pressure pathway and repositioning chart at this time and recommended patient transferred onto pressure relieving mattress as soon as one available. It was noted that morning by day shift that right heel was blistered same elevated off bed and patient place on a ario pro dynamic pressure mattress. repositioning chart completed pts braden score 12 on admission.	commenced on pressure care pathway, commenced on repositioning chart repositioning times 2-4hrly and prn . Pt placed on a dynamic pressure relieving mattress . patients MUST score 0. documented on Patients skin check and MAP area effected . Nurse spoke with pts wife re patients mobility at home stated he has spent a lot of time in bed following a recent UTI and fall. Advice given to patient re importance of pressure relief assistance needed from staff to change position in bed. on 22/3 it was noted that blister had burst same not oozing but slight area of bloody discolourtion noted alleyvn heel pad applied to as friction and sheer is a potential problem as pt requires assistance to transfer in bed by 2 nurses and a sliding sheet and yellow tubifast to secure heel pad in place, same to be checked when repositioning patient.	0	Being reviewed	
Personal	20/03/2021	01:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	skin check revealed g3 on scarum area, not documented within nh notes. no dressing in place	datix, reported to sister , dressing applied, put onto side on trolley	Early recognition and intervention of pressure areas essential. Importance of carrying out skin checks as early as possible and moving patients on to a bed promptly.	Being reviewed	
Personal	20/03/2021	18:15	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Ward 3b	Minor	patient was found sitting on floor in side ward at bedside. stated she had fell and hit her shoulder on waste bin when she fell. stated she did not hit her head. no obvious injury observed.	assisted by staff to standing position and returned to bed. News and CNS observations commenced. ECG and BM recorded. physician associate on ward at time and informed of fall. FY1 and reg on ward a short time following fall and informed. family contacted and informed.	falls assessment incomplete on admission. Foot wear poor and needs to be addressed with family safety brief wit staff to highlight poor record keepinh practice	Final approval	24/03/2021
Personal	20/03/2021	01:50	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Minor	SIGNIFICANT MECHANISM OF INJURY-DRIVER OF CAR INVLOVED IN RTC, ALCOHOL ON BOARD UNDER ARREST, AIRBAGS DEPLOYED-PATIENT WAS DUE C.T NOT CARRIED OUT-PATIENT WAS AGITATED AT TIME SHE LEFT DEPARTMENT. PATIENT OBSCONDED FROM E.D	SECURITY CALLED-GROUNDS SEARCHED-PATIENT NOT FOUND-REPORTED TO POLICE.	nil	Being reviewed	
Personal	20/03/2021	02:15	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Emergency Department DHH	Insignificant	security called to emergency dept, missing person,security had a look round the site no sign of this person so sister in charge told to in form the police.	none	none	Final approval	22/03/2021
Personal	21/03/2021	08:20	Community	Pharmacy	PHARM	PHASEP	South Lakes Leisure Centre	Minor	Technician (Personal) making up Pfizer vaccine in SLLC added Sodium chloride 0.9% to the vial of vaccine. She did not let the pressure equalize properly within the vial and diluent sprayed out. COVID vaccine	Vial of vaccine could not be used as there was small drips od idluent on the tray and on the technician's glove so not all diluent entered the vial.		In holding area, awaiting review	
Personal	21/03/2021	20:50	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	GYNAE	1 East Maternity/Gynae	Minor	Patient had a fall whilst being transferred from chair to the bed. Fall was witnessed by a Health care Assistant	assisted back to bed fy1 called news recorded gcs obs bm checked temporary dressing to ear		Being reviewed	
Personal	21/03/2021	02:00	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Coronary Care Ward	Insignificant	patient became aggressive when staff went to get him back to bed started to kick out an tried to bite staff mapa was used to get him in to bed low level an again when injection was given patient calmed down ,security left at 0250. called back patient hitting out at staff as well as trying to get out of the bed mapa again was used stood down at 04.10	none	none	Final approval	22/03/2021
Personal	21/03/2021	09:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Moderate	Patient admitted from home with DTI and Grade 2 on sacrum. Contacted district nurse who is unaware of same	Mattress ordered, dressing insitu, pressure sore prevention pathway in place with skin bundle. TVN referral completed.	Skin check on admission essential	Final approval	26/03/2021
Personal	21/03/2021	18:00	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	2 West Maternity Post Natal	Minor	postnatal readmission with sepsis ?PE CTPA - prov report no PE 17/3 Report amended by radiology saying cannot exclude PE but no medical staff informed. Ammended report found by chance on 21/3 prior to return to theatre.	repeat CTPA showed no PE Radiology CD emailed for info on processes.		Being reviewed	

Personal	21/03/2021	14:25	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Minor	14:25 2 O neg requested by ward. no red alert was called but a few minutes later a phone call was received staning down the red alert. during the stand own it was stated by the ward that they still required O neg blood. the BMS in the lab stated that group specific blood could be readied for the patient in less than 10 minutes that the lab only required a sample. the ward refused this and insisted on the O neg. A porter then arrived with no sample and got the O neg blood. approximate 3 hours later the ward contacted blood bank to ask about how to send the O neg blood back again as it had not been used	blood provided as requested by ward		In holding area, awaiting review	
Personal	21/03/2021	00:30	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Insignificant	patient was sitting on the beside being aggressive towards staff, while 1:1 was in place and monitoring. patient proceeded to punch hca in the stomach	prn used more than 1:1 staff needed at times	escalate need for 1-1 review meds liaise with pysch liaise with MDT Importance of communicating all patients with risk of aggression with all ward staff at ward safety brief.	Final approval	22/03/2021
Personal	21/03/2021	14:20	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Grade 3 on sacrum and necrotic area to right big toe. District nurse comes out to patient to dress.	Cleansed and redressed sacrum grade 3. Dressing on toe remained intact. Nurse in charge informed.	Early recognition and intervention of pressure areas essential. Importance of carrying out skin checks as early as possible after arrival and moving patients from trolley on to a bed promptly.	Being reviewed	
Personal	21/03/2021	12:15	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	2 South Medical	Minor	Unwitnessed fall in toilet	checked for injury, helped get patient into a chair and into his own chair, observations complete started neuro obs,informed doctors, informed nurse taking care of patient, informed family.	Post falls pathway completed following fall. Safety brief updated, patients who are high risk of falls not to be left unattended	Final approval	30/03/2021
Personal	21/03/2021	20:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Pt is open to OST CAT and is prescribed 10mg Espranor. He last attended community pharmacy on 20/03/21 and was given his dose for 21/03/21 as the pharmacy are closed. Pt was brought to ED CAH by PSNI on 21/03/21 and was assessed by ILS. In ILS summary letter it included that ED staff prescribed a stat dose of espranor for that day. Pt was then return to PSNI custody. Potentially had two doses of Espranor that day.	Discussed at MDT when staff became aware of near miss incident and completion of datix was advised		Being reviewed	
Personal	21/03/2021	19:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Insignificant	SN Personal commenced shift at 1300 During handover informed PT had ?14 episodes of placing himself on floor Pt placed himself on floor x 2 while in care of SN Personal NIC aware of issue and falls risk While SN Personal on break ED SR states patient was about to fall when she ran over and assisted him to ground. No obvious injuries witnessed by ED SR Throughout shift pt very agitated and aggressive Multiple threats, attempts to punch/ kick/ bite SN Personal Pt scratched SN Personal resulting in 5cm minor abrasion to R wrist	NIC aware of ongoing issue of patient placing himself on floor PT assisted back into bed/ chair assessed for injuries Vitals reviewed Medics aware. SN Personal advised to complete Datix by SR Personal Wrist Abrasion cleaned under tap and dressing applied ED SR aware of injury		Being reviewed	
Personal	21/03/2021	10:30	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Moderate	Prescribing error in ED Yellow Area: Isosorbide mononitrate M/R 50mg BD prescribed and then the 50mg dose was written over and changed to say 100mg. Dose signed for at 10pm on 20/3/21 and at 10am on 21/3/21. Drug history completed and patient should only be on 100mg ONCE daily in the morning.	Pharmacy technician highlighted error on Kardex to pharmacist in ED Yellow Area. Pharmacist informed nurse in charge and also nurse looking after patient. Advised hourly observations. Pharmacist corrected the prescription. Datix submitted.		Being reviewed	
Personal	21/03/2021	03:21	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Minor	red alert called at 03:21 on 21/03/21. 3 units of red cells used, 2 FFP used and 2g of fibrinogen used. red alert stood down at 04:30.	red alert protocol followed by blood bank		Being reviewed	
Personal	21/03/2021	21:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	General Male Medical,	Minor	Patient was told by Ward Medics this evening that she could go home,dressed and ready to go at 21.00hrs. Nil handed over re same nil documented in medical notes for home, I informed patient unfortuntley not for home this pm. Patient upset reassured as able.	Nurse contacted at home re situation who states patient not for home. Bed Manager Personal contacted ward re bed situation and if patient had been discharged yet I explained from my side of events she not for discharge this pm, Personal said in handover plan was for home. I explained situation unacceptable me upsetting patient and as per F1 .no paperwork complete for discharge. Personal states patient for home she wants to go and spoken to by F1 re same, patient arranged lift and left ward with HCA no paperwork complete advised to phone ward in am to collect same.		Being reviewed	
Personal	21/03/2021	00:50	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Minor	Female patient witnessed fell on her left side, while walking with ZF towards the toilet.	Assisted to get up, OBS taken, Body checked done		Being reviewed	
Personal	21/03/2021	10:00	Craigavon Area Hospital	Functional Support Services	LOCCB	DOMSCB	Ramone Ward 4	Minor	Dishwasher door flipped up quickly and very minorly cut the left wrist	Details taken, no treatment required	NA	Final approval	25/03/2021

Personal	21/03/2021	12:15	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	AMU	Minor	person affected had a witnessed fall by bedside f1 did not hit his head positioned sat up right by bedside falling back onto bedside locker sustaining a injury to right side of back bruised no open wound.	safety transferred back onto bed person affected states he did not hit his head either sitting bp 131/ 88 standing bp 116/71 fy1 bleeped to reviewed gmaws 4 FY1 review plan chest x ray analgesia nok informed	Managed appropristely	Final approval	30/03/2021
Personal	22/03/2021	13:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Moderate	Patient admitted TO ED, FROM GP asulcerated right leg ulcer to right lower leg being treated for one year to skin and swelling more painful than usual	referred to surgical team for admission and treatment, for antibiotic therapy		Being reviewed	
Personal	22/03/2021	13:00	Daisy Hill Hospital	Surgery and Elective Care	GENSUR	GENSUR	Female Surgical/Gynae	Insignificant	patients admitted on the 19/03/21 WITH PV bleeding, Referred to medics and alchol level completed today level above 200, patients property checked with her request - 2 empty bottles of cutan hand gel in bag states she had taken it for a tooth ache	all alchol gel removed form room , gynae team informed	0	Final approval	26/03/2021
Personal	22/03/2021	10:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Ward 3b	Major	patient has bilateral PE's , had covid vaccine astra Zeneca 12/02/21	Yellow card completed as requested by Dr Moan Patient now being treated with therapeutic enoxaparain and decision regarding anticoagulation still to be made		Being reviewed	
Personal	22/03/2021	15:00	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	Patient arrived to ED on completing skin check noted G4 pressure sore on bottom- district nurse aware	pressure mattress ordered, PACE chart commenced. regular skin checks	Early recognition and intervention for pressure damage, essential in the Emergency Department.	Being reviewed	
Personal	22/03/2021	15:50	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	Patient has cannula in R arm, was given IV DEX. Noticed swelling therefore administration was stopped. However after checking the site the arm has swollen significantly, red and tracking.	Skin chart completed. observation will continue, IV cannula was removed.	managed appropriately	Being reviewed	
Personal	22/03/2021	15:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Person ATTENDED THE EMERGENCY DEPARTMENT WITH A GRADE TWO PRESSURE SORE TO HER SACRUM. DRESSING WAS IN PLACE. WHEN THE NURSING HOME WAS CONTACTED THEY STATED THEY WERE AWARE OF THE ULCER AND HAVE BEEN MANAGING IT THEMSELVES AS Person IS NEW TO TE NURSING HOME IN THE LAST WEEK AND CAN NOT SEE DISTRICT NURSE UNTIL HER ISOLATION PERIOD IS OVER?	DRESSING EMOVED, AREA CLEANSED AND CLEAN DRESSING APPLIED USING ANTT		Being reviewed	
Personal	22/03/2021	21:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Minor	out of handover and bed manager insisting for patient to come to AMU with tracheostomy when no staff members are trained in this and no senior band6 to support staff, no respiratory nurse cover on night duty anymore unsafe environment for patient and staff who didn't feel competent in fulfilling their job role no support received, stated head of service/directors would be involved if patient wasn't accepted (even though patient was not medically accepted and required ENT out of hours to scope patient) lack of communication another patient in sideroom1 which was already on ward prior to our night duty, whom I refused on sat night and band 6 refused on sun night due to no staff training for these type of patients as a result in risk to staff and patients, inaccurate information given as we were told that patient was independent and selfcaring with laryngectomy which is not the case-patient is 1:1 risk of falls, confused+++ and is not independent with his needs patient centred care not achieved and a dangerous environment to work on and unable to fulfil their job role. this is risking our NMC Registration and extremely unsafe	bed manager aware and concerns highlighted numerous times +++ cc aware that we were unhappy due to lack of support in this difficult situation as a band5 to make this decision and same agreed	Managed appropriately at the time and ward sister sent further dates for training to be arranged to support staff	Final approval	30/03/2021
Personal	22/03/2021	11:00	Daisy Hill Hospital	Surgery and Elective Care	GENSUR	GENSUR	Female Surgical/Gynae	Insignificant	Personal receive a needle stick injury Correct procedure completed occ health informed and pathway completed	pathway completed	follow sharps guidance	Final approval	26/03/2021
Personal	22/03/2021	15:35	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	Patient signed CTMA, however did not wait to get IV access removed before leaving.	NIC informed Patient called 3 times, phone ringing but call being cut off after ringing.	nil	Being reviewed	

Personal	22/03/2021	18:00	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	DIAGNO	IMAMRI	MRI Unit	Moderate	Patient arrived from the care home with two staff members, the MRI safety form had been filled out and signed by staff nurse from the home in the NOK section. Patient wasn't compesmentis therefore MRI staff rang his sister to check the safety form for any contraindications to MRI. She said he had a gastric band operation in Personal and head surgery, neither of which were mentioned on the MRI safety form completed by the staff nurse or on the initial request form sent in by the referring dr.	The patient had to be sent back to the care home without the scan as we had no information on either surgery. Care home staff were informed as to why the patient couldn't have the scan done.		Being reviewed	
Personal	22/03/2021	13:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	3 North Medicine	Insignificant	On completing ward round Kardex check I came across a Kardex which had Mirtazapine 75mg prescribed. I thought this dose was higher than what I have ever seen before and asked my ward pharmacist for advise. The persons NIECR stated 45mg. The pharmacist double checked the dose and confirmed it should have been 45mg. Dr on ward informed and ECG carried out. Patient informed. (patient administered one dose)	Dr on ward informed. Patient informed. Note: Unaware who prescribed this initially as signature illegible.		In holding area, awaiting review	
Personal	22/03/2021	16:08	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Patient presented to ED with TLNWL. Absconded from ED despite being advised to stay. PSNI phoned. Brought back to department by PSNI. Patient's name	NOK Perso (wife) phoned and informed.	Ensure MHRA completed at triage if identified to be at risk. place in cubicle of observation which was done. Protocol followed well and patient returned safely.	Being reviewed	
Personal	23/03/2021	21:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Moderate	Pt was found in carpark of hospital by bystander acting bizarrely. same brought into ED. then absconded after triage.	porters were there at time of absconding. absconding protocol commenced. psni contacted. pt guardian/home informed. sister aware. events documented in notes.		Being reviewed	
Personal	23/03/2021	19:00	Daisy Hill Hospital	Surgery and Elective Care	GENSUR	GENSUR	High Dependency Unit	Insignificant	Worked long day on 23/03/21 .All aids utilized for patient care. At approximately 1900hrs I felt a pain across my lower back.	Continued to work until 2030hrs Off for 2 days and rested during this time but no improvement.	0	Final approval	26/03/2021
Personal	23/03/2021	17:30	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Stroke / Rehab	Insignificant	SECURITY GOT A CALL FROM STROKE\REHAB WARD PATIENT HAD GONE MISSING FROM THE WARD .SECURITY SEARCHED THE HOSPITAL SITE WITH THE HELP OF WARD STAFF NO SIGN OF PATIENT.INFORMED LATER BY WARD SISTER PATIENT HAD MADE HER WAY HOME.	NONE	none	Final approval	27/03/2021
Personal	23/03/2021	17:30	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	REHAB	Stroke / Rehab	Minor	At approximately 17:30 hours switchboard staff rang ward to inform staff that the above patients daughter was on ground floor waiting to collect her to take her home. HCA took call unaware that patient was not for discharge he escorted her to front door to daughter and he then went off duty.	When it was noticed that patient was absent from ward. Ward was searched security contacted.3 staff left ward to look for patient. patient flow contacted. advised to ring police. S/N Persona firstly rang next of kin who informed her that Patient was in her care. she informed S/n Persona that patient had rang her and informed her she was allowed to go home. This was not the case. Patient has a known confusion. Daughter advised to bring patient back to ward. Agreeable to same. She returned to ward at 18:30 hours.	Effective communication required between all team members re plan of care for patients. Ensure next of kin are made aware that a staff member will always contact them if patient is for discharge from hospital.	Final approval	25/03/2021
Personal	23/03/2021	05:20	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Ward 3b	Minor	PATIENT FOUND LYING ON FLOOR BESIDE BED SITTING UPRIGHT PATIENT DENIES LOOS OF CONSCIOUNESS .HAD BEEN TRYING TO GET OUT OF BED TO GO TO TOILET.PATIENT SLIPPED TO FLOOR NO SLIPPER ON FEET JUST SOCKS. PATIENT DID NOT PRESS THE BUZZER.PATIENT ASSESSED FOR SIGNS OF INJURY ASSISTED BACK TO BED GCS15/15 BED MANAGER INFORMED FY1 INFORMED FALS PATHWAY FOLLOWED	FY1 INFORMED BED MANAGER RINFORMED GCS 15/15 FAMILY TO BE INFORMED.PATIENT INSIDE WARD AS AWAITING REPEAT COVID SWAB .SPOKE WITH HCA(AGENCY) WHO HAD WALKED PATEINT TO THE TILET AT ABOUT 3AM AND FEELS SHE HAD FORGOTTEN TO PUT UP SIDE RAILS	HCA REFLECTED ON INCIDENT AND AWARE OF NEED TO REPLACE BEDSIDES WHEN IN BED . SAFETY BRIEF IGHLIGHTED REGULAR CHCKING OF HIGH RISK FALLS PATEINTS ENSUTING CALL BELL IN REACH OF PATEINTS	Final approval	24/03/2021
Personal	23/03/2021	06:00	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Minor	witnessed fall of patient onto both knees. low impact. patient lowered himself down to ground.	patient assessed by dr. assisted to feet with minimal assistance. observations recorded.	incident managed appropriately	Being reviewed	
Personal	23/03/2021	12:15	Craigavon Area Hospital	Medicine and Unscheduled Care	CSMUC	CARDIO	1 North Cardiology	Minor	Patient arrived to cath lab. On checking patient details he informed ourselves that he was given the razor to do own skin prep and had nicked a skin tag in groin area.	Assessed Skin tag in groin area, small ooze noted. Steri strips applied prior to procedure. SHO Personal then assessed area, still oozing pressure dressing to be applied.		Being reviewed	
Personal	23/03/2021	21:30	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Female Medical	Minor	Grade 2 pressure sore on Pts Right Buttock on admission to FMW.	Pressure relieving dressing, Pressure relieving mattress, Incident reporting ie - Medical team reposition chart	Nil	Final approval	25/03/2021
Personal	23/03/2021	08:00	Craigavon Area Hospital	Surgery and Elective Care	ATICS	THEAT	Theatres 1-4 CAH	Minor	Trauma Patient added to emergency list, ORIF right metacarpal for the next day. Covid swab was sent when patient was booked onto emergency list. Swab did not get tested or reported ?where swab was misplaced. When sending this morning for patient rapid swab had to be sent delaying sending for patient.	Rapid swab sent,40min delay, delayed sending for patient. Nurse in charge and surgeons informed of delay. Trauma coordinator informed theatre of issues.		Being reviewed	

Personal	23/03/2021	04:30	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Minor	patient attended ED with suicidal ideation. absconded before psych could complete their assessment.	brother called patient at home with him. refusing to return. psni called for welfare check.- psni states patient at home safe with brother, refusing to return and states that patient will seek medical treatment of own gp.	incident managed appropriately	Being reviewed	
Personal	23/03/2021	23:30	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Female Medical	Minor	patient found lying face down on the floor beside her bed her head was on a pillow unwitnessed patient stated she was tryng to get pillow from floor then unsure what happened patient assisted back to bed post fall pathway commenced no obvious injury doctor informed will ask day staff to tell N.O.K in am	checked for any lumps/bumps abrasions and pain , nil found 1/2 news for 2 hrs 1 hrly news for 4hrs then 2 hrly news cns obs the same 15/15 skin unmarket patient denies any pain from incident asked doctor martin to review still a/w r/v at time of writing datix	Nil	Final approval	25/03/2021
Personal	23/03/2021	23:45	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Patient attended ED with her daughter, who is her main carer. when skin check was attempted earlier in day, daughter stated skin was intact. Daughter went home, pt assisted to toilet and skin checked. Grade 2 discovered on right buttock.	dressed using N-A ultra and covered with alevyn. skin check documentation completed. patient advised to move while in bed.		Being reviewed	
Personal	23/03/2021	21:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	Female Medical	Insignificant	Resident was discharged from hospital yesterday late afternoon, staff were not informed by the hospital until after she was back in the bedroom in the building. Resident arrived with no discharge letter or medications.	SN on duty made contact with the ward for advice and was told they would be sent later. Home Manager called the Home around 9pm and there was still no documentation from the ward. SN on night duty tried to call the Ward at 10.15pm. SN managed to get through at 11.30pm. Verbal handover given by the SN on the ward. Resident should have received last dose of antibiotic therapy with her discharge paperwork. Additional changes were made at ward level and were not communicated to the Home. Commence laxido. Atorvastation and Ferrous Fumarate discontinued. Home Manager tried to call the ward this morning but have been unable to get through.	Discussed with SN that handover must be given to NH before patient leaves the ward. Issue also raised at PSB. Discharge checklist implemented on ward. Staff to ensure that if Red Cross are delivering medication that the d/c medication are delivered before 8pm.	Final approval	30/03/2021
Personal	23/03/2021	00:00	Community	Medicine and Unscheduled Care	GMMUC	GENMED	A* Homecare	Minor	Homecare provider administered dose 2 weeks and 6 days late . Discovered by GI pharmacist incidentally when she was copied into an email from homecare nursing re the patient's next dose. Nurse who administered dose contacted by pharmacist and nurse unaware dose was late. She stated nursing shortages causes problems.	Consultant informed by pharmacist . Pt reviewed by consultant. Incident reported officially to homecare provider for official response . Consultant reports incomplete response to therapy so far.		In holding area, awaiting review	
Personal	23/03/2021	07:00	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Minor	unwitnessed fall-patient found lying on ground against chair in seated area.	patient assessed by DR for injury. assisted to feet with minimal assistance. put on wheel chair + taken to cubicle for further assessment.	incident managed appropriately	Being reviewed	
Personal	23/03/2021	10:56	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	GYNAE	Gynae Clinic	Minor	smear under this patient's ECR record from Jan 2021 no smear taken had baby 28/01/2021	due for smear 4/52		Being reviewed	
Personal	24/03/2021	15:00	Craigavon Area Hospital	Functional Support Services	LOCCB	PORTCB	Portering	Insignificant	unable to use Portering computer system (Portertrac)	Fault logged on with IT and company contacted		In holding area, awaiting review	
Personal	24/03/2021	10:00	Armagh Community Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Antenatal Clinic	Minor	WOMAN ATTENDED A CIR APPOINTMENT IN ARMAGH THIS MORNING Personal NO CHART SENT AND NO OLD NOTES EITHER	REPORTED TO SISTER		Being reviewed	

Personal	24/03/2021	20:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	STROKE	Stroke / Rehab	Moderate	Patient discharged from level 4 stroke and rehab ward on 24.03.21 with an increase task to assist with feeding. Increase was agreed via email with community social worker on 24.03.21. Post discharge - hospital social worker was informed on 25.03.21 at morning MDT meeting that family phoned in at approx. 8pm to complain that careers would not assist with feeding due to no information in relation to modified diet or assist with medications in care plan. At point of discharge planning on 23.03.21 at MDT meeting hospital social work was informed feeding task required due to encouragement. Hospital social work was not informed of any SALT input. Hospital social work was not made aware of modified diet. Hospital social worker spoke with son and nephew on 24.03.21 and advised package of care would continue as per prior to hospital admission and to include feeding task due to encouragement- family was in agreement and no new needs or additional support needs identified.	Hospital social worker completed a retrospective NISAT to reflect need for assistance with medications and feeding. Hospital social worker included information to advise community of modified diet in NISAT. Hospital social worker requested nursing staff to complete a medication management form to facilitate medication and modified diet in care plan. Hospital social worker emailed community social worker to advise of issues post discharge, actions to resolve issues and updated information provided in a NISAT.		Being reviewed	
Personal	24/03/2021	13:40	Daisy Hill Hospital	Functional Support Services	LOCNE	PORNE	Occupational Therapy Dept	Insignificant	[redacted] approached me to a health care assistant came to at the supervisors office asking for assistance. She informed me there was a lady sitting on a chair at the Occ Therapy doors with a head wound. I took a wheelchair to and assisted the HCA. Upon arrival I saw a lady sitting on a chair, very upset, holding a tissue to her head. There was a small amount of blood on the tissue. This lady was accompanied by her friend. I asked the injured party her name and what happened. She stated that she was clipped on the head by an ambulance door and that the driver took her to a seat, fetched her some water and then told her to wait there and she would be back in 15 minutes. After ascertaining what had happened, myself and the HCA took the lady to A+E. I helped book the lady in and assisted her in to the waiting room. Myself and the HCA then assisted her friend the main foyer to wait. At approx. 14:20 an ambulance driver called to the supervisors office. I asked her name and told her I had taken the lady to A+E as she had a head injury. Ambulance driver had said she was a 'green light driver'	Assisted HCA to injured person. Got person affected's name and brief description of what happened. Took the person to A+E and got her booked in. Took ambulance drivers name.	None.	Final approval	25/03/2021
Personal	24/03/2021	08:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	Female Medical	Insignificant	Resident was discharged from hospital after 8 days, diagnosis of left limb extensive DVT, likely recurrence of colonic cancer, catheter associated UTI. Letter and medication did not arrive back with the resident at 1700 - they arrived at 1900. Multiple changes to her medication during the hospital stay.	When SN reviewing the discharge paper work states Morphine Sulphate (MST) 5mg MR - 5mg tables twice daily. In addition, it stated Morphine Sulphate 10mg in 2mg 5ml oral solution when required. However, the subcutaneous prescription chart states Morphine Sulphate 2mg SC 4 hourly. Home Manager has tried to contact the ward to establish the preferred treatment but unable to get through. Staff have proceeded to administer the MST tablets and will try to contact the ward again, if required GP advice will be sought. Resident is not presenting in any pain at present but will be monitored closely until resolved.	Discussed with staff at PSB of informing NH of medication changes. Discharge checklist implemented on ward.	Final approval	30/03/2021
Personal	24/03/2021	17:40	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	REHAB	Stroke / Rehab	Insignificant	DCW D.O. advised that SU[redacted] had come home from hospital, the paramedics had left him sitting in the chair and he had no mobility at all. A daughter was in the house when they brought him home but the paramedics said SU will be ok. DCW unsure how to get him to bed also SU now needs to use thickeners. DCW were not written up or trained for that, DCW on text was informed only that SU has to be spoon fed. Family said that they cant feed because she is afraid. Family stated that they said to hospital as well that there is nobody to look after SU but he was still discharged	I have phoned Daisy hill hospital spoke with nurse who stated completely opposite to family. Nurse stated that family insisted for SU to come home, SU was offered respite, but family insisted for SU to come home. I have phoned RESWS who asked the family to follow up with GP OOH to get their advice. Family stated that they instructed her how to feed SU. resws advised the family as well if they don't think SU is not safe to call the ambulance. DCW called back later but SU still at home family got him into bed, but nearly had a fall. NOK will stay till midnight but they will not phone the ambulance. There was a miscommunication, I am not to sure if that was a pure discharge.		Being reviewed	

Personal	24/03/2021	04:55	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Personal WAS BROUGHT TO ED - FOLLOWING HIS MUM CONTACTING PSNI DUE TO TLNWL DENYING TLNWL BUT WHEN ASKED HE SAID HE WOULD GO HOME AND TAKE ALOAD OF TABLETS Personal WAS THEN ASSESSED BY MENTAL HEALTH TEAM AND AGGREABLE TO A VOLUNTRAY ADMISSION TO BLUESTONE - WHILE WAITING TO TRANSFER TO BLUESTONE, PATIENT WAS NOTED TO HAVE LEFT DEPARTMENT. HE WASNT IN AREA WHICH HE PREVIOUSLY WAS, MENTAL HEALTH TEAM CONTACTED ED TO SAY Personal HAD MADE HIS OWN WAY OVER PSNI AND ABSCONDING PROTOCOL HAD ALREADY BEEN IMPLEMENTED	DEPARTMENT CHECKED SECRUITY INFORMED PSNI CONTACTED ABSCONDING PROTOCOL COMPLETED	After triage place patient in area of close observation in department if high risk.	Being reviewed	
Personal	24/03/2021	13:30	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Ramone Ward 4	Insignificant	Unwitnessed fall. Pt confused and climbed out of bed. Found sitting on floor beside bed by HCA	Dr informed and assessment done. Falls protocol commenced. Neuro obs commenced. Family informed. Documented in nursing notes.	ensure patients that are high risk of falls are supervised at all times.	Final approval	25/03/2021
Personal	24/03/2021	18:45	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	REHAB	Stroke / Rehab	Minor	Patient supervised to the toilet. Nursing staff heard bang from the toilet. Patient found sitting on the floor. Patient stated wanted to see what was in the toilet.	Examined patient no evident injury. Observations checked news 0, GCS 15/15. Dr informed. Falls protocol commenced.	Ensure patient is supervised when mobilizing to bathroom with Zimmer frame. Reinforce with patient not to get up unaided. Ensure Nursing handout reflects patients mobility needs and level of supervision.	Final approval	26/03/2021
Personal	24/03/2021	23:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	2 North Respiratory	Insignificant	Staff numbers on ward reduced due to staff being moved to staff other areas, leaving 3 trained staff on ward. Necessitated in staff having to leave hospital building to go to outside pod on their own for red area breaks. Very vulnerable & feeling unsafe.	Ward manager informed	in review	Being reviewed	
Personal	24/03/2021	02:00	Craigavon Area Hospital	Medicine and Unscheduled Care	CSMUC	CARDIO	1 North Cardiology	Minor	At approx. 2am patient became agitated and aggressive	security called. bed manager and co Ordinator in attendance also		In holding area, awaiting review	
Personal	24/03/2021	01:30	Craigavon Area Hospital	Clinical and Social Care Governance	CSA	CSA	Emergency Department CAH	Moderate	Grade 3 pressure sore noted to right heel when checking patient's skin- same was dressed.	Pressure relief of heels- blanket under heels as no pillows available in department.	always skin check within 4 hours of admission an document if checked and what state skin is. if risk identified ensure an intervention is preformed. Query if TVN referral needed while IP.	Being reviewed	
Personal	24/03/2021	15:15	South Tyrone Hospital	Surgery and Elective Care	ATICS	DPU	Theatres/DPU STH	Insignificant	Patient observed leaving optometrist apt accompanied by her son at 15.15, patient was feeling weak. I got her a wheelchair and checked her clinical observations. BP 184/91 pulse 78, I checked her BM as she had started to feel warm her BM was<1.8. I got help Sr Mc Personal and gave her rapilose gel 40 at 15.25 hrs, I rechecked her BM and it was still 1.8 at 15.30 we gave her another rapilose gel and rechecked BM at 15.40 it was 2.4. Patient looked better we gave her tea and toast with jam and got Dr K O Connor to assess patient who stated patient was able to go home when BM was above 5. I rang patients GP to inform them as to what had happened. Dr Conlon doctor on call at Gp to call patient and assess when patient when patient got home	Son was kept informed throughout incident, Sr Personal informed, Dr K O Connor was asked to assess patient. Gp contacted all documentation complete as per SHSCT policy and datix completed	NONE	Being reviewed	
Personal	24/03/2021	02:36	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Moderate	Blood transfusion commenced in ED resus. Temperature elevated after 1 hour with other observations within normal limits. Bloods transfusion continued under direct of medical doctor as temperature elevation ?due to raised crp. at 0230 temperature not resolved with paracetamol, resp rate now rasied at 25 and sp02 dropped to 93% on RA.	Medical doctor contacted Transfusion stopped Patient commenced on 1/2 hourly observations Labs contacted and informed of reaction and alert used units being sent back Further Group & Hold sent for assessment by Lab due to reaction. Suspected transfusion reaction report completed Nurse incharge Sr Personal nformed		Being reviewed	
Personal	24/03/2021	20:00	Craigavon Area Hospital	Surgery and Elective Care	ATICS	THEAT	Theatres 1-4 CAH	Insignificant	During a drainage of left scrotal haematoma(left)operation the surgeon noted that a mosquito clip was loose. I removed the clip from the instruments and upon checking the clip the top of the clip fell off. Surgeon and nurse in charge were made aware of same. both parts of the clip were there and placed into a separate tray for repair.	Once I had noted that the clip was broken I informed the surgeon and the nurse in charge. clip was removed from the tray and had not been used on the patient after we noticed the issue with same. Complaints form and repair form completed for cssd. Datix completed	To be vigilant on checking instrument's prior to use. SMA	Final approval	29/03/2021
Personal	25/03/2021	06:30	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	GENSUR	4 South	Insignificant	Bag of 500mls NaCl 0.9% with 40mmol KCL erected instead of 500mls NaCl 0.9% with 20mmol KCL erected. Ran for one hour before error was noted.	IVF discontinued. Clinical observations checked and satisfactory. Error documented in CD book. FY1 made aware - IVF prescription reviewed.	As above.	Final approval	30/03/2021
Personal	25/03/2021	18:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	GENSUR	4 South	Minor	Patient received 500mls NaCl 0.9% with 20KCL instead of 1000mls NaCl 0.9% with 20KCL as prescribed.	Clinical obs satisfactory following same. FY1 informed - nil ordered.	As above.	Being reviewed	

Personal	25/03/2021	17:21	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, CAH	Minor	Personal po at term iol for lga emergency cs for delay in 1st stage baby 5150gms red alert 3040mls transfused 3 units rbc 2 unitsffp/ 1 unit cryo /backri/ b lynch suture synto urometer covid neg aki hb 9.8 transferred to icu at 2230 gdm	red alert activated ,backri inserted b lynch suture urometer inserted as above blood products administered		Being reviewed	
Personal	25/03/2021	13:35	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	REHAB	Stroke / Rehab	Insignificant	by SLT dept citing that 'social work or family were not informed about modified diet- family require more information in relation to groceries or meals required for this gentleman'. It also stated that this gentleman was discharged on the 24/03/21 and that carers refused to assist with feeding due to no information being available in relation to modified diet. Social work advised SLT to contact family to ensure they have appropriate guidance. A copy of SLT assessment was also requested by social work. SLT responded to social worker via e-mail and advised that SLT were aware that patient was pending discharge however there was no specific date regarding patients discharge in his notes. (However of note is that after SLT assessment on 24/3/21 - a Swallow Care plan for discharge was added to the Nursing Notes, written up in Medical notes and a Wall chart with swallow advice - but at that point there was no hospital discharge plan was in place.) The social worker was advised that the family had received previous telephone contacts from SLT however there was no contact from SLT was made this week (-wk beg 22nd March) On the 25/03/21 Lead Social work	contacted via telephone on 25/03/21 to provide a verbal update on the most recent recommendations on the swallow care plan which includes suitable food and drinks as per IDDSI descriptors as well as a written copy of these documents to be posted out and copied on email to social work department. All of the above completed however NOK did not answer phone call and therefore voicemail left. SLT team lead requested that social work re-contact NOK to discuss ongoing family concerns regarding discharge arrangements. Social work team lead advised on contacting family that she would also confirm if thickening powder for the patients drinks was present at home and if carers were now in a position to administer foods and drinks when she was liaising with the family. Liaison with DHH SLT and SLT Lead completed regarding this incident with agreement that other SLT colleague who would endeavour to make further telephone contact with NOK again in the absence of DHH SLT in the PM. SLT colleague completed second call to NOK on 25/03/21 PM – again with the purpose of explaining the swallow care plan		Being reviewed	
Personal	25/03/2021	08:00	South Tyrone Hospital	Surgery and Elective Care	ATICS	DPU	Theatres/DPU STH	Insignificant	Son and husband tested positive Pers swabbed in unit and also received positive test result no symptoms to note. occ health contacted and adicve followed	nic of unit informed occ health advice followed datix completed		Being reviewed	
Personal	25/03/2021	06:30	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	2 West Maternity Post Natal	Minor	Incorrect drug given to patient in antenatal in error. (Ibuprofen instead of cocodamol)	Dr Henderson informed patient that drug had been given in error. Patient happy with explanation		Being reviewed	
Personal	25/03/2021	13:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	Ramone Ward 4	Insignificant	Acute SLT department received a telephone call from patients NOK on Monday 22.3.21 following discharge from CAH on Friday 19.03.21. NOK expressed concern about having received a discharge prescription of Nutilis clear thickening powder and not having been given instructions on how to administer same. Domiciliary care workers involved in care were not able to administer thickened drinks as need for same had not been communicated. NOK expressed dissatisfaction that as a result she was having to visit multiple times per day to provide food /drinks. Acute SLT advised NOK that her mother had not been seen by our service during her hospital admission and therefore we were unable to give advice regarding the thickener prescription. Acute SLT signposted NOK to Ward 4 Ramone for further information. Escalated to SLT team Lead.	clinical sister on duty in Ramone Ward 4 on 22.3.21. Clinical sister reported that patients baseline was Level 2 drinks and Level 5 foods and that she had continued to be offered same during her hospital stay however that she frequently refused thickened drinks and would have taken normal drinks. Clinical sister was unclear exactly where this information had been sourced. SLT team lead checked NIECR where there was a discharge report dated 27.1.21 from RVH stating level 2 drinks and Level 5 foods HOWEVER there was also an SLT report from RVH dated 1.2.21 stating that patient had chosen to have normal food and drinks and had accepted the risks and demonstrated understanding of same. Clinical sister reported the patient had not been referred to Acute SLT as she was deemed to be on modified food/drinks prior to CAH admission. The ward were of the understanding that thickener had been used at home previously by family. SLT requested that nursing staff contacted the NOK to explain. Ward manager contacted SLT on 23.3.21 to update that NOK has been contacted and was happy to continue to provide Level 2 drinks and Level 5 foods until	To ensure the patient and family have a full understanding of a modified diet and that all is documented correctly.	Being reviewed	
Personal	25/03/2021	13:30	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Coronary Care Ward	Insignificant	STAFF NURSE FROM MALE MEDICAL CALLED TO SAY A PATIENT HAD GONE MISSING OF THE WARD HE WENT FOR A SMOKE AN DID NOT RETURN THE HOSPITAL SITE WAS SEARCHED AS WAS AREA,S INSIDE MAIN BUILDING NO SIGN OF PATIENT SO ADVISED STAFF TO CALL THE POLICE.AREA SEARCHED AGAIN AT 13.30 NO SIGN SO IN FORMED WARD AGAIN.	NONE	none	Final approval	27/03/2021
Personal	25/03/2021	15:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	GENSUR	4 South	Minor	Patient had grade 1 on bottom developed into grade 2 on ward level	Patient updated on pressure sore Sister in charge updated patient happy to inform family documentation completed continued on repositioning and pressure sore pathway commenced adequate mattress in place skin map completed Braden updated	As above.	Being reviewed	

Personal	25/03/2021	16:00	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	Emergency Department CAH	Insignificant	A male patient sitting outside porters office on a wheel chair had been verbally abusive to portering staff as they came in and out of the porters office, calling 1 porter a wanker and threatening to hit another. Security staff spoke to the male and asked him not to speak to staff in such a way. He continued to b abusive and came up into a security porters face in a threatening manner with his hands raised. He was asked to sit down but continued and had to be restrained onto the floor for short time and then we moved him back onto a wheel chair. Patient continued to be verbally abusive and then he called the police to say he had been assaulted. Security left soon after. At approx. 2045 security were sent to look for the patient as he had absconded from EDBA. We met the male in the front hall and spoke to him. He again became verbally abusive and threatened to have a security porter killed. He again had his hands up in porters face. Patient had to be escorted back to EDBA in a medium level MAPA hold. Patient was given a chair and security left soon after. At approx. 2135 patient had been discharged and was in the front hall so was asked to leave the building. Patient again was verbally	Security called	none	Being reviewed	
Personal	25/03/2021	13:30	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	General Male Medical,	Minor	disorientated patient left ward at approximately 1pm. staff noticed patient gone around 1:30pm. noted to have cannula in place.	tried to call patient - stated he was hiding as a doctor had said something bad to him. staff nurse searched hospital ground for patient. security also contacted and description given. daughter contacted and informed of her absconding. missing person protocol completed. psni contacted - stated he was vulnerable. recontacted patient - stated he was going for a paper and hung up. phone no longer ringing out. kept in regular contact with family. lead nurse informed of missing patient	ensure that all confused patients are identified at safety brief and are closely monitored at ward level.	Final approval	26/03/2021
Personal	25/03/2021	19:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Routine skin check commenced on patient @19:00. Found skin did not match with what was recorded on body map from initial presentation & from what was recorded @16:00. Grade 2 pressure sore on right buttock & possible moisture lesion to same area. Noted on initial body map Grade 1. Also noted ?SDTI to right heel. Noted at grade 1 when initially presented. However noted on nursing home documents "blood blister".	Dressings applied to sacrum to protect. Ward made aware. Nurse in charge informed. Turned onto right hip 45 degree tilt. New body map completed. Ward to contact TVN for review.	Early recognition and intervention of pressure areas essential. Importance ofcarrying out skin checks as early and frequently as possible. Update risk assessment and care plan and document changes on body map. Move at risk patients from trolley to a bed promptly. Provide patient with dynamic mattress if waiting in ED for a bed in ward. Ensure heels are inspected and free from pressure at every skin check.	Being reviewed	
Personal	25/03/2021	03:20	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Insignificant	Whilst taking patients blood injured myself with the used needle.	Encouraged to bleed the site ran under cold water soap used and washed again Informed sister in charge of department Spoke h medical dr looking after patient	Careful disposal of all needles, adhering to trust policy.	Being reviewed	
Personal	25/03/2021	08:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Minor	Attended shift on 24/3/21, assigned D and sides by nurse in charge of day shift. One patient with laryngectomy which required suctioning and this patient also required PEG feeds and medications. Second patient had a trachyostomy which required suctioning. Another patient was on BIPAP and required 1:1 nursing and was constantly trying to leave the ward. Another patient was requiring AIRVO and needed a blood transfusion. No nursing staff on unit had any training to facilitate or meet patients care needs with any of the above.	Ward manager made aware, nurse in charge aware. Respiratory specialist nurse informed and attended unit, Resp team felt that staffing levels were not adequate to meet patients needs as patients requiring 1:1 nursing care. I felt completely out of depth and overwhelmed, as I could not facilitate the needs of these patients with no training. We also had to keep donning and doffing between A B and C and D and sides in order to get medications, equipment and notes, which we then ran out of PPE. This was so unsafe and I did not feel supported in any way.	?	In holding area, awaiting review	
Personal	25/03/2021	14:18	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Minor	Security were requested to attend 3 North by another Security Porter who was already at the scene where a confused male patient was refusing to return back to 3 South.	Security arrived to level 3 and witnessed two members of nursing staff with a male patient Personal Security asked the patient to return to his own ward in 3 south, The patient complied and walked back with security and nursing staff to his room in 3 South. The patient then said he was leaving and attempted to push past Security staff. Security stood in front of the patient to prevent him from leaving at which point he then grabbed one of the Security staffs arm and also bent the finger back of another security porter. Security managed to take control of the situation by securing both patient arms and assisting him on to the chair using MAPA. The patient then settled and Security were then stood down.	Ward staff to be aware security use appropriate MAPA training at all times. Continue with 1-1 supervision for patient.	Final approval	30/03/2021

Personal	25/03/2021	08:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	ENT	CEAW	Minor	Patient was admitted electively for procedure on 25/03/21. Patient is type 2 diabetic on insulin. Patient had attended pre-operative assessment where he had been advised to hold all oral medications the morning of surgery but was not advised re insulin. Patient was fasted from 1800 on 24/03/21 and administered usual dose of insulin morning of surgery (48 units novomix). Patient felt symptoms of hypoglycemia (extreme thirst) blood sugar was 4.3 mmols.	Patient was advised he should not take insulin if he is fasting. Anesthetics contacted and GKI fasting protocol commenced. Blood sugars observed hourly.		Being reviewed	
Personal	25/03/2021	13:45	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, CAH	Minor	transfer down to del suite at 9 cm with slight meconium. suspicios CTG.Post normal vaginal delivery- 2nd degree tear sutured by reg-trickling. 2 doses syntometrine given. measured EBL 2000mls. pre hb 129.	fundus firm. 2 doses syntometrine given. sutured by REG. weighed swabs and incos.		Being reviewed	
Personal	25/03/2021	04:00	Craigavon Area Hospital	Medicine and Unscheduled Care	CSMUC	CARDIO	1 North Cardiology	Minor	At approx. 4am patient became aggressive, shouting and attempting to leave ward	security called		In holding area, awaiting review	
Personal	25/03/2021	04:30	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	1 North Cardiology	Insignificant	Security called for a male patient who seemed confused, agitated and unpredictable. Security and bed manager tried to speak with the patient to calm down.	Security remained on the ward due to his unpredictable behavior. When nursing staff felt comfortable and where happy for security to stand down they went back to portering duties.	None	Final approval	
Personal	25/03/2021	07:00	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	1 North Cardiology	Insignificant	Security was bleeped at 07:00 to 1north. On arrival security found patien Personal at the rear doors of 1north, Personal insisted he was leaving the ward to go see his wife and child as they did not know were he was. Patient was very confused as security was told that he did not have a wife are child.	Security tried to reason with Personal and explain to him he needed to come back to his bed. Personal agreed to come back to his bed. Personal continue to want leave the ward but security talked to him and managed to contain him in his room. Ward manager Personal brought a male member off staff to sit with him and security was stood down and went back to portering duties.	None	Final approval	
Personal	25/03/2021	15:00	Daisy Hill Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Maternity Ward	Minor	Personal known to social work team - not disclosed at booking - no UNOCINI completed. Member of staff in clinic wrote email to SW team which was printed for filling - email subsequently went missing. When admitted staff had no information regarding social case.	Sr of ANC aware - tried to locate email - same missing.		Being reviewed	
Personal	25/03/2021	07:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Moderate	Patient absconded from ED. Found in foyer of hospital at approx. 10mins after last seen. Found face down, blood visible around head. Patient responding to Pain. Called for help.	Patient absconded at approx. 06:50 And found at approx. 07:00 Called for help from staff nurse and HCA. Patient scooped onto hospital trolley and transferred to amber resus. ?Postictal as per ED Doctor. full ABCDE assessment carried out. No NOK detail available to contact.	Appropriate observation and assessment of patients at risk of absconding or seizures.	Being reviewed	
Personal	26/03/2021	16:30	Daisy Hill Hospital	IMWH - Cancer and Clinical Services	MIDWIF	GYNAE	Gynae Clinic	Minor	An unlabelled gynae cytology vial was received in the Cellular Pathology lab on 26/03/21. The vial was attached to a form with patient details DOB Personal and HCN Personal. The sample had been taken at GOPD DHH.	LSM contacted Dr Sharmas secretary on 29/03/21 to inform them that the specimen was being returned to source. She indicated that the smear was taken at the nurse lead clinic and should be returned FAO Personal Ref Personal		Being reviewed	
Personal	26/03/2021	07:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	2 North Respiratory	Minor	? if Oxygen point at wall is faulty, pressure dropping on its own.	Patient being monitored closely overnight and came to no harm. Patient moved to another side room.		Being reviewed	
Personal	26/03/2021	08:15	South Tyrone Hospital	Surgery and Elective Care	ATICS	DPU	Theatres/DPU STH	Insignificant	an OGD, declined to give admitting nurse full medical history details as he felt all hospital notes from other trusts should be present and all medical history should have been known in advance and notes from Belfast and Dublin should be present. Patient became increasingly verbally aggressive in a loud tone and I came to assess the situation. Patient stated he has taken tea with milk before attending (7am) and I tried to discuss the risks of not fasting. The admitting nurse attempted to offer to defer the patient to the afternoon list, but patient would not let her speak. Patient very argumentative and would not let me answer or speak and continued to shout in a loud voice. He complained that he was not told where to park his car and that the hospital should have given him a layout of the building. He wanted to know why I had not researched his medical noted from Belfast and Dublin, again I could not respond as he was verbally aggressive. The theatre manager had been contacted and came to introduce herself at, patient stood at this stage shouted that he was being 'ganged up on.' Theatre manager requested for him to lower his voice and he declined and remained verbally aggressive. I	Nurse in charge was contacted Patient cancelled from list. fasting policy and procedure was attempted to be discussed with patient declined we value your views form. Attempted to discuss deferring procedure until safe. Explained zero tolerance policy	Zero tolerance policy adhered too.	Being reviewed	

Personal	26/03/2021	08:15	South Tyrone Hospital	Surgery and Elective Care	ATICS	DPU	Theatres/DPU STH	Minor	Patient difficult from the beginning of admission and got more obstructive, aggressive and angry during the admission. Refused to confirm allergies and current medications, voiced his concern that he had to give me medical history and felt that I should have this before admitting him. Tried to explain the reasons for this but patient refused to listen and wanted to speak to someone who would know this. I got the Nurse endoscopist to speak with him and left the area as I was very upset and tearful at the way he has spoken to me. All queries and questions asked by patient were answered appropriately but he was unsatisfied with this. As he disclosed he had not fasted I attempted to discuss possibility of getting an afternoon appointment but patient would not let me speak.	Reported to nurse in charge	none	Being reviewed	
Personal	26/03/2021	20:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Minor	PATIENT DISCHARGED FROM 3 SOUTH CAH ON 25/3/21 SYRINGE DRIVER. NO REFERRAL MADE TO DISTRICT NURSING TEAM. FAMILY CONTACTED OOH ON 26/3/21 AT 20.00 TO ADVISE NO NURSE HAD VISITED THAT DAY TO RENEW SYRINGE DRIVER. TWILIGHT NURSE CALLED TO HOME AT 21.00. NO EQUIPMENT IN HOME TO RENWEW SYRINGE DRIVER AND HAD TO GO BACK TO BASE TO GET SUPPLIES. DELAY IN SYRINGE DRIVER BEING RENEWED. (Patient required oral pain relief)	REPORTED TO ON CALL MANAGER. ATTEMPTED TO CONTACT WARD ON 26.3.21AT 22.30 BUT ONLY AGENCY STAFF ON WARD. PATIENTS AND FAMILY REASSURED AND SYRINGE DRIVER RENEWED. SPOKE WITH WARD MANAGER 29/3/21 ADVISED THEY HAD THOUGHT REFERRAL WAS PUT THROUGH ACCESS AND INFORMATION AND THAT THEY HAD TRIED TO PHONE DISTRICT NURSING (Personal)AND THERE WAS NO REPLY AND THEY HAD NO TIME TO KEEP RINGING AND HAD FORGOTTEN TO FOLLOW UP THE NEXT DAY.	See attached new checklist for staff Communication between acute and district nursing	Final approval	31/03/2021
Personal	26/03/2021	22:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	TRAUSU	Trauma Ward	Minor	Query medication error. Noticed on Kardex 22.00 pm apixaban on hold but signed for by night nurse. clexane also signed for on Kardex. Spoke with sho who said datex same. and fy1 Perso reviewed karex. Clexane bd still to be given as apixaban half life 1 hours. No ooze noted for wound but same monitored.Patient not sure when asked did he receive he said he cant remember. Staff involved to be asked if signing error or not.	spoke with sho and patient and fy1.	For all staff to be mindful when both clexane and apixaban are prescribed. To make sure that both are that administered at same time and if unsure to liase with doctors with regards to same and to make sure that one or the other is stopped on Kardex as prescribed.	Final approval	29/03/2021
Personal	26/03/2021	10:10	Craigavon Area Hospital	Functional Support Services	LOCCB	DOMSCB	1 South Medical	Insignificant	Bending down to scrub a floor, when getting up again she banged her head against the large TV with patient names on it (Outside Bay 1 Front)	Evaluated and no evident injury.		In holding area, awaiting review	
Personal	26/03/2021	17:30	Craigavon Area Hospital	Medicine and Unscheduled Care	CSMUC	CARDIO	Cardiac Catheterisation Lab	Minor	while cleaning and preparing sideroom in cath lab post DCC procedure, Midazolam syringe was discovered in sharps tray. 3mls in total remaining in syringe. CD was checked out by SN Personal Information and Staff Personal Information redacted and same recorded in CD register. Incorrect wastage not documented in CD register.	Sr Personal Information informed of same Remaining 3mls discarded by Sr Personal and SN Perso datix completed	The importance of following the SHSCT policy for controlled drugs and ensuring that the administrations and the disposal is witnessed by 2 registrants. Ensure that the 1 nurse who signs the drugs out does not hold all responsibility as they may not be in the room during procedures so the CD book is changed to a theatre book.	Final approval	30/03/2021
Personal	26/03/2021	19:25	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Coronary Care Ward	Insignificant	Security called to male medical to help doctors, patient had to get a needle into his arm. Porters restrained patient using MAPA techniques, low level. Doctors informed security team they were no longer required and stood them down.	none	none	Final approval	27/03/2021
Personal	26/03/2021	19:30	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	1 South Medical	Moderate	Pt was discharged home with a covid swab obtained from another pt.	Apologised to relative, asked if they could return swab to ward- unable to. State they will dipose of swab in a pharmacy. Bedmanagers informed.		In holding area, awaiting review	
Personal	26/03/2021	04:15	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, CAH	Moderate	stillbirth	as per hospital policy		Being reviewed	
Personal	26/03/2021	18:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	REHAB	Stroke / Rehab	Insignificant	out hrs received a phone call to say that the client as been out from hospital , from 24/3/2021 and as never received any medication due to hospital discharged , that medication was not a task requested resulting the client missing full 48hr before medication was given	spoke to twilight who as advised that medication is being wrote up on the 27th march 2021 family will give medication btb 26/3/2021 27/3/2021 am		In holding area, awaiting review	
Personal	26/03/2021	18:30	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Minor	Patient x found by HCA on floor on knees at bedside. Unsure if patient had hit her head off stool. Patient assisted x2 onto feet and onto the chair. Patient had previously been sitting on chair before fall.	Clinical observations and GCS observations checked, medical staff informed, CT brain to be carried out, Falls protocol commenced and next of kin to be informed.		Being reviewed	
Personal	26/03/2021	16:00	Daisy Hill Hospital	Functional Support Services	LOCNE	PORNE	Entrance/Exit	Insignificant	Security called by switchboard over the radios for a wheelchair to assist a HCA who was with a patient who had taken a seizure. POT and PC responded the patient was having a seizure, porters assisted patient into the wheelchair and patient was taken back to the ward.	none	none	Final approval	27/03/2021

Personal	26/03/2021	06:40	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Coronary Care Ward	Insignificant	security called to male medical patient was at the front lifts looking to leave doctor an nurse got patient to sign himself out . security stood down at 06.50 am.	none	none	Final approval	27/03/2021
Personal	26/03/2021	10:10	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Ward 3b	Insignificant	While on ward round with consultant and medical team. curtain was being pulled for dignity of patient. Railing and curtains fell with the metal bar hitting doctor on the head causing swelling and pain.	Consultant present, staff member declined to go to A+E, Domestic services informed estates manager informed, prompt replacement of rail	To ensure railings are fixed securely.	Being reviewed	
Personal	26/03/2021	23:30	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	Emergency Department CAH	Minor	Security were requested by ED Amber Resus as a male patient had became violent towards the prison guards accompanying him.	Security attended and witnessed a male patient acting aggressively and violently towards two prison staff. Security assisted prison staff with restraint and the police were also alerted. Nursing staff managed to administer sedation which helped calm the patient down. A short time later police then arrived and took over from security staff. Security were then stood down.	NONE	Being reviewed	
Personal	26/03/2021	16:00	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Moderate	Personal female, brought to DHH ED following, fall, ? long lie, lives alone. on examination, chronic leg ulcer in R lower leg. buttocks very red (blanching erythema), sacrum Grade 2, non blanching, dark red	skin chart completed nurse in charge made aware transferred onto a hospital bed for comfort swab sent for O+S from leg ulcer		Being reviewed	
Personal	26/03/2021	00:00	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	patient fell at bedside	falls protocol, assessed by doctor, gcs and news completed	Doctor must document post falls assessment in ED notes.	Being reviewed	
Personal	27/03/2021	22:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	grade 2 pressure sore on patient sacrum from home blister in heel. documented in PACE	documented in PACE SR in charge aware daitex		Being reviewed	
Personal	27/03/2021	23:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Patient daughter had contacted ED reception she had a raised voice and stated she wanted to make a compliant. I spoke with daughter (Personal) she spoke to me in a raised voice and stated she was going to take me to court. Stated staff in the hospital had gave information about her mother to someone they shouldn't have. Personal had stated her sister Pers had found out informatio about her mother, when questioned what information was given she couldn't tell what it was. States her sister Pers does not speak with family stated that staff should recognize her and sisters voices	spoke with staff in area, staff had documented in notes that Personal s the NOK and to only give her information regarding her mother Patient sister Personal had also contacted ED, staff had advised patient was in department and comfortable Spoke with patient she also confirmed Personal is NOK and to give her information, was aware Personal had phoned also and was happy with same		In holding area, awaiting review	
Personal	27/03/2021	22:50	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	ORTHSU	Orthopaedic Ward	Minor	Ortho ward contacted to get critical medications madopar for a new admission on the trauma ward, Staff nurse confirmed they had the medications and an HCA from trauma ward asked to collect the medications from the ortho ward. The HCA arrived back to the ward with the madopar loose inside a paper towel with the drug name and dose handwritten on the paper towel, not inside the original drug packaging.	The drug could not be given as we could not confirm that this was the right drug or the right dose as prescribed for the patient on the ward. Drug then obtained from another ward. Clinical co-ordinator Personal aware as on the ward at the time the drug was received from ortho. A photograph of medications and paper towel has been emailed to SR Person and SR Personal	For orthopeadic ward to review	Final approval	29/03/2021
Personal	27/03/2021	16:30	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Insignificant	I was asked to assist patient to ambulance at main entrance for transfer to Royal Hospital Belfast. I was stopped by the ambulance supervisor who stated that patient cannot travel in the ambulance without a doctor present as he has a chest drain inserted.	Patient was left in ambulance with ambulance staff present. I contacted the ward and spoke with medical doctor who stated she would have to speak with the medical registrar on call as they were short staffed. I came back to unit informed sister in charge At 17:45 medical doctor went on transfer to Belfast On booking ambulance they were made aware that patient had a chest drain and oxygen. Patient was left in ambulance at main entrance for approximately for one hour.		In holding area, awaiting review	
Personal	27/03/2021	17:50	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	GYNAE	1 East Maternity/Gynae	Minor	Personal fell when mobilizing to the toilet with rolater states her leg give way and fell down she did not hit her head.	observations checked , Personal got back into bed herself dr informed		Being reviewed	
Personal	27/03/2021	12:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	3 North Medicine	Insignificant	Patient X noted to have slipped from chair onto floor by HCA. HCA advised fall was witnessed and patient did not hit head.	Nurse in charge informed of same and patient assisted x3 back onto chair. Clinical observations checked and GCS observations checked. Next of kin to be informed of same.	Post fall risk assessment not completed. Highlighted in patient safety briefing.	Being reviewed	

Personal	27/03/2021	17:00	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	GYNAE	1 East Maternity/Gynae	Moderate	Patient underwent hysteroscopy 25/3/2021. uterine perforation, laparoscopy at time no definite bowel injury. Admitted and slow recovery CT sat 27th demonstrated likely perf. so went to theatre were surgeons undertook small bowel resction for perf. patient admitted to ICU	as above		Being reviewed	
Personal	27/03/2021	15:45	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	ORTHSU	Orthopaedic Ward	Minor	Heard a noise and patient call out. Went into the double side room and patient was lying on the floor. States she had hurt her back and unsure if she had hit her head. Unwitnessed fall. Patient states she had got up from the bed to sort out her belongings for going home.	Called for help. Assessed patient and gave her reassurance. Bleeped FY2. Safely assisted onto bed. Clinical and neurological observations recorded.	as above	Final approval	29/03/2021
Personal	27/03/2021	04:00	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Emergency Department DHH	Insignificant	Security called to ED regarding a missing patient, grounds searched around hospital patient could not be located. Security informed ED staff.	none	none	Final approval	01/04/2021
Personal	27/03/2021	12:00	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	2 West Maternity Post Natal	Minor	infant born 39+4 NVD. IOL due to LGA. Personal Information redacted by the USI infant transferred to NNU from 2west at midday 27/3/21	Personal Information redacted by the USI noted by paediatrician on ward. transferred to NNU for further monitoring and investigation		Being reviewed	
Personal	27/03/2021	19:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	4 North	Minor	Arrived to ward 4 North after 1900 to transfer patient from ED. on arrival approached by staff nurse they weren't accepting patient as he was now being referred medically. Explained couldn't transfer back to ED as per sister which a discussion then took place between staff on ward and bed manage, doctor and ED sister on phone. This was done all in front of patient in corridor. patient was distressed and fully aware what was going on and stated 'he didn't want to be causing any hassle'	following discussion patient to stay on 4 North. transferred to room.	as above	Being reviewed	
Personal	27/03/2021	08:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	ORTHSU	Orthopaedic Ward	Minor	Patient was first on the list for surgery. This patient is a type 2 diabetic and received 2 doses of insulin overnight as Bms were extremely high. Insulin regime was not considered overnight or administered at 7am as staff were newly qualified and new to elective surgery. No harm came to the patient at all. Consultant and surgical staff requested a datix to be completed.	Insulin regime was administered at 8 am instead. Doctors and consultant were made aware. 1hourly bms carried out. Patient changed from 1st on surgical list to 2nd on the surgical list.	ensure staff aware of insulin regime protocol	Final approval	29/03/2021
Personal	27/03/2021	21:10	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Healed pressure ulcer to boney provenance below sacrum. Two grade 1 pressure ulcers to sacrum.	Dressed and cleansed. Reposition patient every 4 hours. Nurse in charge aware.	Early recognition and intervention of pressure areas essential. Importance of carrying out skin checks as early as possible after arrival. Move patients from trolley on to a bed promptly.	Being reviewed	
Personal	28/03/2021	01:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Moderate	Patient presented to ED with OD Medically fit and seen by mental health Mental health offered voluntary admission Patient declined Mental health team rang son Perso with plan he stated the house is locked up and she wont get in I then rang Perso introduced myself, Perso also stated the house is locked and she wont get in Person was verbal aggressive. Stated "I better not dare and ring his father Personal husband." Personal explained her husband has a disability when I kindly asked would his dad be ok overnight, Perso got very angry with I attempted to explain it was my job. Continued to shout at me and Was angry I asked him Perso contacted department back and Spoke with medical staff stated it would cause to much fuss if his mother came home Agreed medical admission and OOH SW	OOH SW contacted APP1 complete medical admission		in holding area, awaiting review	

Personal	28/03/2021	21:40	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Minor	From commencement of shift at 20.30pm - patient agitated and displaying signs of auditory and visual hallucinations (said patient admitted with alcohol withdrawal and psychosis. 2houry GMAWS commenced. From 21.40pm security at ward level as patient becoming both physically and verbally aggressive and as ward staff unable to manage - attempted to hit myself two times, as well as FY1 who came to ward level to review. Patient continued to get worse from this time onwards even with sedation prescribed and administered as per rapid tranquilization policy - very aggressive and security having to restrain patient as risk of harm to both himself and staff as cursing, hitting and kicking and trying to bite - patient very difficult to restrain as per security. Security remained at ward level until after 3am due to aggressiveness of patient.	Clinical sister made aware. Security contacted. Clinical coordinator aware and at ward level also. FY1 bleeped who then involved Registrar as patient became more difficult to manage and more combative towards staff.		In holding area, awaiting review	
Personal	28/03/2021	14:50	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	4 North	Insignificant	Blood Glucose form for H&C Personal filed in incorrect patients chart, filed in H&C Personal	Form removed from patients chart for filing in correct chart		Being reviewed	
Personal	28/03/2021	01:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Patient admitted to ED with suicidal and overdose and poisoning High risk of self harm need 1;1 care as he is agitative and his responses refused cares and indented to go home patient left the emergency department before commencing full care	Absconded pathway done porters contacted Checked PSNI contacted	Keep patients at risk of absconding in area visible to staff.	Being reviewed	
Personal	28/03/2021	21:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Ramone Ward 4	Minor	patient was very distressed and agitated and it was during this episode it was identified by 2 carers who where changing and repositioning pt, skin break on left heel and outer aspect of right ankle. Pt rubbing heels up and down sheets causing a lot of friction.	Analgesia given. Dry dressing and allevyn heel pads applied to each foot. Zero pressure to both heels. Pressure sore prevention pathway implemented. 2-4 hourly repositioning already in place. Braden reviewed same 10. Already on airwave mattress. Dr informed. NOK not informed due to late hour.	I feel everything was done correctly. Clinical judgement suggests that this is not pressure, but friction, due to the patients severe agitation. TVN advised a Sliding sheet at the patients feet, so when the feet move they will move freely on the sliding sheet rather than the bed sheet. Ensure correct documentation when filling in the reposition chart.	Being reviewed	
Personal	28/03/2021	15:30	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	Emergency Department CAH	Insignificant	Security called to ED waiting room at approx. 1530 to assist with an abusive female patient who had been discharged. On arrival female was shouting at the nurses and demanding her taxi be paid for. Security and nursing staff spoke to her and asked to leave as her taxi was here. She left but was verbally abusive as she left and made hand gestures at staff as she left.	security called		Being reviewed	
Personal	28/03/2021	15:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	noticed wristband applied to patient was not the correct patient details.	wristband removed and correct wristband applied. patient was independent and able to give correct details. spoke with member of staff regarding it. NIC informed	Details written on patient armbands should be verified by patient to ensure correct identification. Confused patient's should have details confirmed by a family member or member of staff known to patient.	Being reviewed	
Personal	28/03/2021	15:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Female Medical	Minor	This lady has presented with Chronic ulcer leg (r) and a G3 pressure sore to sacral area on admission to FMW (G3 Datixed in ED) Not known to TVN or District Nursing team in community. Patient has refused family to care and has dismissed any aid. Dressing ulcer Independently in community with TCP. Daughter reports strong smell in house. Son has purchased at request of Personal New* development of Blistering/discolouration to 4th + 5th toes ® foot on ward. ?SDTI	Nurse incharge informed, Nok informed,all relevant documentation updated. Medical team made aware of ?SDTI. Patient aware. Not appropriate to give patient information at present re; adequate pressure relief. To maintain zero pressure to toes. strict 4 hourly repositioning.		Being reviewed	
Personal	28/03/2021	02:45	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Emergency Department DHH	Insignificant	security called to Ed regarding a missing patient, security searched grounds of hospital patient could not be located informed ED staff.	none	none	Final approval	01/04/2021
Personal	28/03/2021	16:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	TRAUSU	Trauma Ward	Moderate	I admitted Person on sunday the 28.03.2021 She had transferred from ward 5 with pressure sores noted on there admission. When contacted they were unsure if a datix was done- unsure if this was hospital acquired but have selected no in the drop down box as unable to obtain information from ward 5 regarding if datix was complted however noted on there admission. A and e have recorderd dressing on there skin assesment	Referred to dietian needs tvn referral to be done nursed on aria mattress repositioned scedual insitu mepilex dressing insitu Braden 13 must one food chart insitu		In holding area, awaiting review	

Personal	28/03/2021	23:32	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Minor	Security paged to attend AMU as a male patient was refusing medication, attempting to leave and attempting to strike out at staff.	Security arrived to the ward and witnessed the male patient chatting to the doctor. The male patient then attempted to swing his bag at the doctor at which point security intervened and restrained the patient onto his bed. Nursing staff then administered medication via injection which did not seem to take any affect. Security continued to retrain the highly confused patient on the bed who kept struggling. 4 more doses of medication were given, the patient eventually then started to settle and security were then stood down. This incident was ongoing for 4 Hours.		In holding area, awaiting review	
Personal	28/03/2021	18:30	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	Emergency Department CAH	Insignificant	Security called to EDYA at 1830 approx. to assist with a confused male patient who had been aggressive towards nursing staff. Security staff had to restrain the patient as he was striking out. Security staff stayed with him until he settled down. Security left at approx. 1930.	security called		In holding area, awaiting review	
Personal	28/03/2021	18:30	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	Emergency Department CAH	Insignificant	Security called at 1830 to EDYA to assist with a confused male patient. Patient was aggressive towards nursing staff, he was striking out and had to be restrained onto the trolley. Patient received an injection and security stayed with him until he settled down. Security left at approx. 1930.	security called		In holding area, awaiting review	
Personal	28/03/2021	02:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	PATIENT WAS BROUGHT TO ED FOLLOWING ALCOHOL ON BOARD AND TLNWL. REQUIRING SUPERVISION AT TIMES DUE TO WANTING TO LEAVE WAS ASSESSED BY DR KENNEDY AND PATIENT WAS NOT FIT TO BE REFERRED TO MEDICS, SO NEEDED TO REMAIN IN ED UNTIL MORE SOBER PATIENT WAS NOT IN CUBICLE AT 0200, ABSCONDING PROTOCOL COMMENED AND PSNI CONTACTED	ABSCONDING PROTOCOL COMMENCED PSNI CONTACTED	Keep patients at risk of absconding in area visible to staff.	Being reviewed	
Personal	28/03/2021	20:33	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Insignificant	Security called to AMU. On arrival we met a male patient at main door of the ward who wanted to leave. Staff informed him he had to wait for the doctor. Patient told security porter he would break his jaw. patient was walked back to f bay. Security left soon after.	security called		In holding area, awaiting review	
Personal	28/03/2021	11:50	Craigavon Area Hospital	Surgery and Elective Care	ATICS	THEAT	Theatres 1-4 CAH	Minor	Patient in theatre 1 for OGD for arrest of bleeding under GA and 2nd theatre needed opened for a torsion on child aged Perso Also maternity called a section so nurse on bleep left department to respond to this emergency.	Staff split between 3 theatres in two different departments.	none	Final approval	29/03/2021
Personal	29/03/2021	20:00	Craigavon Area Hospital	Medicine and Unscheduled Care	CSMUC	CARDIO	1 North Cardiology	Minor	Band 5 staff nurse taken to another ward leaving cardiology ward short staffed for entire night shift. Left 3 nurses on the ward floor covering 32 patients. Left cardiology staff unable to cover cardiac bleep for hospital site.	Bed management aware. Nurse in charge aware. clinical coordinator aware staff are unable to cover cardiac bleep.		In holding area, awaiting review	
Personal	29/03/2021	11:20	Lurgan Hospital	IMWH - Cancer and Clinical Services	DIAGNO	IMAOTH	Ward 2, Stroke	Minor	patient came down for a xray of ng tube position with no ng tube in place- near miss. patient from Lurgan ward 2, dr lauren murphy requested without tube in place.	sent back to ward and ward informed		Being reviewed	
Personal	29/03/2021	13:30	Community	Pharmacy	PHARM	PHASEP	South Lakes Leisure Centre	Insignificant	bit of bung floating in pfizer covid vaccine after reconstitution. noticed by pharmacy tech on recon. vial discarded BN EM4965 exp 06/21	vial discarded		In holding area, awaiting review	
Personal	29/03/2021	07:00	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	Emergency Department CAH	Insignificant	Security contacted by ED Triage at 07:00 to inform us that a male patient with a head injury had gone missing at 06:15.	Security got a description from ED Reception and searched all areas as per our SOPs we did not manage to locate the patient. Ward staff were informed and the police were then contacted for assistance.	none	Being reviewed	
Personal	29/03/2021	23:05	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Female Medical	Insignificant	Security received call over the radio from switchboard that security was needed on female medical ward. Upon arrival staff informed security that a patient was being aggressive towards staff, Security staff spoke with patient and deescalated situation and patient returned to his bed. Security stood down short time later.	none	none	Final approval	01/04/2021

Personal	29/03/2021	19:00	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	Patient has grade 2 pressure sore inside buttocks. 0.5 by 0.5. patient normally mobile and self caring. asked patient if she minded me having a look after having a grade two pressure sore on right ankle.	pressure area care maintained. sister incharge informed	Patients with history of Pressure damage to skin should be nursed on a hospital bed when awaiting ward placement where possible. preferably within 4-6 hours	Being reviewed	
Personal	29/03/2021	19:00	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	Patient arrived to ED, grade two pressure sore to right ankle. 1cm by 1cm.	pressure area care maintained. wound swab sent. sister incaharge informed	all patients with history of pressure damage to be nursed on hospital bed where possible while awaiting ward placement ideally within 4-6 hours	Being reviewed	
Personal	29/03/2021	16:30	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Female Medical	Minor	PATIENT CONFIRMED AS GDH POSITIVE CDIFF	PATIeNT INFORMED. MEDICS INFORMED. cdi paperwork commenced and completed. advice leaflets given to patient treatment commenced Bristol stool chart insitu. domestic services aware enhanced cleaning.	Infection control issues discussed with staff at PSB.	Final approval	30/03/2021
Personal	29/03/2021	13:30	South Tyrone Hospital	Medicine and Unscheduled Care	GMMUC	REHAB	Ward 2, Assessment & Rehabilitation	Minor	Patient had unwitnessed fall on ward. Patient was sat out in her chair for dinner in open bay. While nursing staff handing over, a crash was heard. Patient found lying beside bed.	Patient attended to by 3 staff nurses and a doctor. Observations taken, neurological observations taken. Patient inspected for signs of trauma. Patient was able to stand with assistance and walk to bed. Helped into bed. Regular observations and neuro observations will be taken. Falls risk plan up dated. Nurse in charge and ward manager aware.	Patient will now needed to be in high visibility area and there will be a staff member present at all times	Final approval	30/03/2021
Personal	29/03/2021	17:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	TRAUSU	Trauma Ward	Minor	Patient transferred to trauma ward 28/03/2021 from ward 5 as MRI showed # R NOF. Patient has history of CDIFF. After transfer to trauma patient started having T7 Loose stools. Stool sample sent for O+S and CDIFF. Stool result come back as CDIFF Positive 29/03/2021.	Patient already isolated in SR as was in contact with a COVID positive patient in ward 5. Already commenced on Bristol stool chart. FY1 informed of CDIFF+VE by microbiologist and treatment discussed. CDIFF pathway commenced. Patient informed and information leaflet given. FY1 asked to review patients medications and to complete checklist. Patient is keeping own equipment in side room so that there is no cross contamination with other patients via equipment. All relevant staff informed including domestic staff and isolation sign put on patients door.	staff to continue to act on incidents such as these correctly to manage the situation	Final approval	30/03/2021
Personal	29/03/2021	08:15	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Insignificant	When the above patient was returning from the toilet he fell. He had been trying to put tissue paper in the bin on return from the toilet.	I staff nurse Personal Information found the patient on his right side on the floor beside the bin. He was assisted to his feet and was able to walk back to his bed using his zimmer aid. He informed me that he had not hit his head. His observations were stable The medical staff were informed.	nil	Being reviewed	
Personal	29/03/2021	17:33	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	2 West Maternity Post Natal	Minor	D7 POSTNATAL READMISSION WITH BACK PAIN AND VOMITING ON ANTIOBIOTICS ALREADY FOR ENDOMETRITIS.	ANALGESIA ,CHEST X-RAY, USS ABDOMEN ,IV FLUIDS.		Being reviewed	
Personal	29/03/2021	18:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	AMU	Moderate	PATIENT OUTSIDE IN COURTYARD HAVING A CIGARETTE WHEN HE RAN OFF OUTSIDE AND ENTERED BUILDING AGAIN THROUGH FIREDOORS.	SN AND HCA RAN AFTER PATIENT. SECURITY FAST BLEEPED AND CAME TO WARD AND COMMENCED A SEARCH OF THE HOSPITAL SITE. PSNI THEN TELEPHONED TO REPORT PATIENT AS HAVING ABSCONDED. NEXT OF KIN INFORMED ALSO		In holding area, awaiting review	
Personal	29/03/2021	13:18	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Insignificant	Security requested by AMU as a male patient had became unsettled and aggressive towards staff and was trying to leave the ward.	Security attended AMU and on arrival the patient had already settled down and security were no longer needed. Security were called back again a short time later for the same thing Security stayed with the patient until he settled and were then stood down.		In holding area, awaiting review	
Personal	29/03/2021	17:48	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Insignificant	Security called to AMU as a male patient had managed to leave the ward via the fire exit.	Security arrived to AMU and were informed that their patient had managed to leave the ward via the fire exit in F Bay. Security searched the premises and did not manage to locate the patient the ward staff were informed and the police were then contacted.		In holding area, awaiting review	
Personal	29/03/2021	18:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	STROKE	Stroke / Rehab	Insignificant	Patient admitted to Roxborough house for rehab bed from level 4 stroke rehab DHH 29/03/21 Patient prescribed lamotrigine 25mg OD on DC letter. No clinical indication included on the letter. No start date included on the letter. Titrating dose of lamotrigine also not prescribed. F/up TFT's for GP in 3 months not annotated on letter either.	Spoke with Dr Rizeq consultant; advised •Previous Hx vacant episodes •Previsou Hx CVA •Absent episode 25/03 and 26/03 commenced on lamotrigine given new diagnosis absent seizures. •Titrating dose to be initated with dose to be increased to 25mg BD in 2/52 •TFT's in 3 weeks with the GP •F/up appointment with Dr Rizeq in DHH in 8/52. Spoke with FY1 on ward Personal DC letter being revisited and updated with clinical information and titration for lamotrigine DATIX submitted		In holding area, awaiting review	
Personal	29/03/2021	09:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	1 South Medical	Moderate	Grade 2 found on left side of spine	Dressing applied, NIC aware, body map updated, NOK aware		Being reviewed	

Personal	29/03/2021	03:31	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	patient given iv tazocin but penicillin allergic	noticed on nightduty after day staff went offduty reported by non involved staff who had checked through notes		In holding area, awaiting review	
Personal	29/03/2021	14:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	STROKE	3 North Stroke	Minor	Patient clerked in, Kardex completed. Sertraline prescribed as 50mg twice daily. Unable to identify prescriber as signature not clear SHO was documented, or time and place of clerk in. NIECR and letter from GP state sertraline once daily. Error detected at discharge on ward. No medication history completed	Kardex amended, doctor informed		In holding area, awaiting review	
Personal	29/03/2021	01:50	Daisy Hill Hospital	Surgery and Elective Care	ATICS	THEAT	Theatres DHH	Minor	Death of patient post surgery	Next of Kin contacted		Being reviewed	
Personal	29/03/2021	02:30	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	GENSUR	4 North	Minor	three patients on the ward required 1:1 supervision with only 1 HCA to supervise. Patient fell while HCA on break only 1 Staff nurse to cover one side of the ward. unwitnessed fall, patient found sitting on bottom.	falls protocol f1 informed GCS NEWS person incharge informed	1. Ensure all high risk pt are escalated to Site manager OOH. 2. Speak to SN who submitted Datix.	Final approval	30/03/2021
Personal	29/03/2021	10:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Minor	Patient found by the doctor lying on the floor and was last seen sat on the chair	doctor who found the patient examine the patient, assessed the patient and assisted back to bed with assistance of two staff the NOK the daughter informed	nil	Final approval	31/03/2021
Personal	29/03/2021	09:30	Craigavon Area Hospital	Functional Support Services	LOCCB	DOMSCB	4 South	Minor	Excess water from geyser came out over hand and gave a minor burn to the left hand	Ran under cold water tap and anti burn plaster put on hand		Being reviewed	
Personal	30/03/2021	03:20	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Moderate	Patient has a grade 4 pressure sore to sacral area known by TVN in community	Assisted onto (R) side to relieve pressure and redressed. Informed nurses caring for patient in handover		Being reviewed	
Personal	30/03/2021	00:30	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Moderate	Necrotic grade 3 on (L) ankle	wound redressed, document on patients notes		Being reviewed	
Personal	30/03/2021	07:55	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	PATIENT IN CUBICLE ONE IN YELLOW AREA I HEARD A BANG AND FOUNF THE LADY ONT THE FLOOR ? HIT HEAD OF OBS TROLLEY ATTENDED WITH HEAD INJURY HAD CT AND FIR FOR HOME	NEEDS TO BE RE CT'D		Being reviewed	
Personal	30/03/2021	13:50	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	ORTHSU	Orthopaedic Ward	Minor	Patient had an unwitnessed fall from his chair- likely mechanical fall/slip. Stated he had hurt his bottom but nowhere else. Patient's observations were recorded, FY1 was bleeped and patient was safely assisted onto chair. Sho doctor came to ward to assess patient and stated there was no apparent injury and no current indication for CT brain.	I made sure patient was feeling ok, they said they had sensation of pain to buttocks area. I called for help and got one member of staff to get an obsmachine and the other to inform the nurse looking after patient. GCS was 15/15, assistance given to safely transfer to chair and FY1 was bleeped. Family have been informed and reassured that he has been examined by the doctor and no apparent injuries.		Being reviewed	
Personal	30/03/2021	21:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	Ramone Ward 4	Minor	I gave oral 40mg pantoprazole, was prescribed as IV administration route	made patient aware of the medicine incident at 2130 after noticing incident, I myself was in charge, informed other staff nurse, informed FY1 via medical coordinator, no concerns reported from fy1, no need for clinical assessment.	To ensure no distractions during a medication round. Read the Kardex correctly, and Take time.	Being reviewed	
Personal	30/03/2021	20:45	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	Grade 2 skinned area found on both buttocks. Skin very red and excoriated poor hygiene maintained by patient as he lives alone Left ankle red and very dry small dressing soaked with serous fluid - may potentially lead to pressure ulcer	Area cleaned and pressure relieving cream applied	nil	Being reviewed	
Personal	30/03/2021	08:00	South Tyrone Hospital	Surgery and Elective Care	ATICS	DPU	Theatres/DPU STH	Insignificant	doris reported feeling lethargic, son had a positive covid test. Doris received swab result for self and coivd positive swab result also.	Reported to nic contacted occ health and adived followed track and trace carried out		Being reviewed	
Personal	30/03/2021	17:15	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	DIAGNO	IMAMRI	MRI Unit	Minor	Personal old patient arrived for MRI appointment with a support worker. The safety questionnaire had been completed by a support worker, the patient does not have any next of kin and NIECR was used to complete the form. There was no recent imaging on the system to allow any implants to be excluded.	Unable to scan the patient – advised the support worker of the procedure for patients who do not have capacity and no next of kin- procedure printed and given to support worker. Email sent to referrer with procedure attached and advising D/W Radiologist.		In holding area, awaiting review	

Personal	30/03/2021	00:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Ramone Ward 4	Minor	Patient's discharge completed on Friday afternoon, and included Pregabalin 50mgx56 caps (Dose=50mg BD. Patient supposed to go to Roxborough Hse). Patient no longer going to Roxborough Hse so Pregabalin signed into Yellow Pages of PODCD register. Ward ran out of Pregabalin over weekend and so used the patient's discharge medicine (rather than using liquid or ordering further supply from pharmacy), 2 caps missing on Monday AM. S/N responsible had written 'x2' and her name in register, but no details of when doses were administered or who to. (Assume using Kardex this was for same patient, Sat & Sun night doses)	- S/N responsible to add in patient details and date of administration in PODCD register to allow for an audit trail of where the capsules went when she is next on duty - Patient discharged 30/3/21 with 54 capsules that were left. Myself and another staff nurse made a record in CD register of reason why (2 caps used for inpatient administration) and both signed.	To ensure adequate stock of Control drugs available, and also that Discharge medications are not to be used on the ward before the patient is discharged.	Being reviewed	
Personal	30/03/2021	12:20	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Patient- Personal on repositioning round and toileting patient. noticed a moisture lesion on tip of penis and ungradable mark on 2nd toe on right foot pre admission.	Repositioned patient, documented on ED skin intervention chart. Cavilon barrier spray applied to area and clean pad. Patient aware to ask staff for assistance to toilet. Regular repositioning. Patient has POC in place at home. Heels elevated as blanching and red.		Being reviewed	
Personal	30/03/2021	21:45	Craigavon Area Hospital	Surgery and Elective Care	ATICS	THEAT	Theatres 1-4 CAH	Minor	2 theatres running at same time , Child lap Appendix and ENT case for difficult airway and tracheostomy	consultant anesthetist called in and a member of nursing staff called in so as both Theatres could be safely staffed , bed manager informed of same , no help offered from bed manager		In holding area, awaiting review	
Personal	30/03/2021	07:10	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	CANCER	HAEMNU	Haematology	Insignificant	Sacrum red and excoriated	Cavilon cream applied and advised to relieve pressure were possible. Must and braden updated and relevant care plans commenced		In holding area, awaiting review	
Personal	30/03/2021	02:45	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Minor	HCA was in side room with patient, who required 1:1 supervision. Patient was unsettled, walking around room. he passed urine on the floor. As HCA attempted to assist the patient with hygiene needs, he became aggressive and slipped on the wet floor. Witnessed fall with no apparent injury. Patient was assisted to his feet with the help of 3 staff members.	Clinical co Ordinator informed.	nil	Final approval	31/03/2021
Personal	30/03/2021	17:30	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	GENSUR	4 South	Insignificant	patient admitted 29.03.21 with abdominal pain and diarrhoea from ED. admitted to 4 south room 5 rear side. patient has stool sent by GP on 26.03.21 and as per phone call from infection control CDiff positive toxin postive	Phoned FY1 to prescribe treatment @18.10 Cdiff bundle commenced Patient informed and leaflets of Hand hygiene and cdiff and laundry advice given Registrar canning informed via phone of cdiff sample		In holding area, awaiting review	
Personal	30/03/2021	18:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	TRAUSU	Trauma Ward	Insignificant	The patient is a day 1 post operative neck of femur fracture. He has been positive for delirium and has been nursed in a bay at the top of the ward. The patient had been requiring close supervision as he had been identified as a falls risk. He had been sitting out on the chair at his bedside this evening but was then found lying on the floor beside the bed by a staff nurse. The patient stated that he needed the toilet but due to delirium had forgotten that his catheter was in situ.	The patient denied any new pain, no injury was apparent and there was no obvious deformity. The T+O SHO was on the ward and was happy for the patient to be assisted off the floor. The patient was able to help himself off the floor with assistance from staff. The FY1 was contacted and asked to review the patient. Falls pathway was commenced, vital sign and GCS monitoring ongoing. Risk assessments to be updated. Next of kin to be updated.		In holding area, awaiting review	
Personal	30/03/2021	00:30	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	General Male Medical,	Minor	Staff alerted to bay by a noise, patient found sitting on floor at side of her bed. States her feet slipped from under her	Examined for injury Assisted back into bed Observations recorded Doctor informed		In holding area, awaiting review	
Personal	30/03/2021	01:10	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Moderate	PT FELL AND HIT HEAD (WITNESSED). ALSO LIT CIGARETTE AND STARTED SMOKING IN CUBICLE WHILST ON O2	DATIX, SENIOR STAFF INFORMED, SURGICAL DR INFORMED		Being reviewed	

Personal	30/03/2021	07:00	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	Emergency Department CAH	Minor	Security requested to ED triage as a male patient had become verbally abusive towards staff.	Security arrived to ED Triage and witnessed a highly confused male who was also very unsteady on his feet he was carrying a bag of medication and was refusing to listen to staff. Security tried talking to the patient asking him to return to his cubical in Green Area but instead he made his way down the CDU Corridor and entered ED Pead's. Security then made the decision to escort the patient back to the green Area using MAPA the patient struggled throughout and was threatening to hit Security staff. Once the patient was place in Cubical 3 in the green area he got up and threatened to head but a member of Security staff and made a lunge towards us. Security then had to restrain the patient and place him back on his trolley. Whilst this was ongoing nursing staff phoned the police. About 10 minutes later the police then arrived and spoke to the patient. The patient then agreed to settle and security were stood down.		In holding area, awaiting review	
Personal	30/03/2021	10:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	TRAUSU	Trauma Ward	Minor	new patient admitted in ward with ankle fracture . she was in sore . I have given 10 am MST 30 tablets.the same medicine was given in ED at 4.50 am which was documented in flimsy .. I checked the Kardex only.later I noticed the flimsy and aware that I have given an extra dose	informed ward manager,sister in charge ,SHO , pharmacist and painteam..checked the news ,gcs .informed the patient about same and apologized. reviewed the patient by doctor.patient missed her night MST 10 yesterday night and had a dose in ed at 4.50am speak with the pain team about same..as the patient is in pain doctor reviewd the Kardex and changed and increased the MST doses .		In holding area, awaiting review	
Personal	31/03/2021	22:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	MAU	AMU	Minor	Patient approached staff member from behind. Placed 1 hand to the front of her neck and 1 hand to the back of her neck and attempted to choke staff member.	Security button pressed and 2 staff nurses approached patient to remove his hands from around healthcare's neck. Escorted back to his bed.		In holding area, awaiting review	
Personal	31/03/2021	03:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Moderate	Patient came out of cubicle to say he was going home as the department is "too loud" he "cant sleep" and "the bed manager doesn't have a bed for me so im not staying here all night". After trying to convice patient to stay in ED he got irritable and angry. Security bleep bleeped twice. I then told patient that if he was to leave I would need to get him returned to the department by the PSNI. pt then phoned a taxi and left.	absconding protocol started. NIC and doctor in charge aware. 101 called.		Being reviewed	
Personal	31/03/2021	12:40	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Haematology Lab	Insignificant	Porter Per was over by the labs and noticed a patient wandering with a canula in his arm. Per called over the radio for support and assistance Perso and Po responded they escorted patient back to his ward.	none		In holding area, awaiting review	
Personal	31/03/2021	23:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Patient was sitting in porters wheelchair missed the step and fell. Patient states she lowered herself onto her knees then onto her left side.	Dr checked patient over- no injuries, NIC aware of same. NOK informed. Datix completed		In holding area, awaiting review	
Personal	31/03/2021	19:55	Daisy Hill Hospital	Functional Support Services	LOCNE	SECNE	Coronary Care Ward	Insignificant	Security called to male medical, on arrival security came across patient by the front bed lifts trying to leave the hospital. Security escorted patient back to his bed, patient became very aggressive towards staff so security staff applied low level MAPA holds on patient. Security had to hold patient for over an hour, nursing staff administered medication. Patient calmed down and security stood down.	none	none	Final approval	01/04/2021
Personal	31/03/2021	09:30	Craigavon Area Hospital	Medicine and Unscheduled Care	CSMUC	CARDIO	1 North Cardiology	Moderate	Patient attended Cath Lab today to have a 48hour U&E obtained due to no appointments in his GP surgery. On asking which arm had better access patient stated could you not take it out of that as he pointed out a green 16G cannula in his left forearm.	Cannula removed. Site checked same satisfactory phlebitis score 0. Apologies given to patient.		In holding area, awaiting review	
Personal	31/03/2021	11:50	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Antenatal Clinic	Minor	NEEDLE STICK INJURY FOLLOWING TAKING BLOOD SAMPLE FROM PT	AREA WASHED WITH SOAP AND WATER AND SITE ENCOURAGED TO BLEED. IR1 COMPLTED OCC HALTH INFOMRED AND PT COUNSELLED BEFORE BLOOD SAMPLE TAKEN FOR HIV, HEP B + C		Being reviewed	
Personal	31/03/2021	11:00	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	GENMED	Isolation Ward 1 Ramone	Minor	This man was discharged from hospital 29/03/2021. Home visit was carried out by Dungannon ICT SCW and SW. SCW observed that cannula was still in place in left arm.	Niece Personal informed. Spoke with Personal surgery DN Personal Information and referral completed for DN to remove same.		In holding area, awaiting review	

Personal	31/03/2021	09:30	Community	IMWH - Cancer and Clinical Services	MIDWIF	COMM	Crossmaglen Health Centre	Minor	Personal attended for 34 wk app in Personal H/C and had not been seen by midwives from 22/12/20. 20 week scan was attended on 12/01/21. No NIMATS booking page or grow chart in notes and documented in chart Personal required consultant led shared care but unable to determine who made this decision. Personal attended Dr Sharma's clinic on 16/12/20 but no documentation seen in notes from same. Antenatal clinics contacted re follow up from Dr Sharma's clinic's but unable to determine from outcome sheet if Personal was to continue with consultant led care or transfer to MLC and no follow up date was noted. 28 week app therefore missed, so bloods and growth scan/fundal height not carried out, and 32 week app also missed.	28 week bloods obtained today (31/3/21) and fundal height measurement recorded along with routine antenatal check. Appointment arranged in DHH antenatal clinics for 7/4/21 to attend Dr Sharma's clinic and Personal declined app this week (31/3/21) due to work commitments and transport issues. NIAMTS booking and grow chart printed and placed in notes. Apologies given to Personal and issues reported to line manager Personal Information		Being reviewed	
Personal	31/03/2021	15:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	GENSUR	4 South	Minor	Ungradable pressure sore to left heel of patients foot noted when repositioning patient.	Zero pressure applied to heel, datix completed, pressure relieving pathway commenced. Pt already nursed on pressure relieving mattress		Being reviewed	
Personal	31/03/2021	18:00	Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	General Male Medical,	Insignificant	Patient's BM was 26.4mmols and Ketones 0.1. Asked Doctor to review and she pointed out that patient had missed his tea time dose of Insulin Novomix 30.	Doctor asked nurse to recheck BM an hour later and if going down no correction dose needed. Nurse in Charge inform of incident.		Being reviewed	
Personal	31/03/2021	00:47	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	2 North Medical	Minor	Security requested by telephone to attend 2 North as a male patient had become aggressive towards nursing staff and was refusing to return to his bed.	Security attended 2 North and witnessed a male patient acting aggressively towards staff. Security spoke to the male and escorted him back to his bed. the patient continued to act aggressively and started striking out at staff. He then had to be restrained on his bed as medication was being administered. The male did not settle and continued to be abusive kicking and punching out at Security and staff. Under instruction from the Bed Manager Security stayed with the patient whilst another 4 doses of medication was given. After the last dose of medication the patient finally started to settle and security were then stood down. The incident lasted 4 Hours in total. Security were then called back to the same patient at 06:15am but on arrival were not required.		In holding area, awaiting review	
Personal	31/03/2021	15:30	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Insignificant	Patient admitted to ED with UTI and confusion. Normally on novorapid TDS and lantus at night. Blood glucose recorded pre-breakfast and novorapid given but no blood glucose levels recorded and no insulin prescribed until pharmacist noticed at 15:30. patient received lunch without normal insulin and no BM checked. BM checked at 15:30 and was 13.9, med reg contacted who advised not to give insulin as too long since meal and to give teatime dose when due.	Nurse looking after patient informed to check BMs and that this should have been done earlier. Medical SHO looking after patient informed.	Monitoring of blood sugars in Insulin dependent patients hourly in ED Importance of pre meal blood sugar monitoring in Insulin dependent patients Importance of time critical medications	Being reviewed	
Personal	31/03/2021	13:00	Craigavon Area Hospital	Medicine and Unscheduled Care	CSMUC	CARDIO	1 North Cardiology	Minor	Missed insulin Noticed at 13.00, blood sugar recorded 17mmols,Doctor Cambell informed and patient corrected insulin given as prescribed by Doctor.	Nurse in charge informed, patient and Doctor Campbell		In holding area, awaiting review	
Personal	31/03/2021	06:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Moderate	at approximately 0600H, patient Per , with history of dementia and on going confusion, tried to get up from chair where he had slept all night; agitated, refused any help and pushed away staff. Patient then fell forward and hit head on nozzle of bedside hand sanitizer, caught himself with the palm of his hands, head did not hit floor. Laceration to right eyebrow and nose bridge.	Doctor present. Obs taken every 15 mins. GCS obs started. Blood glucose taken. FY1 applied steristrips and premierepore to wound. CT Brain requested.	nil	Final approval	31/03/2021
Personal	31/03/2021	13:30	Craigavon Area Hospital	Surgery and Elective Care	OUTPAT	OUTPAT	General Surgery Clinic	Minor	Patients son phoned to confirm an appointment for RED FLAG MRCP and reported to staff the patient has a pacemaker cardiac stents and a loop recorder. On the referral received 25/03/2021 for M.M H&C Personal the Safety section was incorrectly completed saying NO to any implants.	Clerical staff cancelled the appointment informing the patients son that the implants had to checked and referred to Radiography staff to check if implants suitable for scanning		In holding area, awaiting review	
Personal	31/03/2021	14:34	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	Delivery Suite, CAH	Minor	I looked after this woman in labour. 36/40 IOL PET. It was found this woman was GBS positive after delivery. There was no handover or evidence of GBS in notes, therefore no antibiotics were given in labour.	Patient informed. Apologies given. GBS positive result printed from NICER, signed and placed in notes. Midwife informed on postnatal ward at handover of care. Infant on 2hrly observations.		In holding area, awaiting review	

Personal	31/03/2021	20:30	Craigavon Area Hospital	Clinical and Social Care Governance	CSA	CSA	Gynae Clinic	Moderate	patient was seen in gynae clinic in the pm. she had a covid swab taken prior to admission by gynae staff. Swab result not available at 5 pm as gynae staff were leaving. midwifery staff left to follow this up. approximately at 1845 results still not available as per bed manager. porters and laboratory contacted re same. Apparently swab had not arrived in laboratory. Repeat swab carried out at 1910hours by midwifery staff. the same was taken to laboratory reception by midwifery staff and handed directly to laboratory staff who informed staff member swab would take 40 minute. at 2030hours swab result not available and laboratory contacted who informed staff that result had to be re run asper an error in laboratory. patient who had been sitting in waiting room all afternoon and evening awaiting result was informed about situation and apologies given	Patient informed bed manager informed Dr Henderson informed Laboratory staff informed Porters informed		In holding area, awaiting review	
Personal	31/03/2021	17:00	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Insignificant	Security requested by AMU as a male patient had managed to leave the ward via the back fire exit.	Security arrived to AMU and witnessed the male patient outside in the courtyard at F Bay. Security managed to talk the patient back onto the ward where he then settled. Security were then stood down.		In holding area, awaiting review	
Personal	31/03/2021	17:50	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Insignificant	Security requested by AMU as a male patient was trying to leave the ward against medical advice.	Security arrived to AMU and managed to talk to the patient convincing him to return to his bed. Once the patient was settled the Doctor then came to speak to him and explained that he was not fit to leave. Security were then stood down.		In holding area, awaiting review	
Personal	31/03/2021	20:00	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Insignificant	Security requested by AMU as a male patient was trying to leave the ward against medical advice.	Security arrived to AMU and witnessed an agitated male patient who was trying to leave the ward. Security escorted the male patient back to his bed using a low level MAPA. Security spoke to the patient and managed to settle him down and convince him to stay. Security were then stood down.		In holding area, awaiting review	
Personal	31/03/2021	20:52	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Insignificant	Security called to attend AMU as a male patient was refusing to return to his bed and was walking about other patients bed areas.	Security arrived to AMU and witnessed a male patient talking to nursing staff outside H Bay. Security tried asking the patient to return to his bed but he refused. Security then made the decision to escort the patient back to his bed using Low level MAPA. Nursing staff then administered medication which helped settle the patient. Security were then stood down.		In holding area, awaiting review	
Personal	31/03/2021	23:00	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	AMU	Insignificant	Security called to AMU as a patient was trying to leave the ward against medical advice.	Security arrived to AMU and were met with a confused male patient looking to leave the ward for a smoke. Security explained to the patient that he could not leave the ward and had to return to his bed. The patient refused to do so, Security then escorted the patient back to his bed using MAPA. The patient was then given medication by nursing staff to help settle him. Security remained with the patient who continued to be unsettled and was struggling with security staff. After about an hour nursing staff then give the patient more medication to help settle him. The patient then began to settle and security were stood down.		In holding area, awaiting review	
Personal	31/03/2021	05:25	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	GENSUR	CEAW	Minor	I had just taken blood from a patient and as I went to withdraw the needle the patient moved her arm causing the needle to stick into the tip of my left middle finger	Spoke to bed manager Spoke to doctor who assessed patient as low risk to contact occupational health this am		In holding area, awaiting review	
Personal	31/03/2021	13:30	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	2 West Maternity Post Natal	Minor	P2 at 35+2 weeks emergency C/S Perse 03/21 at 1550 in DHH. History of 2 previous c/s presented in labour breech presentation. infant transferred to NNU CAH Mother taken to CAH via partner in car 30/01/2021 - not yet discharged wound noted to be gaping +++ and oozing	Review by registrar and consultant swab obtained to return to theatre for wash out and repair		Being reviewed	
Personal	31/03/2021	00:50	Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC	ACUTE	2 North Respiratory	Moderate	Patient became agitated,aggressive, physically and verbally aggressive towards staff. wandering around ward walking into other patients rooms and sisters office. Charging towards staff. Assisted back to bed by security	security, night co-ordinator and FY1 contacted at 0050.		Being reviewed	

Personal	31/03/2021	18:00	Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF	OBSTET	2 West Maternity Post Natal	Minor	infant born via NVD 31/2 at 1500hrs 34+2 weeks gestation. spontaneous onset labour weight 2120g apgars 8/1 9/5 transferred to 2west with mum 1750hrs on admission to ward very dusky episode	infant to resusitaire, help summoned, facial oxygen provided. infant transferred to NNU		In holding area, awaiting review	
Personal	31/03/2021	23:00	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Patient attended ED from home, patient noted to have a G3 pressure damage to sacral area.	nurse in charge informed. protective dressing applied to sacrum. patient advised to rotate from side to side while in bed.		In holding area, awaiting review	
Personal	31/03/2021	14:35	Craigavon Area Hospital	Functional Support Services	LOCCB	SECCB	Emergency Department CAH	Insignificant	Security contacted by ED Blue area reporting a missing patient.	Security took the description of the patient and searched all areas and did not manage to locate the patient. The ward staff were then informed		In holding area, awaiting review	
Personal	31/03/2021	14:30	Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department CAH	Minor	Patient presented to ED with thoughts of life not worth living. Patient had taken overdose and alcohol was on board on initial presentation. Patient absconded from department after being advised to stay.	Absconding protocol commenced. Police phoned. Patient has not been returned to the department yet. NOK kim informed. Patient does not have a mobile so unable to contact him.		Being reviewed	
Personal	31/03/2021	11:30	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	TRAUSU	Trauma Ward	Insignificant	fire alarm at 11:30 this AM.zone b33 b853 (sideroom 3).	area checked. no fire detected. workmen outside and on roof and strong smell of 2 stroke in room.	nil	Final approval	31/03/2021
Personal	31/03/2021	14:30	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	TRAUSU	Trauma Ward	Insignificant	fire alarm sounded this PM approx. 14:30. same area as this Am b33 b853	area reviewed. no fire detected. estates contacted to replace fire alarm in room. Same being completed at present	nl	Final approval	31/03/2021
Personal	31/03/2021	11:30	Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC	A/E	Emergency Department DHH	Minor	patient attended clinic for fractured wrist, upon removal of cast , applied in a&e DHH, grade 2 pressure sore noted to head of 2nd MC	same photographed, patient and niece informed tissue viability referral completed, trauma co-ordinators informed as patient is due for surgery on same wrist		In holding area, awaiting review	

ID	Incident date	Time
Personal Information redacted by the USI	01/03/2021	21:30
	01/03/2021	12:40
	02/03/2021	12:00
	02/03/2021	14:30
	03/03/2021	14:30
	03/03/2021	12:30

	Personal Information redacted by the USI	03/03/2021	20:13
		03/03/2021	14:00
		04/03/2021	09:44
		04/03/2021	00:00
		04/03/2021	00:00

	Personal Information redacted by the USI	04/03/2021	09:00
		05/03/2021	10:00
		05/03/2021	11:00

	Personal Information redacted by the USI	05/03/2021	13:30
		05/03/2021	00:25
		05/03/2021	12:00
		05/03/2021	04:55
		06/03/2021	10:00

	Personal Information redacted by the USI	07/03/2021	15:00
		08/03/2021	11:15
		08/03/2021	20:00

	Personal Information redacted by the USI	09/03/2021	21:00
		09/03/2021	07:30
		09/03/2021	15:00
		09/03/2021	11:00
		09/03/2021	07:00

	Personal Information redacted by the USI	09/03/2021	10:00
		09/03/2021	07:30
		09/03/2021	07:00
		10/03/2021	10:20

	Personal Information redacted by the USI	10/03/2021	14:15
		10/03/2021	02:00
		10/03/2021	15:00
		10/03/2021	06:00
		11/03/2021	20:40

	Personal Information redacted by the USI	12/03/2021	10:30
		12/03/2021	18:45

	Personal Information redacted by the USI	12/03/2021	09:59
		13/03/2021	01:30
		13/03/2021	06:15
		15/03/2021	00:00
		16/03/2021	16:24

	Personal Information redacted by the USI	16/03/2021	01:00
		17/03/2021	19:53
		17/03/2021	18:00

	Personal Information redacted by the USI	17/03/2021	12:30
		17/03/2021	12:20
		17/03/2021	11:20

Personal Information redacted by the	17/03/2021	18:43

	Personal Information redacted by the USI	17/03/2021	16:10
		17/03/2021	19:00
		18/03/2021	06:45
		19/03/2021	10:30
		19/03/2021	12:20

	Personal Information redacted by the USI	19/03/2021	19:30
		20/03/2021	23:30
		20/03/2021	21:00

	Personal Information redacted by the USI	20/03/2021	11:00
		20/03/2021	21:00
		21/03/2021	09:00
		21/03/2021	10:30
		22/03/2021	13:00
		22/03/2021	10:00

	Personal Information redacted by the USI	22/03/2021	18:00
		23/03/2021	21:00
		24/03/2021	20:00

	Personal Information redacted by the USI	24/03/2021	01:30
		24/03/2021	02:36
		25/03/2021	07:00
		26/03/2021	19:30
		26/03/2021	04:15
		26/03/2021	16:00
		27/03/2021	17:00

	Personal Information redacted by the USI	28/03/2021	01:00
		28/03/2021	16:00
		29/03/2021	18:00

	Personal Information redacted by the USI	29/03/2021	09:00
		30/03/2021	03:20
		30/03/2021	00:30
		30/03/2021	01:10
		31/03/2021	03:00
		31/03/2021	09:30
		31/03/2021	06:00

	Personal Information redacted by the USI	31/03/2021	20:30
		31/03/2021	00:50

Site	Division	Service Area
Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC
Craigavon Area Hospital	Surgery and Elective Care	GENSUR
Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF
Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC
Craigavon Area Hospital	Pharmacy	PHARM
Craigavon Area Hospital	Surgery and Elective Care	ATICS

Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF
Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC
Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF
Craigavon Area Hospital	Surgery and Elective Care	GENSUR
Craigavon Area Hospital	Surgery and Elective Care	GENSUR

Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC
Daisy Hill Hospital	IMWH - Cancer and Clinical Services	MIDWIF
Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF

Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC
Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC
Community	IMWH - Cancer and Clinical Services	MIDWIF
Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC
Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC

Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC
Craigavon Area Hospital	Surgery and Elective Care	GENSUR
Craigavon Area Hospital	Surgery and Elective Care	GENSUR

Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC
Craigavon Area Hospital	Functional Support Services	LOCCB
Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF
Craigavon Area Hospital	Functional Support Services	LOCCB
Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC

Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC
Craigavon Area Hospital	Functional Support Services	LOCCB
Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC
Daisy Hill Hospital	IMWH - Cancer and Clinical Services	DIAGNO

Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC
Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC
Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF
Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC
Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC

Craigavon Area Hospital	Surgery and Elective Care	ATICS
Community	IMWH - Cancer and Clinical Services	MIDWIF

Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC
Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC
Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC
Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC
Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF

Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC
Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF
Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC

Daisy Hill Hospital	IMWH - Cancer and Clinical Services	MIDWIF
Craigavon Area Hospital	Surgery and Elective Care	GENSUR
Craigavon Area Hospital	Medicine and Unscheduled Care	CSMUC

Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC

Craigavon Area Hospital	Functional Support Services	LOCCB
Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC
Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC
South Tyrone Hospital	Medicine and Unscheduled Care	GMMUC
Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC

Daisy Hill Hospital	Functional Support Services	LOCNE
Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC
Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC

Daisy Hill Hospital	IMWH - Cancer and Clinical Services	MIDWIF
Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC
Craigavon Area Hospital	Surgery and Elective Care	GENSUR
Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC
Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC
Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC

Craigavon Area Hospital	IMWH - Cancer and Clinical Services	DIAGNO
Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC
Daisy Hill Hospital	Medicine and Unscheduled Care	GMMUC

Craigavon Area Hospital	Clinical and Social Care Governance	CSA
Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC
Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC
Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC
Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF
Daisy Hill Hospital	Medicine and Unscheduled Care	AEMUC
Craigavon Area Hospital	IMWH - Cancer and Clinical Services	MIDWIF

Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC
Craigavon Area Hospital	Surgery and Elective Care	GENSUR
Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC

Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC
Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC
Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC
Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC
Craigavon Area Hospital	Medicine and Unscheduled Care	AEMUC
Craigavon Area Hospital	Medicine and Unscheduled Care	CSMUC
Craigavon Area Hospital	Surgery and Elective Care	GENSUR

Craigavon Area Hospital	Clinical and Social Care Governance	CSA
Craigavon Area Hospital	Medicine and Unscheduled Care	GMMUC

Speciality	Loc (Exact)	Severity
A/E	Emergency Department CAH	Moderate
UROSUR	3 South	Major
GYNAE	Gynae Clinic	Moderate
GENMED	MRI Unit	Moderate
PHCLIN	1 South Medical	Moderate
ICU	ICU CAH	Major

OBSTET	Delivery Suite, CAH	Moderate
A/E	Emergency Department DHH	Major
OBSTET	Delivery Suite, CAH	Moderate
GENSUR	4 North	Major
GENSUR	4 North	Major

GENMED	General Male Medical,	Moderate
GYNAE	Gynae Clinic	Major
OBSTET	2 West Maternity Post Natal	Moderate

GENMED	General Male Medical,	Moderate
A/E	Emergency Department CAH	Moderate
COMM	Home of client	Moderate
GENMED	General Male Medical,	Moderate
MAU	Emergency Department CAH	Moderate

A/E	Emergency Department CAH	Moderate
UROSUR	3 South	Moderate
UROSUR	3 South	Moderate

MAU	AMU	Moderate
DOMSCB	Domestic Services	Moderate
GYNAE	Gynae Clinic	Moderate
DOMSCB	Domestic Services	Moderate
A/E	Emergency Department CAH	Moderate

GENMED	X-ray Dept (Radiology)	Moderate
DOMSCB	Domestic Services	Moderate
GENMED	2 South Medical	Moderate
IMACT	CT Scanner	Moderate

A/E	Emergency Department CAH	Moderate
A/E	Emergency Department CAH	Moderate
OBSTET	Antenatal Clinic	Moderate
GENMED	General Male Medical,	Moderate
A/E	Emergency Department CAH	Moderate

ANAES	Theatres 5-8 CAH	Moderate
COMM	Home of client	Moderate

GENMED	3 South	Moderate
A/E	Emergency Department CAH	Moderate
A/E	Emergency Department CAH	Moderate
GENMED	3 North Medicine	Moderate
OBSTET	Delivery Suite, CAH	Moderate

A/E	Emergency Department CAH	Catastrophic
OBSTET	Delivery Suite, CAH	Moderate
A/E	Emergency Department CAH	Major

OBSTET	Delivery Suite, DHH	Moderate
GENSUR	CEAW	Moderate
CARDIO	1 North Cardiology	Moderate

A/E	Emergency Department CAH	Moderate

SECCB	Emergency Department CAH	Moderate
GENMED	General Male Medical,	Moderate
A/E	Emergency Department CAH	Moderate
GENMED	Ramone Day Clinical Centre	Moderate
GENMED	2 North Respiratory	Moderate

DOMNE	Surgical Assement Unit	Moderate
ACUTE	3 North Medicine	Moderate
ACUTE	3 North Medicine	Moderate

OBSTET	Delivery Suite, DHH	Moderate
A/E	Emergency Department CAH	Moderate
UROSUR	3 South	Moderate
A/E	Emergency Department CAH	Moderate
A/E	Emergency Department CAH	Moderate
GENMED	Ward 3b	Major

IMAMRI	MRI Unit	Moderate
A/E	Emergency Department CAH	Moderate
STROKE	Stroke / Rehab	Moderate

CSA	Emergency Department CAH	Moderate
A/E	Emergency Department CAH	Moderate
A/E	Emergency Department CAH	Moderate
GENMED	1 South Medical	Moderate
OBSTET	Delivery Suite, CAH	Moderate
A/E	Emergency Department DHH	Moderate
GYNAE	1 East Maternity/Gynae	Moderate

A/E	Emergency Department CAH	Moderate
TRAUSU	Trauma Ward	Moderate
GENMED	AMU	Moderate

GENMED	1 South Medical	Moderate
A/E	Emergency Department CAH	Moderate
A/E	Emergency Department CAH	Moderate
A/E	Emergency Department CAH	Moderate
A/E	Emergency Department CAH	Moderate
CARDIO	1 North Cardiology	Moderate
UROSUR	3 South	Moderate

CSA	Gynae Clinic	Moderate
ACUTE	2 North Respiratory	Moderate

Description	Action taken
on completing skin check with pt noted g2 to right hip.	first aid, dressing applied to pt. pt informed of same, nurse in charge informed, body map completed, pt placed on hospital bed for comfort.
no one to take bloods for three south. leading to delays in discharges. And patient safety issue as bloods need to be handed over to night team.	datix and escalated to sister in charge
differentiated VIN added to waiting list for surgery 22/10/2020 Given date or 31/12/2020 then list reallocated to another specialty admitted 27/01/2021 for procedure - cancelled due to difficult first case and theatre over-run admitted to Kingsbridge for surgery. Histology - cancer - 2 mm deep therefore will require lymph node dissection	apologized to patient
PT HAS PACEMAKER INSITU. This was not documented on safety section of referral and is therefore counted as a near miss.	Referral cancelled. Ward informed to ask DR to send new referral with correct safety info documented.
medications wrongly entered in clerk in - apixaban, propranolol spironolactone and metformin, lansoprazole prescribed, not on preadmission -wrong dose furosemide rx -vte risk ass not filled in given dose of propranolol which could have reduced heart rate	spoke with ward SHO and FY1 and rectified Kardex nursing staff reported drop in heart rate - patient given bed rest and ECG(background of hyperkalemia)
A DNAR form was completed on patient on 12/10/20 in ICU signed by Dr Raymond Mckee. This was not communicated to patient or his family at any stage.Patient's son contacted a member of our team after finding ambulance copy of DNAR form recently and was clearly distressed that they were not involved in this decision and neither informed regarding this. Patient has been in and out of hospital several times in last few months.	Phoned son, apologized and informed that we will inform the relevant team and complete and incident form as an educational opportunity to stop similar incidents happening in future.

LIVEBORN MALE DELIVERED BY KIWI AND BNF. APGARS 2,2,2 CORD PH ART 7.042 BE -15.8 VEN 7.124 BE -14.2 TRANFERED TO NNU	INFANT TRANSFERED TO NNU
Resus Patient, GCS 7, unclear history, seizures. Pre intubation check by consultant, Desat during intubation. Following intubation noted that C-Circuit attached to Medical Air, not O2 supply. Medical air flow-meter has flap covering Christmas tree nozzle and was functioning.	Patient placed on O2
MBL >1500ML @C/S FOR PLACENTA PRAEVIA Personal Information redacted by the USI	BARKI BALLOON INSERTED. DRAIN INSITU
Hospital Acquired Covid19 in surgical unit	transfer to 2N - died
Hospital Acquired Covid19 in Surgical Unit	Transfer to 4S & then 2north for CPAP

This gentleman was referred for an ERCP for a CBD stone in June 2019. Unfortunately, due to our significant backlog of OP ERCP's, this did not occur in a timely manner. This gentleman was readmitted with cholangitis while awaiting an OP ERCP in Jan 2021, nearly 1 year and 7 months after his initial referral, albeit with COVID affecting OP provisions through 2020. He has had a very stormy course with post ERCP pancreatitis and pseudocyst formation, likely due to an inflammatory CBD stricture he had developed from his initial MRCP in 2019 to his repeat MRCP in 2021. He was admitted on 25/01/21 and is still an inpatient. Main question is if he had been ERCP'ed in 2019, if this current situation could have been avoided.	To be actioned
H&C Personal Information redacted by the USI was seen by a consultant at ANC/GOPD ON 05/03/21 ?ectopic pregnancy Pregnancy test using clinitek machine number 295478 was negative Serun HCG taken Result 126	Due to concern re possibility of ectopic pregnancy HCG had been taken 10/03/21 Machine sent to lab for investigation
pt underwent complex caesarean section for placenta praevia MBL 2000mls mobilized slowly day 1 fell whilst going to toilet fractured clavicle	attended fracture clinic

Patient with cognitive impairment got up without asking assistance from the staff, patient was confused and unsteady on his feet even with the rollator and requires close supervision. He went to the toilet on his own and had a fall. Staff heard noises in the toilet and he was found sitting on the floor. He claims he did not hit his head. Medics assessed patient.	Patient was assisted back to bed, NEWS: 0, Falls protocol commenced. GCS: 14/15 due to confusion. Assessed by medics and advised not requiring any scan at present. NOK informed. patient clinically stable.
Patient from PNH, has G2 pressure sore to right inner buttock, dressing insitu from nursing home, no documentation about same from nursing home. For regular rounding to maintain skin integrity. Surrounding sacrum area blanching but intact.	NIC informed, new dressing applied, for regular turns to maintain skin.
Day 12 post Barnes Neville Forceps Birth of Baby Girl, discharged home initially 23.02. 2021 with haemoglobin 78g/l, however required readmission where she was transfused. During admission required psychiatric review due to behavior's on the ward discharged home with daily input from Home treatment Team, medication and constant adult supervision.	Today, 05.03.2021,following home visit from Home Treatment Team the mother was found to be very unsettled and labile in presentation and despite medication was still unable to rest to allow health to improve thus requiring admission to Bluestone unit.
had clinical observation checked. i heard knocking on the door. Personal Information was sitting on the ground. He stated that he could not control rollator and it run away on him	Clinical observation recorded. full body check carried out. Fi contacted. falls protocol followed.
patient prescribed and administered enoxaparin 90mg and apixaban 10mg and clopidogrel 75mg once daily on 6/3/21 at 10am on AMU ward CAH. Initially had been prescribed enoxaparin 90mg BD for PE, then switched to apixaban 10mg BD for one week on 6/3/21. However enoxaparin was not stopped on prescribing apixaban.	I spoke to F1 Dr Caoimhe O'neill, SHO DR Ahern and ward manager. Dr Ahern contacted haematology consultant. Advised for patient to be monitored overnight and to contact stroke re clopidogrel if it is to be held whilst on apixaban or continued.

Patient in cub 7 in green transferred out to x-ray, was brought back from x-ray by two radiographers. Noted by nursing staff skin tear to back of (R) hand. When patient questioned she stated "her hand hit of door on way back from xray" Pace and body map completed prior to transfer and no injury noted to hand patient no history of confusion and coherent	spoke with radiographer and advised him on what patient stated, denied any injury happening wound care and Steri-strips applied
A delirious Insulin Dependent T2DM patient presented to ED on 5/3/21 at 22.10. Admitted medically and clerked in at 01.00 6/3/21, seen on weekend review 7/3/21 and by ward Dr's on the 8/2/21. Pharmacy IP ECR completed on 7/3/21 and documented in medical notes. I took over nursing care of this patient on 8/3/21 at 08.00 and during an independent check of information regarding podiatry for toe ulceration via NIECR, I incidentally discovered that the patient was Insulin dependent and that Novomix '30' BD had not been prescribed from admission. CBG's had been checked QDS by nursing staff and documented as a tablet controlled diabetic on 24 hour nursing admission booklet.	I immediately escalated the findings to the medical team at 11.15, whom had already seen the patient on the ward round that morning, and informed both the ward manager and ward pharmacist.
Took charge of ward to find that no HCA had been booked for 1:1 supervision of an extremely confused and aggressive patient. One HCA had to remain with the patient at all times as has a high risk of falls and is a danger to himself and others (2 security calls were required overnight for this patient) This left only 3 band 5 nurses and 1 band 3 HCA to cover the rest of the ward, which also included 2 other confused patients requiring close supervision. Due to concerns for patient safety, no further admissions could be accepted overnight.	Bed manager contacted to inform of situation at beginning of shift, but no extra staff were available throughout the hospital to help out.

Patient had unwitnessed fall at beside. Loud noise heard and patient found on floor, fell out of chair and chair was on top of patient. Bleeding heavily from nose - found face down. Patient admitted to AMU on 07/03/21 at 04:30am and had 1:1 from PNH in attendance since then. since 20:00 on 09/03/21 no 1:1 provided. contacted PNH regarding same and they stated that they had informed social worker LH that they would no longer be providing staff for 1:1 and it was now up to the trust. same information not relayed.	Stopped bleeding from patients nose. Assisted off floor and into bed. NEWS and GCS recorded as per falls protocol. Medics informed. patients nose looks displaced - contacted PNH to ask if this is how it looked previously or not. IV analgesia given as nose appears to look broken.
Infection attributable to specified work (schedule 3 No.27) tested positive Covid19	Reported to OH Tested at Kernan Testing station Isolating
Personal Information old lady with gelhorn pessary in situ from july 2019. It is not embedded and unable to be removed. clinic appointment at 4 months post insertion did not happen	d/w next of kin, happy for it to stay and understand risks
Infection attributable to specified work (Schedule 3 No 27) Tested positive for Covid19	Referred to Occupational health Staff member isolating
pressure damage noted on right ear and right elbow, both grade 2. patient is known to district nurses and is receiving treatment for same.	encouraging pressure alleviating care where possible and assisting patient with mobilization.

HDU Initially had a CT abdomen reported out of hours reported by everlight radiology system: Conclusion; The main findings consist of pancreatic swelling associated with oedematous changes and peripancreatic infiltration in favour of signs of acute pancreatitis. The patient was very unwell. Surgeons had felt initially was not acute pancreatitis as amylase normal. As clinical picture didn't fit our team re-approached the surgeons who discussed the images (48hours after admission) with our DHH radiology team at X-ray meeting and reviewed by consultant radiologist and initial radiology report amended: The case was discussed at surgical meeting. There is also a residual collection in left paracolic gutter measuring 3.6 cm in transverse diameter and 12 cm craniocaudally . There has been significant interval change in density of hepatic parenchyma since previous CT dated 21st January202 consistent with	Surgical/medical and radiology teams aware As discussed I advised I would complete a datix to raise awareness of significant error made by this everlight radiology reporting system missing this significant collection
Infection attributable to specified work (schedule 3 No 27) tested positive Covid19	Referred to OH Tested at Kernan testing station Isolating
patient admitted to 2 south. on skin check noted extensive bruising, g2 to right buttock, dti to sacrum/buttocks. yellow bruising to upper body. abdo folds red and raw. ? ungradable pressure ulcer to right calf area. extend of skin breakdown not detailed form ed nurse handover. see current body map for more details.	full head to toe examination sr to refer to TVN barrier cream applied to skin where appropriate, await mattress upgrade. ? need for vulnerable adults form, ward manager aware and clinical sister. Not handed over that same was completed in ED
Patient's CT scan was approved by radiologist and patient was brought for scan, which was performed, however neither the radiologist or radiographers realized the patient had been scanned during the night for the same scan.	Reported to CT Lead, Radiologist, site lead and referring clinician.

Grade 2 pressure ulcer on left heel	adhesive foam dressing placed on same heels raised off bed with blanket. Personal Information redacted aware of grade 2, states she has had it but it had been heeled
Personal Information redacted gentleman, BIBA following DSH- cuts to wrist and TLNWL. Triaged on arrival. Dr attempted to see patient, no answer when called from waiting room, mobile no. went direct to voicemail, no answer from NOK, security searched premises and not found.	Missing person proforma completed and PSNI made aware.
Patient came for anti-D appointment but was not on clinic list. Upon investigating it was discovered that patient had been recorded as 'deceased' and all further antenatal appointments had been cancelled as a result.	Medical records contacted and asked to rectify mistake. patient given anti-d and all future appointments reinstated.
CSF samples from Male Medical at DHH taken on consecutive days for two patients listed (Personal Information redacted by the USI and Personal Information redacted by the USI) were not labelled. Unlabelled samples are not normally accepted by the laboratory for analysis. Due to risk of repeat sample of this type samples were analysed and verbal report only issued.	Ward was informed and verbal report was given for immediate management of patient(s). However laboratory will not stand by results and they will not be recorded on LABS or NIECR.
Needlestick injury while disposing of arterial line (hollow) needle used on patient. Wearing gloves.	First aid Patient risk assessed by another colleague Blood taken for storage

Fixation of shoulder injury on Trauma List. PMH Hypertension GORD DH Irbesartan Omeprazole Previous gynae surgery No History of Allergy Had awake interscalene block then modified RSI. Increasing airway pressures 30 mins into case Patient draped and in deck chair position Concerns regarding tube position investigated and satisfactory Unsatisfactory capnograph trace. Concern over mechanical obstruction of airway. second dose of rocuronium given Increasing bronchospasm reduced lung compliance on manual ventilation with ambu bag bradycardia then 20-30 seconds asystole adrenaline given improvement in ventilation adrenaline infusion commenced remaining drugs given as per anaphylaxis protocol patient successfully extubated but requiring ongoing adrenaline infusion	patient referred to ICU for follow up and moved to recovery on adrenaline No ICU bed available ICU agree to review
BABY VISITED ON DAY 3 AT HOME AND NOTED TO HAVE MARK ON OUTER LEFT LOWER LEG, WHICH [AS WELL AS BIRTH MARK ON NAPE OF NECK AND SPOT ON INNER CORNER OF LEFT EYE],WAS NOT RECORDED IN RED BOOK. BRUISING OF BABY PROTOCOL INITIATED. PHOTOGRAPHS THEN SUBMITTED BY PARENTS, AND VIEWED AND ACCEPTED BY CONSULTANT.	LINE MANAGER INFORMED PAEDIATRIC REGISTRAR INFORMED

Medicine written as Valproic Acid on Kardex but Sodium Valproate (Epilim/Chrono) given tiotropium 10mcg inhaler given, should have been 2.5mg but medic had not stated dose Budesonide inhaler no dose so was not given Transtec patch had no dose so not given Vit b co Rxd, should have been Vit B Co Strong	Ward Manager and Pharmacist informed correct medicines supplied and Kardex endorsed to make it clear the correct med was given
Pt arrived to AMU @0120hrs. on admission it was noted that pt did not receive their epilim chrono in ED.	Pt received medication when in amu as it is a critical med
Personal Information redacted by the USI attended CAH ED this morning at 0611 via ambulance after being found by police outside a shop with new self harm marks to arms. Left CAH ED before triage at 0615 and refused to stay.	Police contact & appendix c completed Sister & Doctor incharge informed.
DTI/ ungradable pressure damage developed on coccyx whilst in ward 3 north	repositioning frequency increased from /…… to …… Braden reassessed and documented already on dynamic mattress aria when damage occurred datix completed by TVN after confirmed
Personal Information redacted by the USI lady {speaks and understands little English}arrived at Assessment and admission unit with Personal information redacted by the USI daughter(who speaks and understands English) in premature labour at 23+1 by dates though a late booker) and 24+ with USS. Transferred to D/S room 1 at 1625hrs. Obstetric and Paediatric teams present as fetal heart present. Loading dose MgSo4 given followed by maintenance dose. First Betnasol given in A&A unit. Mx discussed with Registrar and 2 Consultants following abdominal USS. Transferred to RJM Hospital leaving CAH at 1750hrs and arriving at RJMH at 1820hrs. Transferred to assessment and admission unit as arranged with Drs.	Transfer fetus in utero to Belfast

Pt attended Emergency department on the 16/03/21. PT was assaulted by her female friend whilst at her house. PT has longstanding issues with mental health and addiction.	The Emergency Department completed a UNOCINI in regards to PT's [redacted] in foster care. On ED flimsy it was noted that an APP1 was not completed as NIC states no need for APP1 as the assault was done by a friend- not family or partner.
hosp no [redacted] . H AND C NO [redacted]. P1+3 SHOULDER DYSTOCIA anticipated after delivery of head as turtle neck . Sister in charge already in room as decleration previously . Episiotomy , bed flattened ,legs elevated and delivered by one pull axial traction . baby reviewed by paediatrician .parents debriefed .	head delivered at 1953hrs . nvd at 1955 hrs on 17.03/21 . baby wight 3940 gms . had bigger baby previously .
PATIENT ATTENED ED FOR THE 2ND TIME 17/03/2, WAS NURSED AT AMULANCE TRIAGE - CLOSED CUBICLE AS NO OTHER APPROPRIATE ROOM FOR PATIENT TO BE NURSED AND OBSERVED HAD ALREADY LEFT DEPARTMENT AND MADE HIS WAY OVER TO BLUESTONE - BEING BROUGHT BACK BY STAFF CONSTANTLY REQURING 1:1 DUE TO WNATING TO LEAVE AND HAD BEEN TAKEN OUT FOR SMOKES ON REGULAR INTERVALS. MENTAL HEALTH TEAM CAME TO ASSES PATIENT, AND WHEN THEY APPROACHED THE ROOM - REALISED THE DOOR WAS LOCKED, I MYSELF WAS COMING OUT OF AMBER RESUS AND NOTICIED THE STAFF TRYING TO GET INTO ROOM. I COULD HEAR PATIENT WRECKING ABOUT ON THE TROLLEY. I ALERTED SECURITY AND THEY WERE ABLE TO OPEN DOOR WITH MASTER KEY PATIENT WAS NOTED TO BE LYING ON HIS LEFT SIDE ON TROLLEY - DID NOT COMMUNICATE WHEN WE OPENED THE DOOR SN [redacted] APPROACHED [redacted] TO FIND A SHOE LACE TIED AROUND HIS NECK	SHOE LACE CUT OF [redacted] NECK AND MOVED TO RED RESUS ALARMS PULLED AND EXTRA STAFF ASSISTED

Upon getting a 200mg labetalol tablet from the tablet box it was noted there were different sizes in the container - a mixture of 100mg and 200mg tablets.	Pharmacy advice sought - tablets disposed of and new 200mg box ordered.
Was contacted by patients sister on the DN out of hours phone who informed me that her sister had been discharged from hospital yesterday evening the 16/3/21 on clexane following surgery. She had been shown how to use the clexane just once and deemed by staff to be competent however when she got home she wasnt sure she was doing it right and instead of administering 1 40mg injection she gave herself 3 in an attempt to ensure it was going in right. Patients sister was advised to phone District Nursing to come out and administer clexane injection today. I advised patients sister that I would like to phoe OOH GP for advice on giving a further injection after she has taken 3 times her dose and advised I would ring back. Patients sister advised OOH were contacted last night and advised she would be ok.	Contacted OOH GP and gave details of incident. OOH GP phoned me back and explained the incident with the patients clexane. GP I spoke with asked that patient be brought into ED to have urgent bloods checked including coag before administering any further clexane. Contacted patients sister and advised that patient needs to go to ED to have her bloods done. She is going to take her now. I advised if clexane to be given for staff in ED to refer to DN regarding this.
Patient had an unwitnessed fall, this morning, a student observed patient already on the floor, she had sound of bang and saw patient laying on the floor.	Observed for any injury and returned to bed: neuro observations done as per protocol, X-ray obtained, doctor's review obtained, patient's son informed.

18.15 - Integrated Liaison Team paged to ext: 61763, request to see Patient A. Collateral obtained before Staff Member B and Staff Member C went to see Patient A. 18.35 - Staff member B and Staff Member C entered Donning area. 18.43 - Staff member B and Staff Member C entered A&E, took brief handover from staff member D. Staff member D approached "ambulance Triage 2" room. The door was locked from the inside. Patient A was inside the room alone. 18:43 to 18:45 no staff members had a key to the door, patient not responding to verbal command. 18:46 door opened by paramedic with a master key. 18:46 Patient found unconscious with shoe lases around his neck. 18:46 alarm raised. Difficulties in finding scissors / ligature cutter.	
18:47 ligature removed using scissors.	Raised with sister in charge (staff member E).
18:48 Patient A brought to A&E RED resus.	Patient A on 1:1.
18:50 Patient A was responding to pain.	Patient A's CRA updated.

Security heard shouting banging coming from ambulance triage room beside porters office. Went to check it out and seen a male patient who seemed drunk. Patient wet out for a smoke and then a short time after ED staff informed us he had gone missing. Security went to look for him but never found him. ED staff informed us he had went to Bluestone unit. Nursing staff from Bluestone escorted him back to ED. At approx. 1830 ED staff requested security assist with opening the ambulance triage door and the male patient had locked it from the inside. Door was opened with a master key and when medical staff entered the room the patient had wrapped something around his neck to harm himself. Patient was moved by ED staff to red resus. Security called again for the male patient who had just left ED. Patient walked out the door and down the main road. Nursing staff called the police.	Security called
PATIENT ADMITTED 13/03/21. RIGHT BUTTOCKS INTACT AT TIME OF ADMISSION. GRADE 2 NOTED ON 17/03/21	REPORTED TO DEPUTY SR, DRESSING APPLIED, ZERO PRESSURE TO BUTTOCKS APPLIED, REPOSITIONING CHART MAINTAINED. BODY MAP AND BRADEN IN ADMISSION BOOKLET UPDATED
Patient attended ED following an overdose & stating thoughts of life not worth living. CAMHS referral should have been completed prior to discharge however this was not done. Patient has discharged with no Mental Health assessment and no Mental Health follow up for support.	Notified Sister in ED & Doctor's involved in patient care requesting a CAMHS referral is completed urgently.
I sent the syringe driver to EBME DEPT FOR REPAIR, it went via internal post and lost	checked in postal department and EBME department, from last week,
Patient got up to use urinal at side of bed. Lost balance and slid down the wall onto the floor. unwitnessed by staff.	checked for injury, minimal assistance given to stand up, sat back down in chair. News and GCS taken, doctor informed and assessed patient, CT brain already booked from WR- await same. Family to be informed, no answer at present.

DOMESTIC FELL FROM SECOND STEP AS SHE WAS COMING DOWN AFTER HANGING A CURTAIN IN MALE SURGICAL WARD 2 - SHE BANGED HER CHIN ON DOMESTIC WASTE BIN BEFORE SHE FELL ON FLOOR.	DOMESTIC WAS TAKING TO ED FOR TREATMENT BY ANOTHER DOMESTIC ON THE FLOOR.
Unsettled, agitated and confused. States nursing staff have 'set the hospital on fire', are 'trying to kill her' and we are 'horrible people' Re-orientated to time & place to which she replied 'I know where I am'. De-escalation techniques attempted with no effect. Grabbing staff nurses wrists and digging nails into nurses hands. Refusing to sit down and continues to stand in the middle of the corridor. Whilst staff dealing with acutely unwell patient and another aggressive patient (security called for said patient), Personal Information left briefly on her own and went into the office and phoned 999. When realized SN Personal Information spoke to the operator and explained the situation.	Re-orientated patient to time and place - nil effect. De-escalation techniques attempted - nil effect. Reviewed again by medical staff - IM haloperidol given. Assisted to bed with assistance x 2. Sitting on side of bed currently with HCA in attendance. Currently 1 HCA in bay with 2 x 1-1 patients due to high number of 1-1 patients on the ward.
Ambulance arrived to collect patient for transfer. Patient refused to get into chair and be transferred back to nursing home. Very agitated. Phoned daughter to see if she could persuade Personal Information to be transferred. Personal Information refused to speak to Personal Information. Phone put on speaker phone & Personal Information attempted to speak to Personal Information - Personal Information stated it was not Personal Information on the phone. Attempted transfer again after phonecall but unsuccessful. Patient continued to be agitated. Locked herself in the bathroom twice and required nursing staff to pick the lock from outside. De-escalation techniques attempted but unsuccessful. Tea and toast offered. Attempted to give oral meds - grabbed tablets out of hands and threw on the floor. Aggressive towards staff - hitting and grabbing at nursing staff wrists. Assisted back to bed with assistance of 2.	Phoned daughter in attempt to settle and be transferred home. De-escalation techniques attempted but unsuccessful. Oral medication offered and refused. Contacted FY1 to review due to aggression. Reviewed and IM lorazepam given as prescribed. Refusing all observation and interventions.

Personal Information redacted by the USI	delivered
Personal Information old admitted with DKA and commenced on paediatric protocol. Admitted to Blossom Unit under the care of acute medical team as no adult medical beds available. I was contacted by the Paediatric Registrar to inform me that the incorrect bad of fluids had been administered in ED despite appropriate prescription by medical staff. It was noted on the patient's arrival to the ward that 5% Dextrose + 20mmol KCl had been administered (instead of the 0.9% NaCl + 20mmol KCl that had been prescribed) and the batch numbers on the fluid chart and on the fluid bag did not match.	Fluids immediately taken down and appropriate fluids administered. Immediate review by paediatrics registrar and explanation given to family. ED contacted and informed of error
Patient admitted from home with DTI and Grade 2 on sacrum. Contacted district nurse who is unaware of same	Mattress ordered, dressing insitu, pressure sore prevention pathway in place with skin bundle. TVN referral completed.
Prescribing error in ED Yellow Area: Isosorbide mononitrate M/R 50mg BD prescribed and then the 50mg dose was written over and changed to say 100mg. Dose signed for at 10pm on 20/3/21 and at 10am on 21/3/21. Drug history completed and patient should only be on 100mg ONCE daily in the morning.	Pharmacy technician highlighted error on Kardex to pharmacist in ED Yellow Area. Pharmacist informed nurse in charge and also nurse looking after patient. Advised hourly observations. Pharmacist corrected the prescription. Datix submitted.
Patient admitted TO ED, FROM GP asulcerated right leg ulcer to right lower leg being treated for one year to skin and swelling more painful than usual	referred to surgical team for admission and treatment, for antibiotic therapy
patient has bilateral PE's , had covid vaccine astra Zeneca 12/02/21	Yellow card completed as requested by Dr Moan Patient now being treated with therapeutic enoxaparain and decision regarding anticoagulation still to be made

Patient arrived from the care home with two staff members, the MRI safety form had been filled out and signed by staff nurse from the home in the NOK section. Patient wasn't compesmentis therefore MRI staff rang his sister to check the safety form for any contraindications to MRI. She said he had a gastric band operation in Belgium and head surgery, neither of which were mentioned on the MRI safety form completed by the staff nurse or on the initial request form sent in by the referring dr.	The patient had to be sent back to the care home without the scan as we had no information on either surgery. Care home staff were informed as to why the patient couldn't have the scan done.
Pt was found in carpark of hospital by bystander acting bizarrely. same brought into ED. then absconded after triage.	porters were there at time of absconding. absconding protocol commenced. psni contacted. pt guardian/home informed. sister aware. events documented in notes.
Patient discharged from level 4 stroke and rehab ward on 24.03.21 with an increase task to assist with feeding. Increase was agreed via email with community social worker on 24.03.21. Post discharge - hospital social worker was informed on 25.03.21 at morning MDT meeting that family phoned in at approx. 8pm to complain that careers would not assist with feeding due to no information in relation to modified diet or assist with medications in care plan. At point of discharge planning on 23.03.21 at MDT meeting hospital social work was informed feeding task required due to encouragement. Hospital social work was not informed of any SALT input. Hospital social work was not made aware of modified diet. Hospital social worker spoke with son and nephew on 24.03.21 and advised package of care would continue as per prior to hospital admission and to include feeding task due to encouragement- family was in agreement and no new needs or additional support needs identified.	Hospital social worker completed a retrospective NISAT to reflect need for assistance with medications and feeding. Hospital social worker included information to advise community of modified diet in NISAT. Hospital social worker requested nursing staff to complete a medication management form to facilitate medication and modified diet in care plan. Hospital social worker emailed community social worker to advise of issues post discharge, actions to resolve issues and updated information provided in a NISAT.

Grade 3 pressure sore noted to right heel when checking patient's skin- same was dressed.	Pressure relief of heels- blanket under heels as no pillows available in department.
Blood transfusion commenced in ED resus. Temperature elevated after 1 hour with other observations within normal limits. Bloods transfusion continued under direct of medical doctor as temperature elevation ?due to raised crp. at 0230 temperature not resolved with paracetamol, resp rate now rasied at 25 and sp02 dropped to 93% on RA.	Medical doctor contacted Transfusion stopped Patient commenced on 1/2 hourly observations Labs contacted and informed of reaction and alert used units being sent back Further Group & Hold sent for assessment by Lab due to reaction. Suspected transfusion reaction report completed Nurse incharge Sr Personal Information informed
Patient absconded from ED. Found in foyer of hospital at approx. 10mins after last seen. Found face down, blood visible around head. Patient responding to Pain. Called for help.	Patient absconded at approx. 06:50 And found at approx. 07:00 Called for help from staff nurse and HCA. Patient scooped onto hospital trolley and transferred to amber resus. ?Postictal as per ED Doctor. full ABCDE assessment carried out. No NOK detail available to contact.
Pt was discharged home with a covid swab obtained from another pt.	Apologised to relative, asked if they could return swab to ward- unable to. State they will dipose of swab in a pharmacy. Bedmanagers informed.
stillbirth	as per hospital policy
Personal Information redacted by the female, brought to DHH ED following, fall, ? long lie, lives alone. on examination, chronic leg ulcer in R lower leg. buttocks very red (blanching erythema), sacrum Grade 2, non blanching, dark red	skin chart completed nurse in charge made aware transferred onto a hospital bed for comfort swab sent for O+S from leg ulcer
Patient underwent hysteroscopy 25/3/2021. uterine perforation, laparoscopy at time no definite bowel injury. Admitted and slow recovery CT sat 27th demonstrated likely perf. so went to theatre were surgeons undertook small bowel resction for perf. patient admitted to ICU	as above

Patient presented to ED with OD Medically fit and seen by mental health Mental health offered voluntary admission Patient declined Mental health team rang son Personal Information with plan he stated the house is locked up and she wont get in I then rang Personal Information introduced myself, Personal Information also stated the house is locked and she wont get in Personal Information was verbal aggressive. Stated "I better not dare and ring his father Personal Information redacted by the USI husband." Personal Information redacted by the USI explained her husband has a disability when I kindly asked would his dad be ok overnight, Personal Information got very angry with I attempted to explain it was my job. Continued to shout at me and Was angry I asked him Personal Information contacted department back and Spoke with medical staff stated it would cause to much fuss if his mother came home Agreed medical admission and OOH SW	OOH SW contacted APP1 complete medical admission
I admitted Personal Information on sunday the 28.03.2021 She had transferred from ward 5 with pressure sores noted on there admission. When contacted they were unsure if a datix was done- unsure if this was hospital acquired but have selected no in the drop down box as unable to obtain information from ward 5 regarding if datix was complted however noted on there admission. A and e have recorderd dressing on there skin assesment	Referred to dietian needs tvn referral to be done nursed on aria mattress repositioned scedual insitu mepilex dressing insitu Braden 13 must one food chart insitu
PATIENT OUTSIDE IN COURTYARD HAVING A CIGARETTE WHEN HE RAN OFF OUTSIDE AND ENTERED BUILDING AGAIN THROUGH FIREDOORS.	SN AND HCA RAN AFTER PATIENT. SECURITY FAST BLEEPED AND CAME TO WARD AND COMMENCED A SEARCH OF THE HOSPITAL SITE. PSNI THEN TELEPHONED TO REPORT PATIENT AS HAVING ABSCONDED. NEXT OF KIN INFORMED ALSO

Grade 2 found on left side of spine	Dressing applied, NIC aware, body map updated, NOK aware
Patient has a grade 4 pressure sore to sacral area known by TVN in community	Assisted onto (R) side to relieve pressure and redressed. Informed nurses caring for patient in handover
Necrotic grade 3 on (L) ankle	wound redressed, document on patients notes
PT FELL AND HIT HEAD (WITNESSED). ALSO LIT CIGARETTE AND STARTED SMOKING IN CUBICLE WHILST ON O2	DATIX, SENIOR STAFF INFORMED, SURGICAL DR INFORMED
Patient came out of cubicle to say he was going home as the department is "too loud" he "cant sleep" and "the bed manager doesn't have a bed for me so im not staying here all night". After trying to convice patient to stay in ED he got irritable and angry. Security bleep bleeped twice. I then told patient that if he was to leave I would need to get him returned to the department by the PSNI. pt then phoned a taxi and left.	absconding protocol started. NIC and doctor in charge aware. 101 called.
Patient attended Cath Lab today to have a 48hour U&E obtained due to no appointments in his GP surgery. On asking which arm had better access patient stated could you not take it out of that as he pointed out a green 16G cannula in his left forearm.	Cannula removed. Site checked same satisfactory phlebitis score 0. Apologies given to patient.
at approximately 0600H, patient Persona l with history of dementia and on going confusion, tried to get up from chair where he had slept all night; agitated, refused any help and pushed away staff. Patient then fell forward and hit head on nozzle of bedside hand sanitizer, caught himself with the palm of his hands, head did not hit floor. Laceration to right eyebrow and nose bridge.	Doctor present. Obs taken every 15 mins. GCS obs started. Blood glucose taken. FY1 applied steristrips and premierepore to wound. CT Brain requested.

patient was seen in gynae clinic in the pm. she had a covid swab taken prior to admission by gynae staff. Swab result not available at 5 pm as gynae staff were leaving. midwifery staff left to follow this up. approximately at 1845 results still not available as per bed manager. porters and laboratory contacted re same. Apparently swab had not arrived in laboratory. Repeat swab carried out at 1910hours by midwifery staff. the same was taken to laboratory reception by midwifery staff and handed directly to laboratory staff who informed staff member swab would take 40 minute. at 2030hours swab result not available and laboratory contacted who informed staff that result had to be re run asper an error in laboratory. patient who had been sitting in waiting room all afternoon and evening awaiting result was informed about situation and apologies given	Patient informed bed manager informed Dr Henderson informed Laboratory staff informed Porters informed
Patient became agitated,aggressive, physically and verbally aggressive towards staff. wandering around ward walking into other patients rooms and sisters office. Charging towards staff. Assisted back to bed by security	security, night co-ordinator and FY1 contacted at 0050.

Lessons learned	Approval status	Closed
	Being reviewed	
If no medical assistant cover, try to allocate ward staff to complete early morning bloods if ward acuity permits.	Final approval	15/03/2021
	Being reviewed	
AW	Being reviewed	
	Being reviewed	
	Being reviewed	

	Being reviewed	
	Being reviewed	
	Being reviewed	
case to be reviewed as part of the SHSCT COVID outbreak cases review and learning to be shared post.	Final approval	05/03/2021
case to be reviewed as part of the SHSCT COVID outbreak cases review and learning to be shared post.	Final approval	05/03/2021

Increase in capacity required focus on getting funding to implement works	Final approval	29/03/2021
	Being reviewed	
	Being reviewed	

none	Final approval	10/03/2021
	Being reviewed	
	Being reviewed	
	Being reviewed	
	Being reviewed	

Safe transportation of patients whilst in trolleys. Limbs not to outside of trolley. Body map complete ion early essential	Being reviewed	
Prescribing and patient history clarification by medical team	Final approval	15/03/2021
Ongoing staffing review for specials , ensure escalated to site manger overnight.	Final approval	23/03/2021

Essential that 1:1 is requested for patients at increased risk of falls. On this occasion there was a breakdown in communication between care home and ward staff.	Being reviewed	
covid19	Final approval	16/03/2021
	Being reviewed	
covid19	Final approval	18/03/2021
Good practice of skin check on admission and documentation of same but ED Skin intervention chart must be completed in ED to document what interventions have been put in place to prevent further prevention/ deterioration. ? braden score ?TVN referral or DN care plan in community. Lesson to always document an action, regular prevention might have bee done but needs to be documented to ensure continuity of care.	Being reviewed	

	In holding area, awaiting review	
Covid19	Final approval	16/03/2021
ensure staff continue to review skin on admission.	Being reviewed	23/03/2021
	Being reviewed	

	Being reviewed	
Early intervention with absconding protocol. Communicating with PSNI and any updates to be documented in patient notes	Being reviewed	
	Being reviewed	
	Being reviewed	
	Being reviewed	

To continue to be prepared for anesthetic complication and to adhere to protocol for management of same.	Being reviewed	
	Being reviewed	

medics to ensure all elements of prescription are complete. Nurses to ensure any missing elements are escalated.	Final approval	13/03/2021
	Being reviewed	
Protocol followed for absconding patient. MHRA completed at triage. Important follow up as high risk mental health patients.	Being reviewed	
	Being reviewed	
	Being reviewed	

	Being reviewed	
	Being reviewed	
	Being reviewed	

Personal Details, 26/03/2021: Cannot ascertain if mix up occurred in pharmacy or at ward level, ward sister asked to remind all staff importance of correct storage of medicines in properly labelled container.	Final approval	26/03/2021
	Being reviewed	
Email sent to staff for learning -document how the patient was moved -Follow falls pathway -update moving and handling plan post fall -complete falls walking stick	Final approval	24/03/2021

Mental health patients should not be placed in rooms with locks. A more suitable pathway for mental health patients should be implemented. We would benefit from a specific security service that can stay with patient to help prevent them from absconding as patient had previously absconded numerous times.	Being reviewed	

	Being reviewed	
	Being reviewed	
	Being reviewed	
	Being reviewed	
	Being reviewed	

Going forward all steps to be replaced with suction feet as opposed to steps where brakes need to be manually engaged	Final approval	30/03/2021
	Being reviewed	
	Being reviewed	

	Being reviewed	
Appropriate checks and trust policy adhered to. Importance of fluid management/	Being reviewed	
Skin check on admission essential	Final approval	26/03/2021
	Being reviewed	
	Being reviewed	
	Being reviewed	

	Being reviewed	
	Being reviewed	
	Being reviewed	

always skin check within 4 hours of admission an document if checked and what state skin is. if risk identified ensure an intervention is preformed. Query if TVN referral needed while IP.	Being reviewed	
	Being reviewed	
Appropriate observation and assessment of patients at risk of absconding or seizures.	Being reviewed	
	In holding area, awaiting review	
	Being reviewed	
	Being reviewed	
	Being reviewed	

	In holding area, awaiting review	
	In holding area, awaiting review	
	In holding area, awaiting review	

	Being reviewed	
	Being reviewed	
	Being reviewed	
	Being reviewed	
	Being reviewed	
	In holding area, awaiting review	
nil	Final approval	31/03/2021

	In holding area, awaiting review	
	Being reviewed	

CORPORATE RISK REGISTER

August 2020

Southern Health and Social Care Trust

Quality Care - for you, with you

INTRODUCTION

The SH&SCT Corporate Risk Register identifies corporate risks, all of which have been assessed using the HSC grading matrix, in line with Departmental guidance. This ensures a consistent and uniform approach is taken in categorizing risk in terms of their level of priority so that proportionate action can be taken at the appropriate level in the organization. The process for escalating and de-escalating risk at Team, Divisional and Directorate level, is set out in the Trust's Risk Management Strategy.

Each risk on the Register has been linked to the relevant Corporate Objectives contained within the Trust's Corporate Plan 2017/18 – 2020/21 as detailed below:-

Corporate Objectives

1: Promoting safe, high quality care.
2: Supporting people to live long, healthy active lives
3. Improving our services
4. Making the best use of our resources
5. Being a great place to work – supporting, developing and valuing our staff
6. Working in partnership

Risk scoring is based on likelihood and impact as summarized in the Risk Assessment Matrix below.

Risk Likelihood Scoring Table			
Likelihood **Scoring Descriptors**	**Score**	**Frequency** **(How often might it/does it happen?)**	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

OVERVIEW OF CORPORATE RISK REGISTER AS AT AUGUST 2020

LOW	MEDIUM	HIGH	EXTREME	TOTAL

	3	10	1	14

Risk No.	Risk Area/Description	Corporate Objective	Risk Rating	Page	Movement from last review
1	**BSO Shared Services** • Payroll/Travel • Recruitment	1&4	**MEDIUM**	**5**	Unchanged
2	**Cyber Security**	1	**HIGH**	**10**	Unchanged
3	**Medical Workforce shortages and vacancies**	1	**HIGH**	**16**	Unchanged
4	**Locum Engagements**	1	**HIGH**	**19**	Unchanged
5	**GP Out of Hours**	1	**HIGH**	**21**	Unchanged
6	**Registered Nursing Workforce Shortages**	1	**HIGH**	**26**	Unchanged
7	**HCAI**	1	**HIGH**	**34**	Unchanged
8	**Deterioration of exposed concrete on building exterior, Daisy Hill Hospital**	1	**HIGH**	**36**	Unchanged
9	**Loss of electrical power to main hospital block, Craigavon Area Hospital**	1	**HIGH**	**37**	Unchanged
10	**Compliance with procurement and contract management guidance**	1&4	**MEDIUM**	**39**	Unchanged
11	**Breach of statutory duty of break-even in-year** **Destabilisation of services due to the inability to secure recurrent funding and over reliance on non-recurrent support**	4	**MEDIUM**	**42**	Unchanged
12	**Clinical risk associated with inability to manage patient care within clinically indicated timescales**	1	**HIGH**	**47**	Unchanged
13	**Compliance and Implementation of the Mental Capacity Act (2016) Phase 1**	1	**HIGH**	**52**	Unchanged
14	**Risk to safe, high quality care as a result of Covid-19 Pandemic**		**EXTREME**	**54**	New risk added on 5.5.2020

CORPORATE OBJECTIVES: 1 & 4 – PROMOTING SAFE, HIGH QUALITY CARE & MAKING BEST USE OF

RESOURCES				
Likelihood: Possible (3) **Impact: Moderate (3)** **Total Score: 9** **Risk Rating: MEDIUM** **Previous Score: 9**		**RISK OWNER: Director of Finance, Procurement and Estates** **DATE RISK ADDED: August 2016** **Reworded: July 2018** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
1	**Shared Services Centre:-** **Payroll & Travel** The risk that staff pay and travel reimbursements are inaccurate due to the control environment of the Business Services Organisation (BSO). This has the potential for financial hardship for staff, negative media attention and reputational damage for the Trust.	1. A range of KPIs have been agreed with BSO for each Trust which identifies where there has been improvement or deterioration and triggers appropriate action	Assistant Director of Finance	1. Monthly KPIs
		2. The Trust has a process of reimbursing staff as quickly as possible once an underpayment is identified as quickly as is feasible	Assistant Director of Finance	2. Payroll data
		3. Once an overpayment has been identified, BSO enact the overpayments policy	Assistant Director of Finance	3. Schedule of Overpayments and Recovery Plan
		4. Annual Internal Audits	Assistant Director of Finance	4. Internal Audit reports and action plans
		5. Regional audit of BSO Payroll Shared Services, currently twice a	Assistant Director of Finance and	5. Audit reports and action plans

		year	Internal Audit	
		6. Trust wide communication to all managers to remind all in respect of timely completion of paperwork	Assistant Director of Finance	6. Global communications
		7. Trust active participation in a number of regional groups to provide guidance, assistance and challenge to achieve necessary improvements	Finance Directorate	7. Minutes of meetings

Additional actions and timescales

1. Progress updates continue to be provided to Audit Committee and from October 2018 onwards, BSO have been providing a written report in advance of each Audit Committee. An updated progress report prepared by BSO which covers all outstanding recommendations will be presented at February 2020 Audit Committee. Mid-year review of BSO Payroll remains limited.
2. Ongoing review of Internal Audit recommendations. For those that are the responsibility of the Trust, they will be picked up and reported on at the IA Forum initially before going to Audit Committee.
3. Ongoing attendance at Customer Forums and Business as Usual meetings.
4. Ongoing attendance of Director of Finance at Customer Assurance Board which has been established to oversee 3 new payroll workstreams in an attempt to address the issues.

CORPORATE OBJECTIVES: 1 & 4 – PROMOTING SAFE, HIGH QUALITY CARE & MAKING BEST USE OF RESOURCES

Likelihood: Likely (4) Impact: Moderate (3) Total Score: 12 Risk Rating: MEDIUM Previous Score:12	RISK OWNER: Director of Human Resources and Organisational Development DATE RISK ADDED: August 2016 Reworded: July 2018 TIMESCALE FOR REVIEW OF CONTROLS: Monthly			
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
1	**Shared Services Centre -** • **Recruitment and Selection** The delays in recruitment and selection pose a risk to service continuity for front line services	1. Implementation and monitoring of a local operational and service improvement plan ('Inspire, Attract, Recruit') to progress a range of local resourcing solutions. 2. Use of Bank and Agency for short/medium term interim cover, where possible and subject to appropriate approvals. 3. Internal Audit reviews of RSSC and Trust Recruitment & Selection. 4. Trust participation at Head of Service / Deputy Director level in regional Strategic Resourcing Innovation Forum (SRIF), with 4 workstreams each with a 12-month workplan to deliver and report to HR Directors. 5. Bi-monthly customer forum and fortnightly Team Leader Clinics with	Head of Resourcing	1. Resourcing Operational Plan and SMT updates 2. Monthly Bank Block Booking and Agency reports 3. Internal Audit assurance reports 4. SRIF annual work plans and dashboard 5. Minutes of Customer Forum

		Regional Shared Services Centre to escalate issues requiring to be addressed. 6. Trust representation on Operational Group within SRIF to meet monthly and develop/implement key service improvements. 7. Monthly KPI data shared with the Trust which identifies where there has been improvement or deterioration and triggers appropriate action. Trust management information reports issued to Directorates in relation to vacant posts and requisition requests in the approval process. 8. Trust wide communications in relation to managers' roles and responsibilities for recruitment and selection, as well as associated Key Performance Indicators. 9. Alignment of Resourcing Team Leaders to support Directorates taking action to minimise any delays in the recruitment process in conjunction with RSSC 10. Development and introduction of new approach to reduce pre-employment checks for internal (within Trust) and inter-Trust appointments.		6. Minutes of Operational SRIF Group 7. Monthly RSSC Performance Reports and Directorate vacancy reports 8. Global communications to Trust managers, process documents and user guides 10. Process documents for Pre-Employment checking process 11. HSC Recruitment and

		11. Development and launch of new HSC Recruitment and Selection Framework and associated guidance for managers 12. In-house recruitment days for various staff groups, supported by Trust Resourcing Team 13. Updates to HSC recruitment website in order to increase numbers of applicants and improve the applicant experience 14. New report developed for managers at all levels to be able to report on Requisition Requests in Progress (i.e. not yet approved) in order to minimize delays at this stage		Selection Framework and associated guidance for Managers 12. Notes of Planning meetings/action plans 13. New website operational from 14th January 2019 14. Requisition Requests Overview Report

Additional actions and timescales

1. Significant piece of work to be undertaken in conjunction with service directorates to further streamline corporate waiting lists and Trust approach to maintaining these. The start date for this has been delayed due to the need to divert resources to Transformation activity. Alternative models of recruitment have been discussed and tested as part of the regional SRIF group, and implementation has started in the Trust for some groups of staff (Admin & Clerical posts; Nursing Assistants) but requires further planning prior to wider implementation for other high-volume staff groups during 2020/21.

2. Engagement events with key stakeholders organised via the regional SRIF group throughout 2019/20, to ensure their continued involvement in the process of design and implementation of solutions.

3. Roll out of Recruitment and Selection skills training for managers during 2020/21.

4. Launch of HSC 'branding' and advertising concepts to increase applicant traffic to the recruitment website is the subject of ongoing discussion with DOH in relation to funding and HSC-wide implementation. Timescale for this is outside the control of the Trust.

LINK TO CORPORATE OBJECTIVE - PROMOTING SAFE, HIGH QUALITY CARE

Likelihood: Likely (4) **Impact: Major (4)** **Total Score: 16** **Risk Rating: HIGH** **Previous score: 16** The National Cyber Security Centre (NCSC) has indicated that Cyber attack is very likely to affect the UK and is a high level National Risk		**RISK OWNER: Performance and Reform Directorate (Cybersecurity Lead)** While this risk will be led by P&R from a cybersecurity assurance perspective, this risk is a corporate risk requiring ownership by Directorates as follows: • **Performance & Reform Directorate** (in relation to assurance of 'technical' ICT **DEFEND & RECOVER** / back up processes) • **Medical Directorate** (in relation to lead role in assuring effective Emergency Planning) • **Operational Directorates** (in relation to assurance of effective Business Continuity Plans to **RESPOND** to potential incidents)		
		DATE RISK ADDED: July 2017 **Reworded: June 2018**		
		TIMESCALE FOR REVIEW OF CONTROLS: Monthly		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
2	The key risk emanating from a cyberattack is potential for **significant business disruption.** Information security across the HSC is of critical importance to delivery of care, protection of information assets and many related business processes. If a Cyber incident should occur, HSC information, systems and infrastructure may become unreliable, not accessible (temporarily or permanently), or compromised by unauthorised 3rd parties, including criminals. This could result in unparalleled HSC-wide disruption of services due to the lack of/unavailability of systems that facilitate HSC services	**1.<u>REGIONAL</u>**: In the context of Northern Ireland, with a single Health and Social Care structure, and also a single HSCNI network, with Regional diagnostic services and NIECR, the impact in Northern Ireland of a cyber attack affecting the Network or Regional Data Centres has been assessed as potentially a National Civil Contingency (NCSC). Therefore, critical to managing risk at local level is the work progressed at regional level to mitigate risk through the <u>Cybersecurity Programme Board</u> and the extant policy and processes for <u>Regional Emergency Planning</u> led by the Chief Medical Officer. Letter from Permanent Secretary 11th Feb 2019 - all Investment & implementations decisions on Cyber Security across the HSC must receive advanced approval from	1. Regional Cyber Security Programme Board (Director P&R) established 2nd May 2018. 2. Regional Cyber Security Officers Forum established in June 2018. First meeting January 2019 - meetings scheduled bi-monthly.	Minutes of meetings This Group makes recommendations to Regional Programme Board Minutes of meetings and Action List – all papers posted onto SharePoint.

	(e.g. appointments, admissions to hospital, ED attendances or diagnostic services such as Labs or NIPACs) or data contained within. This could lead to a range of impacts or core service areas for example: • Service disruption impacting on operational service delivery including waiting times, delayed urgent clinical interventions, suboptimal clinical outcomes etc. • Risks in the ability to deliver safe care in the community, for example, accessing electronic records for the c. 5,000 clients in receipt of domiciliary care. • Potential for unauthorised access to Trust systems or information (including clinical/medical systems), theft of information or finances, breach of statutory obligations. • This could potentially bring liabilities for the Trust including potential fines and reputational damage.	Regional Cyber Security Programme Board. **2.<u>LOCAL - TRUST LEVEL CONTROLS:</u>** If information systems are not available, the Trust needs to consider contingencies to accessing information on patients, clients, care packages in the community etc Current controls to DEFEND, RESPOND and RECOVER are as outlined below.	Trust Internal Cyber Security Task and Finish Group has been established to take forward recommendations of internal reports as appropriate in line with regional Cyber Security Programme Board	Minutes of meetings and Action List - all papers posted onto SharePoint.

Additional actions and timescales
There are three aspects to the management of this risk within the Trust, as outlined below.

		Key Current Controls	**Who monitors the control?**	**How is it evidenced?**

	1. DEFEND: To maximise the Trust's technical defences to minimise the risk of a cyber attack;	**1. <u>Technical Infrastructure</u>** • HSC security hardware (e.g. firewalls) • HSC security software (threat detection, antivirus, email & web filtering) • Server / Client 'Patching' regime • 3rd party Secure Remote Access • Data & System Backups **2. <u>Policy, Process</u>** • Regional and Local ICT/Information Security and Incident Management Reporting Policies and Procedures All Trust IT Policies updated and approved at Scrutiny Committee - July 2019. • Data Protection Policy • Change Control Processes • User Account Management processes • Disaster Recovery Plans • Awareness raising • IT Risk training for senior managers (advanced) and front line staff (basic). • Resources – 2017/18 -SMT agreed financial resources for Internal Cyber Security Team to support progress of Priority 1 actions from Internal Audit and Foursys report. • Regional Network Security Review	Head of IT Bi-monthly reporting to Cyber Task and Finish Group and Quarterly Reporting to Governance Committee Regional Policy – not yet developed Head of IT Network Security	IT Self-Assessment against NCSC10 Steps (I) IT Audit (I) Network Information Systems (NIS) self-assessment carried out & submitted to 'Competent Authority' in May 2019 Technical Risk Assessments, or Penetration Tests (E) FourSys (Network Security Expert) Report May 2017 Findings of Phishing Exercise reported to SMT Cyber assimilated event in January 2018. Action plan to be followed up by Cyber Task & Finish Group.Global emails 'SIRO says' campaign highlighted in desktop messages and Southern-I IT risk training programme Dedicated Cyber Security Team (1 x Band 7 and 3 x Band 6 staff in post September 2019).

		underway	Project Board	

Additional actions planned and timescale

Policy, Process

Regional Security Policies currently being developed. Work underway with Cyber Teams and Deloitte.

The following recommendations remain outstanding to maximise technical defences (subject to funding and regional approval as per Permanent Secretary letter):

Priority 2:

Incident Management (Regional Cyber Incident Response Plan was agreed at Regional Cyber Programme Board 6/12/2019. Launch was planned for March 2020.
Monitoring (being considered as regional procurement through Cyber Programme)

Priority 3:

Secure Messaging is on the regional Cyber workstream list for 2020/21
Education and Awareness (Regional Cyber Security E-learning module has been created. Currently being reviewed by a test group of users before it can be signed-off by the Regional Cyber Security Programme Board

1. Vulnerability scanning is ongoing, but is not licenced for full Trusts assets – this was increased to 15,000 devices in March 2020, but Trust has almost double this. Raised at Regional level – cannot report on full vulnerabilities.
2. In addition, the level of vulnerabilities raised is placing demands on the ICT Operational to manage risk. There is not enough resources to do this. A paper is being produced by the Head of IT to identify resource gaps.
3. Project Team continues to progress the implementation of recommendations made by 3 Internal Audits.

		Key Current Controls	Who monitors the control?	How is it evidenced?

	2.RESPOND: Services to consider how they would deliver safe and effective care in the event of diagnostics, appointment and client information being unavailable and plan for this;	**1. Policy, Process – Operational Services** • Emergency Planning & Service/Business Continuity Plans • Corporate Risk Management Framework, Processes & Monitoring • Regional & Local Incident Management & Reporting Policies & Procedures **2, <u>User Behaviours - influenced through:</u>** • Regional IT Security Module updated to include Cyber Awareness. • Induction Policy • Mandatory Training Policies, particularly Information Governance • HR Disciplinary Policy • Professionals Academic training includes DPA • Contract of Employment • 3rd party Contracts / Data Access Agreements • Communication and Awareness • Cyber Incident Response Planning meeting with Medical Directorate	Emergency Planning Team – Medical Directorate Cyber Security Task and Finish Group Human Resources and Organisational Development, Education, Learning and Development/Line Managers Corporate Policy Review Group Assistant Director Informatics	Business Continuity Plan – logs Minutes of meetings To be made Mandatory Corporate Mandatory Training reports Corporate Policies Regional desktop Cyber exercise carried out in June 2019. A further exercise to be arranged March/April 2020
Additional Actions planned and timescale				
Business Continuity Plans need to be updated by all services to plan for a cyber attack				
		Key Current Controls	**Who monitors the control?**	**How is it evidenced?**

	3. RECOVER: To test and improve 'Back up and Recovery' of critical information systems in the Trust and BSO to be assured that in the event of a cyber attack, data can be recovered by IT as quickly as possible to minimise impact on services.	There are 3 levels of restore available PC Level; Application and Server. PC restore is fully tested; Application level and Server restore require agreement to bring down specific systems which has not yet been performed in the Trust. However there have been system upgrades and outages that have required the IT team to restore. Therefore there is some level of intelligence for a range of applications and servers. Additional disaster recovery infrastructure has been purchased and to be installed in Daisy Hill Hospital for virtual servers (Zerto) – testing to be scheduled.	IT Controls Assurance Board (CAB) meets weekly Head of IT	Minutes and full audit trail from LanDesk. Task & Finish Group

Additional Actions Planned and Timescale

CORPORATE OBJECTIVE: PROMOTING SAFE, HIGH QUALITY CARE

Likelihood: Almost Certain (5) Impact: Moderate (3) Total Score:15 Risk Rating: HIGH Previous score: 15	RISK OWNER: Director of HROD and Medical Director DATE RISK ADDED: July 2015 Reworded: April 2019 TIMESCALE FOR REVIEW OF CONTROLS: Four weekly			
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
3	Risk to Patient safety due to medical workforce shortages and vacancies within some specialties. At this time, specialties particularly vulnerable include: • Geriatric Medicine/Acute Care at Home • Stroke • Acute Medicine • Community Paediatrics • Haematology • Oncology • Psychiatry Old Age • Trainee doctors	1. Monitoring of vacancy position through Medical Staffing and Directorates 2. International recruitment 3. Analysis and improvement of recruitment and advertising strategies 4. Collaborative working with other Trusts, when required 5. Use of Independent Sector 6. Greater use of alternative roles through advanced practitioners – nursing and AHPs and more recently Physician Associates 7. Escalation of pressures to HSCB and DOH 8. Adverts now include a sentence asking for expression of interest from	Director of HROD Medical Director	• Updated list of Trust posts out with international recruitment – updated by Associate Medical Directors • Increase in use of social media platforms for advertising • SHSCT Paper re NI training numbers • Recent appointments of Physician Associates • Sample advert with the sentence

		doctors who would wish to apply for Consultant posts, but are not yet eligible. A formal log is being kept and doctors notified when posts advertised. 9. 10 Physician Associates have been appointed to provide additional support in DHH. 10. Expansion of Clinical Co-ordinators in the out-of-hours period to improve the trainee experience of FY1s. 11. Appointment of overseas doctors via the Medical Training Initiative scheme in Renal DHH, Gastro DHH and a further one due to start in Cardiology DHH soon. 12. Updated LNC process & approved rate agreed for consultants covering absent colleagues. All consultants now on our bank and able to claim additional work electronically. 13. Locum agencies continue to be used to fill vacant posts on block booking or ad hoc basis 14. *(COVID19 specific)* Temporarily recruited 50 Medical Student Technicians (band 4) & 33 FYi1 teamed up with our existing FY1 doctors. Commenced approx. 6 additional consultants who had		regarding those doctors who have yet to get Certificate of completion of training