Financial and Resource Management

1. Be accountable for the delegated financial management of urological services within the Clinical Nurse Specialist Team, to ensure Trust priorities, financial targets and service objectives are met.

2. Ensure the effective implementation of all Trust financial policies and procedures within delegated area of responsibility.

3. Support the Head of Service by providing assurances that financial governance requirements are met.

Information Management

1. Ensure the effective implementation of all Trust information management policies and procedure within the urology service in Thorndale Unit.

2. Ensure systems and procedures for the management and storage of information within the Thorndale Unit meet internal and external reporting requirements.

Human Resource Management Responsibilities

1. Maintain staff relationships and morale amongst the staff reporting to him/her.

2. Review the organisation plan and establishment level of the service for which he/she is responsible to ensure that each is consistent with achieving objectives, and recommend change where appropriate.

3. Participate, as required, in the selection and appointment of staff for Thorndale Unit in accordance with procedures laid down by the Trust.

4. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

General Requirements

The post holder will be required to:

- Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions.

- Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining

a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

- The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.

- Adhere at all times to all Trust policies/codes of conduct, including for example:
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - standards of attendance, appearance and behaviour

- Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.

- Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.

- All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004, the Data Protection Act 2018 and General Data Protection Regulations. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

- Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

- Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner. Seek to engage and involve service users and members of the public in keeping with the Trust's Personal and Public Involvement Strategy and as appropriate to the job role.

This post may evolve over time and this Job Description will therefore be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

Southern Health and Social Care Trust

PERSONNEL SPECIFICATION

Title of Post: Urology Clinical Nurse Specialist

Band of Post: To be agreed

Notes to applicants:

1. *You must clearly demonstrate on your application form under each question, how you meet the required criteria as failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Shortlisting will be carried out on the basis of the essential criteria set out in Section 1 below, using the information provided by you on your application form. Please note the Trust reserves the right to use any desirable criteria outlined in Section 3 at shortlisting. You must clearly demonstrate on your application form how you meet the desirable criteria.*
3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

ESSENTIAL CRITERIA		
SECTION 1: The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage. You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.		
Factor	**Criteria**	**Method of Assessment**
Experience / Qualifications/ Registration	Currently a Registered Nurse Level 1, (Adult) on the Live NMC Register. **AND** University degree or relevant health/social care qualification plus at least 3 years' experience within the last 5 years at Band 7 in a hospital or community environment delivering health or social care service. **OR** Have worked for at least 5 years in a senior role[1]	Shortlisting by Application Form
Other	Hold a current full driving licence which is valid for use in the UK and have access to a car on appointment. This criteria will be waived in the case of applicants whose disability prohibits driving but who have access to a form of transport approved by the Trust which will permit them to carry out the duties of the post	Shortlisting by Application Form

Factor	Criteria *Ideally no more than 6-8 criteria in this section*	Method of Assessment
Skills / Abilities	1. Ability to influence and manage change, including the promotion of evidence based practice. 2. Have effective communication skills to meet the needs of the post in full. 3. Demonstrate evidence of highly effective planning and organisational skills. 4. Demonstrate experience of leadership and independent decision making. 5. Demonstrate ability to work effectively as part of a multi-disciplinary team. 6. Must possess a proven track record and have expert knowledge and skills of clinical examination and history taking 7. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement 8. Competent IT skills	Interview
Knowledge	9. Have a sound knowledge of changing trends within Health and Social Care 10. Experience of audit and research in clinical specialty. Robust understanding of all aspects of Clinical Governance including previous experience of quality issues, audit and risk management.	Interview

[1] "*senior role" is defined as experience gained at Band 7 or above*

SHORTLISTING

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified.

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this leadership role that they have the required competencies to be effective in this demanding leadership role. The competencies concerned are set out in the NHS Healthcare Leadership Model, details of which can be found at:
http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model.

Particular attention will be given to the following dimensions:

- Inspiring Shared Purpose
- Leading with Care
- Evaluating Information
- Connecting Our Service

- Sharing the Vision
- Engaging the Team
- Holding to Account
- Developing Capability
- Influencing for Results.

As part of the Recruitment & Selection process it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

THE TRUST IS AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment
All staff are required to comply with the Trust's Smoke Free Policy

EFFORT FACTORS

Title of Post Urology Nurse Specialist

Directorate Acute Services

Department/Ward SEC Urology

Location Thorndale Unit

Post holder (s) Personal information redacted by USI

Line Manager Martina Corrigan

For HR Use

Job Ref

Verified

HR Officer

PHYSICAL EFFORT

Does your post require any of the following?

Job Requirements	YES / NO	Examples	Average number of shifts per week	Number of times per shift	Average duration of each occurrence	Average weight
Lifting, pushing, pulling objects?	Yes	Moving diagnostic equipment within the unit and adapting it to patient needs e.g. for prostate biopsy	all shifts		continuously	kgs
Bending, kneeling, crouching, stretching?	Yes	During clinics, it is often necessary to bend or crouch to accurately perform invasive diagnostic procedures.	all shifts		continuously	N/A
Crawling, climbing?	No		less than once per month		less than 10 mins	N/A
Working in Physically cramped conditions?	No		less than once per month		less than 10 mins	N/A
Working at heights?	No		less than once per month		less than 10 mins	N/A
Standing/sitting with limited scope for movement for long periods	No		less than once per month		less than 10 mins	N/A
Walking for substantial periods of time?	No		less than once per month		less than 10 mins	N/A
Making repetitive movements?	Yes	Intricate positioning of rectal probe, instillation of local anaesthetic and performing numerous biopsy	more than once per week		less than 10 mins	N/A
Controlled restraint?	No		less than once per month		less than 10 mins	N/A
Running?	No		less than once per month		less than 10 mins	N/A

Lifting weights/equipment with mechanical aids?	Yes	Use hoist / stedy and adapt equipment to patient need	once to three times per month	1	10 to 20 mins	kgs
Clearing tables?	No		less than once per month		less than 10 mins	N/A
Manoeurvring/manipulating objects/people?	Yes	Assisting patients on and off examination couch, transfer on and off chair and / or toilet.	all shifts		continuously	kgs
Transferring people from bed to chair or similar?	Yes	As above	all shifts		continuously	kgs
Lifting weights/equipment without mechanical aids	No		less than once per month		less than 10 mins	kgs
Manual digging?	No		less than once per month		less than 10 mins	N/A
Heavy duty pot washing/oven cleaning?	No		less than once per month		less than 10 mins	
Other, please specify	Yes	Cleaning and preparation of faecal soiled rectal scopes to facilitate decontamination process	more than once per week	1	less than 10 mins	kgs

MENTAL EFFORT

Concentration

Describe the duties that you undertake that require concentration. List the most important first

Give examples of activities or tasks, for example checking documents, carrying out calculations, operating machinery, taking minutes, carrying out therapy, carrying out intricate clinical interventions, driving etc

Using an USS machine I repeatedly use precision hand to eye co-rdination to locate specific areas within the prostate gland which have been identified on MRI scanning as suspect for prostate cancer, and then perform intricate prostate biopsy. Each patient has approx 12-18 biopsies per setting and I perform over 200 per year, evidenced in a recent audit presentation to Patient Safety Meeting.

Manage the entire Prostate Biopsy Service. Determine suitability of patient for CNS, Radiology, Urologist lists and plan accordingly inclusive of those who require procedure under GA. Engage with a variety of specialists regionally for guidance for the most complex of cases such as those on biological treatments to facilitate biopsy under the strictest management.

Interpret complex results from a variety of CT, Bone and MRI scans, laboratory and histopathology and discuss the findings with patients/carer. This information is delivered in a highly specialised manner which empowers the patient to make informed decisions regarding their treatment choices, as discussed at MDT meetings of which I am a core member.

In conjunction with the other Urology Nurse Specialist:
(1) Overall management of Thorndale Unit and Stone Treatment Centre and the complex services provided within them. (2) Staff Management - inclusive of appraisal, supervision, revalidation, rostering and maintaining records (3) Professional/Service Development Role : (a) Lead audit presentations at patient safety / governance meetings (b) Strategic level representation locally and regionally at NICAN / CAG groups etc. providing nursing input to urology services for the future (c) Provide education and mentoring sessions for multi-disciplinary colleagues in relation to prostate biopsy within the Trust. (4)Devise and implement clinical policies and standard operating procedures essential for safe working practice within the unit, and identify gaps in service provision collaborating with others to address issues.

In conjunction with the Head of Service, drive service improvement through:
(1) Identify means to manage demand / capacity deficits in relation to new referrals / diagnostics/ reviews and waiting list issues
(2) Managing care of patients who are overdue urological review for a variety of urological disorders
(3) Provision of additional nurse led services - face to face appointments or virtual clinic activity i.e. casenote review
(4) Determine appropriate training needs of team members and negotiate funding to enable advanced practice opportunities

How many shifts during the week?

I provide formalised prostate biopsy clinics, ad hoc services to new clinics and accomodate inpatients where necessary. This has erased the need for any delay in having the procedure performed which assists in meeting government targets (excluding those who must be delayed due to eg.anticoagulation therapy). Virtual activity occurs on every shift engaging with patients to prepare them for procedures or discuss results. Managerial duties addressed throughout the week.

How long for each shift?

In a typical 9 hour shift, 6 - 8 hours spent on direct patient care with remainder on duties outlined above

Interruptions

If you are interrupted in the course of your work, describe the nature of the interruption and say whether you have to stop what you are doing to respond to the interruption and whether you have to re-prioritise your work as a result of it

Give examples including what you were doing before the interruption and what you had to start doing as a result of the interruption

In performing complex and invasive procedures, there is a significant risk of patients becoming acutely unwell or emotionally distressed and this requires immediate intervention or support resulting in an interruption to planned care. Procedures may need rescheduled or adapted to suit the circumstance and patients will need supported through this episode.

1. Following biopsy patients can experience significant vaso vagal episodes or large volume rectal bleeds - these episodes require immediate life perserving intervention, stabilisation of the patient and transfer to ED or inpatient admission. During these episodes other patients need to be reassured and delays explained. Every effort is made to resume clinical activity as soon as the emergency situation has been dealt with.

2. During every clinical session distressing news is delivered. Patients deal with this in various manners and require a variety of support to explain diagnosis and treatment options. It is important that the patient does not feel hurried during this process and is provided with the relevant site specific information and key worker contact details.

3.A junior member of the team may need assistance to perform a difficult procedure such as a complicated change of supra-pubic catheter, or complex urethral catheterisation. Episodes such as these are seen as teaching opportunities and require time and effort.

Where possible, every attempt to deal with interruptions such as phone calls etc. is minimised however this is not always possible as urological medical staff will often ring / call into the unit to arrange an urgent procedure for a patient. These occurences require re-organisation of workload within the unit to ensure safety for patients and to maximise resources to ensure all patients receive the care they require. When the Trust is under extreme bed pressures, opportunities are taken to accomodate inpatient procedures to facilitate prompt diagnostics, avoid the need to use main theatre, facilitate earlier discharge and improve patient flow.

State how often this would happen

Indicate how many times per shift and how many shifts per week

It is variable and dependent upon clinical activity and staffing levels however there would be interruptions during every clinical shift.

Received from Martina Corrigan on 07/07/2022. Annotated by the Urology Services Inquiry.

EMOTIONAL EFFORT

Please complete the table below, indicating whether you carry out the activities listed.

Examples	Yes / No	Number of occasions per week/month/year	Please describe, including the degree of involvement with the distressed/angry patient/client/staff
Processing (e.g. typing/transmitting) news of distressing events	Yes	more per week	Describe when you have had to do this and the nature of the events invovled My primary focus is Prostate Cancer and all admin & virtual sessions involve interpretation of results, planning appointments and contacting patients. I maintain excel spreadsheets of biopsy patients, results & complications post procedure for audit purposes.
Providing a service for distressed/angry patients/clients/staff	Yes	more per week	Give examples I act as Key Worker contact for those I have met at time of diagnosis of any form of uroligical cancer. It is essential that site specific information is not only provided in the written format, but that it is explained with empathy in a manner that the patient understands. For young men diagnosed with Testicular Cancer, discussion of treatment options involves concerns regarding fertility treatment. The patient requires ongoing access to you via telephone or face to face where necessary to alleviate anxiety/confusion/queries in the days and weeks ahead.
Giving unwelcome news to patients/clients/carers/staff	Yes	more per week	Give examples As the lead CNS for prostate cancer there is a huge component of my workload which demands communicating very sensitive, complex and distressig news to patient/carer. The cumulative effect of this can be very demanding and indeed exhausting at times.
Dealing with difficult situations	Yes	more per week	Give examples and describe your role in dealing with them Prostate cancer is further complicated for the patient who has

			intermediate risk disease as they have a variety of choices of treatment options including robotic prostatectomy, radical radiotherapy or brachytherapy. It is challenging to assist the patient through this complex decision making process and may require several visits/phone calls. Regretably for patients with advanced disease, in some circumstances further treatment options are not available and the discussion regarding supportive end of life care is required, with the necessity to engage/signpost to other services.
Designated to provide emotional support to front line staff	Yes	1 per month	Give an example of the type of support you provide and why it is necessary Opportunities are identified where debriefing is required following any significant clinical incident within the unit.
Caring for the terminally ill	Yes	3 per week	Describe your responsibility for terminally ill people and the nature of your professional relationship with them The patient and family need significant information provided in an empathetic manner when their disease has progressed to the terminal phase. Reassurance is vital and engagement of other community based services essential. Contact numbers are provided to provide rapid access back into the service should the need arise to avoid unpleasant delays in a busy ED.
Providing a therapy service to emotionally demanding patients/clients/staff	Yes	more per week	Give examples Virtual contact via telephone is available to all patients and used mostly by those who are awaiting results of biopsy or scans. Reassurance re prompt review are essential.
Communicating life changing events to patients/clients/staff	Yes	more per week	Give examples All treatment options for prostate can bring with them significant changes to men and their partners. In addition to widely recognised side effects such as incontinence and erectile dysfunction, recent patient satisfaction questionnaires have identified issues such as ongoing depression and the need for additional engagement with

			inpatients. We continue to attempt to improve service provision/support for these men.
Dealing with people with challenging behaviour	Yes	1 per month	Give examples and describe your role in dealing with them There are occasional visits from patients who have challenging behaviour. Every effort is made to accomodate their needs and ensure that they are seen promply on arrival to the unit.
Arriving at the scene of a distressing incident	No	1 per week	Give examples
Other (Please list)	No	1 per week	

WORKING CONDITIONS

Please describe where you work. If you work in more than one area, state the percentage of time in each.

I manage and work in an outpatient urological investigation unit in an acute care setting which has 2 treatment rooms for procedures such as urodynamic studies, flexible cystoscopy and prostate biopsy and 5 consultation rooms, one of which is used for the administratiuon of intra-vesical chemotherapy. It is unique from many outpatient settings as many complex and invasive procedures are provided within the unit.

Please complete the table below concerning the conditions in which you are required to work.

Are you required to use or be exposed to	Yes / No	Frequency per week/month/year	Please describe requirement
Using transport on a regular basis	No	1 per week	
Using road transport in emergency situations	No	1 per week	
Outdoor working	No	1 per week	
Using a computer/VDU	Yes	more per week	Email, Accessing patient electronic records, Dictation, Creating and storing equipment records, Creating and storing staff information
Extreme temperatures	No	1 per week	
Unpleasant smells or odours	Yes	more per week	During biopsy procedures I insert a probe into the rectum in order to scan the prostate, inject local anaesthetic and perform the biopsy. Digital rectal examination may also be required if the probe is difficult to insert, or to apply pressure within the rectum should significant bleeding occur following biopsy. When necessary I also insert a pack to reduce bleeding. It is necessary to test all urine prior to biopsy procedure and visibly assess voided urine following the procedure to identify

			bleeding risk.
Excessive noise or vibration	No	1 per week	Give examples including when and why
Dust or dirt	No	1 per week	Give examples including when and why
A humid atmosphere	No	1 per week	Give examples including when and why
Dangerous chemicals/substances in containers	Yes	1 per week	For equipment decontamination purposes we use: Perasafe, Cidezme & Steelco Spray
Aggressive verbal behaviour	Yes	1 per year	This can happen following a bad news encounter or in response to waiting times in the department or on the waiting list for a procedure. As manager in the unit i am often called to deal with these encounters
Unpleasant substances/non household waste	Yes	more per week	Clinical waste as described previously would be a major component of every clinical shift I work
Severe weather conditions	No	1 per week	Give examples including when and why
Noxious fumes	No	1 per week	Give examples including when and why
Infectious materials or foul linens	Yes	1 per week	Clinical waste as described previously
Fleas and lice	No	1 per week	Give examples including when and why
Bodily fluids, faeces, or vomit	Yes	more per week	Give examples including when and why Exposure to urine on every clinical session as part of the urinary assessment process and exposure to faeces for all prostate biopsy patients.
Aggressive physical behaviour	Yes	1 per year	Does not occur frequently however we often have patients attending for investigation who have dementia or learning difficulties and can find hospital environments challenging
Dangerous chemicals or substances that *are not contained*	Yes	1 per week	as above. We are exposed to these chemicals during the decontamination processes
Life threatening hazards	No	1 per week	Give examples including when and why
Other	No	1 per week	

Subject: RE: Urology Nurse Specialist Role
From: [redacted]
To: Corrigan, Martina [redacted]
Sent: 01/09/2017 08:41:33

Dear Martina,

Further to our discussion last week I wish to request a formal reassessment of my Urology Nurse Specialist grading within the Southern Trust.

I believe the personal additional training undertaken, expanded practice which I perform and adjustments to new services requiring complex discussions with patients and carers has significantly altered both the character and content of my job description and no longer reflects the banding when first appointed in 2005.

I would appreciate if you could take this matter forward and thank you for your assistance.

Regards,
[redacted]

Urology Nurse Specialist

[redacted]

[redacted]

[redacted] 14/01/2019

Corrigan, Martina

From: Corrigan, Martina
Sent: 02 June 2019 13:53
To: Personal information redacted by USI
Subject: FW: AFC
Attachments: Changed post sign off sheet CNS.docx; Organisational Chart Urology CNS.doc; new JD for Personal information redacted by USI - 8A.doc; Effort Factors Personal information redacted by USI .doc

Importance: High
Sensitivity: Confidential

Good afternoon Personal information redacted by

Please find attached:

1. Amended job description for your comments/agreement
2. Organisational chart
3. Effort Factors
4. Changed post sign off

Have all look at the attached and any changes amendments let me know, if none then if you are happy can you add your electronic signature to the sign-off sheet and send through to me please.

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology & Outpatients
Craigavon Area Hospital

Telephone:
EXT Personal Information redacted by (Internal)
Personal Information redacted by USI (External)
Personal Information redacted by USI (Mobile)

Southern Health and Social Care Trust

Quality Care - for you, with you

APPENDIX 2

Confirmation of Banding – Changed post

NAME:

JOB TITLE:

CURRENT BAND OF POST:

This job description and associated documents (i.e. organisational chart, effort factors questionnaire etc.) is an accurate reflection of the duties undertaken and responsibilities held by the above post holder.

SIGNATURES:

_____	_____
Post holder	**Date**
_____	_____
Line Manager	**Date**
_____	_____
Assistant Director	**Date**
_____	_____
Assistant Director of HR	**Date**

Please list/note any changes to the substantive post held for the period in question (e.g. Acting up, temporary secondments etc.)

_____
_____
_____
_____
_____
_____

Where there is more than one post holder please complete the table below.

Additional Post holder(s)	Signature

Please indicate by circling below how you would like to be notified of your outcome:

E-mail

_____

(please state your e-mail address)

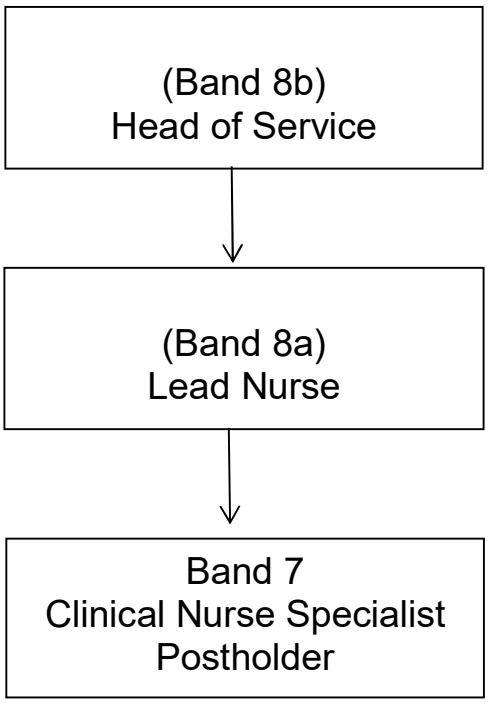
OR

Post – to your home address.

Please return this form to:

[redacted]
Irrelevant information redacted by the USI

Current Structure



Southern Health and Social Care Trust

JOB DESCRIPTION

JOB TITLE	Urology Clinical Nurse Specialist
BAND	To be agreed
DIRECTORATE	Acute Services
INITIAL LOCATION	Craigavon Area Hospital
REPORTS TO	Head of Service for Urology
ACCOUNTABLE TO	Assistant Director Surgery Elective Care Division & ATICS

JOB SUMMARY

The post-holder will:

Provide strategic leadership to drive forward sustained improvements in urological service provision for those with both malignant and non-malignant conditions

Deliver high quality specialist nursing care through the promotion of continuous professional development and innovative nursing practice

In conjunction with their medical and nurse colleagues the role will also involve the development of protocols for nurse led clinics and nurse management for Urological patients. The post holder will be a member of the Urology multidisciplinary team and will work closely with them to ensure that high quality patient care is maintained.

In collaboration with the Head of Service and medical colleagues the post-holder will develop, co-ordinate and deliver patient–centred urological services throughout the Southern Trust which are both cost effective and efficient

They will liaise closely with members of the multi-disciplinary team to improve channels of communication, allow maximum utilisation of resources, and promote continuity and co-ordination of the services within their sphere of responsibility

Promote reflective practice, complete personal development plans, and manage competency issues through the Trust capability procedure in order to achieve revalidation requirements.

This post will form close links with the specialist network of support coordinator's across the UK e.g. prostate UK, Macmillan, BAUN etc.

KEY DUTIES / RESPONSIBILITIES

Service Delivery

1. Support the Head of Service to achieve agreed Trust and regional targets for urological patients by co-ordinating the delivery of high quality clinical care in collaboration with Medical Teams and the Heads of Departments

2. Independently manage a clinical caseload in accordance with agreed levels of experience and competency

3. Provide innovative advanced nursing practice undertaking procedures including diagnostic and surveillance Flexible Cystoscopy, Prostate Biopsy and Removal of Ureteric Stent and injection of Botox into Bladder.

4. Deliver timely ongoing urological person-centred assessment and review services.

5. Identify opportunities for expanding practice, develop and sustain a team culture of continuous quality improvement, develop and lead service improvement initiatives and support the team to achieve competencies resulting in a highly skilled, flexible and motivated workforce.

6. Represent the Southern Health and Social Care Trust, in making an active contribution on local, regional and national working groups in the development of standards and guidelines.

7. Develop and implement a clinical governance framework for urological services which provides assurance to the Head Of Service that staff/team are fit for purpose, care meets standards enshrined in best practice guidelines and is responsive to learning opportunities arising from complaints, adverse incidents and feedback from service users

8. Evaluate service delivery against key performance indicators. Collect, analyse and utilise information to review performance and effectiveness, benchmarking with other similar service providers, in compliance with local data protection agreements

9. Ensure effective arrangements are in place for the identification, assessment and management of risks.

10. Ensure the processing and management of complaints, incidents and serious adverse incidents comply with the Trust policies and procedures, and are underpinned by transparency and a culture of continuous improvement.

11. Continue to improve patient experience through engagement in on-going education, research and audit of advanced nursing practice services inclusive of presentation at Patient Safety Meetings, amending service provision where indicated.

Service Planning and Modernisation

1. Actively lead service planning and modernisation initiatives relevant to urological services in conjunction with the Head of Service.

2. Assist the Head of Service with change management to meet the requirements of service provision and agreed strategies within the reform, modernisation and efficiency agenda for Urological Services.

3. Participate in research, evaluation of projects, quality initiatives and developments and facilitate staff undertaking research and audit projects ensuring clinical and social care governance requirements are achieved.

Communication

1. Develop good relationships with clinical staff so that service delivery issues can be addressed and implemented, to assist in the delivery of corporate and directorate objectives

2. Provide Reports to the Head of Service to ensure they are kept appraised of progress and priorities at all times.

3. Ensure strict confidentiality of correspondence, reports, meetings and verbal communications as appropriate.

4. Liaise with all representatives of associated agencies and organisations.

5. Maintain confidentiality of information at all times.

Professional Leadership

1. Act as a role model inspiring and ensuring that nurses within the Thorndale Unit think creatively, challenge current practice and implement new ways of working in a safe and measured manner

2. Contribute to a culture of continuous improvement through robust review of clinical standards, benchmarking against similar services, participating in local, regional and national audit and amending practice accordingly

3. Oversee the implementation of professional standards of practice within the urology department. Identify poor practice, support staff to meet the required standards and initiate trust procedures related to conduct and capability where improvement plans fail

4. Facilitate the Clinical Nurse Specialist team to work within and across professional and organisational boundaries maximising effective multi-disciplinary working.

Financial and Resource Management

1. Be accountable for the delegated financial management of urological services within the Clinical Nurse Specialist Team, to ensure Trust priorities, financial targets and service objectives are met.

2. Ensure the effective implementation of all Trust financial policies and procedures within delegated area of responsibility.

3. Support the Head of Service by providing assurances that financial governance requirements are met.

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1. Ensure the effective implementation of all Trust information management policies and procedure within the urology service in Thorndale Unit.

2. Ensure systems and procedures for the management and storage of information within the Thorndale Unit meet internal and external reporting requirements.

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1. Maintain staff relationships and morale amongst the staff reporting to him/her.

2. Review the organisation plan and establishment level of the service for which he/she is responsible to ensure that each is consistent with achieving objectives, and recommend change where appropriate.

3. Participate, as required, in the selection and appointment of staff for Thorndale Unit in accordance with procedures laid down by the Trust.

4. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

General Requirements

The post holder will be required to:

- Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions.

- Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining

a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

- The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.

- Adhere at all times to all Trust policies/codes of conduct, including for example:
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - standards of attendance, appearance and behaviour

- Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.

- Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.

- All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004, the Data Protection Act 2018 and General Data Protection Regulations. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

- Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

- Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner. Seek to engage and involve service users and members of the public in keeping with the Trust's Personal and Public Involvement Strategy and as appropriate to the job role.

This post may evolve over time and this Job Description will therefore be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

Southern Health and Social Care Trust

PERSONNEL SPECIFICATION

Title of Post: Urology Clinical Nurse Specialist

Band of Post: To be agreed

Notes to applicants:

1. *You must clearly demonstrate on your application form under each question, how you meet the required criteria as failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Shortlisting will be carried out on the basis of the essential criteria set out in Section 1 below, using the information provided by you on your application form. Please note the Trust reserves the right to use any desirable criteria outlined in Section 3 at shortlisting. You must clearly demonstrate on your application form how you meet the desirable criteria.*
3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

ESSENTIAL CRITERIA		
SECTION 1: The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage. You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.		
Factor	**Criteria**	**Method of Assessment**
Experience / Qualifications/ Registration	Currently a Registered Nurse Level 1, (Adult) on the Live NMC Register. **AND** University degree or relevant health/social care qualification plus at least 3 years' experience within the last 5 years at Band 7 in a hospital or community environment delivering health or social care service. **OR** Have worked for at least 5 years in a senior role[1]	Shortlisting by Application Form
Other	Hold a current full driving licence which is valid for use in the UK and have access to a car on appointment. This criteria will be waived in the case of applicants whose disability prohibits driving but who have access to a form of transport approved by the Trust which will permit them to carry out the duties of the post	Shortlisting by Application Form

Factor	Criteria *Ideally no more than 6-8 criteria in this section*	Method of Assessment
Skills / Abilities	1. Ability to influence and manage change, including the promotion of evidence based practice. 2. Have effective communication skills to meet the needs of the post in full. 3. Demonstrate evidence of highly effective planning and organisational skills. 4. Demonstrate experience of leadership and independent decision making. 5. Demonstrate ability to work effectively as part of a multi-disciplinary team. 6. Must possess a proven track record and have expert knowledge and skills of clinical examination and history taking 7. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement 8. Competent IT skills	Interview
Knowledge	9. Have a sound knowledge of changing trends within Health and Social Care 10. Experience of audit and research in clinical specialty. Robust understanding of all aspects of Clinical Governance including previous experience of quality issues, audit and risk management.	Interview

[1] "*senior role" is defined as experience gained at Band 7 or above*

SHORTLISTING

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified.

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this leadership role that they have the required competencies to be effective in this demanding leadership role. The competencies concerned are set out in the NHS Healthcare Leadership Model, details of which can be found at:
http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model.

Particular attention will be given to the following dimensions:

- Inspiring Shared Purpose
- Leading with Care
- Evaluating Information
- Connecting Our Service

- Sharing the Vision
- Engaging the Team
- Holding to Account
- Developing Capability
- Influencing for Results.

As part of the Recruitment & Selection process it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

THE TRUST IS AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment
All staff are required to comply with the Trust's Smoke Free Policy

EFFORT FACTORS

Title of Post Urology Nurse Specialist

Directorate Acute Services

Department/Ward SEC Urology

Location Thorndale Unit

Post holder (s) [redacted]

Line Manager Martina Corrigan

For HR Use

Job Ref

Verified

HR Officer

PHYSICAL EFFORT

Does your post require any of the following?

Job Requirements	YES / NO	Examples	Average number of shifts per week	Number of times per shift	Average duration of each occurrence	Average weight
Lifting, pushing, pulling objects?	Yes	Moving diagnostic equipment within the unit and adapting it to patient needs e.g. urodynamic / flexible cystoscopy procedures	all shifts		continuously	kgs
Bending, kneeling, crouching, stretching?	Yes	During clinics, it is often necessary to bend or crouch to accurately perform invasive diagnostic procedures.	all shifts		continuously	N/A
Crawling, climbing?	No		less than once per month		less than 10 mins	N/A
Working in Physically cramped conditions?	No		less than once per month		less than 10 mins	N/A
Working at heights?	No		less than once per month		less than 10 mins	N/A
Standing/sitting with limited scope for movement for long periods	No		less than once per month		less than 10 mins	N/A
Walking for substantial periods of time?	No		less than once per month		less than 10 mins	N/A
Making repetitive movements?	Yes	Specialist procedures require fine motor skills which are repetitive for short periods of time such as removal of a ureteric stent using a flexible cystoscope	once to three times per month		less than 10 mins	N/A
Controlled restraint?	No		less than once per month		less than 10 mins	N/A

Running?	No		less than once per month		less than 10 mins	N/A
Lifting weights/equipment with mechanical aids?	Yes	Use hoist / stedy and adapt equipment to patient need	once to three times per month	1	10 to 20 mins	kgs
Clearing tables?	No		less than once per month		less than 10 mins	N/A
Manoeurvring/manipulating objects/people?	Yes	Assisting patients on and off examination couch, transfer on and off chair and / or toilet.	all shifts		continuously	kgs
Transferring people from bed to chair or similar?	Yes	As above	all shifts		continuously	kgs
Lifting weights/equipment without mechanical aids	No		less than once per month		less than 10 mins	kgs
Manual digging?	No		less than once per month		less than 10 mins	N/A
Heavy duty pot washing/oven cleaning?	No		less than once per month		less than 10 mins	
Other, please specify	Yes	Cystoscope storage cabinet requires cleaning and maintenance each week which involves lifting stainless steel shelving, twisting, turning, bending and kneeling to reach all internal parts of drying cabinet	once per week	1	20 to 30 mins	kgs

MENTAL EFFORT

Concentration

Describe the duties that you undertake that require concentration. List the most important first.

Give examples of activities or tasks, for example checking documents, carrying out calculations, operating machinery, taking minutes, carrying out therapy, carrying out intricate clinical interventions, driving etc.

The following clinical duties require intense concentration for the duration of the activity and can be prolonged over a clinic session (4 hours)

Responsible for the independent assessment, treatment planning and timely review of patients with red flag and urinary symptoms inclusive of:
(1) Performing diagnostics such as Flexible Cystoscopy, Urine flow studies, Bladder scanning and Urodynamic studies and performing procedures such as removal of a ureteric stent using a flexible cystoscope, intra-detrusor injections of Botulinum toxin injections using a flexible cystoscope and local anaesthetic (In training) and managing patients with difficult / complex catheterisation. (2) Interprepretation of diagnostic findings and consideration of treatment options involving the communication of highly complex and sensitive information to patients and relatives to aid decision making (3) Add to appropriate waiting list for surgical intervention such as TURP or TURBT and complete pre-assessment documentation (4) Prescribing appropriate pharmacological treatments and / or medical devices (5) Managing designated caseload of patients who require urological review - face to face and virtual clinic activity (6) Discharge patients to the care of their GP following nurse led assessment and treatment (7) Manage the TROC service and first change of supra-pubic catheter service

In conjunction with the other Urology Nurse Specialist:
(1) Overall management of Thorndale Unit and Stone Treatment Centre and the complex services provided within them.
(2) Staff Management - inclusive of appraisal, supervision, revalidation, rostering and mantaining records
(3) Professional / Service development Role : (a) Lead audit presentations at patient safety / governance meetings (b) Strategic level representation locally and regionally at NICAN / CAG groups etc. providing nursing input to urology services for the future (c) Provide education and mentoring sessions for multi-disciplinary colleagues in relation to urodynamic studies and flexible cystoscopy within the Trust and in outside agencies such as Queens University Belfast (4) Devise and implement clinical policies and standard operating procedures essential for safe working practice within the unit and identify gaps in service provision collaborating with others to address any issues.

In conjunction with the Head of Service, improve service provision through:
(1) Identifying the means to manage demand / capacity deficits in relation to new referrals / diagnostics/ reviews and waiting list issues
(2) Managing care of patients who are overdue urological review for a variety of urological disorders
(3) Provision of additional nurse led services - face to face appointments or virtual clinic activity i.e. casenote review
(4) Determine appropriate training needs of team members and negotiate funding to enable advanced practice opportunities

How many shifts during the week?

Clinical duties are performed on every shift. Managerial duties are required daily, Professional / service development duties when required

How long for each shift?

In a typical 9 hour shift, 6 - 8 hours spent on direct patient care with remainder on duties outlined above

Interruptions

If you are interrupted in the course of your work, describe the nature of the interruption and say whether you have to stop what you are doing to respond to the interruption and whether you have to re-prioritise your work as a result of it

Give examples including what you were doing before the interruption and what you had to start doing as a result of the interruption

In performing complex and invasive procedures, there is a significant risk of patients becoming acutely unwell or emotionally distressed and this requires immediate intervention or support resulting in an interruption to planned care. Procedures may need rescheduled or adapted to suit the circumstance and patients will need supported through this episode.

As joint manager in a unit where several clinics and services run parallel, interruptions can be frequent. In addition to emergency situations such as fire alarms or patients becoming unwell during their visit to the unit, other situations can arise which demand immediate attention such as a patient presenting to the unit requiring attention or a junior member of the team needing assistance to perform a difficult procedure such as complicated change of supra-pubic catheter or insertion of urethral catheter when a patient is in distress and needs attention promptly. This can also happen when patients are receiving distressing news of their diagnosis or prognosis and need emotional support. Where possible, every attempt to deal with interruptions such as phone calls etc. is minimised however this is not always possible as urological medical staff will often ring / call into the unit to arrange an urgent procedure for a inpatient or for someone attending the ED. These occurences require re-organisation of workload and relocation of staff within the unit to ensure safety for patients and to maximise resources to ensure all patients receive the care they require.

State how often this would happen

Indicate how many times per shift and how many shifts per week

It is variable and dependent upon clinical activity and staffing levels however there would be interruptions during every clinical shift.

EMOTIONAL EFFORT

Please complete the table below, indicating whether you carry out the activities listed.

Examples	Yes / No	Number of occasions per week/month/year	Please describe, including the degree of involvement with the distressed/angry patient/client/staff
Processing (e.g. typing/transmitting) news of distressing events	Yes	more per week	Describe when you have had to do this and the nature of the events invovled I perform diagnostic cystoscopy for new patients with haematuria and on occasions where a bladder tumour is visualised, i inform patients / families of the possibility of a bladder cancer which will require biopsy / resection. Understandably patients can become distressed and require sensitive communication of this information and emotional support. Education is also required and appropriate pre-operative assessment duties will need actioned in a timely fashion to enable planned surgical / chemotherapy intervention
Providing a service for distressed/angry patients/clients/staff	Yes	4 per week	Give examples Patients can become angry or distressed when faced with life changing information such as a cancer diagnosis and may often question the timeframe of the diagnosis or treatment pathway. This can be a challenging situation to deal with and there are often many other influencing factors such as a recent family crisis or bereavement or concerns regarding their future / childcare etc. Using clear language and providing information sensitively in a private location, acknowledging that it can be difficult but reassuring patients that support, help and treatment is available is often required
Giving unwelcome news to patients/clients/carers/staff	Yes	4 per week	Give examples Informing patients that they may require life changing surgery such as creation of an ileal conduit for urinary symptoms / pain or

			incontinence which has failed to respond to other therapies. This requires multi-disciplinary discussion and support and is a difficult conversation for patients to understand the potential of living with a stoma. Informing patients that although they require surgical intervention (e.g.such as TURP) to treat bothersome symptoms which have not responded to other therapies and which negatively affect their quality of life, the waiting lists for surgery can be in excess of 1 year. Patients can react negatively to this news and this can be challenging and emotionally draining given this is unlikely to change in the current climate.
Dealing with difficult situations	Yes	4 per week	Give examples and describe your role in dealing with them Informing patients that further treatment may not always be possible and acknowledging that whilst symptoms are difficult to live with, surgical or medical intervention may not be appropriate for example if a person has not responded to medical treatment, is unfit for surgical intervention, is unable to self catheterise their bladder or requires indwelling catheterisation long term.
Designated to provide emotional support to front line staff	Yes	1 per year	Give an example of the type of support you provide and why it is necessary This would be an infrequent event when staff debriefing would be required for example following a significant clinical incident
Caring for the terminally ill	No	1 per week	Describe your responsibility for terminally ill people and the nature of your professional relationship with them
Providing a therapy service to emotionally demanding patients/clients/staff	Yes	1 per week	Give examples As a nurse prescriber, i will review patients who have commenced oral preparations or intra-vesical therapies to evaluate their response and advise accordingly. Patients attending for intra-vesical therapy or following pelvic radiotherapy may also require assessment or

			treatment for bothersome or painful urinary symptoms and they may have concerns that their cancer has returned, which needs addressed in a sensitive and holistic manner
Communicating life changing events to patients/clients/staff	Yes	4 per week	Give examples Patients can experience life changing side effects following surgical or oncological treatments such as urinary incontinence or erectile dysfunction which can negatively impact on emotional and mental health and well being. On occasion these side effects may represent a permanent change in lifestyle and this is a difficult consultation as often treatment options can be limited
Dealing with people with challenging behaviour	Yes	1 per week	Give examples and describe your role in dealing with them As manager in a busy clinical assement unit with many clinics and services running parallel, patients with challenging behaviour can often present and their visit needs managed thoughtfully and effectively i.e. reducing unecessary waiting, ensuring all diagnostics are completed by the same personnel and having family members / carers present where possible whilst ensuring the smooth running of the unit. Ensuring all staff equipped and knowledgeable to deal with patients with a variety of conditions such as dementia, learning disability or those who may have difficulty communicating.
Arriving at the scene of a distressing incident	No	1 per week	Give examples
Other (Please list)	Yes	1 per week	

WORKING CONDITIONS

Please describe where you work. If you work in more than one area, state the percentage of time in each.

I manage and work in an outpatient urological investigation unit within an acute care setting which has 2 treatment rooms for invasive procedures such as urodynamic studies, flexible cystoscopy and prostate biopsy and 5 consultation rooms, one of which is used for the administration of intra-vesical chemotherapy.

Please complete the table below concerning the conditions in which you are required to work.

Are you required to use or be exposed to	Yes / No	Frequency per week/month/year	Please describe requirement
Using transport on a regular basis	No	1 per week	
Using road transport in emergency situations	No	1 per week	
Outdoor working	No	1 per week	
Using a computer/VDU	Yes	more per week	Email, Accessing patient electronic records, Dictation, Creating and storing equipment records, Creating and storing staff information
Extreme temperatures	No	1 per week	
Unpleasant smells or odours	Yes	more per week	During every clinical activity i am required to deal with urine and /or faeces whether to perform bladder function tests / insert or change a urinary catheter or rectal balloon or to perform flexible cystoscopy. The nature of urinary symptom assessment often means that patients attending for these diagnostic procedures will have difficulty maintaining continence and urine spillage is a frequent occurrence. Urinary leakage is also deliberatley provoked during urodynamic testing to

			objectively diagnose the cause and so help identify the correct treatment pathway. Patients may arrive to clinic soiled and will need washed / changed before the procedure.
Excessive noise or vibration	No	1 per week	Give examples including when and why
Dust or dirt	No	1 per week	Give examples including when and why
A humid atmosphere	No	1 per week	Give examples including when and why
Dangerous chemicals/substances in containers	Yes	1 per week	For equipment decontamination purposes we use: Perasafe, Cidezme & Steelco Spray
Aggressive verbal behaviour	Yes	1 per year	This can happen following a bad news encounter or in response to waiting times in the department or in relation to waiting times for surgical procedures etc. As manager in the unit i am often called to deal with these encounters
Unpleasant substances/non household waste	Yes	more per week	Clinical waste as described previously would be a major component of every clinical shift
Severe weather conditions	No	1 per week	Give examples including when and why
Noxious fumes	No	1 per week	Give examples including when and why
Infectious materials or foul linens	Yes	more per week	Clinical waste as described previously
Fleas and lice	No	1 per week	Give examples including when and why
Bodily fluids, faeces, or vomit	Yes	more per week	Give examples including when and why In each clinical session there is exposure to urine and / or faeces as outline above.
Aggressive physical behaviour	Yes	1 per month	Does not occur frequently however we often have patients attending for investigation who have dementia or learning difficulties and can find hospital environments challenging
Dangerous chemicals or substances that *are not contained*	Yes	1 per week	We are exposed to chemicals during the decontamination processes used in the cleaning and maintenance of the drying cabinet
Life threatening hazards	No	1 per week	Give examples including when and why
Other	No	1 per week	

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 10 March 2017 11:20
To: Murray, Helena
Cc: Best, Paul
Subject: RE: Green light laser

Thanks Helena

Paul,

The requisition number is :R974298

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

INTERNAL: EXT [redacted] ***if dialling from Avaya phone. If dialling from old phone please dial 7753 61344***
EXTERNAL : [redacted]
Mobile: [redacted]

From: Murray, Helena
Sent: 10 March 2017 11:15
To: Corrigan, Martina
Subject: RE: Green light laser

Martina do you have the requi number? Paul best in stores then should be able to help you.

Regards
helena

From: Corrigan, Martina
Sent: 10 March 2017 10:21
To: Murray, Helena
Subject: Green light laser

Helena

I need to receipt that theatres has received the greenlight laser. Can you get someone to send me through the goods receipt number with the date etc…. please?

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

INTERNAL: EXT Personal Information redacted by USI ***if dialling from Avaya phone. If dialling from old phone please dial*** Personal Information redacted by USI
EXTERNAL : Personal Information redacted by USI
Mobile: Personal Information redacted by USI

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 12 December 2019 13:00
To: Corrigan, Martina
Subject: Urology Elective Care Meeting
Attachments: FW: Urology DECC Group Meeting (10.5 KB)

Subject: Urology Elective Care Meeting
Location: Boardroom, Trust HQ's CAH
Categories: Followup email
Importance: Normal
Start: 2019-12-12 13:00:00Z
End: 2019-12-12 17:00:00Z
Body:

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} --></style> </head> <body> <font face="Calibri" size="2"><span style="font-size:11pt;">
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Corrigan, Martina

From: Turbitt, Andrea <[redacted]>
Sent: 04 November 2019 11:41
To: Corrigan, Martina
Subject: FW: Urology DECC Group Meeting

Hi Martina,

See below confirmed date on next Urology DECC meeting. Apologies you should have been included in the circulation – hopefully you will be able to make it. I have asked David if he can push out the Urology PIG meeting to January (its currently scheduled to take place day before the DECC) so we can share our progress and get sign off for pathways etc.

Would you have any availability to meet with me in the next couple of weeks – I'm keen to see what I can pull together in advance of the DECC meeting and your expertise and knowledge would be appreciated!

Thanks Andrea

Andrea Turbitt
Head of Planning – Acute Services
Directorate of Performance and Reform
Brackens, Craigavon Area Hospital Site
Portadown BT 63 5QQ

Tel: [redacted]
Email: andrea.turbitt[redacted]

[redacted]

From: Harrison, Eric [redacted]
Sent: 30 October 2019 12:15
To: Turbitt, Andrea; Haynes, Mark; 'alex.macleod[redacted]'; 'Helen.Murray[redacted]' 'David McCormick'; 'Cathy Gillan'; Elliott, Joanne
Cc: Magwood, Aldrina; PADirectorofP&RSHSCT
Subject: RE: Urology DECC Group Meeting

Following on from the poll below, the date chosen for the Urology DECC Group Meeting is Thursday 12 December from 2pm.

The venue will be the Boardroom in the Trust HQ in Craigavon (not the main hospital boardroom).

Thanks,

Eric
Hospital Services Reform Directorate

From: Harrison, Eric
Sent: 29 October 2019 15:18
To: 'andrea.turbitt[redacted]' <andrea.turbitt[redacted]>; 'Mark.Haynes[redacted]' <Mark.Haynes[redacted]>;

'alex.macleod[redacted]' <[redacted]>;
'Helen.Murray[redacted]' <[redacted]>; 'David McCormick'
<[redacted]>; 'Cathy Gillan' <[redacted]>; Elliott, Joanne <[redacted]
[redacted]>
Cc: 'Aldrina.Magwood[redacted] <Aldrina.Magwood[redacted]>;
'PADirectorofP&RSHSCT'[redacted]>
Subject: Urology DECC Group Meeting

As the dates for a meeting in November were not suitable, please see a link below to a Doodle poll with possible times for a Urology DECC Group meeting in December.

The venue will be in Craigavon.

[redacted]

Please indicate your availability.

Regards,

Eric Harrison
Hospital Services Reform Directorate

Approach

- Demand / Capacity / Efficiency
- Efficiency of Consultant time
- Operative capacity primary challenge
  - Benchmarked against another trust.
  - By procedure type (not case number).

Delivery 1 – Elective new referrals

- New patient clinic
  - All new patients.
  - Aim where possible all required tests performed prior to attending OPD (bloods, Imaging).
  - Some Direct listing
  - Deliver diagnostics at time of attendance.
  - **Efficiency of consultant time.**
  - End of clinic aim = list or discharge with treatment plan to GP.
  - Phased implementation, full implementation from Jan 2015.
- Impact
  - Reduction in dedicated elective TRUS biopsy sessions from 2 per week to 1 every fortnight at present.
  - Reduction in Consultant delivered diagnostic Flexible cystoscopy and haematuria sessions.
  - New outpatient waiting list (>9 week wait);
    - March to July 2014 increase from 522 to 1006 patients
    - Dec 2014 to Feb 2015 1169 to 1144 patients
    - New outpatient waiting list (total) 1812 Jan 2015 to 1775 April 2015

Delivery 2 – Elective Operating

- Extended day operating (8am-8pm).
- No cross cover of leave.
- Impact
  - Increased available inpatient theatre time (28hrs per week average with cross cover to 31hrs per week with no cross cover).
  - Elective operating increased (322 vs 295 Jan- March 2015 vs 2014).
  - Inpatient waiting list >13 weeks static (499 March 2015 vs 494 March 2014).

Delivery 3 – Inpatient Care

- Consultant of the week
- Impact;
  - Jan-March 2015 vs Jan-March 2014
    - Non elective LOS reduced (4.5 days vs 5.0 days)
    - Non-elective admissions reduced (203 vs 232)
    - Non elective operating (82 cases vs 80 cases)
    - Urology Bed-days reduced (1741 vs 2009)

Summary

- Meeting Demand
  - At present but as demand increases will cease to.
- Historic Backlog major challenge
  - Requires additional solution outside of current capacity
- Capacity analysis suggested additional staffing required to deliver required capacity
  - Without additional staffing waiting lists will start to grow this year.

Moving Forwards

- Demand / Capacity models.
  - Case mix
  - Bench marking
- Capacity must be responsive.
  - Commission to meet demand.
  - Performance data compared against agreed benchmark data.
  - Operating capacity.
- Demand management.
- Primary care capacity critical.
- Delivery of core services with networked delivery of sub-speciality services.

DEPARTMENTAL MEETING 22nd SEPTEMBER 2016

Chair: Mr Young

Present: Mr Glackin, Mr O'Brien, Mr Suresh, Mr O'Donoghue, Pamela Johnston, Theatre Manager & Sr. England

Apologies: Mr Haynes , Mrs Corrigan

TOPIC: SALINE RESECTION

The specifications for the saline resectoscope system were presented. Mr Young outlined the history behind the move to the saline resection, also explaining that the last year had been spent trialling the various resectoscopes. Mr Young asked the forum if they had regarded enough time had been given to each of the resectoscope providing companies so that an adequate assessment could be made for each of the scopes. The unanimous decision was that the trial period for each of the resectoscopes was adequate to make an opinion.

We all agreed that the appraisal form used was of a good standard and certainly adequate to make a surgeons' assessment of each scope. The overall assessment looked at scope quality, ease of use, product design and effectiveness of the core principal of diathermy and resection of tissue. Second component to be evaluated were costs of generators and disposables. Thirdly was the topic of CSSD and backup. Scoring was undertaken from the feedback forms with the result that the WOLF system was the poorest and was not fit for purchase. In third place was the TONTARRA system which was described as having a variable performance with regards to the resection loop activity. The STORZ and the OLYMPUS system scored virtually equally on the various points with an overall equal score. It was recorded that there was no cystoscope present on the OLYMPUS resectoscope tray for evaluation but we generally felt that this was not an issue to take into account. There was general record of a fairly good ease of use and that the vaporisation module component was good. Several negative points related to the working element of inflow/outflow not being ideal; there were some comments on excessive bubble formation on the resectoscope loop as well as some other comments relating to slow resection. Overall however this was a system that could be purchased. With regards to the STORZS system, it was felt that the cutting modality of the resectoscope loop was excellent. Overall the scope components were easily constructed and there was a generalised good ease of use. Comments with regards to consistency and haemostasis had been positive. One of the major points in its favour was that the STORZ system could be easily changed if required on an urgent basis to the use of glycine. This in the current climate of change from one system to another in association with the range of urologists within the unit was a more suitable system for the team in Craigavon Area Hospital. The STORZ system certainly was a system that could be purchased.

Purely on the ease of use principal, excluding other criteria (i.e. cost and CSSD), the option came down to either STORZ or the OLYMPUS system, the other two being excluded. Four surgeons voted for the STORZ, one electing for the OLYMPUS. Mr Haynes was not present for this vote but on subsequent conversation later in the day, Mr Young put the same question to Mr Haynes asking for his comments on ease of use and again he had no particular preference and was happy to run with the global opinion.

On reviewing the various costs, it was noted that the disposables did have a variable range. It was accepted that loop quality did vary and that loops could be purchased from different sources. We all felt that this was not a particularly focused point for making a decision (namely cost of loop).

The price of the individual resectoscope systems was recorded noting that the OLYMPUS system was significantly more expensive in totality. The OLYMPUS system would have to be purchased completely whereas the STORZ system could be involve both new scopes and modification of current sets. (The costs set out for this meeting were significantly in favour of the STORZ system but it was appreciated that if a STORZ completely new systems was to be included that this information was to be presented to the forum before a final decision was made).

A further significant contributor to decision making was the generator needed for the electrical input. Although the OLYMPUS company was going to offer a free £40,000 generator, we did record that we may need up to three generators in view of the amount of urology sessions occurring at the same time. (The forum did not know if the company would supply three free generators. They felt it unlikely but enquiries would be made). The current generator system available within the Trust is multifunctional and therefore would already suit the STORZ system more appropriately. Even with the OLYMPUS generator system, this would result in increased machinery parking within the theatre environment. Overall this was regarded as a fairly substantive pointer in favour of the STORZ system.

CONCLUSION

In concluding, the vote on several aspects namely ease of use, cost, generator type were all in favour of the STORZ system. All the urologists have backed this decision with a unanimous vote.

This decision was based on the information supplied with a final decision pending the outstanding enquiries, namely the cost of a completely new STORZ resectoscope system and the cost of the OLYMPUS cystoscope. This would give a truly like for like comparison. The additional enquiry related to the OLYMPUS generator issue.

Mr Young will add an addendum to this document when the above information becomes available before final sign off.

The paperwork with regards to this has been forwarded to the Service Administrator, Martina Corrigan and to Pamela Johnston, Theatre Manager.

M Young
22nd September 2016
Chair of Session

ADDENDUDEM to outstanding information in relation to Saline resection Systems

1/ Full cost specification for STORZ and OLYMPUS resectoscope systems (excluding generator) have now been supplied and presented by the Theatre management. This is included on the updated evaluation sheet. (see enclose document)

(*The conclusion of the forum group remains the same – namely that STORZ is less expensive*)

2/ OLYMPUS will only supply one free generator

This information is to be presented at the next Departmental meeting for ratification

M Young

12th October 2016

Urology Departmental Meeting
23 July 2015

AGENDA

1. Introduction of New Medical Director and discussion of the issues and challenges in Urology.
2. Infection Control issues – 4th Floor
3. RQIA Visit to 3 South
4. Regional Review Paper for discussion along with nominations for sub-groups
5. Peer Review – Serious Concerns (update)
6. New Clinics – Stocktake
7. Any Other Business

Urology Departmental Meeting
8 October 2015

AGENDA

1. Apologies
2. Administration of Mitomycin
3. Infection control
4. FY1 duties on the wards
5. Saline TURP System (agree a date that suits for Susan England at meeting)
6. Antibiotic Stewardship (do we need to invite Melanie Pathiraja – Consultant microbiologist to a future meeting?)
7. Paediatrics – Daisy Hill Hospital
8. Emergency Theatre utilisation
9. Urology oncall Registrar rota
10. Working Group updates (SBA/CCG referral for advice and banner guidance)
11. Triage
12. Greenlight laser – Rep Mark Devoy would like to attend a future meeting to provide information on this.
13. Hospital at night
14. TROC pathway (Kate and Jenny to attend)
15. FPSA or not FPSA?? (Derek McKillop attending the meeting on 22 October at 12:30)
16. Any other Business

Corrigan, Martina

From: Hogan, Kerri [redacted]
Sent: 19 December 2019 16:27
To: Anderson, Jenna; Biggerstaff, Frances; Boyce, Joan; Burke, Mary; Burnett, Victoria; Caddell, Caroline; Campbell, Elaine; Caraher, Margarita; Carmont, Nigel; Carroll, Kay; Carroll, Ronan; Carson, Stephanie; Clarke, Wendy; Collins, Jeanette; Connolly, Connie; Conway, Barry; Cooke, Janet; Corrigan, Martina; Cullen, Lorna; Dawson, Mary; Devlin, Louise; Digney, Clare; Donegan, Kay; Donnelly, Barbara; Donnelly, Claire; Donnelly, MargaretA; Donnelly, Rachel; Farley, Maureen; Finnegan, Mairead; Forde, Jacinta; Garvey, Maria; Gildernew, Ursula; Gurbanova, Esmira; Harris, Anne; Haughey, Mary; Heasley, Rosemary; Hislop, Sarah; Holmes, Sharon; Hull, Davena L; Johnston, Pamela; Joyce, Paula; Kearney, Emmajane; Kelly, Brigeen; Kelly, Karen; Kelly, Trudi; Loughan, Patricia; Mallon, Mary; Martin, CarolynS; Matthews, Josephine; Maxwell, Kate; McAlinden, Jacinta; McAlinden, Matthew; McAteer, Hannah; McAteer, John; McAteer, Siofra; McAuliffe, Laura; McCann, Emma; McClenaghan, Nichola; McClurg, Lois; McCourt, Leanne; McCullough, Katrina; McGeown, Ann; McGeown, Annie; McGibbon, Eileen; McGlade, Joanne; McGoldrick, Kathleen; McGuigan, Tracey; McKenna, Marti; McKeown, Sinead; McMahon, Jenny; McParland, Ruth; McVey, Anne; Moan, Alison; Murray, Helena; Nelson, Amie; Nowak, Mary; OHagan, Julie; ONeil, Laura; ONeill, Kate; OReilly, Ann; Owens, Fiona; Percival, Joanna; Poots, Myra; Porter, Valerie; Portis, Michelle; Quin, Clair; RAMSEY, JOANNE; Reddick, Fiona; Sharpe, Dorothy; Sherry, Ann; Sloan, Olive; Small, Lisa; Smith, Paul; Trail, Elaine; Vallely, Lavina; Ward, Sarah; Weir, Ruth; Witczak, Maria
Subject: Quarterly Sisters Meeting
Attachments: Quarterly Sisters Meeting 20.12.19.docx

Good Afternoon,

Please find attached the Agenda for tomorrow's meeting.

Kind Regards,

Kerri Hogan
Personal Secretary to Mrs Anne McVey
Assistant Director Medicine and Unscheduled Care Division
Acute Directorate
Admin Floor, Craigavon Area Hospital
[redacted] **(Internal: [redacted] – prefix by [redacted] if dialling from legacy telephone)**
Email [redacted]

Southern Health and Social Care Trust

Acute Services Directorate

AGENDA

Ward Sister/Charge Nurse Meetings

Date: Friday 20 December 2019
Time: 9.30am-11.30am
Venue: Meeting Room 1 CAH vc Committee Room 1 DHH

Apologies:

Matters Arising – Actions from last meeting

minutes AQSM 20.09.19.docx

1- Operational

General Operational Issues	Security Incidents Uncoded Discharges	
Nursing Operational Issues	Medical Devices/Equipment Controllers RQIA Inspections Readiness & Actioning recommendations	

2- Governance

Risk Register		
Complaints/Compliments		
Datix/IR1's		
SEA/SAI Update/progress		
Mandatory Training		
Audit updates – NQI's	Falls Pressure Sores Medication Incidents – Omission of critical medications	KPI Report Trustwide (Clinical Indicators) - KPI Report Trustwide (Clinical Indicators) -
Standards & Guidelines	Standards & Guidelines Monthly Activity Report for new regionally endorsed guidance	20191211_S&G MUSC Activity Report

	1st September – 31st September 2019)	

3- Finance/HR

Budget Position	Payroll & E&S	
Spending Trends	Bank/Agency/OT	
Workforce Vacancies & Recruitment		
Finance Report	Acute Services Nursing at Oct 2019 (Mth 7)	
Collaborative Planning (CP) Training		

4- Performance

Targets as related to Division		
DC's before 1pm		
Service Reform - BC/IPT's		
Escalation Plan		

5- Reflection and Learning

Bed Management Contract		

A.O.B

Date of Next Meeting: Friday 20 March 2020 at 9.30am in Board Room CAH vc Committee Room 1 DHH

UROLOGY PLANNING AND IMPLEMENTATION GROUP – ACTIONS/ISSUES REGISTER – 26 JUNE 2015

	MATTERS ARISING	LEAD
1.	**Terms of Reference** **Issue:** Board submitted terms of reference to the Group for comment or approval.	
	Terms of Reference accepted by the Group with no amendments made.	
2.	**Excess Patients Waits** **Issue:** The HSCB delivered presentation on excess patient waits including: new outpatients, review outpatients, and in patients day cases. Dean Sullivan sought the views of the Consultant Urologists present in relation to the clinical priority of the different cohort of long waiting patients. It was agreed that the following groups should be addressed as a priority; • resection of outlet of male bladder • review waiting list backlog	
	<u>New Outpatients</u> **Issue:** There are currently 1,117 patients waiting over 12 months for a new outpatient appointment. South Eastern Trust and Southern Trust advised admin and clinical waiting list validation has been undertaken. Belfast Trust advised admin validation has been completed and agreed to now undertake clinical validation. The group discussed the potential implications of recently published NICE guidance which relates to macroscopic and microscopic haematuria. This may result in a reduction of red flag urology referrals. SET advised that an audit of OP waiting lists showed that a significant number of long waiting patients had vasectomy or	

	circumcision as reason for referral. Dr McKenna, representing Primary Care, highlighted lack of information regarding waiting times as an issue for GPs when referring patients. The group discussed the potential benefits of one stop clinics, the concept of one visit clinics was also presented by SHSCT who have implemented this model. Physical space and decontamination requirements were discussed as being some of the potential barriers to implementing these models. Dean Sullivan asked that each Trust should ensure that, given the clinical risk associated with long waiting times for cystoscopies, the development of one stop/visit clinics should be discussed at Director level in each Trust.	
	Action: - Each Trust to ensure that their outpatient waiting list is validated (both administratively and clinically); - Each Trust to assess how many patients there currently were on the outpatient waiting list with an indication of referral being for vasectomy or circumcision; - Each Trust to bring forward definitive proposals and timelines for implementation of one stop/visit model. Where infrastructure constraints do not currently allow for a one stop/visit model, Trusts should advise on alternative models to improve the pathway for flexi cystoscopy procedures.	**Trusts**
	<u>Review Outpatients</u> **Issue:** There are currently 1,135 patients waiting longer than 15 months beyond their clinically indicated date and approximately 3,100 waiting longer than 6 months. Following discussion with Trust clinical and service representatives the following was agreed: • administrative and clinical validation to be carried out if it had not already been undertaken. • the review backlog would be best managed by the Trust in which the waiting list was held. Models of outpatient review pathways, such as telephone review and mega clinics in Belfast Trust and nurse led review in clinically appropriate cohorts in the Western Trust, were discussed. Dr McKenna suggested that there may be clinically appropriate roles for the GP in review of urology patients in primary care and	

	the group agreed that this should be considered in any future reform work relating to review pathways. Each Trust to identify the actions required to reduce outpatient review waiting times to no patient waiting longer than 3 months past their clinically indicated date for review. It was recognised that this would be over a period of time and should be done in parallel, and in consideration with, plans for reform.	
	Action: - South Eastern Trust and Southern Trust to each submit an action plan to address the cohort of patients waiting longer than 15 months past their clinically indicated review date; - Each Trust to consider actions required to reduce outpatient review waiting times to have no patients waiting longer than three months past their clinically indicated date for review.	**Trusts**
	<u>IPDCs</u> **Issue:** There are currently 879 patients waiting longer than 12 months for their elective treatment. The waiting list comprised of 300 cystoscopies, 200 vasectomies, 114 resection of outlet of bladder, 77 operation on prepuce and 186 other operations. *Vasectomies and Circumcisions* The group discussed the commissioning of vasectomies and circumcisions and noted that due to clinical risk associated with other urology referrals that they are not being offered treatment dates at present. It was agreed that an Independent Sector solution should be explored for treatment of vasectomies and circumcisions. *Flexible Cystoscopy* Current waiting times for flexible cystoscopies were reviewed. In recognition of the prolonged waiting times it was agreed by all that both administrative and clinical validation was essential as a first step where this had not already been carried out. Potential solutions to address were discussed and it was agreed that a regional approach with contribution from as many operators as possible and all day operating would be the most effective way of addressing this backlog. It was noted however, that this may result in more patients being listed for IPDC treatments and this should be considered as part of the planning. It was recognised that there would be a requirement for HSCB and Trusts to work together to identify physical and clinical (medical and nursing) capacity to	

	facilitate WL reduction. *Resection of outlet of male bladder* The group discussed the bed and nursing support required to address those patients waiting greater than 12 months for resection of outlet of male bladder. It was acknowledged that these patients would be best managed in units where there was a urology presence and experienced support staff. It was suggested that the Causeway Hospital would be suitable for potential weekend use.	
	Action: - HSCB to take the lead on exploring the option of an IS solution for vasectomies and circumcisions; - Belfast, South Eastern and Southern Trusts to undertake an administrative and clinical validation of all patients waiting longer 12 months for their procedure; - Each Trust to confirm what operator capacity would be available to support a regional waiting list initiative; - HSCB to discuss potential for utilising staff and physical resources in Causeway.	**HSCB & Trusts**
3.	**Opportunities for Integrated Working** The opportunities presented by technology, for example, GP referral to Consultant for advice was recognised. It was agreed that the potential for a project echo model and collaborative working between Urologists & GPs (such as that currently underway in neurology) should be explored further in pathway work. The HSCB referred to the development of regional referral guidance which would sit on the CCG urology banner page. It was advised that this would be best developed on a regional basis would input from both consultants and GPs.	
	Action: - Each Trust to provide nominations for a working group (membership of the group to include GPs and Consultants) which will focus on CCG both in terms of referral for advice and the development of CCG banner guidance.	**HSCB, GPC & Trusts**

4.	**Workforce Planning** Board advised that it requires a sub group including medical representation from the PHA in order to: • update 2014 stocktake workforce position; • review middle grade support across the region; • explore extended roles of nursing.	
	Action: - Each Trust to advise HSCB of nominated medical and managerial representative to sit on this group.	**Trusts**
5.	**Urological Cover for Acute Sites** David McCormick presented data relating to in-hours & out of hours non elective admissions and sought views on providing cover to sites with no urology presence. Current models were discussed with input from Belfast and Western Trusts regarding cover to Northern Trust. The group agreed that current processes in place to provide cover for urology emergency presentations were in place but it was acknowledged that they should be formalised and therefore written protocols should be developed which reflect these arrangements.	
	Action: - The development of a written protocol for staff requiring urology advice on sites where there is no urology presence to be taken forward by the Workforce Planning Group. This should be taken forward by Belfast and Western Trusts.	**Belfast and Western Trusts**
6.	**Elimination of Pathway Variations** It was agreed that NICaN should review the current cancer pathways and bring any revisions to these pathways to the implementation group for review/discussion.	
	Action: - NICaN to review relevant urology cancer pathways.	**NICaN**

7.	**Procedure Based Service and Budget Agreements** It was agreed that there was a need to review the current urology SBA currencies and move to a procedure based SBA in line with agreed pathways.	
	Action: - Each Trust to advise the HSCB of nominated medical and managerial representative to sit on this group.	**HSCB & Trusts**
8.	**Boundary Arrangements for Urology Referrals** Lynne Charlton referred to the interim arrangement for the redirection of urology referrals from the Northern Trust. It was agreed that the HSCB should write formally to GPs to clarify the current interim referral arrangements. Colin Mulholland highlighted the risk of using two booking systems and advised that urology referrals would be best managed through one centre.	
	Action: - HSCB to write formally to GPs in the Northern LCG advising of the interim referral arrangements; - Current booking processes in Western and Northern Trusts to be reviewed.	**HSCB & Western & Northern Trusts**
9.	**Regional Solutions** • **Reconstruction (AUS and urethroplasty)** • **prostatectomies** The South Eastern Trust explained that clinicians across Trusts were already meeting regularly to discuss urology reconstruction cases. It was agreed that further work was required to understand the activity volumes, skill mix and theatre capacity required to support this service. Chris Hagan explained that training for radical prostatectomies is gradually moving to robotic which will have a significant impact on service provision. He explained that approximately 300 patients per annum (gynaecology and urology) could utilise the robot and therefore this would be a cost effective option.	

	The Trust also referred to the potential investment from Men Against Cancer for robotic equipment. The Trust enquired if the current cost of sending patients via ECR (Extra Contractual Referrals) could be used to offset the running costs of the robot.	
	Action: - Each Trust to advise the HSCB of nominated medical representative to sit on the reconstruction group; - The Belfast Trust to write formally to HSCB detailing the business need for robotic prostatectomies.	**HSCB, PHA & Trusts** **Belfast Trust**
10.	**AOB** <u>Peer Review</u> Board advised it will consider formal feedback from peer review once it is received.	
	<u>Date of Next Meeting</u> Board recommends using time allocated on **28 July 2015** for sub group workstreams and advised next Planning and Implementation Group meeting will be held on **Wednesday, 26 August 2015 at 10.00am, CR2 & CR3 Linenhall Street**	

NOTES OF UROLOGY PLANNING AND IMPLEMENTATION GROUP MEETING

11 NOVEMBER 2015

BOARD ROOM COUNTY HALL, BALLYMENA

MATTERS ARISING	LEAD
TEAM NORTH WEST UPDATE Paul Doherty gave an update on the Team North West PPI Consultation which officially launched on 6 November, running for a period of 3 months. Mr Doherty stressed that they were consulting only on the implementation of the proposed model as the model itself had previously been consulted upon. Mr Doherty further updated that work streams have been identified and schedules of work are making progress. Pathways are expected to be delivered by the end of February 2016. Paul Doherty outlined progress on recruitment of the consultant post. This post has been vacant and unfilled in the NHSCT since Oct 2013. The Job Description was submitted and expressions of interest have been received. Proposed job plans are expected to be ready by the end of December. The Implementation is to be completed by 6 April 2016 and a HR process is underway to assist this timescale. **UPDATE ON WORKING GROUP UPDATE** • **CCG GUIDANCE** Update and presentation given by David McCormick (presentation attached). **Actions:** 1. Agreed need for GP representation On Group: Dr Frances O'Hagan nominated. 2. Further refinement of guidance required before populating CCG	**Chris Hagan** **Paul Doherty**

PROCEDURE BASED SBA Update and presentation given by Lynne Charlton (presentation attached). **Actions:** 1. HSCB will work with Trusts to complete the procedure based modelling based on 2 methodologies 2. HSCB will visit individual Trust's to discuss the models for implementation. 3. Louise McManus will arrange dates for Trust site visits. **COMMISSIONING LOWER VOLUME UROLOGICAL PROCEDURES** Darren Campbell gave a presentation and updated on progress and next steps following the first meetings (presentation attached). **Actions:** 1. Submission of business case to SMT for the dual robot. Belfast Trust recently submitted an outline proposal for the Robot that will be internally considered by HSCB and PHA. 2. Regional agreement required for Uro-Gynae Pathways. Darren Campbell to obtain Gynae representation and convene a Regional meeting. 3. CAWT proposed a Cross-Border Robot. Sara Long advised that she would find out the detail and get back to the group.	**Lynne Charlton**

WORKFORCE PLANNING Lynne Charlton gave an update on progress to date and next steps as per attached slides. **Actions:** 1. Dr Janet Little suggested that the group reflect on the title to reflect purpose – Lynne Charlton to review. 2. Dr David Ross to be included in distribution list for this workstream.	**Lynne Charlton**
N CODE PROPOSED REGIONAL SOLUTION (SWAH) **BELFAST UPDATE** David McCormick gave an update on the movement of long waiting N code patients from Belfast Trust to SWAH. **Actions:** 1. Belfast Trust to continue contacting clinically suitable patients. 2. Western Trust to ensure that weekend lists are organised up until end of March 2016. 3. Primary Care eager to progress to direct referral to SWAH.	**David McCormick**
AUDIT OF REFERRAL Lynne Charlton updated the group on the results of the 2 months referral audit carried out by the 5 Trusts. Referral Audit looked at volume and percentage of OP referrals with Vasectomy/Circumcision indication added t Trust waiting lists in July and August 2015. Trust data received from four of five Trusts and data from remaining Trust expected imminently. It is expected that the audit will help inform future planning regarding N Code work. **Actions:** 1. Lynne to draft findings report when final data received and share at next Planning Implementation Group.	**Lynne Charlton**

OUTPATIENTS Darren Campbell presented the current Performance position on: - Review Outpatients numbers waiting greater than 15 Months - Review Outpatients numbers waiting greater than 3 Months - New Outpatient numbers waiting greater than 9 weeks. Dr Allen McCullough discussed his difficulty in picking out waiting times for his NHSCT patients because of the interim arrangements with his patients going to both BHSCT and WHSCT. SET's Dr Duggan outlined waiting times for routine OP's are increasing as the Trust is concentrating on urgents and red flags which leaves minimal available capacity. This view was shared across many of the trusts. Mr Chis Hagan expressed concern that reconfiguration of post codes in the Northern Trust area has proved difficult for BHSCT to manage as there was no resultant increase in capacity associated with this. **Actions:** Sara Long suggested now that the formal consultation process has been started around team North West it is now appropriate to meet with the Belfast Trust to formalise and agree the process and volumes of former NHSCT patients that are heading to BHSCT. Meeting to be arranged to discuss this. Team North West to invite Dr Brendan O'Hare to attend Project Board meetings where waiting times and other issues of interest would be discussed.	
IP/DCs Darren Campbell presented the current Performance position on Inpatients and Day case waits - > 12 MONTHS - > 13 WEEKS Sara Long advised the group that the DHSSPS are due to release additional funding from the November monitoring round. Sara advised that her initial feedback to the DHSSPS is that it was the view of the Urology Project Implementation Group that Urology patients must	

remain as an additional in house activity and using the Independent Sector is not a solution because of previous experiences. This was a view shared by the group. Trusts are encouraged to review current plans based on the fact that new funding is available and advise the HSCB of any additional activity that can be undertaken. **Action:** Darren Campbell will correspond with Trust service managers to get completed action plans for review. Trusts to review internal capacity and get back Sara Long with the outcome.	
CANCER Darren Campbell gave an overview of: - Longest waits - Average waits - Numbers actively waiting over 62 days - Recovery Plans – BHSCT and SET Darren Campbell ended the meeting outlining that performance position in urology was improving and thanked the clinical and managerial teams for all of their hard work in this area. Three of the Trusts now have minimal numbers of patients actively waiting over 62 days and the other two Trusts have made significant improvement in the last 10 weeks.	
AOB Sara Long discussed the location of the meeting and suggested that future meetings should take place in Antrim for ease of travel. **Actions** Louise McManus will secure new venue for future meetings. **DONM** 18 February 2016, 10.00 – 12.00. **Venue**: .Clotworthy House, Antrim.	

Health and Social Care Board

Directorate of Commissioning

HSC Board Headquarters
12-22 Linenhall Street
Belfast
BT2 8BS

Tel : 028 90321313
Web Site : www.hscboard.hscni.net

Director of Surgery and Specialist Services, BHSCT

Director of Acute Services (NHSCT, SEHSCT, SHSCT and WHSCT)

Our Ref*: DS/LETTERS/Urology*

Date: 14 July 2015

Dear Colleague

UROLOGY PLANNING AND IMPLEMENTATION GROUP

I refer to the recent meeting of the Urology Planning and Implementation Group at which we discussed the need to agree arrangements and identify resources for a system-wide approach to the organisation and profile of urology services across Northern Ireland. A copy of the notes from this meeting is attached.

It was agreed at the meeting that a range of actions were required to improve the quality of service provision and reduce the current waiting times for both new and review outpatient appointments and elective treatments. These actions were as follows:

<u>New Outpatients</u>

- Each Trust to ensure that their outpatient list is validated (both administratively and clinically);
- Each Trust to assess how many patients there currently are on the outpatient waiting list with an indication of referral being for vasectomy or circumcision;
- Each Trust to bring forward definitive proposals and timelines for implementation of one stop/visit model. Where infrastructure constraints do not currently allow for a one stop/visit model, Trusts should advise on alternative models to improve the pathway for flexi cystoscopy procedures.

Review Outpatients

- South Eastern Trust and Southern Trust to each submit an action plan to address the cohort of patients waiting longer than 15 months past their clinically indicated review date;
- Each Trust to consider actions required to reduce outpatient review waiting times to have no patients waiting longer than three months past their clinically indicated date for review.

IPDCs

- HSCB to take the lead on exploring the option of an IS solution for vasectomies and circumcisions;
- Belfast, South Eastern and Southern Trusts to undertake an administrative and clinical validation of all patients waiting longer 12 months for their procedure;
- Each Trust to confirm what operator capacity would be available to support a regional waiting list initiative;
- HSCB to discuss potential for utilising staff and physical resources in Causeway.

In addition to the above actions to address the current long waiting times, it was agreed that a number of working groups would be established to lead on discrete areas of work. Each Trust is therefore asked to nominate a relevant managerial and/or clinical lead for the following groups:

Working Group	**Required Nominee**
Development of CCG referral for advice and banner guidance	Consultant
Workforce planning	Consultant and Service Manager
Development of procedure based SBAs	Consultant and Service Manager
Prostatectomies service provision	Consultant
AUS and Urethroplasty service provision	Consultant

Trusts should ensure that all of the agreed actions are addressed and that the relevant information is forwarded to the HSCB. Information pertaining to each action and Trust working group nominees should be

sent to Rae Browne, Business Support Manager Personal information redacted by USI by Friday 31 July.

Yours sincerely

Personal information redacted by USI

Dean Sullivan
Director of Commissioning

Enc Note of Urology Planning and Implementation Group meeting (26 June 2015)

CC: Trust Clinical Leads for Urology
Lynne Charlton
David McCormick

Monthly 1:1 Present: Sarah Ward/ Martina Corrigan

Date : 24.7.19

Induction	• Aim to meet 2nd Wednesday morning of every month with Martina. Between 8.45-9.15am, accommodating bed meeting at 8.30am. • ENT Speciality Meeting- 2nd Friday of each month. Looks at performance, back logs, waiting lists, complaints, staffing and job planning. • Urology- patient safety meeting monthly. Looks at patient safety, M+M and wards activity. Next one is on 13th August. Martina to send Sarah meeting appointment as it will interfere with HOS/AD meeting but we need to attend. • Staffing- 3rd Monday of month, staffing meeting with RC. To have vacancies, leavers, sickness etc up to date for this. • Keep Martina up to date with all issues in areas.
Performance/ Staffing	• Ciara McElvanna- commenced post in 4N. To put Ereq out for her as band 5 post. • Lynn Steenson- accepted band 5 post in Cathlab. I will be meeting with Lynn this week to discuss. • Personal information redacted by USI [redacted]. • Kate McGinn has been in touch-coming in August to meet with me to discuss return to work. To let Martina know when date is to allow her to meet with

	Kate also to discuss her role on return. Catherine English is funded by Macmillen until October 31st. • Averil Anthony- housekeeper. To monitor attendance at union days. • To update staffing list for each Tuesday as part of 3 South Action Plan review meeting • Lead Nurse Spot Checks- please let Martina know of issues before sent to RC. Keep informed of them as they arise. Confirm if spot checks are completed with ward sister/ band 6. • Risk Assessment to be updated. Aware that training figures are slowly improving, however staffing situation is worsening and the forcasted stop of agency staff will have a significant impact on the ward. • X1 Pre Reg Personal Information redacted by the USI has withdrawn from post. • Personal Information redacted by the USI spoke to Sarah last week, unhappy with how Personal information redacted move was facilitated. Advised Personal information redacted by USI she went through the appropriate channels and secured a post. Personal Information redacted by the USI is being facilitated to move to pre op assessment and has assurances that this will happy when we can allow. Any reasons for expediting transfer are based solely on circumstance and at discretion of Head of HR. To date there is no overwhelming reason that this is to be facilitated at this time.
Workload Management	• Thorndale will move to Josie Matthew as Lead Nurse. Structure currently under DS but agreed as outpatient department this should be under the outpatient Lead Nurse. This wont happen until the new band 6 posts are filled. Thorndale & Josie Mathews are aware of the transition. • Complaint outstanding for Personal information redacted by USI notes requested numerous times via secretary. Still awaiting.

Finance	• Funding secured for additional 3 CNS.
Governance	• Mitomycin administration- as per Sr Caddell there is no issues to date. They have not had to administer at ward level. Informed that Rep has not been in contact, to get number and forward to Martina.
Service Development	• Nil new at present
AOB	• Raised that Sr Caddell seems to be giving conflicting information to Sarah and Caroline. Last week, Sarah spent lots of time with Caroline and felt we were making progress, however this does not seem to be the case when Martina speaking with Caroline. [redacted]. Moving forward we have agreed to both attend the meeting scheduled with band 6s and 7. To date have had limited response to agreed date, Ronan Carrol is aware of this. New date sent to all for 13th August. Awaiting reply. Sarah will draft agenda and rules for the meeting in advance. • Next meeting 21st August.

Corrigan, Martina

To: Matthews, Josephine
Cc: Corrigan, Martina
Subject: Josie one-one 10/04/18
Attachments: Martina had a quck chat with Anite re Saviance and full consultant usage... (3.37 KB); Re: Diploma course (15.9 KB)

Hi Josie

Wee update from our meeting this morning.

1. ***Diploma course-*** all in place for 14-18th and happy to support additional staff to attend. MC also sent email to Michele Bekmez, about GP practices. Also nurse from Dublin to attend.
2. ***Banbridge*** – work has commenced, but no co-ordination so MC has emailed Mark Bloomer for name of a project manager to link in with
3. ***Saviance*** – Josie has emailed all OPD sisters and asked them for lists of names that don't use Saviance – once received respective HOS will be asked to link in with their consultants.
4. ***Payment of band 5's*** – once information is received on back-pay MC will approve. Moving forward need to determine what are the duties in ophthalmology that merit this role being paid at a band 6. MC has emailed all OPD sisters to determine what is done at a clinic currently
5. ***Cathy Rocks*** - MC to speak to Ronan and then speak with CR about going down a band
6. ***Ophthalmology*** – MC emailed Mary Hanrahan for roles and responsibilities and how many staff per clinic etc…
7. ***Roles and Responsibilities*** – MC has emailed Altnagelvin Hospital to see if we can visit or speak to someone regarding what way their clinics are supported/are run. we will revisit the work commenced previously and

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

INTERNAL: EXT Personal Information redacted by USI
EXTERNAL : Personal Information redacted by USI
Mobile: Personal Information redacted by USI

Corrigan, Martina

From: Carroll, Ronan [redacted]
Sent: 06 April 2018 16:00
To: Corrigan, Martina
Subject: Martina had a quck chat with Anite re Saviance and full consultant usage - what's the story ?

Importance: High

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 06 April 2018 19:12
To: Matthews, Josephine
Subject: Re: Diploma course

You too and yip can talk about both on Tuesday along with the payment of the band 5's.

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

Office: [redacted]
Mobile : [redacted]

From: Matthews, Josephine
Sent: Friday, 6 April 2018 17:32
To: Corrigan, Martina
Subject: FW: Diploma course

Hi,
Yes talk Tueday- include this also
Have a nice weekend
Regards

Josie

Josephine Matthews
Lead Nurse
SEC & Outpatients
Mob: [redacted]

From: Mills Linda, Head of Service [redacted]
Sent: 05 April 2018 16:07
To: Matthews, Josephine
Subject: RE: Diploma course

Hi Josephine

We are really looking forward to coming over. I have booked the Armagh City Hotel as that was the cheapest option and our Trust is very careful with how much money we spend. I think you said you may be able to arrange a lift each day – that would be fantastic if you could – do you think that's still an option?

We are coming into Belfast City Airport on the Sunday evening.
Please can you confirm the 'plan' …. How many nurses will be attending the full 5 days and how many will be attending some days – and which days?

We will certainly plan the course around your needs

Do you wish to have microsuction included in the course? If so I know a nurse from Dublin who wants to attend microsuction training – I could maybe put her in touch with you if you wanted to sell her a seat?

Susan our Administrator has asked me to confirm that as previously quoted the cost will be £7328. Do you need to raise a purchase order to cover the cost and who should Susan address the invoice to?

I think that's all for now

Kind Regards
Linda

Linda Mills
Head of Service
Primary Ear Care and Audiology Services

The Rotherham NHS Foundation Trust
Rotherham Community Health Centre
Greasborough Road
Rotherham
S60 1RY

Tel: Personal Information redacted by USI
Internal: Personal Information redacted by
E-mail Personal Information redacted by USI

Winners of Care of Older People Award

Corrigan, Martina

From: O'Brien, Aidan [redacted]
Sent: 06 February 2019 23:33
To: McCaul, Collette
Cc: Young, Michael; Glackin, Anthony; Haynes, Mark; ODonoghue, JohnP; 'derek.hennessey [redacted] Corrigan, Martina
Subject: FW: Patients awaiting results

Importance: High

Dear Ms. McCaul,

I have been greatly concerned, indeed alarmed, to have learned of this directive which has been shared with me, out of similar concern.

The purpose of, the reason for, the decision to review a patient is indeed to review the patient.
The patient may indeed have had an investigation requested, to be carried out in the interim, and to be available at the time of review of the patient.
The investigation may be of varied significance to the review of the patient, but it is still the clinician's decision to review the patient.
One would almost think from the content of the process that you have sought to clarify, that normality of the investigation would negate the need to review the patient, or the clinician's desire or need to do so.
One could also conclude that if no investigation is requested, then perhaps only those patients are to be placed on a waiting list for review as requested, or are those patients not to be reviewed at all?

Secondly, if all patients who have had an investigation requested are not to be placed on a waiting list for review, as requested, until the requesting clinician has viewed the results and reports of all of these investigations, when do you anticipate that they will have the time to do so?
Have you quantified the time required and ensured that measures have been taken to have it provided?

Thirdly, you relate that it is by ensuring that the results are 'seen' by the consultant that patients will not be missed.
I would counter that it is by ensuring that the patient is provided with a review appointment at the time requested by the clinician that the patient will not be missed.

Perhaps, one example will suffice.
The last patient on whom I operated today is a [redacted] lady who has been known for some years to have partial duplication of both upper urinary tracts.
She has significantly reduced function provided by her left kidney.
She also has left ureteric reflux.
However, she also has had an enlarging stone located in a diverticulum arising by way of a narrow infundibulum from the upper moiety of her right kidney.
She has been suffering from intermittent right loin and flank pain, as well as left flank pain when she has a urinary infection.
Today, I have managed to virtually completely clear stone from the diverticulum after the second session of laser infundibulotomy and lithotripsy.
She is scheduled for discharge [redacted]
I planned to have a CT scan repeated in May and to review her in June.
The purpose of reviewing her is to determine whether her surgical intervention has relieved her of her pain, reduced the incidence of infection, and as a consequence, reduced the frequency and severity of her left flank pain.
Review of the CT images at the time of the patient's review will inform her review.
It will evidently not replace it.

Lastly, I find it remarkable that your process be clarified with secretarial staff without consultation with or agreement with consultants who, by definition, should be consulted!

I would request that you consider withdrawing your directive as it has profound implications for the management of patients, and certainly until it has been discussed with clinicians.
I would also be grateful if you would advise by earliest return who authorised this process,

Aidan O'Brien.

From: Elliott, Noleen
Sent: 01 February 2019 13:17
To: O'Brien, Aidan
Subject: FW: Patients awaiting results
Importance: High

From: McCaul, Collette
Sent: 30 January 2019 12:33
To: Burke, Catherine; Cooke, Elaine; Cowan, Anne; Daly, Laura; Hall, Pamela; Kennedy, June; McCaffrey, Joe; Mulligan, Sharon; Nugent, Carol; Wortley, Heather; Wright, Brenda; Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Loughran, Teresa; Neilly, Claire; Robinson, NicolaJ; Troughton, Elizabeth
Cc: Robinson, Katherine
Subject: Patients awaiting results
Importance: High

Hi all

I just need to clarify this process.

If a consultant states in letter " I am requesting CT/bloods etc etc and will review with the result. These patients ALL need to be DARO first pending the result not put on waiting list for an appointment at this stage. There is no way of ensuring that the result is seen by the consultant if we do not DARO, this is our fail safe so patients are not missed. Not always does a hard copy of the result reach us from Radiology etc so we cannot rely on a paper copy of the result to come to us.

Only once the Consultant has seen the result should the patient be then put on the waiting list for an appointment if required and at this stage the consultant can decide if they are red flag appointment, urgent or routine and they can be put on the waiting lists accordingly.

Can we make sure we are all following this process going forward

Collette McCaul
Acting Service Administrator (SEC) and EDT Project Officer
Ground Floor
Ramone Building
CAH
Ext Personal Information redacted by USI

Corrigan, Martina

From: Robinson, Katherine [redacted]
Sent: 07 February 2019 10:00
To: Haynes, Mark; O'Brien, Aidan; McCaul, Collette
Cc: Young, Michael; Glackin, Anthony; ODonoghue, JohnP; 'derek.hennessey[redacted]'; Corrigan, Martina
Subject: RE: Patients awaiting results

Folks

Can I just back this up by saying that Dr Rankin introduced this process trust wide many years ago due as a result of safety issues with patients. It actually increases secretarial work load due to extra checks but this is in the best interest of patients. I am aware Mr O'Brien that your secretary in particular does not use DARO in all cases and will put patients directly on the review waiting list as per your instruction. I have expressed my concern with her not implementing the DARO process fully.

Collette McCaul is the Line Manager to Urology, ENT, Opthalmology and Oral Surgery, it is her responsibility to follow directives and remind staff of processes that are in place. Collette was merely doing her job.

Regards

Katherine

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

t: [redacted]
e: [redacted]

From: Haynes, Mark
Sent: 07 February 2019 06:24
To: O'Brien, Aidan; McCaul, Collette; Robinson, Katherine
Cc: Young, Michael; Glackin, Anthony; ODonoghue, JohnP; 'derek.hennessey[redacted]'; Corrigan, Martina
Subject: RE: Patients awaiting results

Morning

The process below is not a urology process but a trust wide process. It is intended, in light of the reality that patients in many specialities do not get a review OP at the time intended (and can in many cases take place years after the intent), to ensure that scans are reviewed and in particular unanticipated findings actioned. Without this process there is a risk that patients may await review without a result being looked at. There have been cases (not urology) of patients imaging not being actioned and resultant delay in management of significant pathologies. As stated this is a trust wide governance process that is intended to ensure there are no unactioned significant findings. There is no risk in the process described.

If the patient described has their scan in May, the report will be available to you and can be signed off and the patient planned for review in June, there is no delay to the patients care. The DARO list is reviewed regularly by the

secretarial team and would pick up if the scan has been done but you hadn't received the report, if the scan hasn't been done etc.

It may be ideal that such a patient described would be placed on both the DARO list and a review OP WL but PAS does not allow for this.

I have no issue (as a clinician or as AMD) with the process described as it does not risk a patient not being seen and acts as a safety net for their test results being seen.

Mark

From: O'Brien, Aidan
Sent: 06 February 2019 23:33
To: McCaul, Collette
Cc: Young, Michael; Glackin, Anthony; Haynes, Mark; ODonoghue, JohnP; 'derek.hennessey[redacted]'; Corrigan, Martina
Subject: FW: Patients awaiting results
Importance: High

Dear Ms. McCaul,

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Cc: Robinson, Katherine
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Can we make sure we are all following this process going forward

Collette McCaul
Acting Service Administrator (SEC) and EDT Project Officer
Ground Floor
Ramone Building
CAH

Ext Personal Information redacted by USI

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 01 October 2015 14:39
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Suresh, Ram; Young, Michael
Subject: FW: Datix Incident Report Number [redacted]

Good afternoon

Ciara submitted this IR1 yesterday.

Any comments?

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: [redacted]
Mobile: [redacted]
Email: [redacted]

-----Original Message-----
From: datix [redacted] [redacted]
Sent: 30 September 2015 11:03
To: Corrigan, Martina
Subject: Datix Incident Report Number [redacted]

An incident report has been submitted via the DATIX web form.

The details are:

Form number: [redacted]

Description:

Over the past few weeks it has been an area of concern that Discharge Letters are not being completed on day of discharge.

Informed by the ward clerk today that currently there are 13 discharge letters not done and when she approached the FY1 she was informed that they were to busy and didnt have time to do them.

This is cause for concern for missed reviews appointments and Gp follow ups.

FY1's have expressed concern that they are under pressure and are unable to complete all their duties and it is usually the discharging that suffers.

Please go to [redacted] view and approve it.

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 01 July 2016 13:37
To: Rocks, Cathy
Cc: Moorcroft, Caroline
Subject: FW: Datix Incident Report Number [redacted]
Attachments: incident occurred involving late rota staff 28/6/16 (9.63 KB)

Importance: High

For your information and action

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology & Outpatients Southern Health and Social Care Trust Craigavon Area Hospital

Telephone: [redacted]
Mobile: [redacted]
Email: [redacted]

-----Original Message-----
From: Carroll, Ronan
Sent: 01 July 2016 13:25
To: Sharpe, Dorothy
Cc: Corrigan, Martina
Subject: RE: Datix Incident Report Number [redacted]
Importance: High

Dorothy
Tks - swift action taken and from the attached email I think they got the message. I would ask for the RN's to reflect on this incident and to include this incident in their revalidation portfolio Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

-----Original Message-----
From: Sharpe, Dorothy
Sent: 01 July 2016 12:44
To: Carroll, Ronan
Cc: Corrigan, Martina
Subject: FW: Datix Incident Report Number [redacted]

fyi

Dorothy Sharpe
Lead Nurse SEC
Ext [redacted] –CAH
MOB - [redacted]

-----Original Message-----
From: Rocks, Cathy
Sent: 01 July 2016 12:42
To: Sharpe, Dorothy
Cc: Moorcroft, Caroline; Corrigan, Martina
Subject: FW: Datix Incident Report Number [redacted]

Hi Dorothy

Please see attached correspondence from Caroline whom investigated same immediately once reported to her by Hca [redacted]. Due to the seriousness of same, I informed Martina and we both felt it warranted a datix. I intend to speak to all staff at time of incident when they next on duty and responsibilities will be discussed at our July staff meeting.

From a security perspective, the Ramone dept is fob locked after these ladies leave at 5.45pm and security is required to open same.

Regards

Cathy

-----Original Message-----
From: Sharpe, Dorothy
Sent: 01 July 2016 12:32
To: Rocks, Cathy; Moorcroft, Caroline
Subject: FW: Datix Incident Report Number [redacted]

Hi girls ... do you have a wee update
D

Dorothy Sharpe
Lead Nurse SEC
Ext [redacted] –CAH
MOB - [redacted]

-----Original Message-----
From: datix [redacted] [[redacted]]
Sent: 01 July 2016 10:43
To: Sharpe, Dorothy
Subject: Datix Incident Report Number [redacted]

An incident report has been submitted via the DATIX web form.

The details are:

Form number: [redacted]

Description:

in adherence to protocol re safe storage of drugs - staff working to 17:45 failed to lock away rheumatology drugs (lidocaine, kenalog, depomedorone) - same left in clinical room 2 overnight (Ramone OPD) staff reporting on duty at 08:30 29/6/16 (HCA [redacted]) discovered the above and reported same to SN [redacted] who was in charge in Ramone OPD in the am

Please go to [redacted] to view and approve it.

Corrigan, Martina

From: Moorcroft, Caroline [redacted]
Sent: 29 June 2016 14:18
To: Rocks, Cathy
Subject: incident occurred involving late rota staff [redacted]

Hi Cathy
FYI -
Synopsis of events:

- HCA [redacted] reported to [redacted] this am that the rheum trolley containing drugs was left in room 6 overnight
- Staff on the late rota [redacted] – [redacted]
- Following investigation – [redacted] had reported prior to going off at 5.15pm to [redacted] that the room needed cleared, cleaned, charts sorted etc (she reported to [redacted] was tied up dealing with a patient who she subsequently had to bring to A&E)
- All ladies spoken too by me individually and informed that: this was a very serious matter (as drugs were left unlocked for possible exposure to anyone and the consequences of them being used in an inappropriate way could have been detrimental/catastrophic): total inadequacy on the staff's behalf re: their diligence etc
- [redacted] was asked why she left the room in the state it was given she was the one [redacted] had handed over too? She said she started to clear the room and was called away by a Doctor. She further went on to affirm that when she returned to the department her colleagues had told her all the rooms were sorted. She assumed same acted upon and left for home. I asked her who she had asked to complete the duty of clearing the room to which she informed me "no one". I then asked her how she was satisfied to conclude that the task in question was adhered too? She did not reply
- [redacted] were able to inform me that the charts and general tidying up were completed. The drugs were not locked away and removed from the room nor was the cleaning sign sheet signed
- I asked all staff in question "who attended to the general tidying up because in my opinion it was their failings re the sign sheet and drugs". No one admitted to this and said "it was not me". In my opinion someone is omitting to tell the truth. All ladies also were informed by me that I would be escalating to you

Datix has not been submitted for us to discuss on your return

Caroline

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 26 May 2016 15:52
To: Sheridan, Patrick
Cc: McVey, Anne
Subject: Re: Datix Incident Report Number [redacted]

Thanks Patrick.

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Craigavon Area Hospital
Telephone: [redacted]
Mobile : [redacted]
Original Message
From: Sheridan, Patrick
Sent: Thursday, 26 May 2016 13:27
To: Corrigan, Martina
Subject: RE: Datix Incident Report Number [redacted]

Hey

This is sorted.

Kind regards

Patrick

-----Original Message-----
From: Corrigan, Martina
Sent: 25 May 2016 21:51
To: Sheridan, Patrick
Subject: Fw: Datix Incident Report Number [redacted]

Hi Patrick

Can you advise if this is sorted.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Craigavon Area Hospital
Telephone: [redacted]
Mobile : [redacted]
Original Message

From: McVey, Anne [redacted] >
Sent: Wednesday, 25 May 2016 17:05
To: Corrigan, Martina; Sheridan, Patrick
Cc: CAH, BEDMANAGER
Subject: FW: Datix Incident Report Number [redacted]

Martina and Patrick, see below can you ensure this patient is under the appropriate Consultant.

Regards Anne

Anne McVey
Assistant Director of Acute Services
Medicine and Unscheduled Care Division
Tel: [redacted]
Mobile: [redacted]
Email: [redacted] @ [redacted]

-----Original Message-----
From: datix [redacted] [[redacted]]
Sent: 25 May 2016 10:00
To: Bradley, Una
Subject: Datix Incident Report Number [redacted]

An incident report has been submitted via the DATIX web form.

The details are:

Form number: [redacted]

Description:

Patient was under my care on Monday, Dx with acute appendix and taken to theatres Mon afternoon/evening. Yesterday patient was in recovery ward and I (medical cons) was still the named consultant. I phoned down to Recovery and spoke to one of the nurses (unfortunately I did not get her name). I explained that given the patient is post-op she should be under the surgeons. I was asked "has the patient been accepted surgically?" I informed the nurse that the patient had a surgical issue and had an operation for this. I was told "I will have to discuss this with the registrar to see if she has been accepted surgically". The patient is now in 3S elective ward and I am still the named consultant.

Please go to h[redacted]
approve it.

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 18 May 2016 07:50
To: Burke, Mary
Subject: FW: Datix Incident Report Number [redacted]

Mary

Please see below - patient name was [redacted]

Regards

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: [redacted]
Mobile: [redacted]
Email: [redacted] @ [redacted]

-----Original Message-----
From: datix [redacted]]
Sent: 18 May 2016 03:05
To: Corrigan, Martina
Subject: Datix Incident Report Number [redacted]

An incident report has been submitted via the DATIX web form.

The details are:

Form number: [redacted]

Description:

Patient transferred to 3 south from A&E, on arrival to ward patient information on kardex not matching the patient information handed over or on A&E admission booklet. Wrong name, address, H&C number and D.O.B. Medications had been administered from this kardex prior to transfer to ward.

[redacted] to view and approve it.

Corrigan, Martina

From: Corrigan, Martina
Sent: 07 February 2016 18:33
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Suresh, Ram; Young, Michael; Farnan, Turlough; Korda, Marian; Leyden, Peter; McCaul, David; Reddy, Ekambar; Hall, Sam; Ted McNaboe [redacted]
Subject: FW: Radiology and Patholoy results

Dear all

See below from Heather

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: [redacted]
Mobile: [redacted]
Email: [redacted]

From: Trouton, Heather
Sent: 29 January 2016 12:51
To: McAlinden, Matthew
Cc: Mackle, Eamon; Corrigan, Martina; Nelson, Amie; Reid, Trudy
Subject: FW: Radiology and Patholoy results

Could you please send the email below to all the consultant?

Happy to discuss if required
Thanks

Heather

From: Trouton, Heather
Sent: 18 January 2016 14:49
To: Trouton, Heather
Subject: Radiology and Patholoy results

Dear All

Following the outcomes of several SAI's, we are writing to remind all consultants that it is their personal responsibility to have checked and signed all radiology and pathology reports to assure that no serious results are missed.

Any concerns regarding the process of how these get to your attention should be raised with your secretary in the first instance.

Kind regards
Eamon and heather

Corrigan, Martina

From: Corrigan, Martina
Sent: 20 July 2016 12:35
To: Carroll, Ronan; Rocks, Cathy
Subject: RE: flooring outpatients corridor - CAH
Attachments: FW: flooring outpatients corridor - CAH; RE: DatixWeb feedback message; FW: Datix Incident Report Number [redacted]; Datix Incident Report Number [redacted]

Ronan,

There has been a datix and follow-up on this – see attached emails

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: [redacted]
Mobile : [redacted]

From: Carroll, Ronan
Sent: 19 July 2016 19:44
To: Rocks, Cathy; Corrigan, Martina
Subject: Fwd: flooring outpatients corridor - CAH

FYI - had we identified this area?

Ronan Carroll
Assistant Director Acute Services
ATICs/ Surgery & Elective Care
[redacted]

Begin forwarded message:

> **From:** "Conway, Barry" [redacted]
> **Date:** 19 July 2016 at 13:13:25 BST
> **To:** "Bloomer, Mark" [redacted]
> **Cc:** "Carroll, Ronan" [redacted]
> **Subject: flooring outpatients corridor - CAH**
>
> Mark,
>
> There is an area on the main corridor in OPD CAH that has become a tripping hazard – one patient tripped there this week (thankfully the patient did not sustain any injury).
>
> I understand this has been logged with you as a works item.
>
> The porters had flagged this to me therefore I agreed to check where it was in the system.
>
> Ronan – copying to you as this is in the OPD.

Barry.

Mr Barry Conway
Assistant Director – Acute Services
Strategy, Reform and Service Improvement
Southern Health and Social Care Trust
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

Corrigan, Martina

From: Rocks, Cathy
Sent: 19 July 2016 13:55
To: Corrigan, Martina
Cc: Moorcroft, Caroline
Subject: FW: flooring outpatients corridor - CAH

Hi Martina

Fyi

Update: estates have red and white tape surrounding 4 areas of uneven, dipped floor surface on the corridor now. I am not being cynical but I think the reason she brought me chocs was to observe the floor surface again.

Regards

cathy

From: Conway, Barry
Sent: 19 July 2016 13:14
To: Rocks, Cathy
Subject: FW: flooring outpatients corridor - CAH

For info..

From: Conway, Barry
Sent: 19 July 2016 13:13
To: Bloomer, Mark
Cc: Carroll, Ronan [redacted]
Subject: flooring outpatients corridor - CAH

Mark,

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Ronan – copying to you as this is in the OPD.

Barry.

Mr Barry Conway
Assistant Director – Acute Services
Strategy, Reform and Service Improvement
Southern Health and Social Care Trust
Mobile: [redacted]
Email: [redacted]

Corrigan, Martina

From: Rocks, Cathy
Sent: 18 July 2016 15:03
To: Bloomer, Mark
Cc: Moorcroft, Caroline; Corrigan, Martina
Subject: RE: DatixWeb feedback message

Hi Mark

Excellent - thank you so much, I will let my HOS know.

Regards

Cathy

Out-Patients Manager
Craigavon Area Hospital
Ext [redacted]
Mob [redacted]
Email: [redacted]
'You can follow us on Facebook and Twitter'

-----Original Message-----
From: Bloomer, Mark
Sent: 18 July 2016 15:01
To: Rocks, Cathy
Cc: 'Peter Black'
Subject: RE: DatixWeb feedback message

Cathy

Please see attached order issued 06.07.2016 to the contractor for the works to the flooring so it should be happening very soon.

Kind regards

Mark Bloomer RIBA FIHEEM
Assistant Head of Estates Development and Capital Works
Southern Health and Social Care Trust
Direct Line [redacted] Mob [redacted]

-----Original Message-----
From: Cathy Rocks [mailto:[redacted]]
Sent: 18 July 2016 14:51
To: Bloomer, Mark

Subject: DatixWeb feedback message

This is a feedback message from Cathy Rocks. Incident form reference is [redacted]
The feedback is:
Good afternoon Mark, please see link to Datix [redacted] in relation to fall possibly due to uneven floor surface in Main OPD corridor, outside room 29. This has been included in our recent Minor works submission, which you had advised was under going assessment. Due to this incident, can I escalate same as urgent and needing your depts. intervention/direction please.

kind regards

Cathy Rocks

OPD Manager
Craigavon Hospital ext [redacted]

Please go to http://v[redacted] to view the incident

Corrigan, Martina

From: Rocks, Cathy
Sent: 18 July 2016 15:07
To: Corrigan, Martina
Cc: Moorcroft, Caroline
Subject: FW: Datix Incident Report Number [redacted]
Attachments: OUTPATIENTS - [Personal information redacted by USI]

Importance: High

Hi Martina

Please see below datix which I submitted this am. Please note I have same recorded on datix system as under review by me and have sent action plan request and feedback message to Mr Mark Bloomer in Estates as this was escalated to him and estates team via minor works requisition and he advised me that he was assessing same.

Patient left ED dept without treatment as per Triage nurse in ED. [Personal information redacted by USI] [redacted]

She left the dept, appeared well and was [Personal information redacted by USI] [redacted]

Actions to date:

1. minor works (urgent)- resubmitted ref no: 271526 2. caution signs (caution uneven floor surface) erected in 3 areas of corridor in main opd on the main thoroughfare from waiting room to physio dept.
3. datix action plan commenced and feedback message request to Mark Bloomer, Estates who advised of works order that should be scheduled very soon- please see attachment [Personal information redacted by USI]

I will keep you in the loop- Is there anything else you wish me to do at this stage?

Many thanks

Cathy

Out-Patients Manager
Craigavon Area Hospital
Ext :2605
Mob: [Personal information redacted by USI]
Email: [Personal Information redacted by USI] [redacted]
'You can follow us on Facebook and Twitter'

-----Original Message-----
From: datix[redacted] [redacted]]
Sent: 18 July 2016 13:13
To: Rocks, Cathy
Subject: Datix Incident Report Number [redacted]

An incident report has been submitted via the DATIX web form.

The details are:

Form number: [redacted]

Description:

service user en route to audiology dept was reported to myself as collapsed walking down corridor outside room 29, (Sisters office). on observation, she appeared conscious/alert and no apparent injuries observed. person concerned advised of no pain and no injuries to self. she stated that she usually uses a walking stick but left same in the car but tripped due to uneven floor surface at area of fall. person concerned advised that she was due insulin and BM was 23mmols at 11.50approx. BP,188/86 pulse:79 spo2:98%. person concerned was able to stand with assistance of 2 and was transferred to a wheelchair for transport to E.D.
staff completed her visit her behalf to audiology and informed them and her of outcome.

Please go to http://v[redacted] view and approve it.

Corrigan, Martina

From: Bruce, Jan [redacted]
Sent: 06 July 2016 15:33
To: Gary Black [redacted]
Cc: [redacted]'; Bloomer, Mark
Subject: OUTPATIENTS - [redacted]
Attachments: SKMBT_C22016070615260.pdf

ORDER ATTACHED

Jan Bruce
Estate Management Dept.
Tower Block
Craigavon Area Hospital
68 Lurgan Road
PORTADOWN
BT63 5QQ

From: jan.bruce[redacted] [mailto:[redacted]]
Sent: 06 July 2016 16:27
To: Bruce, Jan
Subject: Message from KMBT_C220

Corrigan, Martina

From: Bruce, Jan [redacted]
Sent: 06 July 2016 15:33
To: Gary Black [redacted]
Cc: 'maintenance[redacted] Bloomer, Mark
Subject: OUTPATIENTS - [redacted]
Attachments: SKMBT_C22016070615260.pdf

ORDER ATTACHED

Jan Bruce
Estate Management Dept.
Tower Block
Craigavon Area Hospital
68 Lurgan Road
PORTADOWN
BT63 5QQ

From: [redacted]@[redacted] [mailto[redacted]
Sent: 06 July 2016 16:27
To: Bruce, Jan
Subject: Message from KMBT_C220

Corrigan, Martina

From: Datix
Sent: 18 July 2016 13:13
To: Corrigan, Martina
Subject: Datix Incident Report Number [redacted]

An incident report has been submitted via the DATIX web form.

The details are:

Form number: [redacted]

Description:

service user en route to audiology dept was reported to myself as collapsed walking down corridor outside room 29, (Sisters office). on observation, she appeared conscious/alert and no apparent injuries observed. person concerned advised of no pain and no injuries to self. she stated that she usually uses a walking stick but left same in the car but tripped due to uneven floor surface at area of fall. person concerned advised that she was due insulin and BM was 23mmols at 11.50approx. BP,188/86 pulse:79 spo2:98%. person concerned was able to stand with assistance of 2 and was transferred to a wheelchair for transport to E.D.
staff completed her visit her behalf to audiology and informed them and her of outcome.

Please go to http[redacted] to view and approve it.

Corrigan, Martina

From: Evans, Marie
Sent: 02 May 2019 11:11
To: Carroll, Ronan; Robinson, Katherine; Carroll, Anita; Corrigan, Martina
Cc: Tyson, Matthew; Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael
Subject: Backlog Report - April 2019
Attachments: UROLOGY.xlsx

Dear All,

Please find attached Backlog Report for April 2019.

If you have any queries please don't hesitate to contact me.

Kind Regards

Marie Evans
Service Administrator (SEC)
Ground Floor
Ramone Building

T: Personal Information redacted by USI
E: Personal Information redacted by USI

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinics to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Aslam							
Mr Glackin	2 (Dec/Jan)	8 (26.01.17)	0	37 (25.01.17)	86 (Jan/Feb)	15 (31.01.17)	2 lever arch files
Mr Haynes	0	0	0	4 (Jan 17)	12 (Jan 17)	63 (Dec/Jan)	Nil recorded
Mr Jakob							
Mr O'Brien	11	0	0	20 (02.02.17)	20	0	6 lever arch files
Mr O'Donoghue	0	0	0	0	0	7 (02.02.17)	1 lever arch file
Mr Suresh							
Mr Young							
Sub Speciality Totals							

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinics to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Alsam	0	0	0	0	5 (21.02.17)	0	1 lever arch file
Mr Brown	0	0	0	0	15 (20.02.17)	0	
Mr Suresh	0	0	0	0	4 (Jan 17)	0	
Mr Glackin	3 (Jan 17)	4 (10.02.17)	2 (06.02.17)	33 (03.02.17)	30 (Feb 17)	28 (10.02.17)	2 lever arch file blocks
Mr Haynes	0	0	0	8 (23.02.17)	25 (Mid Feb 17)	0	approx 50 sheets
Mr Jakob	0	0	0	0	37 (Jan/Feb)	0	
Mr O'Brien	0	0	0	0	0	0	6 lever arch files
Mr O'Donoghue	0	0	0	4 (17.02.17)	0	11 (15.02.17)	1 lever arch file
Mr Young							
Sub Speciality Totals							

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinics to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Aslam							
Mr Glackin	0	8 (20.03.17)	0	19 (21.03.17)	18 (March)	6 (24.03.17)	2 1/4 lever arch files
Mr Haynes	0	0	0	34 (24.03.17)	5 (March 17)	40 (29.03.17)	ICATS & Mr Haynes - 80
Mr Jakob							
Mr O'Brien							
Mr O'Donoghue	0	0	0	0	0	0	1 lever arch file
Mr Suresh							
Mr Young							
Sub Speciality Totals							

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinics to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Alsam							
Mr Jakob							
Mr Suresh							
Mr Glackin	2 (Mar/Apr 17)	8 (13.04.17)	2 (04.04.17)	11 (10.04.17)	100 (Various)	32 (06.04.17)	2 1/2 lever arch files
Mr Haynes	0	0	0	0	25 (April 17)	10 (April 17)	45 sheets
Mr O'Brien							
Mr O'Donoghue	0	0	0	0	0	0	1 lever arch file
Mr Young							
Sub Speciality Totals							

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinics to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Alsam/Suresh							1 lever arch file
Mr Jakob	0	0	0	0	58 (May)	2 (23.05.17)	
Mr Glackin	10 (April/May 17)	13 (28.04.17)	1 (04.04.17)	35 (03.05.17)	21 (May 17)	19 (16.05.17)	3 lever arch files
Mr Haynes (& ICATS)	0	0	0	4 (16.05.17)	40 (May 17)	0	65 sheets
Mr O'Brien	0	0	0	6 (11.05.17)	4	0	Approx 6 lever arch files
Mr O'Donoghue	0	0	0	62 (10.05.17)	0	8 (16.05.17)	1 lever arch file
Mr Young							
Sub Speciality Totals	**10**	**13**	**1**	**107**	**119**	**27**	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinic letters to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Alsam/Suresh							1 lever arch file
Mr Jakob	0	2 (23.06.17)	0	23 (22.06.17)	20 (June)	8 (June)	
Mr Glackin	6 (May/June)	5 (14.06.17)	2 (06.06.17)	18 (13.06.17)	67 (May/June)	8 (14.06.17)	3 1/2 lever arch block files
Mr Haynes	0	7 (26.06.17)	0	0	0	0	60 sheets
Mr O'Brien	8 (03.05.17)	0	0	0	4	0	Approx 6 lever arch files
Mr O'Donoghue	0	0	0	59 (14.06.17)	0	20 (15.06.17)	1 lever arch file
Mr Young							
Sub Speciality Totals	**14**	**14**	**2**	**100 (13.06.17)**	**91**	**36**	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinic letters to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Alsam - No longer here							1 lever arch file
Mr Jakob	0	9 (21.07.17)	0	14 (19.07.17)	20 (21.07.17)	16 (18.07.17)	
Mr Suresh - No longer here							
Mr Glackin	23 (11.07.17)	6 (june/July)	4 (04.04.17)	18 (11.07.17)	47 (July 17)	30 (13.07.17)	3 1/2 file blocks
Mr Haynes	0	0	0	3 (20.07.17)	8 (July 17)	0	50 Sheets
Mr O'Brien	9 (27.06.17)	0	0	0	14	0	6 lever arch files
Mr O'Donoghue	0	0	0	0	0	0	1 lever arch file
Mr Young	30 (Nov 16)	0	0	0	12 (May 17)	0	Approx 1 1/2 box files
Sub Speciality Totals	**62**	**15**	**4**	**35**	**101**	**46**	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinic letters to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Alsam	Left						1 lever arch file
Mr Jakob	0	0	0	11 (31.08.17)	0	2 (28.08.17)	
Mr Suresh							
Mr Glackin	2 (July 17)	3 (25.08.17)	6 (04.04.17)	0	75	18 (24.08.17)	2 3/4 lever arch files
Mr Haynes	0	0	0	0	10 (Aug 17)	0	40 sheets
Mr O'Brien	10 (24.08.17)	1 (02.09.17)	0	0	35	0	1 small file & Monica backlog
Mr O'Donoghue	0	0	0	0	0	4 (22.08.17)	1 lever arch file
Mr Young	38 (Nov 16)	0	0	0	31 (July 17)	0	Approx 1 1/2 lever arch files
Sub Speciality Totals	**50**	**4**	**6**	**11**	**151**	**24**	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinic letters to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Jakob	0	0	0	12 (02.10.17)	35 (25.09.17)	5 (18.09.17)	1 lever arch file
Mr Suresh							
Mr Glackin	1 (Sept)	7 (10.09.17)	2 (06.06.17)	28 (12.09.17)	8 (11.09.17)	7 (22.09.17)	2 1/4 lever arch file
Mr Haynes	0	0	0	0	7 (26.09.17)	0	60 documents
Mr O'Brien	13 (27.06.16)	0	0	0	6	0	6 lever arch files
Mr O'Donoghue	0	0	0	0	0	7 (21.09.17)	1 lever arch file
Mr Young	11 (Jan 17)	17	0	2 (28.09.17)	17 (July 17)	0	1 1/2 lever arch files
Sub Speciality Totals	**25**	**24**	**2**	**42**	**67**	**19**	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinic letters to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Jakob	0	0	0	6 (25.10.17)	34 (25.09.17)	5 (23.10.17)	
Mr Suresh							
Mr Glackin	4 (Oct 17)	6 (24.10.17)	2 (06.06.17)	1 (30.10.17)	81 (16.10.17)	0	2 1/2 Lever arch files
Mr Haynes	0	0	0	0	2 (29.10.17)	26 (30.10.17)	70 sheets
Mr O'Brien	13 (27.06.16)	0	0	0	3	0	Approx 6 lever arch files
Mr O'Donoghue	0	0	0	14 (24.10.17)	0	21 (24.10.17)	1 lever arch file
Mr Young	20 (Jan 17)	0	0	2 (02.11.17)	14 Cons, 11 Reg, July 17	0	1 1/2
Sub Speciality Totals	**37**	**6**	**2**	**23**	**145**	**52**	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinic letters to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Jakob	0	0	0	3 (29.11.17)	11 (27.11.17)	35 (20.11.17)	1 lever arch file
Mr Suresh							
Mr Glackin	3 (Nov)	3 (24.11.17)	3 (06.06.17)	2 (21.11.17)	80 (Oct)	7 (15.11.17)	3 lever arch files
Mr Haynes	0	10 (22.11.17)	0	0	1 (27.11.17)	23 (23.11.17)	60 sheets
Mr O'Brien	12 (27.06.16)	0	0	0	2	0	Approx 6 lever arch files
Mr O'Donoghue	0	0	0	14 (22.11.17)	0	11 (23.11.17)	1 lever arch file
Mr Young	3 (Feb 17)	0	0	36 (27.11.17)	15 MY, 17 Reg, July 17	0	1 1/2 lever arch files
Sub Speciality Totals	**18**	**13**	**3**	**55**	**126**	**76**	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinics to be dictated	Clinic letters to be typed	Results to be dictated	Results to be typed	Filing
Mr Jakob							
Mr Suresh							
Mr Glackin							
Mr Haynes							
Mr O'Brien							
Mr O'Donoghue							
Mr Young							
Sub Speciality Totals							

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinic letters to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Jakob	0	0		3 clinics (03.01.17	20 (01.1.17)	20 (25.12.17)	1 lever arch file
Mr Suresh	0	0					
Mr Glackin	2	2	2 charts 06.06.17	21 (into jan)	37	8 (26.12.17)	2.5 lever arch files
Mr Haynes	0	10 (29.12.17	0	0	0	22 (28.12.17)	80 sheets
Mr O'Brien	12	0	0	7 clinics (29.12.17)	6	0	6 lever arch files
Mr O'Donoghue	0	0		17	0	13 (19.12.17)	lever arch file
Mr Young	Secretary on AL						
Sub Speciality Totals	**22**	**10**	**2**	**approx 100**	**63**	**63**	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics (no of charts) to be dictated**	**Clinic letters to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Jakob	0	0	0	0	0	0	lever arch file
Mr Suresh	0	4		14 (05.02.18)	15 (05.02.18)	6	
Mr Glackin	0	12	1	1	84 (12.01.18)	9 (31.01.18)	lever arch file
Mr Haynes	0	0	0	7 (25.1.18)	2 (29.01.18)	29 (04.02.18)	lever arch file
Mr O'Brien	12	0	0	0	6		6 lever arch files
Mr O'Donoghue	0	0	0	22 (31.01.18)	0	16 (01.02.18)	1 lever arch file
Mr Young							
Sub Speciality Totals							

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinic letters to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Jakob	0	3	0	15	15	19	1 file
Mr Suresh							
Mr Glackin	6	0	10	67	2	12	1 file
Mr Haynes	0	0	0	5	0	9	1 file
Mr O'Brien	21	0	0	0	8	0	6 files
Mr O'Donoghue	0	0	0	48	0	3	1 file
Mr Young	6	0	0	0	6	0	1.5
Sub Speciality Totals	**33**	**3**	**10**	**130**	**31**	**40**	

(all within march)

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics LETTERS to be dictated**	**Clinic letters to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Jakob	0	10 (13.04.18)	0	15 (12.04.18)	0	40 (09.04.18)	2 lever arch files
Mr Suresh							
Mr Glackin	3	10	15 (28.03.18)	1	98 (02.04.18)	3	
Mr Haynes	0	0	0	0	10 (05.04.18)	15 (15/04/18)	70 sheets
Mr O'Brien	30 (06.04.18)	0	0	57 (27.03.18)	10	0	6 lever arch files
Mr O'Donoghue	0	0	0	57 (10.04.18)	0	10 (12.04.18)	1 lever arch file
Mr Young	9	0	1	0	39 (March/April)	0	2 BOXES
Sub Speciality Totals	**42**	**20**	**16**	**129**	**157**	**65**	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics letters to be dictated**	**Clinic letters to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Jakob	0	2	0	3	30 (23.04.18)	0	
Mr Glackin	4	6	3	15 (25.04)	8	14	2 lever arch
Mr Haynes	0	0	0	6 (26.04.18)	12 (16.04.18)	32 (27.4.18)	
Mr O'Brien	9 (01.18)	0	0	1 (27.04.18)	14 (Reg 2017)	28	2 boxes
Mr O'Donoghue	0	0	0	26	0	12	1 lever arch
Mr Young	no sec response						
Sub Speciality Totals	**13**	**8**	**3**	**37**	**56**	**86**	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics (charts) to be dictated**	**Clinic letters to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Jakob	0	3	0	19	16	22	1 file
Mr Glackin	1	10	4	21 (25.05)	84 (14.05)	13	1 box
Mr Haynes							
Mr O'Brien	20	17	54 (10.04.18)	12	8	0	6 files
Mr O'Donoghue	0	0	0	0	0	6	1 lever arch file
Mr Young	15 (Jan 18)	0	0	0	38	0	2 boxes
Sub Speciality Totals							

UROLOGY	Backlog - Number of charts with oldest date in brackets							
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	Results to be typed	Filing
Mr Jakob	10	10	0	0		40	14	1 file
Mr Glackin	1	1	3	7	27.06	84	0	2 files
Mr Haynes	0	0	0	6	29.06.18	44	0	
Mr O'Brien								6 files
Mr O'Donoghue	0	0	0	6		0	23	1 file
Mr Young	0	0	0	0		38	38	2 boxes
Sub Speciality Totals	**11**	**11**	**3**	**19**		**206**	**75**	

UROLOGY	Backlog - Number of charts with oldest date in brackets								
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	Results to be typed	Filing
Mr Jakob	7	7	0		2	06.08.18	60	60	1 file
Mr Glackin	10	13	9	july	0		44	3	2 files
Mr Haynes	0	0	0		23	02.08.18	8	70	
Mr O'Brien	31		44	08.05.18	17	06.08.18	10	0	6 files
Mr O'Donoghue	0	0	0		3		0	47	1 file
Mr Young	0	0	0		12	01.08.18	0	4	2 boxes
Sub Speciality Totals	**48**	**20**	**53**		**57**		**122**	**184**	

UROLOGY	Backlog - Number of charts with oldest date in brackets								
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	Results to be typed	Filing
Mr Jakob	0	8	0		10	03.09.18	10	0	2 files
Mr Glackin	4	19	4	06.06.18	21	23.08.18	49	29	2 files
Mr Haynes	0	9	0		6	30.8.18	15	12	85 sheets
Mr O'Brien	17				81	01.06.18	5		6 files
Mr O'Donoghue					55	28.08.18	14	0	2 files
Mr Young	11	0	2	24.08.18	0		44	0	2 files
Sub Speciality Totals	**32**	**36**	**6**		**173**		**137**	**41**	

UROLOGY	Backlog - Number of charts with oldest date in brackets								
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	Results to be typed	Filing
Mr Jakob					18	25.09.18	30	0	3 files
Mr Glackin	5	6	7	06/06/2018 (1 letter)	11	26.09.18	29	5	1.5 files
Mr Haynes	0	0	19	26.09.18	0		55	0	115 sheets
Mr O'Brien	17	0	91	15.06.18	0				6 files
Mr O'Donoghue					15	26.09.18	12	0	2 files
Mr Young	12	0	0	0	2	27.09.18	35	0	2.5 files
Sub Speciality Totals	**34**	**6**	**117**		**46**		**161**	**5**	

UROLOGY	Backlog - Number of charts with oldest date in brackets											
Consultant	Discharges awaiting Dictation	oldest date	Discharges to be typed	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	oldest date	Results to be typed	oldest date	Filing
Mr Jakob	0	0	0	0		0		22	05.11.18	0		3 files
Mr Glackin	22	26.10.18	2	3	23.10.18	30	23.10.18	0		28	18.10.18	1.75 files
Mr Haynes	0		0	0		2	31.10.18	11	11.10.18	56	01.11.18	150 sheets
Mr O'Brien	17	27.06.16 GP has hard copy	25	0		8	02.11.18	7	6.2018	0		6 files all onoclogy filed
Mr O'Donoghue			2	0		38	29.10.18	28	11.10.18	18.10.18	01.11.18	2 files
Mr Young	12	Mar-18	0	0		26	01.11.18	10	october	0		3 files
Sub Speciality Totals	51		29	3		104		78		84		

UROLOGY	Backlog - Number of charts with oldest date in brackets											
Consultant	Discharges awaiting Dictation	oldest date	Discharges to be typed	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	oldest date	Results to be typed	oldest date	Filing
Mr Jakob	0		5	0		0		5	03.12.18	34	19.11.18	3 files
Mr Glackin	8	oct/nov	0	3	19.09.18	3	28.11.18	25	05.11.18	10	28.11.18	2 files
Mr Haynes	0		20	0		12	26.11.18	6	19.11.18	14	02.12.18	175 sheets
Mr O'Brien	13	27.06.16 gp has the hard copy	5	10	30.11.18	10	27.11.18	13		10		
Mr O'Donoghue	0	0	0	0	0	0	0	0	0	0	0	2 files
Mr Young	12		9	0		26		40		55		3 files
Sub Speciality Totals	**33**		**39**	**13**		**51**		**89**		**123**		

UROLOGY	Backlog - Number of charts with oldest date in brackets												
Consultant	Discharges awaiting Dictation	oldest date	Discharges to be typed	oldest date	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	oldest date	Results to be typed	oldest date	Filing
Mr Jakob	0		0		0		3	03.01.19	30	31.12.18	29	05.01.19	4 files
Mr Glackin	2	Nov-18	19	21.12.18	2	19.09.18	8	31.12.18	7	24.12.18	32	27.12.18	2 files
Mr Haynes	0		10	02.01.19	0		24	02.01.19	6	24.12.18	75	27.12.18	240 sheets
Mr O'Brien	15	27.06.18 but the handwritten discharge in the chart and GP has received a copy of this	10		nothing on report		13	12 of these are triage letters 05.01.19	10				6 files
Mr O'Donoghue	0		0		0		10	03.01.19	60	14.11.2018	24	03.01.19	3 files
Mr Young	0	-	0				11	04.01.19	32	december	27		3 charts
Sub Speciality Totals	17		39		2		69		145		187		

UROLOGY	Backlog - Number of charts with oldest date in brackets												
Consultant	Discharges awaiting Dictation	oldest date	Discharges to be typed	oldest date	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	oldest date	Results to be typed	oldest date	Filing
Mr Jakob	0	0	0	0	0	0	0	0	12	31.12.18	0	0	2 files
Mr Glackin	14	Nov-18	20	25.01.19	1	22.01.19	1	30.01.19	32	24.12.18	19	30.01.19	1.75
Mr Haynes	0	0	9	30.01.19	0	0	6	30.01.19	3	28.01.19	45	01.02.19	1 file
Mr O'Brien	14	27.06.18 but the handwritten discharge in the chart and GP has received a copy of this	5	03.02.19			16	02.02.19	6	02.02.19	2		6 files
Mr O'Donoghue	0	0	0	0	0	0	0	0	3	04.01.19	33	31.01.19	3 files
Mr Young	0	-	0	0	0	0	0	0	41		17	jan	3 files
Sub Speciality Totals	28		34		1		23		97		116		

UROLOGY	Backlog - Number of charts with oldest date in brackets												
Consultant	Discharges awaiting Dictation	oldest date	Discharges to be typed	oldest date	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	oldest date	Results to be typed	oldest date	Filing
Mr Tyson	0		0		0		6	25.03.19	14	February	6	25.03.19	2 lever arch files
Mr Glackin	1	Nov	4	26.03.19	0		27	26.03.19	28	11.02.19	15	26.03.19	2 lever arch files
Mr Haynes	0		5	25.03.19	0		22	26.03.19	37	12.03.19	23	23.03.19	1 lever arch file
Mr O'Brien	18	27.06.16	0		0		39	08.03.19	15	-	0		approx 6 lever arch files
Mr O'Donoghue	0		0		0		20	27.03.19	68	18.02.18	9	27.03.19	3 lever arch files
Mr Young	3	-	0	-	0		14	29.03.19	37	-	9	Feb-19	
Sub Speciality Totals	22		9		0		128		199		62		

UROLOGY	Backlog - Number of charts with oldest date in brackets												
Consultant	Discharges awaiting Dictation	oldest date	Discharges to be typed	oldest date	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	oldest date	Results to be typed	oldest date	Filing
Mr Tyson	0	-	6	24.04.19	0	-	0	-	14	15.04.19	5	25.04.19	
Mr Glackin	3	Mar-19	0	-	3	25.03.19	30	15.04.19	22	08.04.19	1	18.04.19	2 lever arch files
Mr Haynes	0	-	0	-	0	-	27	16.04.19	9	18.04.19	15	19.04.19	
Mr O'Brien	15	27.06.16	0	-	0	-	50	03.04.19	6	-	2	13.04.19	6 files
Mr O'Donoghue	0	-	0	-	0	-	0	-	26	11.04.19	0	-	3 files
Mr Young	2	Jan-19	0	-	0	-	24	19.04.19	23	-	10	-	4 box files
Sub Speciality Totals	20		6		3		131		100		33		

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Closed date
710	ACUTE	24/07/2008	Safe, High Quality and Effective Care	Risk of ENT micoscope failure - impact on patient safety and ability to treat	Risk of ENT microscope failure due to age and poor clinical visual quality - impact on patient safety and the ability to treat patients.	Regular maintenance.	10.05.10 - new microscope purchased - risk mitigated and closed.	VLOW	10/05/2010
713	ACUTE	25/07/2008	Safe, High Quality and Effective Care	Only one ENT drill and nerve monitor - no backup	ENT drill an nerve monitor - currently only one of each available; if fault with equipment, no backup and patients unable to be booked for procedure; this is compounded when dual lists are happening simultaneously and equipment required in both theatres.	List coordinated as far as possible to ensure the equipment is not needed at the same time, however this is not always successful.	10.05.10 - risk reviewed by MMcG + BM - new equipment purchased - risk mitigated and closed.	VLOW	10/05/2010
716	ACUTE	25/07/2008	Safe, High Quality and Effective Care	Flexible Ureteroscopes - currently only two available	Flexible Ureteroscopes - currently only two available in the department; very fine scopes with a very limited usage and break down frequently - happens at least every 3 months, usually unable to be repaired, only replaced.	Replaced as required but would need a minimum of two additional scpes to ensure lists not impacted; need to review the current scopes used and change to a different manufacturer, have a service contractt and then likelihood of the scope being repiared would be increased.	10.05.10 - risk reviewed by MMcG + BM - new equipment purchased - risk mitigated and closed.	VLOW	10/05/2010
720	ACUTE	25/07/2008	Safe, High Quality and Effective Care	Only 3 camera stacks for 5 theatres	There are currently 5 theatres in the department and only 3 camera stacks; impacts on lists and is exacerbated when sessions are back filled and similar specialities are operating at the same time; significant number of procedures require use of a camera stack, equipment used by general surgery, urology, ENT, gynae.	None.	10.05.10 - Risk reviewed by MMcG + BM - equipment purchased. Risk mitigated and closed.	VLOW	10/05/2010
724	ACUTE	25/07/2008	Safe, High Quality and Effective Care	Gastroscopes and colonoscopes lack adequate vision	Gastroscopes and Colonoscopes - clinicians have repeatedely highlighted the lack of adequate vision from scopes; risk that lesions will not be detected resulting in missed diagnosis; risk of procedures being cancelled due to lack of appropriate equipment, resulting in Trust not meeting patient access targets.	Scopes sent for repair as required, however when the scope no longer meets the visual need of the clinician due to age etc, the scope is removed from use.	10.05.10 - Risk reviewed by MMcG + BM - equipment purchased. Risk mitigated and closed.	VLOW	10/05/2010
728	ACUTE	25/07/2008	Safe, High Quality and Effective Care	Risk to staff when having to operate 3 different types of scopes and processors	Health and safety risk to staff when having to operate 3 different types of scopes and processors; 1) Olympus scopes and Olympus processor, 2) Pendax non-digital scopes and processor, 3) Digital Pentax scopes and processor; results in 3 times the number of processors being used than what is required to undertake a list; exacerbates number of cables etc. and increases risk of trips, fire hazard etc.	Staff vigilence; staff attempt to minimis risk by making best use of trolleys they have.			01/10/2009
766	ACUTE	29/07/2008	Safe, High Quality and Effective Care	CAH Day Surgery Unit Automatic Endoscope Reprocessor not compliant	Automatic Endoscope Reprocessor (AER) in CAH Day Surgery Unit is not compliant with HTM 2030 and the Hine review recommendations 2004 - no independent channel monitoring, no reverse osmosis water, leading to potential infection control risk to patients; this 2 chamber AER is designed to decontaminate 2 scopes per chamber; the new digital gastroscopes and colonoscopes are too large to allow 2 scops to be adequately decontaminated together in the same chamber, leading to a 50% reduction capacity for endoscopy lists; the 3 hour time limit on the use of scopes following disinfection compounds this even further.	A control measure for water quality only is in place - weekly monitoring of water quality.	Interim papers have been submitted to SMT March 2008. 10.05.10 AER now replaced and compliant with HTM 2030 - risk mitigated and closed	HIGH	10/05/2010
781	ACUTE	29/07/2008	Safe, High Quality and Effective Care	CAH Day Surgery AER has insufficient capacity	The 2 chamber AER in CAH Day Surgery is designed to decontaminate 2 scopes per chambers; the new digital gastroscopes and colonoscopes are too large to allow 2 scopes to be adequately deconaminated together in the same chamber, leading to a 50% reduction capacity for endoscopy lists; the 3 hour time limit on the use of scopes following disinfection compounds this even further; there is an increased risk of cancellation of patients off lists for non-clinical reasons due to reduced capacity; this impacts on the PFA target for elective procedures and the 2% for cancellation for non-clinical reasons; risk to patients - cancellation of endoscopic procedure; cancellation of patients for colonoscopy having taken their bowel preparation; cancellation of patient with undiagnosed symptoms.	None.	10.05.10 - AER has been replaced and this is no longer a risk. Endoscope drying cabinets have been purchased and commissioned which will facilitate the storage and use of decontaminated scopes for up to 70 hours.	VLOW	10/05/2010
767	ACUTE	29/07/2008	Provide safe, high quality care	STH Day Procedure Unit Automatic Endoscope Reprocessor not compliant	Automatic Endoscope Reprocessor (AER) in this area is not compliant with HTM 2030 and the Hine review recommendations 2004; no single shot detergent, no reverse osmosis water, leading to potential infection control risk to patients; the 3 hour time limit on the use of scopes following disinfection compounds this even further.	A control measure for water quality only is in place - weekly monitoring of water quality.	19/12/12 - CLOSED AS PER AD AND HOS the new decontamination Unit is now in operation and the new EWDs are working well. 23/11/12 - it has been verbally agreed by DoH that it has pasted all testing. Just waiting on written confirmation. Once received it will be put into use. 2/11/12 - commissioning test report has been sent to John Singh who is the AED at Health Estates. John has identified some missing information which has been urgently requested from SMC and Puricore to enable the report to be signed off and AERS to be put into use, if all tests are satisfactory 26/9/12 - SMC are currently undertaking the commissioning test of the new ISIS AERs, and these tests should be completed by the 1/10/12. 30/8/12 - unable to complete commissioning as Alpha technologies ltd have ceased trading. At present the Trust is in communication with Puricore re completing the commissioning process for the AERs. 30/7/12 - commissioning tests have to be witnessed by the Authorised Engineer for Decontamination (AED), Health Estates and authorised person for Decontamination arrangements are in place for these to be undertaken. once completed the AER will commence weekly water tests and appropriate results are received the AER will be put into use. 22/6/12 - commissioning of the ISIS/AERs has commenced. the connection requirements to the network has been completed and working well; and the building works are complete. 25/5/12 - snag list has been completed for all outstanding items/areas of concerns to be addressed. we have asked for confirmation of full completion date to be received beginning of next week. IT will be working to ensure that the ISIS/AERs are connected to the network and that the company will then commence commissioning of the AERs 26.4.12 - Email received from Hugh Warner 26/4/12. RO plant has been commissioned and ready for the Isis machines to be connected since 26/3/12. Air handling until to take place 26/3/12. Return to HoS as of 26/4/12 26/3/12 as below. Building works still on target for	HIGH	19/12/2012

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Closed date
773	ACUTE	29/07/2008	Safe, High Quality and Effective Care	CAH Theatres Endoscope Decontamination room	The interim Endoscope decontamination facilities at CAH theatres do not meet DHSSNI decontamination strategy. There are no transfer lobbies or staff gowning rooms. The process flow is severely compromised by the size of the extremely cramped unit. There is no room for expansion. The workload in the endoscope decontamination facility has increased considerably over the last number of years due to additional theatre and radiology sessions as well as additional clinics in ENT OPD and Thorndale Unit. There is inadequate space for holding the contaminated endoscopes for manual washing prior to the automated process in the endoscope washer disinfectors. This frequently creates a bottleneck and slows down the process flow and turnaround time. The endoscopes and transport trolleys have to be stored in the hospital corridor outside the endoscope decontamination room due to lack of space - increased risk of theft (trolley plus endoscopes). In the event of any prolonged endoscope washer disinfector downtime there would be significant disruption to endoscopic procedures in Theatres, Radiology, ICU or in ENT OPDand Thorndale Unit as there would be insufficient capacity to decontaminate the endoscopes on the Craigavon site. There would also be logistical issues and delays in turnaround times if the endoscopes had to be transported to another Trust site for decontamination ie Daisy Hill or South Tyrone. The endoscope washer disinfectors were installed in 2009 and have a working life of approximately 8 years. The Lancer endoscope washer disinfectors do not have the ability to perform channel patency tests to current DHSS guidance i.e. inability to perform partial blockage of the duodenal channel which is part of the quarterly channel patency testing regime. The EWD manufacturer has confirmed that they will support the FC 2/4 EWD models until 2022 for the electronics and until 2025 for mechanical parts.	Situation being monitored.	12/11/2021 A decontamination meeting is due to take place 19/11/2021 and a further update will be available after this meeting. 15/09/2021- Replacement ISIS EWDs were included in the paper for funding sent earlier this year. Funding still not approved. The procurement process for EWDs can take up to six months and risk remains with the current EWDs not being supported by the manufacturer beyond 2022. 28.06.2021- no update. 16.02.2021- draft paper re funding required has been shared with the Director of Acute Services. 10/08/20 - DOH has set up a regional RDS2 steering group to assess the current provision of decontamination services, identify any shortfalls in compliance with policy and develop a strategy to address any identified gaps. 3.10.19 Replacement EWDs are included on the capital funding list. May 2019 SHSCT provided a summary report to DOH on strategic planning relating to the decontamination of reusable medical devices 24.06.19, 8.8.18, 12.6.18, 7.3.18 Risk remains unchanged 113.9.16 Head of Decontamination Services will work with Acute Planner to explore options for a modular unit adjacent to CAH CSSD to replace the existing the interim arrangement. Given that CSSD will form part of Phase 1 for the CAH Redevelopment, a modular solution will be considered as a further interim arrangement although it will need to address existing concerns. Indicative costs to be detailed in the paper and logged for consideration under capital allocations for 17/18. 23.2.16 Following discussion at Acute senior management team with Head of Acute Planning, the risk will be addressed in the first phase of the redevelopment of the Craigavon site. On this basis it was agreed that nothing further would be done at this stage. 5.1.16 Short paper highlighting the risks shared with Planning Dept and Director of Acute Services	HIGH	
993	ACUTE	06/08/2008	Safe, High Quality and Effective Care	Biochemistry printer is printing incorrectly	Biochemistry printer is printing incorrectly with missing and corrupted data on report forms - intermittent fault; patient at risk through incorrect reports being issued.	Printing has been stopped and wards have been advised to use ward lookup; reported as fault to DIS and waiting resolution.	To be managed by facility/department team manager/leader. 12.05.10 - risk reviewed by R Carroll and B Magee - new printerd purchased - risk mitigated and closed. 12.05.10 - risk reviewed by R Carroll and B Magee - new printerd purchased - risk mitigated and closed.	VLOW	12/05/2010
999	ACUTE	06/08/2008	Safe, High Quality and Effective Care	Building work for the T&O Service has meant no access to the existing laboratory reception	Building work for the T&O Service has meant no access to the existing laboratory reception; porters delivering samples, collecting blood etc. will need to use an alternative route; potential for delay of samples and prolonged turnaround times.	CCTV and alarm to alert reception staff of presence of samples at opposite end of lab is fitted, however access to reception is at the opposite end of the lab.	12.05.10 - risk reviewed by R Carroll and B Magee - risk mitigated and closed.	VLOW	12/05/2010
990	ACUTE	06/08/2008	Safe, High Quality and Effective Care	Currently do not measure bicarbonate as part of the standard U&E profile	Currently do not measure bicarbonate as part of the standard U&E profile; this differs from most other laboratories; likely in NI but is in keeping with the majority laboratories in the UK as evidenced by Keele Benchmark; it is available by request from Medical Staff but only a handful are requested on a monthly basis; a failure to identify serious acid base disturbances may lead to missed or delayed diagnosis; this could result in serious injury or death with the potential of significant medial legal consequences; example is a patiend in DHH who had been admitted with recurrend hypokalaemia over a period of several months.	Education of all all grades of Medical Staff as to the importance of measuring bicarbonate in the clinical cases that merit it; initiate reflex testing of bicarbonate when potassium's as/or chlorides fall outside a certain critical range; to be reviewed after education and Trust response to risk assessment.			18/12/2008
963	ACUTE	06/08/2008	Safe, High Quality and Effective Care	Risk to Radiology staff who have to push and pull ill patients on trolleys without assistance from 5pm to 9am	Risk to Radiology staff who have to push and pull ill patients on trolleys without assistance from 5pm to 9am.	A&E staff are supposed to stay with trolley patients in X-Ray.			02/12/2009
1023	ACUTE	07/08/2008	Safe, High Quality and Effective Care	Disruption caused due to violent/aggressive patients or relatives	Disruption caused due to violent/aggressive patients or relatives - big demand on nursing time causing time spent away from other patients; health and safety and wellbeing of visitors, patients and staff when dealing with/managing violent/aggressive patients; all wards, CAH and DHH.	Staff awareness or proactive approach; availability of security; review staffing levels; medical review of patients by doctor; consultation with Consultant and Bed Manager; training and awareness for staff re Dementia Strategy is ongoing		MOD	19/10/2009
1024	ACUTE	07/08/2008	Safe, High Quality and Effective Care	Health and safety of patients and staff could be compromised if staffing falls below safe levels	Health and safety of patients and staff could be compromised if staffing falls below safe levels when dealing with staff absence, e.g. maternity leave, sick leave; all wards, CAH and DHH.	Reallocation of existing staff to area of greatest need; in the event of further unplanned absences (e.g. sickness) implement the use of additional hours/bank.	25.09.13 - Workforce review carried out September 2013. 01.02.13 - Ongoing review of staffing levels. E-Reqs completed for all vacant posts. Workforce review of MAU and ED being completed. 29.11.12 - Review of funded establishements plus deficits sent to AD. Use of band and redeployment as required. 19.10.12 - Head of Service monitors workforce with Ward Sister. Staff recruited to block bookings. 25.09.12 - Staff levels monitored monthly by HoS and Ward Sisters. HoS and Lead Nurse working closely with Nurse Bank Staff. Ward Staff to work within 25% uplift and if ward has deficit > 25% due to maternity or sick, issue escalated to AD. 18.07.12 - Monthly review of staffing levels, vacancies being recruited to and use of block bank booking.	LOW	12/02/2014
1028	ACUTE	07/08/2008	Safe, High Quality and Effective Care	Inappropriate prescribing and administration of oxygen	Management of oxygen therapy; inappropriate prescribing and administration of oxygen; inappropriateness of administration rate; no medical review; no Acid Blood gas, staff recording of SP02 and respiratory rate; all wards, CAH and DHH.	Audit of prescription and administration at ward level; NMC administration of medicines; record keeping; code of conduct; prescription sheet in place at present.		MOD	19/10/2009
1020	ACUTE	07/08/2008	Safe, High Quality and Effective Care	Health and safety of staff/patients/public due to missing and broken floor tiles in Ward 2 North	Health and safety of staff/patients/public due to missing and broken floor tiles in Ward 2 North.	Risk assessment; caution signs; liaison with maintenance department.	07.09.09 - work complete	LOW	07/09/2009
1041	ACUTE	08/08/2008		Extra patient on ward due to increased workload from waiting time targets	Extra patient on ward due to increased workload from waiting time targets; leading to increased risk in the management of fire, manual handling, lack of privacy and dignity, and CPR.	Staff training in mandatory training issues; provision of screens for extra space; patient allocation according to illness and stability; additional staff for additional workload; Fridays are main issue - working over the limit.	07.09.09 - Eventuality is now rare - risk closed.	MOD	07/09/2009

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Closed date
1046	ACUTE	08/08/2008	Safe, High Quality and Effective Care	Health and safety of Cardiac Clinical Physiologist due to repetitive strain injury from posture	Health and safety of Cardiac Clinical Physiologist due to repetitive strain injury from posture; potential for back injury.	All staff must attend manual handling training on induction which is regulary updated; rest and counter stretch between patients.	07.09.09 - Ergonomic couches and chairs suitable for echocardiography now in place	LOW	07/09/2009
1079	ACUTE	11/08/2008	Safe, High Quality and Effective Care	Difficulties experienced in getting staff released from wards/departments to attend training (mandatory and otherwise).	Due to manpower issues and availability of training dates, wards and departments not meeting requirements of mandatory yearly training for lifting, manual handling, CPR and fire, right patient right blood, safeguarding and hyponatraemia.	Prioritisation and allocation of staff for training days. Training matrix available at ward level to monitor compliance.	Focus remains at ward level- sisters have been advised to utilise bank hours available to secure training days. Also trying to secure additional in house training days. 29/03/13: Focus remains on securing all available places to improve position 01.03.13 - Focus remains at ward level using the Training Matrix and sourcing and utilising all available training dates to improve position at ward level.	MOD	28/01/2014
1174	ACUTE	14/08/2008	Safe, High Quality and Effective Care	Unsterilised instruments being used on patients to an increasd infection risk	Unsterilised instruments being used on patients to an increasd infection risk; potential for harm - increased infection risk to patients, potential litigation risk to the Trust; Truama and Orthopaedic instrumentation require a 60 minute cycle for effective cycle for effective sterilisation; all other surgical instrumentation require a 40 minutes cycle for effective sterilisation; the 3 sterilisers currently in use are running with the 2 different cycles, 40 minutes and 60 minutes - there is the potential risk that the wrong cycle is initiated for T&O instrumentation resulting in ineffective sterilisation of instruments.	Inform staff; train staff; use of notices; limit the operators who commence T&O cycle.	Capital money has been agreed for the purchase of a steriliser and the associated building works. Capital money has been agreed for the purchase of a steriliser and the associated building works.	HIGH	21/12/2009
1177	ACUTE	14/08/2008	Safe, High Quality and Effective Care	Increased turnaround time for sterilisation leading to lack of available instruments	Increased turnaround time for sterilisation leading to lack of available instruments, cancellation of surgery and Trust not meeting waiting list targets; potential for harm - surgical procedures cancelled leaving patients at risk from untreated conditions and further complications; litigation for the Trust; Trauma and Orthapaedic instrumentation require a 60 minute cycle for effective sterilisation, all other surgical instrumentation require a 40 minute cycle for effective sterilisation; if all sterilisation cycles are extended to 60 minutes this will lead to a loss of 99 cycles over an average working week of day shifts.	None.	Capital money has been agreed for the purchase of a steriliser and the associated building works. Capital money has been agreed for the purchase of a steriliser and the associated building works.	HIGH	21/12/2009
1166	ACUTE	14/08/2008	Safe, High Quality and Effective Care	Clinical pharmacy service reactive as opposed to proactive	Clinical pharmacy service reactive as opposed to proactive; patient may have received a drug before clinical check performed by pharmacist; no clinical pharmacy service out of hours or at weekends.	Some pharmacists attend ward rounds - there at point of prescribing; daily ward visits (Mon-Fri).		LOW	21/08/2008
1266	ACUTE	19/08/2008	Safe, High Quality and Effective Care	Infection control risk to health and safety of patients who are ventilated	Infection control risk to health and safety of patients who are ventilated because there are insufficient quantities of ventilator parts to allow decontamination in SSD.	Staff are currently using the benchtop steriliser in dental room; benchtop steriliser does not meet HTM 2030 requirements.	10.05.10 - Risk reviewed by MMcG + BM - written protocol in place. All ventilator parts now decontaminated in SSD - risk mitigated and closed. 10.05.10 - Risk reviewed by MMcG + BM - written protocol in place. All ventilator parts now decontaminated in SSD - risk mitigated and closed. 10.05.10 - Risk reviewed by MMcG + BM - written protocol in place. All ventilator parts now decontaminated in SSD - risk mitigated and closed. 10.05.10 - Risk reviewed by MMcG + BM - written protocol in place. All ventilator parts now decontaminated in SSD - risk mitigated and closed.	VLOW	10/05/2010
1267	ACUTE	19/08/2008	Safe, High Quality and Effective Care	Infection control risk to patients and staff in Day Surgery Unit - patient chairs are covered in fabric material	Infection control risk to patients and staff in Day Surgery Unit - patient chairs are covered in fabric material and should have a wipeable cover.	None.	10.05.10 - Risk reviewed by MMcG + BM - chairs replaced - risk mitigated and closed. 10.05.10 - Risk reviewed by MMcG + BM - chairs replaced - risk mitigated and closed.	VLOW	10/05/2010
1874	ACUTE	09/12/2008		Air quality in Andrology laboratory needs to be brought up to the standard required by HFEA.	Air quality in Andrology laboratory needs to be brought up to the standard required by HFEA. A license will be withdrawn if this condition is not met.	None	12.05.10 - risk reviewed by R Carroll and B Magee - new printerd purchased - risk mitigated and closed.	VLOW	12/05/2010
1873	ACUTE	09/12/2008	Be a great place to work	Lack of ergonomic microscope workstations for staff involved in cervical screening in Screening Room 1	Staff are at risk from developing musculoskeletal problems	Staff have ergonomic microscopes and seating. Not possible to have control measures for benching.			16/11/2009
1916	ACUTE	13/01/2009	Safe, High Quality and Effective Care	Laboratory failing Accrediation due to External Clinical Waste Bins being kept in a unsecure location	External Clinical Waste bins are kept in an insecure location. This has been highlighted as a critical non compliance during recent Clinical Pathology Accreditation Inspections and could lead to the laboratory failing Accreditation.	Where possible bins are locked using a key but often locks are faulty.	11.05.10 - risk reviewed by R Carroll and B Magee -- risk mitigated and closed. Letter sent to Mr A Metcalfe requesting that the waste bins be secured. Referred to Directorate Risk Register 11.05.10 - risk reviewed by R Carroll and B Magee -- risk mitigated and closed.	VLOW	11/05/2010
1922	ACUTE	19/01/2009	Safe, High Quality and Effective CareEffective organisational governanceBest use of resourcesFinancial viability, reform, and control of costs	Oral surgery instrumentation used in CAH OPD is not currently decontaminated in line with DHSSPS March 2008 recommendations	Risk of cross contamination to patients due to ineffective decontamination of dental instrumentation. Risk of non compliance with Regional Decontamination strategy.	Currently using 'Little sister' bench top sterilizers to decontaminate instrumentation. Bench top sterilises are tested daily by the users and quarterly by Estates in house staff and external contractors.	Update 27.5.11 - Significant instruments have been purchased. However the full order has not been received. Further orders have been processed but there is still a delay in supply. continue to check delivery 25.3.11 - Waiting delivery of new instruments which will improve access to decontamination. Will review any residual gap after delivery. 05.05.10 - Business case to be with SMT by 26.05,10 Business case to be submitted by 31.03.09 for transfer of local decontamination to a centralised facility.	HIGH	05/09/2011

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1931	ACUTE	23/01/2009	Safe, High Quality and Effective Care	Risk to health & safety of patients in ENT, OPD with ongoing extra clinics	Cross infection risk as ENT sinuscopes are not decontaminated in line with DHSSPS recommendations due to lack of sufficient scopes to meet demands. 10 scopes available for clinic with potential to need to access 40 decontaminated scopes as all are new patients. Risk to organisation through litigation; adverse publicity/ complaints; loss of reputation; breach of Hine Review Recommendations. Inequality of care for patients - Friday (clean scopes), Saturday (wiped and sheathed scopes).	10 scopes available for potential need to access 40 scopes therefore decontamination between patients is not possible - scopes will be wiped using alcohol wipes and single use sheath applied (in breach of Decontamination Regulations)	"Reviewed 6/12/10- Still awaiting the fitting of cabinet scope. 1.0 Wte Band 2 to be appointed and funded by all users of decontamination to support the integration of the Naso Pharyngeal Scopes awaiting circulation. R Carroll reminded of issue 2/12/10. Meeting re funding now January 2011. Large ENT OPD clinics still operating on selected Weekends, and this risk assessment is relevant to all. 21 July 2010 - currently awaiting the fitting of specialist plug for scope cabinets. Awaiting the sourcing of stainless steel cabinets to facilitate transport of scopes to sites and departments. Paper being prepared for SMT regarding the permanent appointment of CSSD staff that will provide enhanced access to scope cleaning (to be complete by 31 July 2010). Aiming to have new scopes in circulation by 31 August 2010. The risks highlighted in this assessment are applicable to clinics which will be held on 24 July 2010 and 31 July 2010." Reviewed 19/5/11- Decontamination cabinet installed in DHH. DHH theatre staff awaiting validated decontamination specification from CAH OPD. Decontamination meetings ongoing with ATICS, SEC and S McLaughlin. CC 310W will fund cleaning in theatres on the CAH site for scopes in CAH until dedicated staff appointed. Pamela Mulholland to confirm access to AER and C Moorcroft to confirm support for additional time for cleaning. Theatre staff in DHH will clean during night shift. R Carroll to ensure Nursing support is released to allow for decontamination. 4 Scopes to be released to ACH/ 12 Scopes to DHH/4 BBPC and 10 Scopes CAH. Transport arrangements need to be secured for cross-site delivery Target date for Resolution: 3 June 2011 Reviewed 6/12/10- Still awaiting the fitting of cabinet scope. 1.0 Wte Band 2 to be appointed and funded by all users of decontamination to support the integration of the Naso Pharyngeal Scopes awaiting circulation. R Carroll reminded of issue 2/12/10. Meeting re funding now January 2011. Large ENT OPD clinics still operating on selected Weekends, and this risk assessment is relevant to all. 21 July 2010 - currently awaiting the fitting of specialist	MOD	27/05/2011
2150	ACUTE	13/08/2009	Safe, High Quality and Effective Care	Inadequate immuno cyto chemistry staining facilities	Inadequate immuno cyto chemistry staining facilities to ensure the rapid turnaround of urgent histological samples, including red flagged samples.	No control measures. System is operated to full capacity, delays are frequent.	New system of work implemented which has led to a marked reduction in the throughput of immuno slides. The benchmark is no longer a limiting factor with regard to the turnaround time of immuno cytochemistry	MOD	09/12/2009
2421	ACUTE	13/10/2009	Provide safe, high quality careBe a great place to workMake the best use of resources	Lack of manual handling training for staff	Staff unable to attend MH Training due to limited places being available to cover the whole Trust. Mandatory requirement not met. Injury to staff/patients. Potential litigation for Trust. Potential damage to Trust reputation.	Use of Hoist/slide sheets/repositioning charts/training for Avant Guard beds. Past MH Training. Raised at Nursing governance meetings on an ongoing basis.	25.09.13 ongoing issue which is on Governance agenda lead nurses to scope how many staff trained and how many outstanding and forward to ELD for for action. 29.11.12 - Reviewed by AD. Ongoing issues which are being kept on the agenda. 19.10.12 - Training now organised weekly at ward level in medical wards. 25.09.12 - Ward Sisters still experiencing difficulty in securing places for ward based staff. Mrs Carroll liaising with ELD re provision of locally based training. 28.02.12 - Heads of service to scope how many staff have been trained, how many need trained and consider how this could take place. 23.01.12 - position remains unchanged. 01.10.11 Reviewed 27.09.11 by MB, EM, PS, KC, & SB - minimal backfill available but same not sufficient to allow staff out for any form of training. Escalated to Michael McConville and Anne Ross on 20.09.11. 17.05.10 - Risk reviewed by E O'R, LA and BM.	MOD	22/10/2013
2422	ACUTE	13/10/2009	Provide safe, high quality care	Multiple training schedules for staff at Trust Level. Lack of resources to facilitate staff to go to training.	Staff unable to attend training due to multiple training schedules, therefore leaving ward short staff or staff not being updated. Mandatory requirements unable to be facilitated. With staff at training there is a potential risk of not providing safe high quality care to patients. It will deplete staff numbers at ward level therefore failure to meet the expected standards of care. This will apply pressure on colleagues who remain on the ward.	Ward Sister to manage off duty rotas and prioritise training needs/where there are high dependency levels responsibility of nurse in charge to assess situation and take decision on releasing staff for training/more flexible approaches to training eg delivered at ward level,e-learning etc.	19/4/22 . Due to gaps at ward level difficult to release staff to undertake training either Face To face or Virtual e learning. 18/08/2021- no change core mandatory training monitoring monthly but Face to Face training still an issue due to social distancing and reduced staff numbers per session. 01/06/2021- provisions have been made to allow staff to do training in their own time and to receive overtime payment to do so. 24.06.19 No change, Monitor compliance monthly. Training now available on-line. Review frequency of training. 23.9.17 - CMT remains challenging to achieve over 80% mainly due to 1- staffing challenges and 2 availability of training which is not 'online'. 1.12.16 No further update. 13.9.16 Awaiting update 27/5/16 - No change.	MOD	
2394	ACUTE	02/12/2009	Provide safe, high quality careMake the best use of resources	The Orthopaedic ICATs are still being sent to Independent sector for MRI scan due to demand outstripping capacity in SHSCT.	Financial risk for the Trust.	None	Write business case for additional MRI scanner and all associated costs 11.05.10 - risk reviewed by R Carroll and B Magee -- risk mitigated and closed.	VLOW	11/05/2010

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2396	ACUTE	02/12/2009	Provide safe, high quality care	Plain film x-ray reporting by Radiologists	"Plain film x-ray reporting by Radiologists is currently 60% resulting the general wards CAH and A+E CAH not being reported by a radiologist. Potential for mis-diagnosis leading to non-treatment of life threatening conditions. Potential litigation and loss of reputation for the Trust"	Referring consultant looks at the x-ray and writes report in patients notes. The introduction of PACS will increase to throughput of the plain film reporting but will not completely remove the risk.	6.5.11 - The contract has been awarded and the directorate is working with the IS company to get the IT connected. We plan to have the pilot testing complete by next week (fri 3th June). It is expected to scan between 500-1000 per month.There is a daily 19 day escalation plan, which is working well. The tender should be up and running by end of June 2011. 09.06.10 - Plain film reporting backlog in CAH was complete 31.03.10 - 3000 plain films in total. New backlog still exists. Briefing/options papers submitted to Director for discussion at SMT 09.06.10. (RC)	HIGH	27/01/2014
2893	ACUTE	04/12/2009	Provide safe, high quality careBe a great place to workMake the best use of resources	RQIA review maternity services - In DHH four out of seven nights there is no middle grade (Registrar) Obstetric cover	Four out of seven nights in DHH only has SHO cover on site Safe care to mothers and babies may be compromised on these four nights	Consultant on call id contactable by telephone and will respond by attending/giving advice as required. Middle grade locums are used.	10 June 2013 Changes again to the middle grade rota is incomplete and weekends are being covered by internal locums. 14-01-13 despite recruitment to all of these posts, there is still a vacant post from April 2013 caused by a resignation. 28.05.12 There is only 1 mid grade vacancy in DHH. All shifts covered by locums known to the service. Efforts to recruit staff continue. 31.8.11- 1 specialty doctor has been appointed	MOD	11/02/2014
2514	ACUTE	09/03/2010	Provide safe, high quality careMake the best use of resources	Vacant admin post in the Social Work department DHH as of April 2010	No admin worker for the Social Work department DHH resulting in 1. Band 6 Social Workers completing admin tasks competing with their social work role and responsibilities 2. Issue with the completion of delegated statutory functions eg child care and vulnerablae adults on to SOSCARE and COMCARE 3. No admin worker to populate COMCARE 4. No admin worker to type RIT supervision records 5. No admin worker to provide a reception service to the department. 6 Backlog of filing and processing of record Potential for harm: 1. SOSCARE not populated resulting in incomplete computerised records and failure to comply with Regional Child Protection Policy and procedures. 2. Community and hospital professionals have an incomplete case history resulting in communication failures. 3. Delayed discharges 4. Potential for complaint against the Trust 5. Potential for Litigation against the Trust 6. Professional standards not met.	1. e requisition completed for maternity cover 25.09.009 2. Admin post discussed at Corporate scrutiny 3. Staff advised of the need to separate recording for child care and vulnerable adults admin currently prioritising this work	09.03.10 - no progress to date 18.08.10 - A temp admin worker commenced in DHH, at the end of July 2010, so the stated risk is no longer valid.	VLOW	18/08/2010
2589	ACUTE	14/04/2010	Provide safe, high quality careMake the best use of resources	From August 2010 the number of junior doctors (F2) in cardiology will be reduced by 50%	From August 2010 the number of junior doctors (F2) in cardiology will be reduced by 50% resulting in 1. A significant impact on the delivery pf patient care 2.Reduced cover across all shifts of duty 3.Increased workload for all other medical and nursing staff 4. Increased need for locum cover - expensive and potentially higher risk to patients 5.Loss of reputation for the Trust 6. Potential risk of litigation.	None at present		HIGH	18/08/2010
2598	ACUTE	15/04/2010	Provide safe, high quality careMake the best use of resources	Failure to identify cardiac structures and abnormalities due to sub-optimal echo images	Due to mis-diagnosis, patient could die; incorrect medication given;reputation of Trust; litigation. Potential to breach waiting times for the Trust.	At present, 33% of echoes are being repeated. Clinical physiologist/ Consultant Cardiologist identifies obvious malfunction scans. Potential for 2 month delay for patients to have repeat scan performed. Audit	12.5.11 - E-mail from B Conway: Yes, this is all sorted and can be removed. 28.3.11 - Due to received the replacement Echo machine in CAH on Tuesday 29th March 2011. 03.02.10 - risk reviewed - Echo machine ordered.	HIGH	12/05/2011
2620	ACUTE	17/05/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsMake the best use of resources	Insufficient capacity and resources to manage patients waiting for a review appointment in MUSC	Potential of harm to the patient secondary to not having timely management of condition and/or disease-possible progression of disease/worsening status of condition. Risk of harm to patient by unmanaged progression or monitoring of condition in a timely manner secondary to SHSCT not having sustained capacity to provide review appointments, within the appointed time. Risk of harm to Medical and Nursing staff as addressing the patients needing review are all done as 'extra sessions'. Potential for exhaustion and escalation of sick leave. There has been inadequate Nursing resources recruited to support the increase work load. Risk of escalation of clinical risks as the Trust is under strict financial constraints, and does not have an obvious form of funding for this risk. Potential harm to patient family secondary to anxiety of not having a timely review Potential of litigation against staff and Trust due to not providing treatment in a timely manner Potential of harm to reputation of Trust due to potential lack of adequate patient management	E O'R and LA are tasked to 'cleanse' the lists of patients waiting, ensuring no duplication or incorrect recording of activity. Monthly update on review backlog to give current position Specialist Nurses working in Consultation with relevant Consultants to screen urgent, and patients waiting the longest length of time. All core clinic template capacity utilised as far as practical. Heads of Service are meeting with Relevant Consultants and conveying current position on a monthly basis Control measures considered but discounted and why (where appropriate): Arranging additional clinics to target primarily Review Backlog patients- not feasible in current financial situation Reduce the current number of new patients within Outpatient template, to increase the capacity of review patients- not feasible, as performance targets will then be breached. Recruit additional Medical staff to address shortfall in capacity- not feasible in current financial situation. . : .		HIGH	16/06/2010

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2629	ACUTE	24/05/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of	Delays in treatments, discharges and transfers due to inadequate ambulance service DHH, MSW, FSW, HDU, Gynae	Poor outcome for patient if ambulance not available for patient to be transferred. Delays in discharges leading to poor bed flow and elective lists to be cancelled. Patients from A +E admitted to ward due to no ambulance cannot be discharged. Patients missing appointments due to lack of ambulance service. Patient may develop surgical complication due to delay in treatment. Risk of litigation to trust. Increase of complaints and loss of confidence in organisation. Death of a patient. Delay in patient flow resulting in theatre cancellation	Early booking of ambulance as patients needs. Infection risk MRSA. Assess patient re chair, stretcher. Family involvement if safe for patient. Use of voluntary drivers. Use of blue light - not appropriate use of service.		HIGH	24/11/2010
2730	ACUTE	30/06/2010	Make the best use of resourcesBe a good social partner within our local communitiesProvide safe, high quality care	The Body Fridge in DHH Mortuary unavailable for use from the 26/5/10.	Bodies may be released to undertakers which have not been stored in optimal conditions and therefore the process of decomposition may be accelerated. James Details	Bodies to be stored in the Chapel of Rest as this room is slightly cooler than other rooms in the mortuary. This is a temporary arrangement while work on the body fridges continues. The Chapel of Rest does not provide the optimal temperature required to stabilize or slow deterioration of the body. Bodies are to be released to the undertaker as quickly as possible. On Friday 25th June arrangement put in place to transfer bodies to CAH, if the undertaker cannot be contacted to organise a quick release the bodies are transferred to CAH Mortuary.	Authorisation from Ronan Carroll (Assistant Director of Acute Services) for Brian to arrange with Cecil Renshaw (Estate Services DHH) to install a portable air conditioning unit in the Chapel of Rest Dr G Rankin (Director of Acute Services) has identified funding (23/6/10). Brian Magee awaiting confirmation that he can proceed with the procurement and installation of body fridges.	HIGH	01/07/2010
2818	ACUTE	25/11/2010	Provide safe, high quality careBe a great place to workMake the best use of resources	Unable to provide maximum Outpatient capacity safely due to level of sick leave & lack of availability of staff in Outpatients	Unsatisfactory level of staff with appropriate training. There are staff who have been redeployed, or working via Nurse Bank that do not have access to appropriate supervision secondary to staffing levels. Staff are unable to attend mandatory training due to staff shortages. Risk of staff sickness and absence continuing to escalate due to the level of stress of working in current conditions, further decreasing Outpatient capacity. Increased risk of staff to omit detail or not have sufficient time to complete task in a measured and timely manner cause patient harm and expose Trust to negative publicity and litigation. Contributing factor is the replacement staff have limited or no Outpatient experience. Potential to directly impact staff attending mandatory training updates. This places the public, staff and the Trust to increase risk of not having access to up to date training/information and validation which may result in harm to patients and staff. Increased risk to staff and patient safety secondary to not being able to provide adequate supervision to redeployed staff, and non registered staff due to low staffing allocation. Potential of reduction in Outpatient capacity resulting in extension of waiting times for patient. Increased waiting time has potential to harm and contribute to advancing of clinical disease and/or condition. Potential to further extend waiting time for patients on the Review Backlog waiting list. Increased waiting time has potential to a harm and contribute to advancing of clinical disease and/or condition. Potential for staff to omit detail or not have sufficient time to complete task in a measured and timely manner cause patient harm and expose Trust to negative publicity and litigation. This also has an impact on the level of appropriate supervision is dictated and expected for staff who have been redeployed to Outpatients or who are allocated through Nurse Bank. Potential for staff sickness and absence to escalate secondary to working with limited nursing support. This can have significant financial harm to the Trust as well as on skill level. Contributing factor is Nurse Bank is not able to fill entire requests and Manager may have hours of notice that a shift cannot be filled. Absence of validated update training risks patient and staff safety and increase risk of harm to the patient, staff, negative publicity and litigation to the Trust. Potential harm to Trust's reputation in relation to the breaching of Outpatient waiting time targets.	Band 7 and Band 6 Managers are providing direct patient care. Band 6 staff have been taken out of the POA results room to provide patient care in Outpatients. Band 5 and Band 2 staff requested to backfill shifts. Bank staff have provided 3 block bookings (2x B5 1x B2). Staff have 'doubled up' on clinics where possible (one staff to work between 2 clinics). Pre Op questionnaires have been given to patients to release Band 5 staff to work in clinics. Specialties have been approached to relocate to alternative accommodation due to lack of staff. Near patient testing devices to be purchased to decrease the demand for staff. All staff on sick leave are being actively managed and have been referred to OHD and HR.		MOD	25/03/2011
2916	ACUTE	10/01/2011	Provide safe, high quality careMake the best use of resources	ASR Monohip ; hip implant Recall	Patient that have received this hip implant are at risk of ; Pain, Immobility, Surrounding tissue breakdown. Higher incidence of Revision surgery within 5 years. Litigation against Trust Patients at risk that have received The Monohip, 208 patients in SHSCT.	Being addressed regionally, patients in SHSCT and Belfast Trust. Implant recall by manufactures " DePuy ", Patients reviewed yearly by a revision orthopaedic surgeon and treatment determined as necessary. Cobalt and Chromium blood ion tests. MRI scan. Plain X Rays.	23.01.12 - All patients have been recalled and reviewed with appropriate interventions carried out if required. Patients are now in the yearly review cycle and will remain there up until 5 years as recommended per medical alert. 10.11.11 There are 148 patients in total on the SHSCT ASR database. These patients have all been assessed, had a plain x-ray, MRI and cobalt and chromium ion levels tested and all have had a first consultation with a SHSCT Orthopaedic Consultant. To date 28 patients have undergone revision surgery. It was considered that all patients should have an annual review after their first consultation however a number of patients are being closely monitored eg a follow up review in 3 months as their ion levels were borderline. Review clinics are being organised on an ongoing basis to see patients who require close monitoring within their clinically required timescales. SHSCT is continuing to liaise with BHSCT with respect to 13 BHSCT patients who had their ASR implant done by the SHSCT surgeon but who are BHSCT patients. These patients have had their tests done and checked by the BHSCT practitioner to ensure they are not high risk patients however they have not had a consultation with an Orthopaedic Surgeon. It is planned that BHSCT surgeons will see these patients. 01.10.11 All patients have had a first apt with the Consultant and are being reviewed at the required intervals. Any patients being listed for revision of surgery are being completed timely. Meetings continue fortnightly. Update 27.5.11; 181 patients allocated to SHSCT to see and treat. To date 21 pts have had revision surgery. 5 pts are listed for revision surgery; 1 pt RIP; 113 pts have been reviewed; 5pts have refused a review. This leaves 36 pts still for review. Clinics are arranged for these 36 pts. A review process will require to be put in place for these patients. Admin Support will be required. HSC Management of ASR Recall Regional Meetings continue to be held weekly.	MOD	23/01/2012

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2915	ACUTE	07/03/2011	Be a great place to work	Staff member suffering from [redacted] requires a saddle chair to prevent the axacerbation of symptoms	A member of staff suffering from the condition [redacted] requires a saddle chair to prevent the exacerbation of symptoms whilst working in the various sections in the Cellular Pathology Laboratory.	Restricted range of duties - The member of staff does not cut routine tissue sections using a microtome as intense prolonged use of a microtome causes fatigue, discomfort and eventually pain. Frequent change of task with micro/mini breaks to prevent fatigue.	21.6.11 - Saddle chair provided. Saddle chair supplier sourced(Fred Storey, 5 High St, Comber, Tele. 91870033/23) and a 4 week trial of a saddle chair organised and trial commenced on the 14/10/10. Risk assessment placed on the laboratory's Q-pulse document control system on the 2/12/10 with a review date on the 1/2/11. Received and signed by the Assistant Director of Acute Services on the 3/12/10. CPL awaiting a copy of the risk assessment.	MOD	21/06/2011
2979	ACUTE	13/05/2011	Provide safe, high quality care	Multiple records/charts per patient e.g. a patient may have STH, CAH, BPC & DHH medical notes	Patient is at risk due to information in multiple charts (no one chart may contain a full record of patient history and investigations). Trust from risk of litigation. Risk to patient of incomplete information being available at time of consultation, incorrect diagnosis due to incomplete information, delay in diagnosis, risk of injury and/or death. Reputation of Trust at risk.	Patient information is available electronically in Patient Centre, NIPACS, Labs, TOMCAT. Charts for CAH and DHH only now registered. All charts are made available if requested.	19.08.2020 Most charts have now been replaced. 24.06.19 New system - one patient one chart for all new and recent patients. Ongoing update for older files for existing patients. 7.3.18 Risk remains unchanged 28.09.17 Further work is to take place with regard to registration of CAH and DHH charts and a move to 1 patient 1 chart. Initial discussions will take place in October with Health Records managers and the Booking Centre to identify issues relating to registration, and following this a proposal will be taken to Acute SMT for discussion and agreement. 28.12.16 - work ongoing with continuing to reduce number of charts per patient in circulation - robust weed and destruction of charts takes place every year and registration reduced. Risk reducing each year. 12.9.16 work still continuing on reducing the number of charts per patient - this is an ongoing exercise. A trial of going "paperlight" was conducted in June - Aug 16 which would reduce the amount of paperwork generated per patient however, until such time as a "write on" information system is available we cannot progress with paperlight / paperless clinics as information still needs to be recorded on the patient visit.	LOW	
2991	ACUTE	26/05/2011	Provide safe, high quality care	Cancer performance risk	Decrease in cancer performance from previous years. 10/11 = 85% for 62 day pathway. Highest risk is urology cancer pathways.	Escalation policy and action plans drafted. Meeting with urology teams. Working towards 1-stop clinics.	See Risk 2942	MOD	07/12/2011
2993	ACUTE	26/05/2011	Provide safe, high quality careBe a great place to work	Gaps in Medical Staffing. Daisy Hill Hospital	Gaps at junior and middle grade level in Medicine in DHH Hospital impacting on numbers of doctors on duty particularly during the out of hours period. Due to the gaps on occasions one junior doctor may be left covering medicine in Daisy Hill Hospital - increased clinical risk and potential for adverse events leading to patient harm.	A locum middle grade recruited in January 2011 to address immediate pressures. Assistance given from Renal Medical Staffing complement for two evenings per week. Ad-hoc locum shifts as and when required to address remaining gaps. However, despite these actions other gaps may remain. In the medium to longer term there is a plan for an additional junior doctor to be provided via NIMDTA however recurrent funding is required for this post.	29.09.22 - Risk Reviewed. Improved allocation of SpR from NIMDTA in August. Also stroke specialty doctor commenced Sept 2011. Risk downgraded to Moderate	LOW	01/10/2011
3002	ACUTE	13/06/2011	Provide safe, high quality careBe a great place to work	Extremely high level of maternity leave in CAH pharmacists	Extremely high level of maternity leave in CAH pharmacists from summer 2011 (15/36). Current recruitment for maternity leave cover is 2 for 1 - 5 junior pharmacists recruited as cover but only 2 have taken up post so will be 9 pharmacists short during period June to Sep 2011 and 7 short from Sep - Dec 2011. Unable to provide clinical cover for wards and no leave cover at all for other clinical pharmacists. Risk of serious medication incidents not being detected on wards before they reach the patient. Risk will increase in August with intake of newly qualified doctors. High work load of remaining pharmacists wild put them at risk of making an error themselves when dispensing/ checking.	Initially remaining pharmacists allocated to highest risk wards and some temporary junior pharmacists recruited as cover. March 2012 three pharmacists on mat leave.	Feb 12 - Currently 6 staff off work, two to return within 4 weeks, remaining 3 by end of March 2012.	LOW	10/06/2012
3019	ACUTE	07/07/2011	Provide safe, high quality careBe a great place to work	Fire	Risk of Fire throughout the Acute Directorate	Evacuation plan implemented for every ward and department. Embedded procedure of simulated drills twice yearly throughout all wards, once in hours and once out of hours. Acute fire committee and reps currently in place for all divisions. All wards have fire files. Checks carried out in basement areas. Estates ensure fire alarm and detection, escape lighting, first aid fire fighting equipment, suppression systems, plant, equipment and other installations are checked, tested and maintained in accordance with good maintenance practice. Regular fire safety checks are being carried out in Residential accommodation on the CAH and DHH sites and records are maintained. Nominated Officers and Deputy Nominated Officers have been identified for all wards and depts on each site. A number of fire risk assessments have been undertaken and actioned to reduce risk. Waste Management Policy and Procedures are in place and subject to monitoring. Smoke Free Policy is in place. Soft furnishings and textiles are purchased through BOS PaLS so comply to standards of fire retardancy. Fire Safety training programme is in place for all staff and fire safety training records are held centrally and reports are issued to Heads of Service. Arson Policy is in place.	18.12.13 Need to have a further desktop	LOW	28/01/2014
3020	ACUTE	18/07/2011	Provide safe, high quality careBe a great place to work	Management of Sex Offenders when accessing hospital services	Potential for sexual, emotional and psychological abuse. Those at risk: other patients, staff and members of the general public. Issues with the management of those convicted sex offenders who are known and not known to Hospital Services. Concerns re unplanned access to Hospital Services. No formal mechanism within the Hospitals to share information gained through LAPPP. Potential for litigation and damage of Trust reputation. No Policy and Procedure in place regionally to manage the risk within the hospital setting.	Trust representative at PPANI. Convicted sex offenders referenced through the Soscare system. No formal mechanism within the Hospitals to share information gained through LAPP. No Policy and Procedure in place regionally to manage the risk within the hospital setting.	07.10.13 - Draft Protocol tabled at the Procedures Committee and document accepted - minor additions required. Document to be shared with Regional Emergency Social Work Service. Draft Protocol allows information provided at the LAPPP meetings to be shared with Acute services. The focus is on registered category 2 & 3 sex offenders. Draft protocol completed January 2013. Document equality screened.	MOD	10/02/2014

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3028	ACUTE	26/08/2011		Staff shortages are adversely impacting on the quality of the Cellular Pathology Service	By 24 august 2011 3 BMS staff were off on long term sick or maternity leave. This equates to 18% of the WTE BMS staffing in Cellular Pathology. A further member of staff whose husband took a stroke on 19 August 2011 has the potential to be off, when included with existing staff off this equates to 23% of the WTE BMS staffing in Cellular Pathology. Coupled with annual leave commitments over the remaining August into October 11 period this reflects a reduction in WTE BMS staffing of 38%. the situation should improve after mid October 2011 with the WTE BMS staffing shortage due to maternity and long term sick falling to 12%.	All part-time BMS and MLA staff were asked if they would consider increasing their hours. One MLA has increased their hours from 0.6 WTE to 0.9 WTE effective from the 24 August 2011 to 30 November 2011.	One has increased their hours from 0.6 WTE to 0.9WTE effective from 24 August 2011 to 30 November 2011. 22.11.11 Temporary arrangements are now in place in the lead up to the accreditation visit. These arrangements include:-1 An increase in part time working hours for a member of staff. 2 An increase in overtime for key staff. 3 The transfer of a maximum of 150 cervical cytology tests per week for a six week period to the Western Trust for processing and reporting. On Monday 22 August 2011 the gynae cytology backlog was 400 smears. On Friday 26 August 2011 the gynae cytology backlog was 700 smears. An increase of 40% in 4 days. The gynae screening backlog will continue to be monitored. If the backlog reaches 1000 smears arrangements may have to be made to have it sent to another laboratory for screening and reporting.	MOD	22/11/2011
3026	ACUTE	02/09/2011	Safe, High Quality and Effective Care	Mixed Sex Accommodation	Mixed Sex accommodation can have a significant impact on maintaining privacy and dignity to patients whilst in hospital. In the following areas emergency treatment will take priority over segregation: coronary care, intensive care, A&E, theatre and recovery wards, medical assessment unit. Those at risk are patients requiring admission to CAH/DHH and patients requiring admission to specialist units.	SHSCT Policy on the admission of patients to a mixed sex ward. Acute Services Directorate Escalation Procedure. Safeguarding Vulnerable Adults Procedure. Patient Support Services. Clear signage on toilet and washing facilities.			03/02/2012
3057	ACUTE	28/12/2011		Arrangements for the transfer of acutely ill patients between acute sites in the SHSCT and to acute sites in other Trusts	This risk has been highlighted due to impact on medical cover when patients are transferred out of hours from Daisy Hill Hospital, however we are now also aware that we do not yet have sufficient robust information in relation to the number, nature and times of transfers in the acute system	1. A Proforma has been issued for completion when transfers arise in our system. Completed Proforma are being submitted to Amie Nelson for collation and analysis 2.On DHH site, efforts are being made to schedule a 3rd SHO to be on duty OOH in the event that one of the doctors need to transfer with a patient. Consultant on-call must be contacted about any transfers OOHs, with a decision taken on who should transfer with the patient and what support is required from the consultant during this time. Work is also underway to put a sustainable OOH rota arrangement in place in the medium term. 3.Meeting has been arranged by Director of Acute for early January 2012 to review out of hours cover in both CAH and DHH in the context of a regional review of H@N	25.09.13 lead nurses to scope number of acutely ill patients transferred between sites/other trusts within past year both in hours and OOH and highlight who accompanied these patients 29.11.12 - Arrangements in place to facilitate transfer of patients between sites.	MOD	22/10/2013
3064	ACUTE	09/01/2012		Faulty Lifts in DHH outside labour ward	Lifts outside Delivery Suite which service the maternity ward, frequently breaking down. Health and Safety Issue for transferring mothers in labour or in an emergency situation.	Plan in place for Estates works to commence early 2012. Currently using second lift. Exploration of possible use of Evacuation Chairs.	29-08-12 one lift replaced and one refurbished. No further issues. 28.05.12 Fire evacuation chairs now purchased. Parts for 2nd lift currently being replaced. 26.04.12 Work completed on back lift.	MOD	29/08/2012
3165	ACUTE	22/06/2012	Provide safe, high quality care	Inadequate Speech and Language Therapist	Inadequate Speech & Language Therapist. Stroke patients waiting up to 3 days to be seen by Speech and Language Therapist. No Speech and Language Therapist allocated to MAU resulting in inappropriate management of patients care/treatment.	Staff trained in swallow assessment	25.09.13 - 80% staff in stroke ward CAH and XX% stroke ward DHH now trained in swallow awareness. Ongoing training for other ward areas.	HIGH	22/10/2013
3166	ACUTE	25/06/2012	Provide safe, high quality care	Urology Access Waiting Times	Urology access waiting times have increased significantly from 36 weeks for inpatient and daycases. First appointment ICAT patients has increased from 17 weeks.	This is currently being addressed via approval to go to Independent Sector and the appointment of new consultants.	3/3/15 - TO BE TAKEN AS PER AD CCS/ATICS 10.12.14 - Cancer targets are being met, i.e., 31 and 62 day pathway. While red flag and urgent appointment times are being met this is utilising all outpatient capacity leaving routine patients with longer waiting times. A new service model is being trialled which may improve the totality of waiting times in the long term. Inpatient/Day Case waiting times for routine patients remain challengin with the focus on treating cancer patients within the standards. 12.5.14 - with respect to the urology performance against the 62-day cancer target, there are 21 patients over 62+days of which 11 pts waiting over 85+days. With respect to haematuria 1st appointment now sitting at D16 which is an improvement on the previous positions due to a combination of drop in demand and extra capacity on a Saturday. 12.02.14 Urology waiting times are extended throughout the Province due to demand and capacity issues. The HSCB have commissioned a further Regional review of Urology Services . The SHSCT will partake in this Regional review. In the meantime, Team South will focus its resources on meeting the cancer waiting times within this specialty	MOD	03/03/2015

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Closed date
3191	ACUTE	03/09/2012	Safe, High Quality and Effective Care	62 Day Cancer Performance	Trust fails to meet performance standard due to increase in red flag, capacity issues, inability to downgrade and Regional issues.	Daily monitoring of referrals of patients on the 62 day pathway. Escalations to HoS/AD when patients do not meet milestone on pathway. Continuous communication with Regional with regard to patients who require PET and ITT patients for Thoracic Surgery, 1st oncology appointment. Monthly performance meetings with AD/HoS and escalations of all late triaging	7/10/21- All tumour site pathways continue to have capacity problems throughout due to the ongoing pandemic. Referral levels for majority of tumour sites have continued to increase and are back to pre covid levels and in some instances higher than original volumes. Most tumour sites are affected by limited access to surgery. The trust continues to engage with RPOG and participate in theatre equalisation meetings. There are internal weekly meetings to review cat 2 surgeries and decisions regarding allocation of theatre sessions are made accordingly. Fortnightly cancer check point meetings continue involving MDT leads and senior management, where clinical teams have opportunities to escalate areas of concerns and potential solutions where possible. Fortnightly cancer reset meetings with HSCB are also continued. 20/09/2021- Covid has continued to have a negative impact on the 62 day pathway due to the fact that face to face appointment slots at outpatients and procedure lists such as endoscopy have been reduced in order to comply with IPC precautions. Attempts have been made to negate some of these losses by increasing virtual activity in the form of enhanced triage and virtual clinic appointments. However, the Trusts access to theatres and endoscopy lists has been reduced due to the fact of ICU beds being increased from 8 to 16 beds. Surgical specialties continue to prioritise their cases in line with the FSSA guidance. This is collated weekly and reported monthly to HSCB. 18/08/2021- Access times monitored but high volumes of new patients waiting to be seen at our Respiratory Clinics. Continue to monitor access for bronch. 24/02/2021- cancer access times have increased throughout due to COVID . Fortnightly meetings with specialties and escalated to HSCB. June 2020 Review of risk remains high due to COVID pandemic. Reduction in services due to social distancing and risk of COVID. Clinical space, theatre capacity availability is a challenge across all services. Dec19 Review of same risk remains unchanged. 06/08/2019 - Ongoing increase in red flag referrals	HIGH	
3304	ACUTE	16/01/2013	Provide safe, high quality care	Lone Workers in X-Ray after 12 midnight	Risk to the welfare of the lone Radiography staff working out of hours shifts either in CT or when performing Mobile radiography in remote areas of the hospital. On both instance the lone Radiographer is required to come into the x-ray department that is located some distance from ED and the wards. This leaves the lone Radiographer vulnerable and at risk from verbal/physical abuse/theft from visitors and patients . This potentially increases the staff's stress levels. Staff have a right to expect a safe and secure working environment.Risk of patients/visitors having free access to the x-ray department during the period from 8pm-8am as the department is not locked down securely during this period.	Staff Awareness. Restricted access in some areas. MOVA policy and procedures. Personal attack alarms issued to all staff. CCTV. Porters available to escort staff. Porters and Radiographers to lock main doors of x-ray when not in use. Radiographers required to checked that all doors into x-ray are locked before 8pm at night.Lone worker policy. IR1 Reporting.	14.11.17 Awaiting update from J Robinson 5.12.16 The lock down system is being installed W/C 12 Dec 16. 13.9.16 Situation continues to be monitored	MOD	07/08/2019
3393	ACUTE	22/04/2013	Provide safe, high quality care	Biochemistry CPA Accreditation	Laboratory has lost its biochemistry accreditation status and is now a non-accredited laboratory	The Lab continues to perform adequately in its external quality assurance and internal quality control.	13.9.16 All findings have been cleared with inspectors. We are awaiting formal confirmation of accreditation status. this may take up to 6 months. 28/6/16 The Biochemistry inspection took place in April 2016. The inspectors recommendation is for the department to be offered full accreditation subject to satisfactory completion of findings by 7/7/2016. 28/6/16 The Biochemistry inspection took place in April 2016. The inspectors recommendation is for the department to be offered full accreditation subject to satisfactory completion of findings by 7/7/2016. 6/1/16 - Inspection to take place 1st week in April 16. 27/11/15 - Pre-inspection took place on the 8/10/15. The Inspectors advised that Biochemistry is ready for the formal inspection subject to a few minor non-conformances being addressed. Formal inspection is expected in April 2016. 8/9/15 Labs - Pre-inspection visit confirmed for 8th Oct 2015 for Biochemistry. The biochemistry team continue to progress with meeting the ISO Standards. Meetings with Dr Hall and the Senior Biochemistry team continues. 3/3/15 - Labs contacted UKAS in January 2015 to check on progress with application, and was advised it had been passed to the scheduler. Still no indication of an inspection date yet. Staffing levels - benchmarking to be undertaken. Anticipated total additionality is 11 staff, no funding identified.	LOW	13/10/2016

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Closed date
3508	ACUTE	24/10/2013	Safe, High Quality and Effective Care	Overcrowding in Emergency Department CAH & DHH and the inability to off load patients from Ambulance due to overcrowding.	Delay in assessment of NIAS patients as no space to off load. Delay in ECG as no space for patient. Delay in resuscitation treatment as Resus overcrowded. Delay in treatment as Majors area overcrowded. Patient may deteriorate in waiting area as no space and delays in getting them to cubicle and doctor. Patients may deteriorate while waiting for admission bed on ward medication errors will increase as nursing staff unable to cope with delayed admissions. Patients basic nursing care may delayed as not enough nursing staff to deliver it in overcrowded ED. Patients may loose confidence in the Trust. Staff may become burnt out and stressed.	Triage (second nurse in triage in intermittent periods when staffing allows. Department escalation plan in place. See and treat pilot with band 6 and ED consultant (pilot finished). Patient flow meetings. 4pm meetings with patient flow. HALO role and ongoing monitoring	20/09/2021- ongoing, risk exacerbated by Covid- bed pressures sustained for long periods. Non commissioned beds have been opened. Surgical beds converted to medical beds. 09/03/2021- ED have completed capacity plan. All areas in acute to do the same. Escalated to Directorate. ongoing workstreams. Funding needs secured for medical gases for ambulance receiving area. Unscheduled care huddle regional actions daily. Estates ordering a modular unit for 6 cubicle receiving area. Ongoing escalation plan. 07.08.2020 - new workstreams have been setup in the Trust which may impact on overcrowding. Ongoing work to review and agree a capacity plan for both ED's. 12.08.19 MD escalation plan to be developed. Bed modelling exercise. 11.03.19- No update. 24.10.13 - There are systems in place to monitor this daily. The problem can fluctuate on certain days and become worse from November to March. Swing ward to be set up by November 2013.	HIGH	
3515	ACUTE	14/11/2013	Provide safe, high quality care	Ineffective Cardiac Monitoring System in certain Wards/Departments in CAH and DHH	The current cardiac monitoring system is old and unable to monitor patients in various wards/departments in the hospital site given their physical location. Monitoring is not available for certain patients and patients then may be required to move to 1 North for monitoring unnecessarily.	Appropriate selection of patients for monitoring.	14.11.17 Waiting on decision to start work with the potential of relocating coronary care beds to the HDU in DHH. 1.12.16 No further update. 13.9.16 In relation to CAH telemetry, this has now been fully implemented in the main acute wards, cathlab, and delivery suite.DHH,is awaiting funding allocation. 27.05.16 - Work in CAH will be completed with 3 months time. Costing obtained in respect of DHH work and added to Capital Estates list for consideration. 1/3/16 Now in place residual witing being carried out. 14.07.15 - Replacement system purchased and installed. Estates undertaking wiring to ensure all acute areas are covered.	LOW	24/06/2019
3526	ACUTE	17/12/2013	Safe, High Quality and Effective Care	Non-compliant bedpan washer disinfectors	Infection control risk to patients due to inadequate disinfection of bedpans throughout wards and departments in the Trust.	Daily testing of bedpan washer disinfectors completed by ward staff. Limited quarterly and annual testing carried out by contractor. Estates plan to provide a fully compliant quarterly and annual testing service early 2014. IPC has advised staff to carry out a visual check for cleanliness of all bedpans before use.	04/11/14 New bedpan washer disinfectors now installed. 23.4.14 Fifty new bedpan washer disinfectors received end of March 2014. Replacement programme underway according to IPC risk - to be completed by August 2014. Estates now providing a fully compliant quarterly and annual testing service. 12.02.14 Informed that order now placed 5.2.14 Contract awarded 18.12.13 Funding has been secured for the replacement of bedpan washer disinfectors. 5.11.13 pre tender meeting with Pals - tender open 8-11-13 and closes on 20-12-13 Tendering currently in progress to be finalised by end of March 2014. 28.3.14 Trust received 50 new bedpan washer disinfectors. A phased replacement programme has been agreed with IPC according to level of IPC risk and is due for completion by September 2014. October 2014 - 45 new bedpan washer disinfectors have been installed and commissioned leaving 5 spares for future new developments / replacements.	LOW	04/11/2014
3528	ACUTE	05/02/2014	Safe, High Quality and Effective Care	Pharmacy Aseptic Suite	The external audit of the pharmacy Aseptic Suite, which prepares all the total parenteral nutrition and the chemotherapy for oncology and haematology patients, has identified The design and fabric of the aseptic building does not meet the modern building standards for pharmacy aseptic dispensing units (critical audit finding). Application of the newly introduced capacity plan has identified the chemotherapy pharmacists' activity is exceeding 100% on a regular basis (Major audit finding) The two isolators used in the cytotoxic reconstitution section of the aseptic suite both require urgent replacement.(Major audit finding)	Increased environmental monitoring to check for failures of sterility in the unit Expiry dates of all products prepared has been reduced to a maximum of 24 hours. A daily report on the chemotherapy pharmacists activity level in relation to the capacity plan has been developed and implemented Additional activity will not be accepted by the aseptic unit until the staffing issue is resolved Additional environmental and function testing is being performed on both isolators to identify any sterility failures.	16.10.17 Unchanged 1.12.16 No further update. 13.9.16 Development Work ongoing 1/3/16 Work commenced for new suite. • Confirmation of the funding for the business case for a new build aseptic suite co-located with the Mandeville Unit was received at the end of July 2017. The design team have met throughout August with the aim of commencing the build in March/April 2017. • Recent deterioration in the fabric of the building has been addressed through an interim plan involving urgent minor works to the aseptic suite which was completed by mid-May 2016. • The external auditor revisited the suite on 26th July 2016. Their report is awaited. From discussions with the lead auditor on the day, it is expected that their report will still class the unit as high risk, but will recognise the work that has been done to manage this risk whilst the new unit is awaited. two additional pharmacist posts were funded by HSCB to address the staffing deficit that was leading to the capacity plan model showing that the pharmacists are working between 130 and 150% capacity. Both pharmacists took up post in Jan 2017 and the capacity score has been reduced to 94% Capital was identified to replace both isolators and this work was completed by January 2015.	MOD	02/03/2020

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Closed date
3529	ACUTE	05/02/2014	Provide safe, high quality care	Non compliance to Standards and Guidelines issued to Southern Trust by DHSSPSNI	There is often a time lag between when the external agencies require the Trust to achieve full compliance against the recommendations outlined within standards and guidelines and when this is actually achieved. Such non-compliance poses the following risks for the patient and the organisation: Reduced ability to deliver quality patient care; Compromised patient safety and wellbeing; Poor patient outcomes - mortality/morbidity, delayed discharge, increased secondary complications; Staff members are non-compliant with evidence based working practices, lack of standardised practice, vulnerable wrt registration; Organisational risk - complaints, incidents, litigation, loss in confidence / negative publicity Service Capacity As of 30 June 2020 there are 2131 standards and guidelines identified on the Trust's S&G database. Of thes1622 were applicable to Acute Services (78%) Lack of suitable IT Recording System Due to volume and complexity of these guidelines it is a challenge for the Trust to monitor and review the compliance status of all the standards and guidelines that have been received. There is a corporate need to invest in a more fit for purpose information system . In 2017/18 BSO gave the WHSCT significant funding to support a pilot of a modified Sharepoint system that would in the first instance record and track the implementation of NICE guidelines and Technology Appraisals. The Regional NICE Managers forum acted as the project group and whilst the scope of the project was not embracive of all the types of standards and guidelines endorsed regionally it was at least a starting point. The ultimate vision was that upon completion this system would then be shared across the HSC (including the HSCB/DHSSPNIS) to provide a harmonised / standardised system that would provide effective monitoring and traceability of guidance implementation. Unfortunately this pilot has not yet yielded these desired outcomes and in the interim the SHSCT continues to use an excel spreadsheet whose functionality falls well short of service requirements. Discussions have been undertaken with Mark Toal to seek out other possbile IT solutions - these have included Qlikvue / the new Datix S&G module (which remains in prototype) / Q Pulse. This scoping work is ongoing. Given the number of standards and guidelines that are now held on this system there is risk of it collapsing and there has been a number of incidents were data saving has not occurred due to capacity issues. As a safe guard a system back up is saved on a weekly basis. There is also the added frustration that if any of the directorate governance teams are using the shared excel spreadsheet no-one else can use it. This can impact on staff not being able to carry out their administrative duties on the system at that point in time. This is inefficient and there is a risk of a lack of timely data capture. S&G Backlog S&G backlog continues since the number of newly issued S&G demands the capacity of the Acute S&G team to ensure timely implementation. Consequently there continues to be a need to review the register, identify the backlog and prioritise those standards and guidelines that need to be implemented by nominated change leads. Since 7 January 2017 the corporate S&G forum has been stood down. Whilst new processes for managing S&G have been developed, one key challenge is the timely implementation of those S&G that have a cross directorate applicability. This includes a delay in identifying the lead directorate and who will lead these pieces of work. This has resulted in some S&G circulars not meeting the required deadline to submit an assurance response to the required external agency. It also has the risk of creating 'siloed' implementation	Provision of bi monthly assurance responses to the HSCB as part of the Trust's Positive Assurance response. Corporate governance have an Excel database in place for logging and monitoring S&G. The accountability arrangements for the management of S&G within Acute Services are well defined to ensure the risk of not complying with a guideline due to identification of an external barrier is communicated to the SMT in a timely way. There are robust processes in place to ensure timely review of E proformas to ensure any change in compliance is identified and should the compliance status be downgraded from red to green the HSCB can then be notified Within Acute Services a directorate S&G forum has been established - inaugural meeting was held 19 January 2017. Terms of reference are in place and the forum is chaired by the Director and attended by the SMT. The forum meets twice a month to review all newly issued S&G so to ensure appointment of a clinical change lead is confirmed in a timely manner, thereby ensuring implementation processes are put in place as early as possible. It also reviews and approves implementation plans requiring submission to the the relevant external agency. It approves any policy/procedures/guidance that has been developed as part of these implementation plans. Standard item for discussion at the monthly Acute Clinical Governance meetings with submission of relevant reports Patients Safety & Quality Manager (Acute Services) attends all divisional governance meetings on a monthly basis and presents tailored activity reports to determine progress at an operational level Meeting schedule is in place to ensure meetings are held with the Heads of Service to review compliance against all S&G within their areas of responsibility A new Acute Services Lead Nurse, Midwifery & Radiology S&G forum - meetings held on a monthly basis Monthly summary report is issued out to Acute SMT to communicate to all staff what new regionally endorsed S&G have been issued. A copy is also shared with the M&M chairs so that they can review and share within their committee meetings Service KPIs are in place and presented to the Acute S&G forum on a quarterly basis Acute S&G procedures manual has been developed and has been operationalised since 1/4/2017. This is subject to ongoing review and updating Acute S&G administration processes maps have been developed and are to be presented at Acute S&G forum on 01/05/2018 Standard item for discussion at SMT (monthly) and Governance	24/02/2021- being reviewed through standards and guidelines process 10/08/20 - Risk reviewed. Updated description of risk provided. March 2020 On-going monitoring and review within Acute S&G forum agenda Discussion with Trust SMT since this risk issue will be the same within the other operational directorates, albeit the number of guidelines are less 10/08/20 - Risk reviewed and description of risk updated. 02/06/2020 standards still difficult to achieve with limited funding, staffing and equipment 09.03.2020, 5.12.16 Information below remains current 19.7.16 - Decision needs to be made regarding the viability of re-appointing an AMD for Standards and Guidelines (Acute Services) - forms part of the current review of Acute Services structures. Administrative support for the Patient Safety & Quality Manager needs to be reviewed - there is currently no administrative support. Patient Safety & Quality Manager (Acute Services) has successfully achieved a one year NICE scholarship - project is to undertake a review of the directorate's process for implementing standards and guidelines - to be completed by 31/03/2017. There continues to be an urgent need to put in place a more effective information system for the logging, dissemination and monitoring of standards and guidelines. Corporate governance is currently designing an inhouse system until an appropriate regional solution is agreed. Due to ongoing work pressures Phase 1 (01/10/2015 to current date) and Phase 2 of the backlog review (all S&G issued from 01/04/2007 - 30/09/2015) will be undertaken from 01/01/2018 to 31/03/2018 has not been progressed as planned and will continue during 2019/20 workplan. Phase 1 (From 2017 to current date) has been completed. Phase 2 of the backlog (from April 2007 - Sept 2015) remains outstanding.	LOW	
3619	ACUTE	11/11/2014	Safe, High Quality and Effective Care	Water Flooding and Sewage Leaks	Water and effluent leaks into any ward / department on the CAH site. Exposure / illness to raw sewage by patients, visitors or staff. - A foul smell in patient and staff areas make for difficult working conditions. - Contamination of water supply. - Increased rates of infection. - Disruption to patient care or activities in the ward / department. - Damage to equipment and the fabric of the building. - Damage to patient records and breaches under the Data Protection Act if records require to be destroyed. - Bad publicity. - No cleaning service provided in areas if Domestic Services resources require to be re-deployed to assist with clean up. - Additional pressure within Domestic Services may mean a longer response time for terminal cleaning / bed cleaning which could effect bed availability.	Bag it and Bin it posters are displayed in all toilets and have been communicated to all staff via desktop messages. On the poster there is a request for staff to report any slow flushing toilets to Nursing staff. - Posters are displayed in all sluice rooms advising staff not to flush wipes, conti wipes, J cloths and hand towels. - Leak detectors are in place in some areas. - Piping has been replaced in two Health Records libraries in the basement. - In the Health Records libraries the roof tiles have been removed to help see any leaks at an early stage and a large number of charts have been moved and sent to secondary storage in Armagh to avoid them having to be placed on top of the filing bays. - Domestic Services have a process for dealing with flood / sewage incidents. - There is weekly jetting of drains. - Heads of Services were asked to ensure all alcohol wipes were removed from all toilet and bathroom facilities (action from a meeting held 14/05/14). - The Assistant Director of Functional Support Services sent a communications to her AD colleagues in Acute and Heads of Service on 8/10/2014 appealing to all staff not to flush wipes down the toilets and requesting their support in dealing with this problem. - Maintenance staff have spoken to Ward Sisters in Maternity and staff in Maternity are advising patients and staff re the Do's and Don'ts of waste. - There is greater awareness amongst Nursing staff regarding the potential problems and consequently there is better reporting to Estates.	3/3/15 Posters are displayed and all staff communicated with. Leak detectors are in place in some areas. Piping has been replaced in two Health Records libraries in the basement and some roof tiles removed to help see any leaks at an early stage. Large number of charts have been moved and sent to secondary storage in Armagh. Process in place to deal with flood / sewage incidents. Weekly jetting of drains. Heads of Services were asked to ensure all alcohol wipes were removed from all toilet and bathroom facilities. Communication from AD FSS to ADs/HOS on 8/10/2014 remind all staff not to flush wipes down the toilets and requesting their support in dealing with this problem. Work between Maintenance & Maternity staff to advise patients & staff re the Do's and Don'ts of waste. Greater awareness amongst Nursing staff regarding the potential problems and better reporting to Estates.	MOD	14/04/2015
3653	ACUTE	15/04/2015	Provide safe, high quality care	Infection control due to release of sewage into clinical areas	Escape of sewage from sewerage system causing: Infection: Exposure of patients, visitors and staff to increased risk of infection, Contamination of catering/food preparation areas Contamination of drinking water Clinical services - disruption: Closure/cancellation/disruption to clinical services (including due to odour) Patient records damage: May cause damage/loss of patient records Property/infrastructure damage: May cause damage to flooring, ceilings, walls and general building infrastructure Possible damage to electrical systems Possible damage to IT systems Equipment damage: Possible damage to medical devices and equipment Public reputation: Adverse publicity Adverse political interest Legal challenge: Possible breach of Data Protection Act Breach of health and safety legislation (Health & Safety at Work Order) Possible breach of common law duty of care Possible breach of environmental legislation Increase use of resources Addition deep cleaning requiring addition staff and consumables	Information, instruction and training: Use of posters in all sluice rooms Use of splash screen information on computers for staff Senior managers informed of measures required to reduce the incidence of sewage leaks (email from Assistant Director of Clinical Support Services) All clinical staff brief on waste disposal and incident reporting Incident management: Incident reporting systems in place - DatixWeb and Estate Services Help Desk Domestic Services have a process for managing reported sewage incidents Estate Services have waste sewage disposal sub-contractor arrangements in place Proactive measures: Jetting of sewerage system in known areas of frequent blocking Ceiling tiles removed in record stores to aid detection of leaks Automatic leak detection installed in some areas Alcohol wipes removed from all toilet areas Restructuring of record stores (surplus files place in Armagh) Pipe runs replace in two record stores Replacing of old "push-fit" pipe system with welded joint system on a cost benefit basis	1.12.16 No further update. 13.09.16 The drainage issues in the main acute ward block has been mainly resolved in last year's ward works and the risks minimised due to the infrastructure issues(blockages still can occur due to inappropriate items being flushed down the sanitary points) In relation to the maternity block, £250k of funding has been allocated,awaiting business case being approved (possibly at next SMT) to commence with the procurement of the works and implementation on site by March 2017. 7/3/16 South side replaced and north side replaced on ground level. Basement works continuing. 22/7/15 This risk continues to be managed. Approval of 475k Revenue funding by SMT will enable some repairs to sewage system in CAH to be completed this year.	MOD	18/09/2017

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Closed date
3660	ACUTE	20/04/2015	Provide safe, high quality careMake the best use of resources	Non compliance with testing of decontamination equipment as per DHSSPS guidance	Insufficient resources to carry out the full range of testing on decontamination equipment as per DHSSPSNI guidance.	All high risk decontamination equipment i.e. sterilisers, washer disinfectors, endoscope washer disinfectors will be tested as per DHSSPSNI guidance. Some of the lower risk contamination equipment i.e. bedpan washer disinfectors will be tested 4 monthly rather than 3 monthly as per DHSSPSNI guidance. Interim revised testing schedule approved by the IPC team and AE(D). Interim revised testing schedule will be reviewed annually. Additional revenue funding will be requested if availability of insufficient resources is on-going.	April 2015 Bedpan washer disinfectors will be tested 4 monthly rather that 3 monthly as per DHHSPSNI guidance.	VLOW	09/12/2015
3663	ACUTE	29/04/2015	Provide safe, high quality care	Single CT Scanner available on DHH	If the CT scanner breaks down there is a potential to cause major operational difficulties in terms of assesssement and treatment of patients and delay in diagnosis.	In the event of a breakdown we have divert arrangements in place with NIAS whereby patients will not be brought to DHH but taken directly to CAH. In the short term there is a second unit on site until March 2020. An IPT business case has been written to reitain a modular CT Scanner in DHH.	6/4/22 There has been a further meeting with HSCB to look at the options - there are currently 2 suppliers have submitted bids through PALS procurement. Only one supplier is within original budget. Still awaiting funding stream Dec2021- meeting with HSCB in January 2022. 03/12/2021 - Currently awaiting feedback from DOH regarding the IPT. The provider is querying if the lease will be extended by March 2022 as they have other third parties interested in the unit. 14/09/2021- Medium term plan to build a CT suite in DHH with 2x X-ray machines and one MRI. Finance and Planning have asked the Regional Imaging Board. Clarification has been sought but not yet received. Trust running at risk even without funding March 2021 Need to secure additional funding to maintain the modular CT scanner for the next financial year March 2020 The Trust will build a new scanning suite in DHH which will provide 2 CT Scanners and an MRI scanner. There is currently no timeframe for the new suite due to the electrical infrastructure which needs to updated before the new suite is put in place 3/12/19 there are 2 CT scanners in place in CAH to cope with capacity and any downtime to the main scanner. DHH has 1 scanner which is being replaced, currently being covered with one ground level modular service in place during replacement. Risk remains as only one scanner in DHH and in case of downtime patients diverted to CAH. 7/8/19 Mobile CT Currently available on DHH site to reduce the workflow on main scanner. Work is planned for Sept/Oct to replace the existing DHH CT scanner and during the building works a mobile scanner will be available to facilitate DHH inpatients and ED patients. In the event of breakdown the transfer policy between CAH and DHH will be implemented. Nov18 Second CT Scanner is now in situ in CAH. 7.3.18 Mobile CT Scan is operational on site. 5.12.16 Mobile CT scanner now on site. Funding up until 31.3.17 to seek further funding to retain on site 17/18.	MOD	
3689	ACUTE	08/06/2015	Provide safe, high quality care	Delayed reporting of Histopathology samples	Patients are at risk of a delay in the diagnosis and treatment of a variety of conditions as a result of a backlog of histopathology specimens for reporting. this backlog is caused by a reduction in the reporting histopathology capacity. Only consultant histopathologists report these samples. There is currently 1 vacancy and a capacity gap of 2 WTe Histopathologists. he delay could result in a delay in diagnosis and or treatment that would affect the efficacy of treatment and or lead to patient harm.	Some additional reporting sessions are being undertaken by pathologists. All samples are triaged in an effort to ensure that the more urgent or critical samples are processed and reported as a priority. A Locum histopathology has been source and the Trust is attempting to identify a second. The Northern Trust has indicated its willingness to report specimens. Recruitment to the vacancy is being pursued Placed on Directorate Risk register on 8/6/2015 ID: 3689. Placed on Performance risk register Oct 2015.	05/09/2017 Recruitment has been successful with outstanding vacancies being filled in September 2017- the is currently a minimal reporting backlog 1st February 2017 update - we have successfully recruited a permanent pathologist who should start 1st April 2017. we have a locum stating soon. we continue to use vacancy funsing and some elective care (endoscopy) funding to close the gap in capacity 5,.12.16 We continue to have 2 Consultant vacancies we are currently using a number of waiting list sessions from both internal staff and consultants from other Trusts for assistance in core time. Turnaround times are being actively monitored. 13.9.16 Locum Consultant pathologists have been employed since June 2016. The first of these has already left and the second is due to leave at the end of September 2016. In addition another part-time pathologist is leaving for a post in Belfast reducing the establishment by a further 6 P.A.s. There is an active recruitment process and the Trust is actively seeking replacement locum pathologists. 13.06.16 Referral to laboratories outside of Northern Ireland. This has been discounted as the histopathology information would be lost to the regional system. It may have to be considered if the risk does not reduce. Referral to Belfast and or WHSCT. Neither Trust has indicated that they have capacity to take additional samples.	LOW	18/09/2017

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3829	ACUTE	13/09/2016	Safe, High Quality and Effective Care	Absconding patients from all Wards & Department	Patients at risk of leaving the ward or department without investigations, diagnosis and management plan in place. Patient risk - Incomplete treatment for medical or mental health issues leading to physical and/or mental health deterioration Risk of self harm / death Staff risk- unable to deliver care to patients, risk of violence and aggression when trying to persuade patients to avail of assessment, treatment and care for their illness.	Level of absconding rates identified. Absconding patient protocol in place. Staff awareness raised. Datix reporting in place. Short life working group established to review access to wards and departs promoting pts and staff safety.	19/11/21 Update from Lead Nurse SEC- A working group is currently developing a criteria method to help guide the level of supervision required in nursing observations in relation to mental health"Enhanced Care Observation (ECO)". A training component is also being developed for staff prior to the pilot of this tool. There is a corporately led MDT working group who have produced a draft SHSCT point of ligature policy which has been shared for consultation prior to final approval. 20/09/2021- Lead Nurse SEC update- absconding policy used at ward level. Patients identified at risk will be placed in a bedspace as much as possible that provides supervision/visibility. Referral to Psych liaison. Also current working group to establish a "patient at risk" assessment tool which incorporates all levels of risk and care planning. There is also work ongoing regarding access to psych services within Acute. 20/09/2021- Escalated as per trust policy in ED. 18/08/2021- Absconding policy in place and escalated to HOS if incident occurs. Reported via Datix process. 09.03.2021- within ED a risk assessment is carried out if PSNI accompany patient under article 130 a joint risk is completed with nursing team. ED AMU review absconding patients with PSNI and mental health at interface meetings 24.02.2021- still ongoing issue and the staff adhering to policy and datix submitted with review taking taking place for each case. 24.06.2019 Absconding policy available - any incidents submitted on Datix, reviewed and staff aware. 23/2/2018 - Additional measures have been introduced to access and egress from ED and AMU. Swipe card is required. Statistics need to be reviewed before consideration can be given to reducing the risk rating.	HIGH	
3869	ACUTE	23/01/2017	Safe, High Quality and Effective Care	Limited Speech and Language Therapist Provision	Inability to provide adequate Speech and Language Therapy to acute based patients due to increased volume of referrals of complex patients over previous 10 years - situation escalated by inability to backfill 2 senior staff on maternity leave and complexity of patients requiring SLT assessment. Capacity to provide Dysphagia treatment significantly reduced. Delayed assessment of patients designated nil by mouth so rehabilitation potential reduced. Delayed review of patients on modified diet Delay in discharge as SLT unable to respond to request for assessment and intervention re: swallow management including information re: food/fluid textures to carers. Potential for SAIs. Patients discharged prior to assessment Limited rehabilitation to patients, hence longer length of stay in hospital. Complaints received re: service provision Inability to consistently meet professional standards Health and wellbeing of staff compromised Staff working outside levels of competency and under significant pressure. Inability to achieve regional PTL waiting time targets	Several requisitions for recruitment of suitably trained staff - unsuccessful Junior locum staff employed but not skilled enough to fully meet caseload demands All core staff offered additional hours Telephone referral system manned by administration staff Triage and prioritisation of referrals Waiting list for in patients Timetable constantly reviewed with staff managed & moved between the 2 sites to attend to priority demands Cancellation of VFS clinics which leads to distress of patients and families.	Dec 19 - deficits remain - recruitment to B7 and B6 posts have been unsuccessful. Retention of B5 locum into substantive post and potential to link B5 post to B6 Jan 2020 Jun19 The deficits in this service will now be major as there has been 2 resignations from B7 staff. 21.11.18 New post appointed Apr 18. However, capacity v demand compared with NHS benchmarking identifies approximately 50% deficit re staff required. Also Band 6 gap as member of staff left post. 22.1.18 Situation has deteriorated and continues to be monitored. 14.11.17 Secured SLT for AMU - recruitment in process, Capacity / Demand paper being revised, Prioritisation of demand continues. 6.6.17 Remains limited due to low investment in this service.	MOD	13/08/2020
3922	ACUTE	13/11/2017	Provide safe, high quality care	Lack of funding to ensure compliance with NICE guidelines that have been regional endorsed by the DHSSPSNI.	In April 2017 a Band 5 Governance Officer commenced work within the Acute S&G team as part of a secondment from the Corporate Governance team. This secondment to the Acute S&G forum ended on 31/12/17. The purpose of this audit was to ensure that an assurance framework is in place to comply with the reporting arrangements to the relevant external agencies (such as the HSCB). The outcomes from this audit are now being operationalised and outstanding actions are presented at the Acute S&G forum and Divisional Governance meeting to ensure progression. As part of this work a significant number of NICE guidelines have been identified as having an external barrier impeding implemention. This work has continued and there are now 79 listed NICE guidelines where an E proforma is required. There is a robust system in place to maintain E-proformas being sent to the HSCB as and when required. However due to COVID 19 pandemic from March 2020 / Industrial Action in November and December 2019 there has been a significant increase in the number of E proformas that are now overdue for review. The number is now 25 (32%) - this work will be deferred until October 2020 when it is agreed that the S&G NICE workplan can recommence. A copy of the updated July 2020 E proforma report provides evidence of this work. The work also provides a timely trigger for the compliance position to be reviewed in accordance with stipulated review timescales. In the past the HSCB would have reviewed 'red' status guidelines for all Trusts and for guidelines were all Trust's identified significant barriers these would have been prioritised as part of their annual work plan and there was the possibility of funding being allocated to support implementation at a local level. With effect from 01/04/2017 this is no longer the process, with all Trust' needing to manage all funding requests within existing financial resources. Given the number of competing demands this makes it very difficult to ensure that the S&G constraints are overcome and presenting a risk for the Directorate. As part of the 2020/21 workplan for the Acute S&G team workplan the 'Green Status' report is currently being reviewed to ensure those NICE guidelines that have been identified as either being fully compliant or have an internal action required to achieve full implementation are accurately reported upon.	Provision of bi monthly assurance responses to the HSCB as part of the Trust's Positive Assurance response. The content of this report is approved by the Director of Acute Services and Director of Performance prior to submission The accountability arrangements for the management of S&G within Acute Services are well defined to ensure the risk of not complying with a guideline due to identification of an external barrier is communicated to the SMT in a timely way. There are robust processes in place to ensure timely review of E proformas to ensure any change in compliance is identified and should the compliance status be downgraded from red to green the HSCB can then be notified	01/06/2021- link with 3529 as per director 24/02/2021- being reviewed through standards and guidelines process 10/08/20 - Risk reviewed. Updated description of risk provided. March 2020 On-going monitoring and review within Acute S&G forum agenda Discussion with Trust SMT since this risk issue will be the same within the other operational directorates, albeit the number of guidelines are less June18 On-going monitoring and review within Acute S&G forum agenda Discussion with Trust SMT since this risk issue will be the same within the other operational directorates, albeit the number of guidelines are less	LOW	01/06/2021

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3921	ACUTE	13/11/2017	Provide safe, high quality care	Extra patients on wards	No piped oxygen or suction in extra bedspace, lack of room for manual handling/attendance at cardiac arrest in extra bedspace, lack of privacy and dignity, increased pressure on staffing, increased complaints by service users, extra patient requiring evacuation in event of fire, increased risk of cross infection	All patients to be assessed on ward at time of requirement to place extra patient, so that most mobile patient may go into the extra bedspace, or the patient with no requirement for continous oxygen or suction. portable oxygen/suction is available at ward level for emergency situations. infection control precautions must be kept to the highest standard, continue to isolate high risk patients and all staff to adhere to good IPC practice placement of patients must also take into consideration manual handling needs of the patient and again place most independent patient in extra bed space. in event of cardiac arrest extra bed should be pulled out into corridor and mobile screens etc used to screen patients who require arrest team all efforts should be made to maintain patients privacy dignity for the patient while the extra bed is in use and visiting rules shouls be strictly adhered to i.e 2 visitors per bed. patients should be encouraged to avail of day room etc if appropiate staff to be made aware that extra bed space is put into use only as a last resort and is a decision made by the director for best care option for all patients at the time of bed pressures staff to be aware of the need to explain to patients and their relatives of the reason for the extra bedspace and try to give reassurance that it will be stood down as soon as possible staff to ensure extra patient is on Immix board and patient handover for fire evacuation Where 1 additional patient is noted to pose risks, it needs to be offset against the risks associated with over crowding in ED when recuss, majors and minors are at maximum capacity resulting in delays in assessment of patients, treatment and inability to deal with blue light calls or a major incident	01/06/2021- no longer a risk closed as per director	LOW	01/06/2021
3929	ACUTE	12/12/2017	Provide safe, high quality careMake the best use of resources	Declaratory Orders for patients who lack capacity	Decisions sought from the court in those cases when someone lacks capacity and wherein a deprivation of liberty is likely to exist. The risk is that for those cases not taken to the court for a declaration order, there is a risk that the Trust could be challenged through judicial review for the best interests decisions it makes obo individuals without capacity.	Advice is that in all cases where a DoL is evident for individuals assessed as lacking capacity, the Trust should seek a decision from the court. This is neither achievalbe not affordable. This paper proposes that Multi-disciplinary teams agree only the most difficult cases are taken to the court for a decision.	30.07.19 There will be partial implementation of Mental Capacity Act NI on 1 October 2019. This may aleviate some of the declarattory orders asTrust Authorisation panels are being set up. 7.3.18 Risk remains unchanged	LOW	
3951	ACUTE	10/04/2018	Provide safe, high quality care	Delays in isolation	Due to lack of side rooms/one to one nursing/lack of bed capacity in the service. Risk of spread of infection. Failure to isolate promptly can lead to outbreaks, close of bays, increased pressure on service. May lead to potential patient harm through the spread of potentially preventable infection or due to a lack of beds.	Trust can emphasise the importance of IPC issues at bed meetings and elsewhere. A recent teaching sessions was arranged to do this amidst the winter pressures. Side rooms are often occupied for reasons other than IPC reasons. IPC reasons for isolation are often of critical importance in that severe harm can be done to other patients and staff by failure to isolate promptly. This is often not the case for other reasons patients are in side rooms and side rooms should be prioritised to maximise patient safety. The Trust should also look to ways to enhance the capacity to isolate a patient when the hospital is full and a patient needs isolated urgently e.g. where a patient could be moved out of a room to facilitate critical IPC isolation.	20/09/2021- all patients who attend ED have Lumira to determine covid status. PCR completed as per protocol. Risk assessments are completed when a high number of beds are closed due to an outbreak vs risks in ED. 01.06.2021- there has been 8.7 million pounds secured from the DOH address nosocomial infections which will allow estates work to progress. This will free up clinical space to accommodate patients. 24.01.21- delays in ascertaining results of swabs and screening and appropriate action delayed based on same and lack of isolation rooms to accommodate this.	HIGH	
3953	ACUTE	10/04/2018	Provide safe, high quality care	Inappropriate antibiotic use (tied to stewardship issues in terms of corporate actions needed)	Inappropriate antibiotic prescribing can lead to a rise in antibiotic resistance which impacts on the safety of the entire public. It can also lead to side effects for individual patients such as Clostridium difficile infection (CDI). The risk of CDI is enhanced where antibiotic treatment is unnecessarily broad spectrum or overly prolonged. Inappropriately narrow spectrum or inadequately long courses of antibiotics can also lead to adverse outcomes for patients including recurrences of infection and death. Inappropriate prescribing most often occurs:- (a) When patients receive antibiotics when they do not have infections - this often occurs whenever a diagnosis is initially unclear and infection is in an initial differential but antibiotics are not stopped whenever the situation becomes clearer. (b) A clear diagnosis is not made e.g. a patient is designated ?LRTI ?UTI - often even when a diagnosis is subsequently made broad spectrum antibiotics are not narrowed as they should be (c) When patients receive prolonged antibiotic courses instead of getting proper source control - all guidelines advise that abscesses or infected collections should be drained promptly if at all possible The patient is at side effects from antibiotics, at risk of acquisition of multi-drug resistant organisms, at risk of Clostridium difficile and potentially death. Other patients and staff are put at risk as bacteria in the hospital environment develop greater resistance, meaning that the number of antibiotics available for future treatments become more restricted. Ultimately bacteria can become panresistant and untreatable. This in turn places greater pressure on side ward capacity in the Trust and risks targets e.g. MRSA target. The Trust has will not be able to meet the upcoming targets for the reduction of broad-spectrum antimicrobial use unless the situation is improved. Staff and the Trust are at risk of litigation and censure from the Coroner and the GMC.	The Trust conducts antimicrobial stewardship rounds to reduce inappropriate antibiotic use. This service however is limited by the inadequate number of microbiologists and antimicrobial pharmacists. The Trust has far fewer microbiologists than neighbouring trusts and the number it is funded for (2) is far short of what the Royal College of Pathologists standards says it requires. The Trust only employs 1 antimicrobial parmacist in comparison to the standard 2 in other Trusts. This means that the stewardship round service is exceptionally vulnerable to leave or illness and at best only is staffed to function two thirds of the year. The service has been severely impacted by the current staffing situation in the Trust. The Trust has only had a single microbiology consultant for over a year and a half. At times there has been no locum cover and there is not capacity to do stewardship rounds when a microbiology is single-handed. Since the Trust's antimicrobial pharmacist was promoted several months ago the Trust has had only had a pharmacist effectively 1 day a week which again had a severe further impact on the antimicrobial stewardship service. Membership of the Trust's Antimicrobial Team Meeting (the main forum for communication for stewardship issues) had waned however the DIPC recently reviewed the membership of the meeting and medical leaders are now expected to attend. This has significantly improved the platform at which stewardship is discussed however the situation of the service as a whole remains critical. The Trust has offered positions to a new antimicrobial pharmacist and a second microbiologist however they have yet to take up posts. A business case is being submitted for expansion of the microbiology and antimicrobial pharmacist services which is critical to address these issues. Medical leads need to be encouraged to take more actions in their areas to emphasise the importance of stewardship. This will be discussed at the next AMT meeting on Tuesday the 27th of March. Lead Nurses and Ward Sisters should be empowered also to encourage nursing staff to challenge prescriptions.	11/08/2020 There is a team of microbiologists and an OPAT team to over see antibiotic prescribing on both sites. No longer a Risk. Removed from Risk Register. Risk added to RR April 2018. Risk added to RR April 2018	HIGH	12/08/2020

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Closed date
3954	ACUTE	10/04/2018	Provide safe, high quality care	Lack of documentation	Root cause analyses are repeatedly picking up incidences of poor documentation e.g. lack of filling out of Clostridium difficile bundle, lack of documentation that the patient has been informed of a diagnosis of Clostridium difficile, lack of filling out of cannula charts, etc. Lack of documentation can reflect either that something that should have happened has not happened or just that it has not been documented. In the former there is a direct risk to patient safety (e.g. death from Staphylococcus aureus bacteraemia from a cannula that was not inspected properly and removed when it should have been, death from Clostridium difficile due to deterioration not being picked up due to lack of due diligence in the application of the bundle). In the latter there is still danger to the patient as staff subsequently on duty will not be able to see what was done as it is not documented. There is also significant risk to litigation to individual staff and the Trust as without documentation to say that good practice has been carried out there is no proof that it has been done.	Medical and nursing training would emphasise the importance of good documentation. Root cause analyses would emphasise the importance of this. The recurrence of this problem as demonstrated by repeat root cause analyses however would suggest that current control measures are not sufficient. When challenged regarding poor documentation excuses given are usually:- (a) A lack of education/awareness regarding aspect s of care bundles (b) A lack of time to document things due to service pressures Problem (a) could re resolved through additional education to staff through Lead Nurses, Ward Sisters and Clinical Directors to their teams where this is needed. Problem (b) can only be resolved by easing the pressure on nursing and medical staff in general. In general the experience of the IPCT is that nursing documentation is better than medical documentation, especially with regards to documenting when a patient has been informed of their diagnosis.	18/08/2021- RQIA guidelines shared with Cardiology Team following SAI. Audit to be carried out in October 2021. 24.02.2021- improvements have been made but still needs continually monitored	HIGH	
3957	ACUTE	30/04/2018	Safe, High Quality and Effective Care	The medical team on the Daisy hill hospital site cannot provide daily senior review for all the Medical in patients	Due to medical workforce they are unable to ensure that all in patients receive a senior medical review. Delay in investigations. Delay in review of investigations. Delay in Diagnosis. Impact on the patient treatment plan. Potential to contribute to overcrowding in ED as some of in patients could be potentially discharged.	Each Ward Sister to identify at the bed meetings if patient has not had senior review. Ensure that outlyers are seen and escalate accordingly to Lead Nurse/ HOS	19/4/22. All wards DHH have 3 consultants aligned to them so all patients are seen daily. Need To review middle tier rota to support additional Medical Beds opened on DHH site. Recruitment in progress for substantive consultant posts. 20/09/2021- unable to secure acute physician for DAU. 18/08/2021- COW model in place and patients reviewed daily. New patients discussed at daily handover at 8.30am and also weekend handover at 12.45 on Fridays. 07/06/2021- There are 5 substantive Consultant post in DHH across Med/ Stroke/Respiratory and Gastroenterology. 4 out of 5 contribute to the 1:8 medical rota. The remaining posts are filled by Locum Consultants. there is a 1:12 weekend/bank holiday rota which is supported by colleagues from OPPC. There is now a substantive 1:8 middle tier rota. From August 2021 there will be a full middle tier out of hours rota with no locum's. At weekend/bank holidays there is an additional Consultant, registrar and SHO who work from 09:00-14:00 hours. 24/02/2021- review of medical staffing on DHH site currently taking place. E- Req in system for specialties. 13/05/20. Zoning introduced but issues identified with this system. Audit carried out. Medical rota is sufficient to provide daily senior review. 24.06.19 No change. Zoning introduce needs evaluated. Review workforce available.	MOD	
3958	ACUTE	30/04/2018	Safe, High Quality and Effective Care	EBUS Provision lack of Funding	The risk is that patients requiring this investigations are waiting in access of 13 week Pot for Harm -Delays in patients being diagnosed, commencing treatment and the appropriate way Delays may contribute to patient death.	We have Cardiac investigations teams across both acute Sites Agreed referral process to be used by CI staff at Triage Avail of funding from HSCB for additional clinics.	10/08/20 - can be removed from risk register. 02/06/2020 Initial funding secured from LCG but then it was utilised for other services. So EBUS funding still outstanding 24.06.19 Additional EBUS session secured and we will continue to monitor. 19/11/18 Measure access times monthly and highlight to HSCB via performance team. Review of cardiac investigation demand and capacity by HSCB.	MOD	10/08/2020
4177	ACUTE	20/06/2018	Safe, High Quality and Effective Care	Chiller Faults causing loss of time- MRI	Chillers are required to supply chilled water to the MRI scanner to remove heat produced during scanning and facilitate circulation of liquid helium which maintains the operation of the supercounducting magnet. For the scanner to operate at the highest levels of efficiency, the magnet inside the scanner has to be kept as cool as possible. Any increase in temperature will result if the the chiller is not operating will cause the scanner to no longer operate. This is a safety mechanism for the scanner to prevent boil off the liquid helium "quenching". This is when the wire in the electromagnet stops being superconducting and starts to generate a lot of heat. At this point, any liquid helium around the magnet repeatedly boils off and escapes from the vessel housing the magnet.	Single chiller per scanner with no back up available. Alarm system in place to business management system when chiller is not operating- no communication from switch or estates re this during recent breakdowns. Siemens will test this to check if the system is working.	08/07/2021- recent chiller failure- temporary chiller installed until fault can be replaced. Several days scanning lost while this was ordered and installed. RED FLAG exams delayed due to downtime. 21/11/2020- no change- still awaiting estates action ongoing follow up with estates for progress. 20/06/2018- automatic emergency bypass system needs integrated instead of manual- to be referred to capital department for design team. Additional secondary chiller with associated pipework as a backup- D/W David Thompson needs referred to capital department design team. Discussion with Estates Team and Switch in relation to procedure for notifying estates and MRI if chiller alarm goes off. Alarm system to be tested.	HIGH	

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3971	ACUTE	28/08/2018	Provide safe, high quality care	Access to cath lab for NSTEMI patients- ST has the highest through put of patients through the Cath Lab in the region.	The ST have highest through put in the region and only have one Cath Lab. If the C Arm breaks down we will not be able to treat Cardiology patients requiring patients to be transferred to another Trust. SHSCT are concerned there is a potential to patient morbidity and mortality due to long waiting list. Standard 18d of Cardio vascular framework that eligible NSTEMI / ACS pts should have Cor Angio +/- PCI within 72 hrs of admission. Angiography within 72 hours improves outcomes for patients. (NICE). MINAP state: The performance of angiography and coronary intervention soon is an important facet of treatment for the majority of patients.	Monitored weekly. Access elective patients. Escalate number of patients waiting for in patient cath procedures daily to AD and Director. There is a Regional Cath Lab implementation group which has been in place since August 2020.	18/08/2021- Have escalated via Elective Performance meeting. Highlighted the impact of high volume of inpatient activity and need for 2nd Cath Lab to address. Meeting held re inpatient plan regarding sharing lists with Belfast and Western Trust. Criteria to be established. Access times monitored monthly. 07/06/2021- The SHSCT has raised with the HSCB the need for decisions re Cath Lab capacity to meet the demand to be made as soon as possible. The Consultant Cardiologist in the SHSCT recommend a second Cath Lab on site. A PID for phase 3 Cath Lab capacity project was finalised in Oct 2020 and it was shared with the interim Director of commissioning in the Board. The process has been delayed due to the impact of Covid. A Clinical Lead is to be appointed to take forward a capacity and demand exercise which will allow a number of different options to be considered. 24/02/2021- working through as part of cardiology network plan but the target is only 33% in 72 hours due to only one cath lab. 5 /11/20 KPI for N STEMI s getting to cath lab within 72 hours has dropped to 35 % from 45% this is impacting on length of stay and bed occupancy at ward level and resulting in patients being admitted to wrong ward 10/08/20 - Regional group has been established PID document agreed. Demand and Capacity for cath lab activity to commence when templates have been distributed to the Trusts. 14/5/2020. Modular Cardiac cath lab was removed in October 2019. Access times for NSTEMIS has dropped to 33% getting to Cath lab within 72 hours . Regionally agreed to establish group to review cath lab activity re access times and demands. 24.06.19 Monitored via MINAP only 50% getting to cath lab despite modular. High volumes of inpatient activity (monitored monthly for each site) Need to secure Funding permanent for modular. Need to reduce elective to facilitate inpatient. 13.08.18 Performance team to liaise with HSCB re funding	HIGH	
4007	ACUTE	28/02/2019	Provide safe, high quality care	Risk that patients receive inappropriate care due to the misuse of point of care testing	Risks arise from the inherent characteristics of the devices themselves and from the interpretation of the results they provide. They can be prone to user errors arising from unfamiliarity with the devices. Patients are at risk of inappropriate treatment as a consequence of inaccurate results. Individuals are sharing passwords/barcodes in contravention of Trust procedures and good governance. Equipment is not being properly maintained which puts equipment at risk of malfunction leaving patients vulnerable. Internal Quality Control review and regular audits have stopped due to a lack of resources. There is a lack of Assurance around temperature control of reagents etc. which has the potential to influence the results. Patients are at risk of receiving an inaccurate test result and receiving inappropriate treatment or not receiving treatment when it is actually required. Patients could come to serious harm / death. Staff are at risk to Trust sanction or Professional body sanction, litigation, dismissal. Trust is at risk of litigation due to improper use of devices. Trust is at risk of litigation due to improper treatment based on inaccurate results or misinterpretation of results.	Training is available on all devices. Quality controls are available. DATIX web is available to report and monitor any incidents. Staff are given unique barcodes to operate Trust equipment where they are deemed competent to do so. It is the responsibility of all staff issuing a POCT device to end users to ensure that the user is adequately trained and competent to use the device.	28/02/2022- Merged with datix[redacted] 20/09/2021- ED has stated that no additional funding given to provide POC service in ED- directly impacts on timing of results. High risk of agency staff. Consideration should be given to commissioning of mini lab in ED managed by main labs. 18/08/2021- this is monitored and issues escalated to Dept manager and LN and HOS. June 2021Re-started the Medical Devices and Equipment Management Group meetings. This group will have the role of promoting the safe use of medical devices and equipment throughout the Trust, providing assurance for the life cycle of all medical devices which includes procurement, use, decontamination, maintenance and disposal by the organisation of all medical devices, to ensure their use and application does not create a risk to patients, clients, staff and visitors. June 2021Expression of interest interviews taking place 04/06/2021 for Rapid Covid Tester in ED, using Lumira devices. May 2021 Requisition in place for POCT Assistant to replace staff member which has moved on. April 2021Re-commencement of user audits by Patient Safety and Quality Manager. This audit looks at barcode sharing. POCT are involved in a regional training programme for both Clinitek and Glucometers for any staff member who needs it. This allows a staff member from another Trust (bank nurse) to use device and would therefore reduce user error. Roche are currently working on a regional INR training structure. July 2021 POCT have developed a barcode sharing policy which will go live in July and will be disseminated to all AD'S and appropriate leads. May 2021 Equipment controller training will re-commence post covid as an online learning via Sharepoint. The powerpoint presentation will be uploaded in the coming weeks and will include a declaration form which will be signed by trainees upon completion. Feb20 Patient safety and quality manager mitigated the risks associated with improper use of Glucometers	LOW	28/02/2022
4009	ACUTE	28/02/2019	Provide safe, high quality care	Delay in the management of oncology patients	Due to significant vacancies in Medical Oncology Consultant workforce across the region there is reliance on locum Consultant cover to support Oncology clinics. Breast Oncology clinic have now 2 substantive visiting Consultants from Belfast, 2 substantive visiting Consultants for Colorectal, there is still 1 Lung Consultant Locum attending.	Trust currently working closely with colleagues in Belfast Trust to complete a look back exercise to ensure patients have all got a management plan. ongoing review of weekly clinic and outcomes from these.	Dec19 non medical prescribing (NMP) funding has been secured to develop nursing and pharmacy NMP. Due to significant vacancies in Medical Oncology Consultant workforce across the region there is reliance on locum Consultant cover to support Oncology clinics. Breast Oncology clinic have now 2 substantive visiting Consultants from Belfast, 2 substantive visiting Consultants for Colorectal, there is still 1 Lung Consultant Locum attending.	LOW	02/03/2020

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4010	ACUTE	28/02/2019	Provide safe, high quality care	Delay in the treatment of Cancer Patients due to vacant Oncology Consultant	Due to vacant Acute Oncology Consultant post and reliance on one Specialty Doctor in Oncology there may be times when unwell patients attending mandeville unit will have to be directed to Emergency Department for further assessment and management. Service heavily reliant on Clinical Nurse Specialist support at present.	Trust currently trying actively to recruit into vacant Acute Oncology Consultant post and working closely with colleagues in Belfast Trust to support the oncology service. Trust currently working closely with colleagues in Belfast Trust to complete a look back exercise to ensure patients have all got a management plan. ongoing review of weekly clinic and outcomes from these.	02.03.2020 The medical oncology staffing pressures continue to be a major issue at this point in time. There appears to be no prospect of recruiting into the Consultant Oncology post. The ST is therefore reliant upon visiting Oncology Consultants from Belfast. In recent weeks Belfast HSCT have advised they may have to reduce the number of consultants visiting. Thereby exacerbating the local problem and requiring the risk rating to increase from moderate to high. To address capacity issues working to skill up NMP both nursing and pharmacy. 3/12/19 Due to significant vacancies in Medical Oncology Consultant workforce across the region there is reliance on locum Consultant cover to support Oncology clinics. Breast Oncology clinic have now 2 substantive visiting Consultants from Belfast, 2 substantive visiting Consultants for Colorectal, there is still 1 Lung Consultant Locum attending. Funding has been secured via early workforce bid through Oncology Services Transformation for 0.8WTE Advanced Practitioner Oncology with 0.25 WTE admin support and 1.0 WTE Specialty Doctor for Oncology. Ongoing work to progress recruitment of these posts. Dec19 non medical prescribing (NMP) funding has been secured to develop nursing and pharmacy NMP. Due to significant vacancies in Medical Oncology Consultant workforce across the region there is reliance on locum Consultant cover to support Oncology clinics. Breast Oncology clinic have now 2 substantive visiting Consultants from Belfast, 2 substantive visiting Consultants for Colorectal, there is still 1 Lung Consultant Locum attending.	HIGH	24/06/2020
4011	ACUTE	28/02/2019	Provide safe, high quality care	Delay in the Management and Review of Haematology Patients	Due to pressures within Haematology service patients requiring review at outpatient Haematology clinic may not be reviewed in a timely manner due to review backlog therefore risk that patients may have delay in diagnosis. A senior Consultant is planning to retire at the end of December and due to difficulties in recruiting medical workforce this may further impact the ability to review patients in a timely manner.	Staff have been offered the opportunity to undertake additional sessions to ensure that the waiting time for patients to be seen is reduced and patients are seen in a timely manner.	June 2020 Nov19 Haematology Consultant workforce is now funded for 5.0WTE however due to 2 senior Consultants retiring earlier this year recruitment is ongoing. There are currently 3.0 WTE in place and following recent interviews for 2 vacant posts, offers were given with one Consultant accepting. This leaves a gap of 1.0 WTE which will be covered by Locum cover. One substantive Consultant has now gone off on sick leave for planned surgery.	MOD	24/06/2020
4005	ACUTE	28/02/2019	Provide safe, high quality careMake the best use of resourcesBe a great place to work	Lack of Availability of Core AHP Staff	Increase volume of complex patients requiring intervention. Increasing demand on services with high patient turnover and additional patients across wards, transition ward, outliers and ED presenters. Staffing across all disciplines below the National average (NHS Benchmarking figures 2017) Gaps in core services with inability/challenge to recruit in timely manner. Lack of backfill for maternity leave. Patients not receiving timely assessment and appropriate level of rehabilitation to maintain patient flow. Patients under nourished, remain nil by mouth for increased length of time due to reduced dysphagia cover especially for stroke patients. Unable to facilitate mobilisation with resulting deterioration in muscle bulk and increased morbidity, lack of facilitation of activities of daily living hence increased dependency and requirement for larger package of care on discharge which will be delayed. Poor SSNAP results Instability of core OT/PT staffing impacts on ability to rollout ward based 7 day working Potential for SAIs. Complaints received re: service provision Inability to consistently meet professional standards Health and wellbeing of staff compromised Staff working outside levels of competency and under significant pressure. Reduced morale and goodwill among teams - staff retention an issue with posts outside of acute attractive.	Regular contact with BSO re recruitment. Requests to contract and non contract agencies for AHP staff, core staff offered additional hours,		MOD	13/08/2020
4006	ACUTE	28/02/2019	Provide safe, high quality care	Lack of robust arrangements and sufficient resources for the management of equipment and medical devices.	The Trust does not currently have in place suitable and robust arrangements to support the management of medical devices and equipment in accordance with the DHSSPS Controls Assurance Standards and MHRA guidance. Stringent management throughout the lifecycle of medical devices (from procurements to disposal) is essential in minimising the associated risks to both patients and staff. The Trust has a duty of care towards its employees and patients to ensure that they are not put at risk from medical devices which are not managed properly, may be unsafe or unsuitable, are not maintained or whose operation is not understood by the user. There is also a risk that the Trust could be subject to litigation if it can be proved that there were not adequate management systems and resources in place to deal with equipment management.	This risk being managed in the Acute Directorate	March 2020 a Trustwide Equipment and Assessment Manager has been appointed and has taken up post March 2020.	LOW	02/03/2020
4031	ACUTE	28/05/2019	Provide safe, high quality care	BTS National Audits (British Thoracic Society)	Patients are being disadvantaged because we can't take part in good quality national audits. Staff can't show evidence of good quality practice. We are unable to be properly benchmarked against similar organisations.	Ongoing backlog in data provision for national audits	10/08/20 - A process for Audit has been agreed with the respiratory team. Risk can be removed from register. Risk placed on Register for monitoring	MOD	10/08/2020
4039	ACUTE	12/06/2019	Provide safe, high quality careMake the best use of resources	Physiotherapy Staffing Difficulties	Inability to provide adequate Physiotherapy to acute based patients due to increased demand for Physio service in The Blossoms Childrens Services (in particular Paediatric Respiratory requirements. Ongoing recruitment and vacancy difficulties	Delayed assessment of patients. Potential Delay in patient discharge. Potential for complaints Limited rehabilitation to patients, hence longer length of stay in hospital. Inability to consistently meet professional standards Health and wellbeing of staff compromised Staff working outside levels of competency and under significant pressure. Inability to achieve regional PTL waiting time targets	Jun19 Bid to the Investment Committee for consideration. Requisitions for recruitment of suitably trained staff. All core staff offered additional hours. Triage and prioritisation of referrals. Waiting list for in patients. Timetable constantly reviewed with staff managed & moved between the 2 sites to attend to priority demands.	MOD	13/08/2020
4046	ACUTE	05/08/2019	Provide safe, high quality care	Gamma camera Breakdown	The Nuclear Medicine department has 2 gamma cameras. The oldest, which is 20 years old, recently broke down and cannot be repaired as parts are no longer available. The remaining camera is 11 years old. If there is any breakdown with it or there is a service day, there will be no delivery of the service. Delay in patient scans, which may lead to a delay in diagnosis. The majority of the scans that are undertaken in nuclear medicine are for cancer patients. This will lead to Trust breaches in the Cancer Pathway.	Keeping the remaining camera serviced and in good working condition If there was a breakdown of any length of time, the wards would need to be informed, and patients transferred to a different trust as there is no other provision for nuclear medicine scanning in the southern trust. Lists cannot be carried out at the weekend as radiopharmacy does not supply radioisotopes at the weekend.		MOD	03/12/2019

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4049	ACUTE	07/08/2019	Provide safe, high quality care	Due to the staffing situation in Maternity there is an inability to accept Inutero Transfers from other Units for Neonatal Cots	The Trust is currently intermittently unable to accept inutero transfers for neonatal cots from other units. This is due to current maternity staffing level difficulties. Possible harm to mothers and babies who require a neonatal cot due to specific health needs and imminent delivery, therefore requiring transfer to this specialised facility. Potental for undue distress to baby and parents.	Continual monitoring of the staffing situation to make best use of existing resources. Transfer accepted when staffing levels permit.	16/03/2021- Ability to accept inutero transfers remains limited due to staffing and capacity ongoing recruitment continues, increased pressures to accept transfers due to regional neonatal capacity. Will continue to monitor Jun20 continue to monitor Dec19 Specific focus on recruitment - recruitment fayre undertaken and appointments made awaiting registration within next year. Retention of staff also focus within division to retain and recruit staff	MOD	
4060	ACUTE	14/08/2019	Provide safe, high quality careMake the best use of resources	Possible breakdown of aging Ultrasound scanners	Increasing difficulty is sourcing spare parts for ageing and outdated models of Ultrasound equipment currently in use in both CAH and DHH. Possible risk to mothers and babies.	monitor and manage patients through the system.	March 2020 new scanners have been purchased so no longer a risk Dec19 Number of scanners that are breaking down x3 Resuscitaires and ultrasound machines	LOW	02/03/2020
4083	ACUTE	05/02/2020	Provide safe, high quality careMake the best use of resources	Unique barcode access to Glucometer Devices	Use of Glucometer device by members of staff who do not have individual barcode access. This can result in difficulty in identifying the member of staff who carried out blood sugar testing. There is also training required to use this device correctly and escalate any concerns appropriately Correct use of device to ensure the patient details are accurately completed. Diabetic team use the data from this device to identify patients for review on twice weekly ward rounds so if details are incomplete or inaccurate the patient is potentially missed from the ward round. This can be approximately 30 patients across both sites per month.	In the event of an incident occurring there is difficulty identifying the member of staff who carried out testing when barcodes are shared or borrowed. This can be problematic throughout Trust and agency staff are also using these devices. This may cause undue risk to patients. All staff required to use Glucometer require individual barcode for clear identification of all tests carried out.	Feb - Added to Risk Reg	MOD	24/02/2020
4090	ACUTE	09/03/2020	Provide safe, high quality careMake the best use of resourcesImproving Health and Wellbeing	Prescribing of valproate not in line with valproate Pregnancy Prevention (PREVENT) Programme	Valproate is associated with teratogenic risks (congenital malformations, neuro-developmental disorders) in children exposed to valproate during pregnancy. Children exposed to valproate in utero are at increased risk of lower IQ and of risk of developing neurodevelopmental disorders. In 2017 and 2018 the DoH issued a number of circulars in relation to the risks of prescribing valproate in women of childbearing age (HSC (SQSD) 19/17, HSS (MD) 8/2018 and HSS (MD) 27/2018) highlighting new resources to support the safety of girls and women who are being treated with valproate. Among the recommendations to Trusts was the requirement to develop an action plan to ensure all girls and women of or nearing childbearing age taking valproate are systematically identified so that all relevant resources can be used to plan their care. In addition, all relevant resources are to be embedded in clinical practice for current and future patients, by revising local training, procedures and protocols.	Currently valproate is prescribed to a small number of patients under the care of SHSCT Consultants, all of whom have been made aware of the various DoH circulars and associated recommendations. A number of SHSCT Consultants sit on the Regional Valproate Group, chaired by PHA. The Trust has also recently established a task and finish group to address outstanding risks in relation to the recommendations in the circulars, namely the systemic identification of all girls and women who may be prescribed valproate. The Drugs and Therapeutics Committee also monitors the implementation of the recommendations within the circulars through the Medicines Governance Pharmacist, also a member of the Regional Valproate Group.	9 March 2020 Consultants manage their own registers of girls and women on vaproate.	LOW	
4100	ACUTE	11/08/2020	Provide safe, high quality care	Replacement programme for Radiology Equipment on all Acute Sites	A radiology equipment replacement programme is required to ensure that ongoing high quality diagnostic imaging services can be provided for patients within the Southern Trust. New Imaging equipment ensures maximum diagnostic capability with minimum radiation dose.	Equipment replacement plan has been drawn up. A Capital Investment stream is required to be identified for Diagnostic imaging.	The equipment plan has been presented at Trust SMT. Unfortuanately at this time capital funding is not available within the Trust to meet the needs of the plan. Equipment records are kept up to date with records of breakdowns and quality assurance testing.	HIGH	09/03/2021
4099	ACUTE	11/08/2020	Provide safe, high quality careMake the best use of resources	Neurophysiology- Due to insufficient staffing levels risk of occasional department closure days	Occasional risk to inpatients as no staff to provide service. There is the occasional inability to provide an inpatients service for EEG. EEGs are an aid to diagnosis. there is no on call/weekend or bank holiday cover	As a rule x2 staff not permitted to have annual leave at the same time however in exceptional circumstances this can occur when staffing levels are insufficient. Change the working pattern for x1 P/T member of staff which will reduce lone working days and therefore reduce risk of closure days	03/12/2021 - A Band 5 MTO commenced in October which alleviates some of the departments staffing pressures. 14/09/2021- Lead has now retired. A new interim lead has been appointed. Continue to train 2 staff- progressing through the 2 year training programme currently. March 2021 - Lead due to retire in August 2021. 1 member of staff has taken a career break for 2 years. Another member of staff will shortly be going off on maternity leave. The remaining member of staff will increase their hours and be assisted by the trainee posts. Staff levels should be 3.22WTE	LOW	
4126	ACUTE	18/11/2020	Provide safe, high quality careMake the best use of resources	Lack of patching- Radiology	could result in the inability to access clinical systems on radiology equipment and server infrastructure. Highlighted by vulnerability scan using Tenable. Loss of essential services.	Patching arrangement need to be formalised. This needs developed within 3rd party agreement. All 3rd party contracts to be reviewed and amended to include patching- regional project looking at 3rd part suppliers being led by BSO	ongoing review with IT in relation to this. All 3rd party contracts to be reviewed and amended to include patching- regional project	HIGH	09/03/2021
4127	ACUTE	07/12/2020	Provide safe, high quality careMake the best use of resources	Unsupported windows operating systems	Radiology- the remote host is running Microsoft Windows XP- support for this operating system by Microsoft ended April 2014 leaving risk of ransomware attacks and or hacking.	Targeted staff awareness training, devices to be replaced, upgraded or if not possible must be segregated. It working with Radiology to highlight all devices		HIGH	09/03/2021
4133	ACUTE	29/01/2021		Unable to off load patients from ambulance when ED is overcrowded	Patients at risk due to being unable to offload patients from ambulance to ED due to overcrowding	HALO role and ongoing monitoring	01/06/2021- Risk linked with 3508 as per Melanie and closed 09/03/2021- need to secure funding for medical gases for ambulance receiving area. Daily monitoring and escalation. Unscheduled care huddle regional actions daily. Estates ordering a modular unit for 6 cubicle receiving area. Ongoing review of escalation plan	MOD	01/06/2021
4142	ACUTE	24/02/2021	Provide safe, high quality careBe a great place to workMake the best use of resources	Recruitment and Retention issues- Trust Wards	Patient safety risk. Identification the deteriorating patients, risk on escalation of same, lack of knowledge of in house processes, potential treatment/management/discharge delays. Increased pressure placed on core team, risk of burn out/work related stress. Potential lack of escalation/risk deteriorating patient not escalated. Potential risk of failed discharge/transfer due to lack of knowledge regarding processes. Risk of non-compliance with appropriate documentation required to manage patients holistic needs.	currently focusing prioritising recruitment to this area. Complete all outstanding e-reqs Internation nurse recruitment Target year 3 nursing students to this area to attract uptake Offer all bank and agency permanent positions Daily review and redeployment of staff to support the skill mix and staff levels with 2 South.	19/4/22. Still ongoing issue with recruitment and retention of Staff. Staffing levels reliant on Bank and Agency to fill gaps at ward level. 20/09/2021- 6 new start band 5 in DHH ED October 2021. 22 New start Band 5 CAH ED October 2021 28.06.2021- ATICS ongoing Band 5 recruitment drive. 8 x band 5 posts from peri-operative work stream. Applications closed 23.06.2021 Action plan completed working collaboratively with the AD from workforce to address this	HIGH	

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4143	ACUTE	11/03/2021	Best use of resourcesProvide safe, high quality care	Replacement programme for Radiology Equipment on all Sites to replace equipment on unsupported operating systems and provide mai	A radiology equipment replacement programme is required to ensure that ongoing high quality diagnostic imaging services can be provided for patients within the Southern Trust. New Imaging equipment ensures maximum diagnostic capability with minimum radiation dose. There is equipment currently running on Microsoft Windows XP - the support ended in April 2014 leaving risks of ransomware attacks or hacking..Failure to patch as per schedule could result in the ability to access clinical systems on radiology equipment and server infrastructure. This has been highlighted by Tenable programme and could result in the loss of essential services.	Equipment replacement plan has been drawn up. A Capital Investment stream is required to be identified for Diagnostic imaging. Patching arrangement needs to be formalised. This needs developed with 3rd party agreement. All 3rd party contracts to be reviewed and amended to include patching - regional project looking at 3rd party suppliers being led by BSO. Targeted staff awareness, devices to be replaced, upgraded or if not possible must be segregated. IT working with Radiology to highlight all devices. "	10/02/2022 -In the financial year 21-22 the following equipment was replaced via Capital Monies: "3 Endoscopes "Technegas "3 General Ultrasound units "2 Breast Ultrasound units "2 Fluoroscopy units Capital priorities for the coming year are: "Funding for a 2nd CT Modular unit at DHH "Second CT scanner CAH "Replacement of 1 MRI scanner CAH "Replacement of DXA scanner and DR room at STH - this is in preparation for a Diagnostic Centre 14/09/2021- 10 year plan drawn up-investment per year shared with Regional Imaging Board- understand that SHSCT needs priority. "The equipment plan has been tabled at Trust SMT. Radiology have also presented to SMT to highlight the issues. This presentation has highlighted specific urgent requirements including breast imaging and fluoroscopy across both sites to include the required ventilation. Unfortunately at this time capital funding is not available within the Trust to meet the needs of the plan. Equipment records are kept up to date with records of breakdowns and quality assurance testing. There is ongoing review with IT regarding patching. " ongoing review with IT in relation to patching. All 3rd party contracts to be reviewed and amended to include patching- regional project. "To be amalgamated with 8, 10 and 11. The equipment plan has been presented at Trust SMT. Unfortunately at this time capital funding is not available within the Trust to meet the needs of the plan. Equipment records are kept up to date with records of breakdowns and quality assurance testing. "	HIGH	
4155	ACUTE	01/04/2021	Provide safe, high quality careMake the best use of resourcesBe a great place to work	Haematology Outliers	Currently only providing a 6 bedded inpatient side room, augmented care capacity for Haematology patients. All other admitted Haematology patients are cared for throughout both medicine and surgery, without the necessary environment to ensure patient satiety regarding hospital acquired infections. Potential risk could be catastrophic for a haematology inpatient. Haematology patients are immunosuppressed and are amongst one of the most vulnerable client groups within the hospital setting. Ultimately if a patient is exposed to one of the many potential hospital acquired infection this could be life limiting.	Patients that are identified as immunosuppressed must be prioritised for an ensuite side room the estate is limited regarding same and as such we are not always able to accommodate this, patients are then placed in side rooms with shared toileting facilities Haematology Teams keep track of all outlying patients and review same providing clinical plans where necessary. Maximising discharges in Haematology Unit, in order to created capacity for admitted patients.	Action plan completed working collaboratively with the AD from workforce to address same	HIGH	
4157	ACUTE	06/05/2021	Provide safe, high quality careMake the best use of resources	MRI Capacity	MRI inpatient demand has significantly increased with an impact on the capacity for red flag, urgent and routine outpatient examination. There has been a 72% increases in inpatient MRI demand comparing March 20 and March 21. Currently there is no MRI facility available on the Daisy Hill Site and patients have to transfer to CAH for MRI imaging. Increased outpatient waiting list and waiting times. Potential for additional queries regarding inpatients to MRI staff adding additional pressures.	Currently some MRI referrals are being outsourced to the Independent Sector. However due to image quality the more complex outpatient MRI referrals remain in the Southern Trust	6/4/22 The MRI options paper is to be presented to SMT on Tuesday 12th April to seek approval to look at non Trust locations for a modular MRI unit. There is also an ongoing MRI optimisation project being facilitated by Siemens and the initial review of the service has occurred and we are currently awaiting feedback. 14/12/2021- brought to CW to raise with Director re corporate register move. The Department are working with planning on a Business Case for a low field strength MRI Scanner to be located at DHH. The Current MRI scanners located in CAH are due for replacement in 2023 and 2024 which are currently on the equipment replacement plan. The costs of low field MRI scanner for DHH has yet to be finalised	HIGH	
4156	ACUTE	19/08/2021	Provide safe, high quality careMake the best use of resources	Referrer MRI Safety	MRI is potentially hazardous and involves significant risk to patient safety. During the period 2019-2021 there has been an average occurrence (one every 3 weeks) of incidents involving incorrectly completed MRI safety referral information. These incidents have involved referrers stating that patients do not have any potential contraindications to undergo MRI(implants) however it is later identified by MRI Team that implants are in-situ. If these events keep occurring at the current rate there is an increased risk of morbidity and mortality because the source of risk has not been reduced.	The MRI Team screen and check all patients and completed questionnaires to attempt to ensure these errors are captured. E Learning MRI safety for referrers is available on HSC E Learning. Where possible notifications are sent to referrers involved to highlight the error and request that they complete the MRI safety training.	03/12/2021 - A national MR Safety training module is being developed and will be released in 2022. This module will replace the current MR Safety module on ELearning. A trend analysis report has been collated over the past 4 months which has not indicated any reduction in the number of incidents. 14/09/2021- requirement for a 3rd scanner, electrical infrastructure in DHH is an issue- cannot be brought forward. Modular MRI scanner on DHH currently. Cannot be progressed by division. To be discussed with Director of Acute Services t to have this risk moved back onto Directorate register. 16/08/2021- memo has been circulated by the medical director to all medical staff regarding the importance of correct protocol when filling out safety questionnaires for MRI. MD has asked for compliance audit data to be shared with MD and AMD to allow this issue to be addressed. A learning letter was sent out with the memo to be shared at the M&M meetings and Governance Co-coordinators to be raised at directorate governance fora and the AMD and DMD for sharing within teams. Posters to be placed on Trust desktops via Communications team by June 2021 The Department would like Referrer MRI Safety Training to become mandatory for MRI referrers by August 2021	HIGH	

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4176	ACUTE	20/09/2021	Accessible and Responsive CareSafe, High Quality and Effective Care	Covid & Non Covid patients on AGPs being cared for in red Resus	Nosocomial Spread and patients at risk	ED consultants/management/IPC/Micro walkaround CDU identified as resus area for patients receiving AGPs CDU converted to Red Resus as IPC/Micro advice Lumira swabbing commenced in ED to determine Covid status The side room is used were possible to provide some protection for e.g. if one non-covid patient on AGP they will be nursed in side room and vice versa. However still a potential risk that aerosols will mix. When this is not possible patients in an open bay have the same air space which means that they are all in direct contact with one another. Covid positive patients in red resus are transferred to a Covid ward as soon as possible to reduce the risk. Ongoing escalation of red resus at APC meetings. All staff in red PPE. Walk around with Estates.	21/09/2021- Datix to be completed when non-covid/covid patients are nursed in red resus at any one time. Patients transferred out of red resus to appropriate ward when clinical condition permits is ongoing. Estates have confirmed that inability to undertake closing off cubical areas due to the estate structure. March 2020- CDU converted to red resus for patients on AGPs. All staff in red PPE	HIGH	
4184	ACUTE	04/10/2021	Safe, High Quality and Effective CareEffective organisational governance	Misuse of POCT devices and non compliance with clinical governance procedures across the Trust	POCT demand has increased exponentially across the Trust, particularly in response to the Covid pandemic. Mistakes made during the course of POCT analysis and incorrect results acted on by the clinical team can have life-threatening consequences for the patient. The risk is not limited to the POCT team; the risk is applicable to all of the clinical teams across the Trust who are performing POCT and relying on the results to inform patient management. All of the following will cause incorrect results to be produced which, if acted upon, could be fatal for the patient and leave the Trust open to litigation: -Poor sampling technique resulting in poor quality of sample. -Lack of training or knowledge on the part of the operator regarding proper and correct use of the POCT device. -Lack of knowledge or reluctance regarding how to perform internal quality control and calibration (this checks if the machine is producing the correct results). -Inadequate compliance with external quality assurance procedures (this checks that the entire procedure from sampling through to result transmission is working as it should). -Lack of understanding of what will adversely affect results e.g. haemolysis, icterus, lipaemia, incorrect storage temperature for reagents. -Poor cleanliness and maintenance of the device and surrounding area. -Use of incorrect or out of date IQC/calibration or test cassettes. Other risks for the patient -Not using the correct H&C number - result will not transmit to NIECR. -Patient HCN mix up, results going into the wrong patient file. -Staff sharing barcodes - risk of an untrained operator using the device incorrectly. -Lack of POCT team support to deal with issues such as poor IQC/EQA performance and -troubleshooting. -Lack of IT support for issues such as devices losing connectivity. In addition, not all devices are able to connect to the Trust network so there is an increased risk with such devices where the POCT team are unable to adequately monitor their performance. -Users not informing POCT of issues with devices when they arise. Risk of faulty device being used to generate inaccurate results that are acted on by the clinical team. The risks to the user and patient are significantly more substantial than risks associated with performing tests in the main laboratory which is staffed by fully trained laboratory staff. Staff performing POCT have basic training in operating the devices and must adhere fully to the rules set out by the POCT team. Mistakes can have serious, fatal outcomes for the patient if the results produced are incorrect or misinterpreted and subsequently acted upon by the clinical team. Staff not adhering to the rules and standard operating procedures as laid down by the POCT team are open to disciplinary procedures. Mistakes made during the course of POCT analysis can leave the Trust open to litigation from the patient. The POCT team regularly audits aspects of the POCT devices and operators. There are repeated instances of staff sharing barcodes, not using H&C numbers, poor maintenance and cleanliness of equipment, failure to run IQC and EQA, poor sampling technique affecting sample quality, incorrect test cassettes being used,	- Online and/or face to face training available for all devices - training sessions are organised and readily available on request from the POCT team. - POCT staffing - POCT staffing has been extended but staffing levels have fluctuated with staff leaving and being replaced. There is a requirement for a Band 6 BMS to provide support to the POCT Band 7 and robustness across the service, particularly with the continuing increase in demand for POCT across all sites. - SOPs and information are available for all devices on the laboratory website and Sharepoint. - Regular audit of POCT in clinical areas is highlighting problems with regards device maintenance, compliance with IQC/EQA etc, and this information is regularly disseminated to all Heads of Service and Lead Nurses in areas of the Trust that use POCT. The emphasis is on these individuals to enforce the compliance with POCT rules within their teams in order to satisfy clinical governance requirements. - IT support is a constant issue within POCT and causes serious delays in troubleshooting and installation of POCT devices. We are currently recruiting a Band 6 IT person for labs, but they will require proper access and administration rights to IT systems (particularly cyber-security) in order to complete their work. This could be a problem if IT are unwilling to co-operate in this respect. These controls are effective to a certain extent, but non-compliance with POCT regulations within the clinical teams is a critical ongoing issue that is possibly not being taken seriously enough across the Trust. The risk to the patient is significant. Removal of devices from clinical areas where non-compliance with POCT rules has been identified as a serious issue - this will only be as a last resort, particularly in areas such as ED where POCT is essential for patient flow (e.g. Covid testing). However, this leaves the Trust open to litigation in the event of errors. Permanent blocking of users who consistently fail to comply with POCT regulations - this is not feasible in practice, particularly with many clinical areas short staffed. All we can do is ensure the individual's line managers are aware of non-compliance issues, and that they both sign an official form committing to compliance with regulations, and undergo re-training procedures.	17/12/2021- "Update Senior Management (CCS) on developments by Jan 2021 "Create a potential structure to provide further support to the Trust by end of Jan 2021 "Secure additional resource to plug the identified weaknesses in current structure TBA "Seek further investment in POCT Governance structure TBA "Reinforce adherence to protocols through existing governance structures Feb 2021 20/09/2021- ED has stated that no additional funding given to provide POC service in ED- directly impacts on timing of results. High risk of agency staff. Consideration should be given to commissioning of mini lab in ED managed by main labs. 18/08/2021- this is monitored and issues escalated to Dept manager and LN and HOS. June 2021Re-started the Medical Devices and Equipment Management Group meetings. This group will have the role of promoting the safe use of medical devices and equipment throughout the Trust, providing assurance for the life cycle of all medical devices which includes procurement, use, decontamination, maintenance and disposal by the organisation of all medical devices, to ensure their use and application does not create a risk to patients, clients, staff and visitors. June 2021Expression of interest interviews taking place 04/06/2021 for Rapid Covid Tester in ED, using Lumira devices. May 2021 Requisition in place for POCT Assistant to replace staff member which has moved on. April 2021Re-commencement of user audits by Patient Safety and Quality Manager. This audit looks at barcode sharing. POCT are involved in a regional training programme for both Clinitek and Glucometers for any staff member who needs it. This allows a staff member from another Trust (bank nurse) to use device and would therefore reduce user error. Roche are currently working on a regional INR training structure. July 2021 POCT have developed a barcode sharing policy which will go live in July and will be	HIGH	
4185	ACUTE	12/10/2021		Risk of not being able to provide a round the clock blood sciences service on both CAH & DHH sites	There is a risk that that the critical provision of Blood Sciences may not be available on one of the main hospital sites. An inability to provide "round-the-clock" cover would compromise the provision of high quality care and in the case of Blood Bank could result in the requirement to close (temporarily) Daisy Hill to emergency admissions. In addition Obstetrics and other specialties, including Theatres would be put at unacceptable risk. Contingency measures that could be brought into operation in Chemistry could compromise patient flow and potentially compromise clinical care. Current contingencies within Haematology / Blood Bank carry even higher risks than Chemistry due to the critical nature of blood bank in particular. The stretching of staff across the 24 hour period and two sites together with the constantly increasing demand for laboratory services is also putting accreditation at risk. Type 1 Emergency Departments and Obstetrics have an absolute requirement for a Blood Bank. If the Blood Bank could not be operated at any stage of a twenty four hour period the Daisy Hill Hospital would not be able to maintain the Emergency Department and patients would need to be directed to other Emergency Departments with potential for delay and significant patient harm or death. It is sobering to reflect that critical hospital services are supported by rotas that are extremely limited and vulnerable to short notice illness with the potential for no available backfill. Unlike nursing agency bank staff are not readily available. In short inability to cover a gap could result in the emergency department having to close and patients on the Daisy Hill site being exposed to significant risk. Therefore the impact could be regarded as a catastrophic. The number of staff available on the Haematology / Blood Bank in the SHSCT is very limited, partly due to the very stringent requirements required to operate autonomously in this discipline. Currently the twenty four hour cycle is covered by too few staff and by utilising substantial overtime. Increased demand on staff has also the potential to increase sickness and stress further compounding the problem. Rotas are effectively so limited that even a few absences could cause one of the rotas to fail. The COVID pandemic has placed significant additional pressures on staff - increased demand and reduced availability of staff. Very tight rotas are highly vulnerable to these issues. Laboratory accreditation (UKAS ISO15189) is at risk where the focus is maintaining a service at the cost of maintaining a rigorous Quality Management System.	"Cross - cover from corresponding site (i.e. CAH cover for DHH) "Cross cover from other departments where relevant and safe "Additional staff in training (two staff due to complete training in the next six months) "Additional support staff through the 24 hour period "Agency support staff These controls have been enabled service provision to continue but they are insufficient to reduce the risk to an acceptable level "Additional Agency Biomedical Scientists - very limited supply (if they can be sourced at all) and likely to be off framework. Introduce additional risk - in terms of competency and experience. "Transferring Blood Bank samples to Craigavon - but there would be an unacceptable delay "Remote release of blood - unacceptable in a Major Haemorrhage scenario "Routinely providing remote Chemistry Biomedical Scientist support from the CAH site with support staff running samples on the DHH site	April 2022-Seek approval to recruit against overtime expenditure. Granted and in progress Discuss contingency with Clinical Leads/ senior staff. - Contingency is limited and has the potential to compromise patient safety Expedite training of B5 Biomedical Scientist. Despite best efforts training is slow due to the obvious constraints and COVID etc limiting further the supply of staff to train and be trained Expedite Chemistry training of Haematology / Blood Bank Biomedical Scientists. Recruit additional Biomedical Scientists and Support Staff. As above but additional staff slowly being recruited - training extremely challenging Discussion with HR around appropriate T&C for working shifts - especially at late notice etc. Procedure to describe the contingency. Completed and has provided some mitigation - however formal sign off from HR pending Plan to ensure return to schedule on all aspects of the Quality Management System. Dependent on above Remote release of results has been introduced where suitable.	HIGH	

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Closed date
4196	ACUTE	16/12/2021	Safe, High Quality and Effective CareEffective organisational governance	Limited implementation and adherence to MCA NI 2016, completion of required STDO and TPA for all patients who lack capacity	Limited Implementation and adherence to the MCA NI 2016 , COMPLETION OF REQUIRED STDO and TPA for all patients whom are deemed to lack capacity in specific decisions .	The DOH training is available to all MDT staff and a live register is maintained of all MDT staff whom can complete the required statutory assessments and documentation , however due to all MDT staff workload capacity and also confidence there is minimal identification of these patients and therefore very low numbers of STDO IN Acute Hospitals .Lead Nurses have been asked to ensure when 1-1 ARE BEING REQUESTED AT WARD LEVELS THESE ARE NOT APPROVED FOR PERSONS WHOM LACK CAPACITY UNLESS A STDO process has commenced .MCA should form part of all daily WBM discussions .The current SOP is not fully implemented as these patients are not being identified early in their journey from ED also. All MDT should agree which staff member / profession is best placed to take forward the MCA process STDO / TPA, this should be shared equally among professions The current STDA are under the management of MHDD Additional bespoke training is available within the SHSCT for any MDT staff group to develop skills and knowledge	18/12/2021- Plan in 2022 that the STDA Team (4.0 wte staff) will come under the operational management of Acute / Non Acute and will suit within HSW management structure's , this will allow more focused work and support to wards , however the challenge will be developing MDT staff to take forward this work as part of their day to day duties	HIGH	

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
745	28/07/2008	Safe, High Quality and Effective Care	Dental Room CAH	Dental room requires UPS/IPS system	The dental room currently does not have any form of backup electrical supply other than the emergency generator; in the event of a power failure all power supplies to socket outlets will drop out for approx. 15 seconds until the generator comes on line.	Battery back up exists on the anaesthetic machine only.	7.11.17 Take off no Dental surgery undertaken on CAH site. 6.6.17 Moved to SEC (ATICS) following meeting with HT 10.05.10 - risk reviewed by MMcG + BM - risk reduced to 5 x 3 = 15 = moderate 2 Sep 2011 Reviewed at Divisional Governace Forum deescalated to HOS Register	MOD	HOS	07/11/2017
750	28/07/2008	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	STH Theatres and Day Procedure Unit requires UPS/IPS syste,	Theatres and Day Procedure Unit at STH currently does not have any form of backup electrical supply other than the emergency generator; in the event of a power failure all power supplies to socket outlets will drop out for approx. 15 seconds until the generator comes on line.	Battery backup exists on the anaesthetic machine only.	12/11/2021- no change 20/09/2021- UPS/IPS need an injection of £200k. Estates are costing. 29/06/2021- less than 50% of the required installation has been completed. I have liaised with estates to advise of the next priorities if a phased approach for installation of further UPS/IPS is being considered when funding becomes available. I have listed the areas below detailing completed works in Green and the work that remains outstanding in red: Theatre 1 pendants Completed Theatre 2 pendants Completed Recovery area main theatre 6 bed spaces and defib plug Not completed DPU recovery 6 bed spaces and defib plug in reception Not completed DPU 1 procedure room pendants Not completed DPU 2 procedure room pendants Not completed DPU Decontamination unit (2 drying cabinets completed and 2 endoscope washers not completed) 15/02/2021- covid remains a priority for estates no change to risk 11/12/2020 - still with estates, priority to covid 20/10/2020 - no change and remains with estates. Priority being given to covid 10/8/2020 - no change, remains a risk. Helena to e-mail Estates re plan to address IPS/UPS. 18.09.19 No change	HIGH	HOS	
799	29/07/2008	Safe, High Quality and Effective Care	Recovery Ward	Risk to health and safety of ventilated patients if required to be nursed in recovery ward	Risk to health and safety of ventilated patients if required to be nursed in recovery ward in the event of an intensive care bed not being available; recovery nursing staff are not trained as ICU nurses.	Patients are ventilated in theatre; cancel theatre list; staff from ICU are brought across to help if available; junior medical staff are only available 9am to 5pm leaving out of hours cover very difficult; explore the availability of ICU bed in another hospital.	28.02.18 Remains the same. 7.11.17- escalation policy in operation. To remain on risk register as pateitns continue to be ventilated in theatre. 30/5/17 - escalation policy in draft in accordance with CCaNNI 28.02.18 Remains the same. 7.11.17- escalation policy in operation. To remain on risk register as pateitns continue to be ventilated in theatre. 30/5/17 - escalation policy in draft in accordance with CCaNNI	LOW	HOS	10/04/2018
795	29/07/2008	Safe, High Quality and Effective Care	Pain Clinic	Risk of bolus of morphine being administered when PCA morphine running with concurrent infusions.	Risk of bolus of morphine being administered when PCA morphine running with concurrent infusions.	Patient must have dedicated IV line or non return valve IV connector.	28.02.17, 7.11.17, & 30.5.17 Risk remains unchanged	LOW	HOS	10/04/2018
797	29/07/2008	Safe, High Quality and Effective Care	Pain Clinic	Risk of tampering with PCA and epidural pump settings	Risk of tampering with PCA and epidural pump settings.	A single lock should be placed on each pump prior to commencement on each new patient.	28.02.18, 7.11.17 & 30.05.17 Risk remains unchanged	LOW	HOS	10/04/2018
879	04/08/2008	Safe, High Quality and Effective Care	Day Procedure Unit CAH	Moving and handling risk to staff when having to move equipment around the department due to inadequate storage space	Moving and handling risk to staff when having to move equipment around the department due to inadequate storage space; equipment (hoist/microscope) being stored in changing facility.	All staff trained in moving and handling; all staff aware of where equipment is stored; staff are informed of position of equipment and of precautions to be taken when in this area.	06.02.19 - To be amalgamated with risk 3727 as per Personal 1.10.18, 8.8.18 Remains an issue and to remain on RR. 12.06.18 Storage space continues to be an issue. 10.4.18, 28.02.18, 6.11.17 & 30.05.17 Risk remains unchanged 2.02.14 Storage space continues to be an issue. Currently seeking approval under capital works scheme for the provision of additional storage facility in DSU.	LOW	HOS	28/02/2019
846	04/08/2008	Safe, High Quality and Effective Care	THEATRES	Diathermy hazards - risk of burns to patients	Diathermy hazards - risk of burns to patients.	Training/education of staff; check patient's position to ensure they are not in contact with metal; proper application of diathermy pad.	28.02.18, 7.11.17 unchanged 30/5/17 - continuous training and new staff inducted to equipment training. Competencies signed and records kept.	VLOW	TEAM	10/04/2018
1054	08/08/2008	Safe, High Quality and Effective Care	Reception Area	Health and safety of wheelchair users is compromised due as front doors are not suitable	Health and safety of wheelchair users is compromised due as front doors are not suitable.	Staff vigilance; staff assistance.	10.12.07 Update - a side door has been reconfigured for wheelchair users as an interim measure until funding released for all work to be completed.	LOW	HOS	05/09/2011
1053	08/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Children/adult patients in the same area during clinic	Children/adult patients in the same area during clinic which is against the Child Order Act 1995 and the National Framework Document.	Patients/guardian accompany children to clinics; staff vigilance; staff aware of risk; clinical incident reporting.	23.01.12 - no further actions undertaken.	VLOW	TEAM	22/10/2013
1063	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Decontamination of resuable instruments in benchtop sterilizer does not meet the standards specified in HTM 2030	Decontamination of resuable instruments in benchtop sterilizer does not meet the standards specified in HTM 2030.	Testing of sterilizer daily, weekly, quarterly, annually.		MOD	DIV	25/03/2010
1068	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Health and safety of patients and staff is compromised due to inadequate clinical and waiting areas in OPD	Health and safety of patients and staff is compromised due to inadequate clinical and waiting areas in OPD; inappropriate seating placed in corridors restricting access.	Main waiting area and patients waiting in corridors outside consulting room.		MOD	DIV	25/03/2010
1055	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Windows opening out more than recommended	Windows opening out more than recommended.	Staff vigilant; staff awareness.	No work planned for financial reasons.	MOD	DIV	21/09/2011

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1077	11/08/2008	Safe, High Quality and Effective Care		Health and wellbeing of patients when high dependency patients are being managed within the general surgical ward area	Health and wellbeing of patients when high dependency patients are being managed within the general surgical ward area.	Reprioritisation of workload; ongoing training for management of high dependency patients; input of pain management nurse; twilight nurses.	24.02.10 risk reviewed - additional action/controls in place. Ward manager to monitor the dependency level of patients on a daily basis, if escalated beyond the safe staffing level to escalate to Nurse Manager/HOS/Patient Flow Manager. High dependency patient monitors being ordered for 4 North / 4 South - 24.2.10 08.06.10 - monitors now in place in 4 North and 4 south - risk closed. 24.02.10 risk reviewed - additional action/controls in place. - Ward manager to monitor the dependency level of patients on a daily basis, if escalated beyond the safe staffing level to escalate to Nurse Manager/HOS/Patient Flow Manager. High dependency patient monitors being ordered for 4 North / 4 South - 24.2.10 08.06.10 monitors now in situ in 4 North and 4 south - risk closed.	MOD	DIV	08/06/2010
1083	11/08/2008	Safe, High Quality and Effective Care		Health and safety of patients and staff could be compromised if staffing falls below safe levels when dealing with staff absence	Health and safety of patients and staff could be compromised if staffing falls below safe levels when dealing with staff absence, e.g. maternity leave, sick leave and delays in recruitment process for vacancies; all wards, CAH and DHH.	Reallocation of existing staff to area of greatest need; in the event of further unplanned absences (e.g. sickness) implement the use of additional hours/bank; in conjunction with consultants and nursing staff discuss the posibility of closing the ward to admissions.	24.02.10 - Escalate through lead nurse, HOS, AD etc re problems . If ward manager is unable to cover wd with available staff; ensure bank forms are filled in and signed in a timely manner 24.02.10 - Escalate through lead nurse, HOS, AD etc re problems . If ward manager is unable to cover wd with available staff; ensure bank forms are filled in and signed in a timely manner 24.02.10 - Escalate through lead nurse, HOS, AD etc re problems . If ward manager is unable to cover wd with available staff; ensure bank forms are filled in and signed in a timely manner	MOD	DIV	05/09/2011
1078	11/08/2008			Health, safety and wellbeing of patients and staff when dealing with/managing violent/aggressive patients	Health, safety and wellbeing of patients and staff when dealing with/managing violent/aggressive patients; wards, CAH and DHH.	Staff awareness of proactive approach; availability of security; guidelines for alcohol withdrawal for inpatients; review staffing levels; medical review of patients by doctor; consultation with Consultant and Bed Manager; liaison RMN in post; personal safety in the workplace training available for all staff; violent and aggressive behaviour towards staff post incident procedure in place; policy and procedure on the management of aggression and use of restraint; transfer to suitable environment/appropriate unit when medical condition stabilised.	01.10.11 Additional/controls in place 24.02.10 - risk reviewed - additional action/controls in place. Good communication from admitting area re status of patient. Ensure medications are administered as per drug kardex/protocol, and effectiveness recorded. Staff trained in MAPA. Call security/police without delay when necessary.	MOD	HOS	23/01/2012
1080	11/08/2008	Safe, High Quality and Effective Care		Risk of spread of infection due to inadequate facilities	Risk of spread of infection due to inadequate facilities, e.g. lack of sidewards/bed space near sinks; all wards, CAH and DHH.	Endeavor to adhere to current Infection Control Policy; use of alcohol gel is in place; training sessions in place for hand hygiene and control for C Diff; ward sisters charter in place.	24.02.10 risk reviewed - additional action/controls in place. - Programme of replacing and upgrading basins in patient areas on going 24.02.10 risk reviewed - additional action/controls in place.	LOW	HOS	05/09/2011
1056	11/08/2008	Safe, High Quality and Effective Care	Banbridge Area	Health and safety of wheelchair users compromised due to entrance ramp to front door being too steep	Health and safety of wheelchair users compromised due to entrance ramp to front door being too steep and not suitable for wheelchair users.	Staff vigilant and provide assistance.	Update - a side door has been reconfigured for wheelchair users as an interim measure until funding released for all work to be completed.	MOD	HOS	05/09/2011
1058	11/08/2008	Safe, High Quality and Effective Care	Banbridge Area	Health and safety of disabled users is compromised due to invalid toilet	Health and safety of disabled users is compromised due to invalid toilet - not in central position in room; too close to wall, not suitable.	Nursing staff provide patient assistance.	Estates staff visited site. Update - funding not released for work to be completed.	MOD	HOS	21/09/2011
1075	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Risk to staff and patients in OPD when liquid nitrogen is stored or used	Risk to staff and patients in OPD when liquid nitrogen is stored or used.	Follow pharmaceutical guidance and Trust policies. Ensure that Liquid Nitrogen is stored as per hospital policy. Report any deviation and address appropriately. Report any faults or fixture failings to Estates immediately.	24.02.10 - risk rated additional action/controls in place. Ensure that Liquid Nitrogen is stored as per hospital policy. Report any deviation and address appropriately. Report any faults or fixture failings to Estates immediately. 24.02.10 - risk rated additional action/controls in place. Ensure that Liquid Nitrogen is stored as per hospital policy. Report any deviation and address appropriately. Report any faults or fixture failings to Estates immediately.	VLOW	HOS	21/09/2011
1069	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Risk to patient if equipment fails during use	Risk to patient if equipment fails during use.	Policies, procedures, protocols; education and training; regular maintenance; service contract; report faults. 24.02.10- Ensure all equipment is checked routinely.	24.02.10 risk reviewed - additional action/controls in place -Ensure all equipment is checked routinely 24.02.10 risk reviewed - additional action/controls in place -Ensure all equipment is checked routinely	LOW	HOS	05/09/2011
1081	11/08/2008	Safe, High Quality and Effective Care		Health, safety and wellbeing of patients due to misinterpretation/misunderstanding of inappropriate use of abbreviations	Health, safety and wellbeing of patients due to misinterpretation/misunderstanding of inappropriate use of abbreviations by health care team; all wards, CAH and DHH.	Vigilance of nursing staff; PSI documentation project ongoing; awareness of use of abbreviations highlighted as part of project. Update abbreviations commonly used in surgery & circulate.Ensure proper use of English Language is adhered to when completing any documentation.	07.06.10 - email from K McGoldrick - 'Beatrice as a follow up to a meeting with Heather, Connie and myself last week would you please look at these entries to 27/05/10, SEC risk register 2635 and 1079 are the same essentially - this should be termed to cover SEC' Piece of work being progressed by Heather Ellis to co ordinate these training needs. 24.02.10 Escalate through HOS/AD to leads in Statutory/Mandatory training that additional sessions are required to meet the needs of service. 24.02.10 risk reviewed - additional action/controls in place - Update abbreviations commonly used in surgery & circulate. Ensure proper use of English Language is adhered to when completing any documentation.	LOW	HOS	23/01/2012

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1057	11/08/2008	Safe, High Quality and Effective Care	Reception Area	Fingers could be trapped in spring loaded swing doors	Health and safety of patients, visitors and staff - fingers could be trapped in spring loaded swing doors; double front doors; inner doors.	Wating room door kepy opened by stopper; staff vigilant. Ensure staff have adequate training in MAPA & follow protocol re same	24.02.10 risk reviewed - additional action/controls in place -Ensure appropriate signage is prominently displayed advising of same. 10/12/2007 - Update - a side door has been reconfigured for wheelchair users as an interim measure until funding released for all work to be completed.	LOW	HOS	21/09/2011
1064	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Extended waiting times for patients due to specific clinics over-running	Extended waiting times for patients due to specific clinics over-running.	Patients adequately appointed; partial booking being introduced to all clinics.	24.02.10 risk reviewed - additional action/controls in place -Escalate to HOS so same can be addressed . 24.02.10 risk reviewed - additional action/controls in place -Escalate to HOS so same can be addressed .	LOW	HOS	05/09/2011
1066	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Unhealthy environment for staff and patients	Unhealthy environment for staff and patients; rooms too hot in summer - no circulation of fresh air, temperature more than 22°C/72°F; rooms too cold in winter - temperature less than 22°C/72°F.	Summer time - use of fans/ineffective skylights; winter time - requests to Estates to increase heating levels.		LOW	HOS	24/03/2010
1067	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Manual doors to OPD entrance could cause entrapment to patients	Manual doors to OPD entrance could cause entrapment to patients.	Doors left open during daytime to facilitate patients.	24.02.10 risk reviewed - additional action/controls in place -Ensure signs are prominently displayed advising of risk of same	LOW	HOS	05/09/2011
1072	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Poor access to Outpatients Department for wheelchair users and mothers with pushchairs	Poor access to Outpatients Department for wheelchair users and mothers with pushchairs.	Middle door left open to allow access.	24.02.10 risk reviewed - additional action/controls in place 24.02.10 risk reviewed - additional action/controls in place	LOW	HOS	05/09/2011
1065	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Continued inappropriate placement of charts on floor by doctors	Continued inappropriate placement of charts on floor by doctors leading to manual handling risk to staff who have to lift charts off the floor.	Trolleys provided for doctors to leave charts on; notices displayed; verbal communication to doctors; built into doctors' induction.		LOW	TEAM	24/03/2010
1073	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Lack of site security - injury to staff or patients	Lack of site security - injury to staff or patients.	Last member of staff to leave department locks doors; porters check all outer doors every evening Mon-Fri. 24.02.10 - Ensure all staff are trained in MAPA.		VLOW	TEAM	21/09/2011
1074	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Fire in OPD - risk to patients, staff and building	Fire in OPD - risk to patients, staff and building; fire evacuation after 9pm, limited staff on site to assist elderly frail.	Nominated fire officer; deputy nominated office on duty has fire training - yearly fire seminar.		VLOW	TEAM	05/09/2011
1071	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Risk to staff and patients through latex allergy	Risk to staff and patients through latex allergy.	Policy in place in department; latex free box in MIU; staff can avail of training and education.	24.02.10 risk reviewed - additional action/controls in place. Ensure latex free gloves/equipment etc are readily available in all wards /depts	VLOW	TEAM	21/09/2011
1082	11/08/2008	Safe, High Quality and Effective Care	3 South CESU	Health and safety of all staff who may be exposed to due to chemotherapy agents while working with urology/surgical patients	Health and safety of all staff who may be exposed to due to chemotherapy agents while working with urology/surgical patients	Procedures in place for the management of administration of agents. Ensure all staff working with chemo agents have adequate training /qualifications	23.01.12 - All approrpriat estaff have training and controls are in place. 01.10.11 Awaiting progress 4.02.10 risk reviewed - additional action/controls in place	VLOW	TEAM	23/01/2012
1062	11/08/2008		Outpatients Dept	Loss of child in Outpatients Department	Loss of child in Outpatients Department.	Staff awareness and vigilance; guidelines drawn up for staff/parents/guardians; secure Paeds Unit with controlled access operational from December 2005.		VLOW	TEAM	24/03/2010
1070	11/08/2008	Safe, High Quality and Effective Care	Trustwide	Risk of wrong patient being seen at clinic	2 or 3 patients with the same name; risk of wrong patient being seen at clinic.	Name and address checked on arrival, receptionists inform nursing staff re duplicate names; nursing staff check name, address when calling patient. 24.02.10 -Ensure patients notes are adequately labelled informing staff at clinic of same.[Alert sticker]	19.06.06 This remains a low risk, there have been no incidents. 24.02.10 risk reviewed - additional action/controls in place - Ensure patients notes are adequately labeled informing staff at clinic of same.[Alert sticker]	VLOW	TEAM	05/09/2011
1084	12/08/2008	Safe, High Quality and Effective Care		Health and Safety of patients and staff could be compromised due to lack of weekend ward clerk cover on surgical wards	Health and Safety of patients and staff could be compromised due to lack of weekend ward clerk cover on surgical wards.	None.		LOW	HOS	24/03/2010
1085	12/08/2008	Safe, High Quality and Effective Care		Health and safety of patients and staff could be compromised if clerical staffing falls below safe levels	Health and safety of patients and staff could be compromised if clerical staffing falls below safe levels when dealing with staff absence, e.g. maternity leave, sick leave and delays in the recuitment process for vacancies; all wards, CAH.	No bank staff available; additional hours used when available; re-allocation of staff to areas of greatest need.	24.02.10 risk reviewed - additional action/controls in place - Escalate through OSLs if Clerical staff are off on sick leave, A/L leave.	LOW	HOS	05/09/2011
1086	12/08/2008	Safe, High Quality and Effective Care		Health and safety of patients, visitors and staff due to adequate storage space for equipment/stock	Health and safety of patients, visitors and staff due to adequate storage space for equipment/ stock; all wards, CAH.	Maximum use of existing facilities with continuous risk assessment.	24.02.10 risk reviewed - additional action/controls in place - Issues to be addressed through the Productive Ward project 24.02.10 risk reviewed - additional action/controls in place - Issues to be addressed through the Productive Ward project	LOW	HOS	05/09/2011
1087	12/08/2008	Safe, High Quality and Effective Care		Infection control risk + Slips/trips/falls for patients, relatives and staff due to loose and missing floor tiles	Infection control risk + Slips/trips/falls for patients, relatives and staff due to loose and missing floor tiles.	Estates Department informed; all wards, CAH. 24.02.10 - Ensure missing floor tiles are reported to maintenance for immediate repair	24.02.10 risk reviewed - additional action/controls in place - Ensure missing floor tiles are reported to maintenance for immediate repair	LOW	HOS	05/09/2011
1205	15/08/2008	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	Trust facilities for the cleaning, decontamination and storage of endoscopes do not comply with standards	Trust facilities for the cleaning, decontamination and storage of endoscopes do not comply with standards recommended in the Hine Review, increasing the risk of infection transmission.	STH have new fully compliant decontamination facility which is JAG accredited. DHH same opened Jan 2014. CAH day surgery has been refurbished with AERS and drying cabinets and is awaiting the installation of new sinks.Interim decontamination facilities for main theatres, Xray and ENT services are in place. Management of this service has been taken over by CSSD staff. Minor works upgrade to the endoscopy theatre and storage facilities is taking place to comply with JAG.	18.09.19 combine with risk 733 on the Directorate RR 26.06.19, 28/3/19, 06/02/2019 - No change. 1.10.18, 8.8.18, 12.06.18, 10.4.18, 28/02/2018, 6.11.17 & 30.05.17 Remains unchanged. All areas compliant with Hine recommendations now. To remain on Risk Register as not achieving JAG accreditation.	LOW	HOS	18/09/2019
1896	19/12/2008		Outpatients Dept	Unable to achieve the sterilisation of ENT flexible scopes between each patient as per policy due to lack of equipment/resources	Flexible ENT Scopes in accordance to policy must be sterilised between use. Due to the invasive nature of the use of this equipment patients are at risk of cross infection if this is not carried out. DHH has no ENT flexible scope. In order to adhere to new protocol/policy, would be required to purchase 5 more at a cost of £25,000 approx. Patient are at risk of cross infection if scopes are not sterilised and Trust is at risk of litigation and lose of reputation. (ENT flexible scope does not have an internal channel. It is a camera only. The user cannot take biopsies, suction or blow using this equipment.)	DHH has been using disposable sheaths for 8 years on removal of sheath, scope is cleaned with alcohol wipes and left to dry. 1 Box of sheaths contains 50 and costs £500 lasts for approx 1 month. (SMcL) (head of Sterile Services) states sheaths must no longer be used as there is no evidence of adequate research into their effectiveness of cross infection protection.		MOD	DIV	19/05/2011

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
1900	19/12/2008		ENT Clinic, Surgical Outpatients	Unable to adhere to SHSCT Decontamination Policy which stipulates endoscopes need to be decontaminated between each patient and	Due to the contact with the mucous membrane surrounding the nasopharynx, patients are at risk of cross infection with the scopes not be decontaminated as per trust policy. (between each case)The Trust is at risk of litigation and loss of reputation if it was proven that the lack of scopes was a contributing factor in a Hospital Acquired Infection/Illness. Craigavon Area Outpatients has 7 Nasophyngeal flexible scopes in use, with 2 scopes currently away for repair. The nature of a flexible Nasopharyngeal scope is that has no internal channel. The scope does not have the facility to take any biopsies,or use any type of suction. It is used as a camera only This site has 10 ENT sessions per week, with an average of 5 patients per session needing an examination with a Flexible Nasopharyngeal Scope. (50 patients per week on average)Patients are at risk of cross infection as there is only one scope available to examine all patients.	Craigavon Outpatients has been using Storz disposable sheaths to cover its scopes if there is insufficient time to decontaminate the scope as per policy. Staff have received training from Storz regarding the application and removal of the sheaths. Scope is sent for decontamination at the end of each day that there is ENT		MOD	DIV	19/05/2011
1901	19/12/2008		Banbridge Area	Unable to adhere to SHSCT Decontamination Policy which stipulates endoscopes need to be decontaminated between each patient.	Due to the contact with the mucous membrane surrounding the nasopharynx, patients are at risk of cross infection with the scopes not be decontaminated as per trust policy. (between each case) The Trust is at risk of litigation and loss of reputation if it was proven that the lack of scopes was a contributing factor in a Hospital Acquired Infection/Illness. Banbridge Outpatients has 1 Nasophyngeal flexible scope in use. The nature of a flexible Nasopharyngeal scope is that has no internal channel. The scope does not have the facility to take any biopsies,or use any type of suction. It is used as a camera only This site has 1 ENT sessions per week, with an average of 3 patients per session needing an examination with a Flexible Nasopharyngeal Scope. (3 patients per week on average) Patients are at risk of cross infection as there is only one scope available to examine all patients.	Banbridge Poly Clinic has been using Storz disposable sheaths to cover its scope as there is only one scope on site. Staff have received training from Storz regarding the application and removal of the sheaths. Scope is sent for decontamination at the end of each day that there is ENT.		MOD	DIV	19/05/2011
1902	19/12/2008		Outpatients Dept	Unable to adhere to SHSCT Decontamination Policy which stipulates endoscopes need to be decontaminated between each patient	Due to the contact with the mucous membrane surrounding the nasopharynx, patients are at risk of cross infection with the scopes not be decontaminated as per trust policy. (between each case) The Trust is at risk of litigation and loss of reputation if it was proven that the lack of scopes was a contributing factor in a Hospital Acquired Infection/Illness. Armagh Community Outpatients has 1 Nasophyngeal flexible scope in use. The nature of a flexible Nasopharyngeal scope is that has no internal channel. The scope does not have the facility to take any biopsies,or use any type of suction. It is used as a camera only This site has 1 ENT sessions per week, with an average of 5 patients per session needing an examination with a Flexible Nasopharyngeal Scope. (5 patients per week on average) Patients are at risk of cross infection as there is only one scope available to examine all patients.	Armagh Community Hospital has been using Storz disposable sheaths to cover its scope as there is only one scope on site. Staff have received training from Storz regarding the application and removal of the sheaths. Scope is sent for decontamination at the end of each day that there is ENT.		MOD	DIV	19/05/2011
1903	19/12/2008		ENT Clinic, Surgical Outpatients	Unable to adhere to SHSCT Decontamination Policy	Unable to adhere to SHSCT Decontamination Policy which stipulates endoscopes (flexible nasopharyngeal endoscopes) need to be decontaminated between each patient and after 3 hours of inactivity. This lack of adherence is secondary to due to the insufficient numbers of scopes within the department. There is also the additional risk of cross infection as all current decontamination equipment within SHSCT do not completely comply with HTM2030 Due to the contact with the mucous membrane surrounding the nasopharynx, patients are at risk of cross infection with the scopes not be decontaminated as per trust policy. (between each case)The Trust is at risk of litigation and loss of reputation if it was proven that the lack of scopes was a contributing factor in a Hospital Acquired Infection/Illness. Daisy Hill Outpatients has one Nasophyngeal flexible scope. The nature of a flexible Nasopharyngeal scope is that has no internal channel. The scope does not have the facility to take any biopsies,or use any type of suction. It is used as a camera only This site has 6 ENT sessions per week, with an average of 5 patients per session needing an examination with a Flexible Nasopharyngeal Scope. (30 patients per week on average)Patients are at risk of cross infection as there is only one scope available to examine all patients.	Daisy Hill Hospital has been using Storz disposable sheaths to cover its scope during each examination. Staff have received training from Storz regarding the application and removal of the sheaths. Scope is sent for decontamination at the end of each day that there is ENT. The manufacturer cannot provide robust scientific evidence that sheaths provide 100% protection against CJD in particular. For this reason (SMcL) Head of Decontamination SHSCT, has not considered sheathing a viable option or substitution for following the Trust's Decontamination Policy.		MOD	DIV	19/05/2011
1932	23/01/2009	Safe, High Quality and Effective Care	ENT Clinic, Surgical Outpatients	Patient Flow difficulties with ongoing additional ENT OPD clinics for NEW patients.	Patient flow for these clinics are in breach of RCOS Guidelines - 3 patients x 15 minutes x 3 Doctors. This clinic has booked 4 patients x 15 minutes x 3 Doctors. - Risk of increase in complaints - Risk of patients walking out of clinic not seen and used to rebook them - Risk of miss diagnosis/loss of comprehensive assessment as time slots are limited - Inequality of care for these patients attending these extra clinics. RCOS Recommendation - 1 patient x 15 minutes (new patient clinic) therefore 3 patients x 15 minutes with 3 Doctors minimum. These clinics are booked on 4 patients x 15 minutes with 3 Doctors	Patient flow - Additional Nursing and Clerical Staff deployed to manage clinic - no additional Medics Request to reduce clinic size to 60 and create 1 additional clinic (x3 in total) rejected by management due to time constraints (PTL breach)	Referred to Directorate Risk Register	LOW	DIV	19/07/2010
1933	23/01/2009	Safe, High Quality and Effective Care	ENT Clinic, Surgical Outpatients	Environmental space to hold patients and families during ongoing additional ENT OPD clinics for NEW patients	These clinics are booked on 4 patients x 15 minutes with 3 Doctors. Environmental space to hold patients and family (Saturday Clinic) (8.45am start to 1.45pm finish) 11 seats available with potential to have 16 patients and relatives waiting at any one time. - Increased risk of complaints - Risk of patients walking out of clinic not being seen and need to rebook them - Risk of overcrowding	Environmental space - Overspill patients will be seated in ENT sub waiting area outside examination rooms and staff will manage this. - Families will be requested to remain in main OPD Waiting Area		LOW	HOS	21/09/2011
2082	09/04/2009	Safe, High Quality and Effective CareAccessible and Responsive CareEffective organisational governance	Trustwide	Inability to meet or maintain AHP access targets for ENT/Voice service	Risk of harm to patient as no access to appropriate SLT service. Unable to provide support for ENT consultants re patient management in hospital outpatient dept's in C/B and A/D. Trust unable to achieve or maintain access targets so breaching will be inevitable Ineffective clinical management of patients Increase in staff stress, pressure and reduced morale Health and well being of SLT staff	Current SLT in post until 30 04 09 AHP ACCESS FUNDING ceased 30th 03.09 Requests to acute for ongoing funding have been made but without success. Current SLT in post until 30 04 09 AHP ACCESS FUNDING ceased 30th 03.09 Requests to acute for ongoing funding have been made but without success. Current SLT in post until 30 04 09 AHP ACCESS FUNDING ceased 30th 03.09 Requests to acute for ongoing funding have been made but without success.		HIGH	DIV	25/03/2010
2463	24/04/2009	Provide safe, high quality careSupport people and communities to live healthy lives and improve their health and wellbeingBe a good social partner within our local communities	Trustwide	Preparedness for Pandemic Flu, specifically a H1N1 current pandemic	Ability to sustain services should there be an outbreak of pandemic flu.	SHSCT H1N1 Plans remain in place Regular SMT/Silver and Bronze Team meetings ongoing at Directorate level Daily monitoring in place - hospitalized patients, attendances at A&E, GP OOHs, MIUs Representation at regional Trust Liaison Group meetings with regional professional fora Vaccination plan submitted for HPA approval Business cases for funding submitted to various work streams Ward 3 (Isolation Ward) operationally ready Vaccination plans have assumed that primary care will cover the six month to five year age group. However, recent information suggests that secondary care may be asked to provide this service. This is likely to create a capacity problem if existing services are to be maintained.		MOD	DIV	17/10/2013

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2085	09/07/2009	Provide safe, high quality careBe a great place to work	Fracture Clinic	Health & Safety of patients, staff and visitors who attend the Fracture Clinic	Health & Safety of patients, staff and visitors could be compromised due to no waiting room for Fracture Clinic as follows:- 1. No seats for patients. Standing with plasters insitu, risk of fall. 2. Narrow corridor - patients sitting with leg plasters on - leg extended. Risk of fall and further injury. 3. Patients waiting in main thoroughfare for A&E - Rushing through with sick patients. Delay of transfer and risk of injury to patients and relatives. 4. Patients in wheelchairs - no room. Risk of injury.	Maintain patient's safety until relocation of fracture clinic.	28.09.12 - Fracture clinic relocated. 01.08.12 - Works nearing completion. Plan to move into new location by end August 2012. Review in 1 month. 19.06.12 - Refurbishment programme progressing well. Due for completion July 2012. Review in 1 month. 17.04.12 - refurbishment programme commenced. Works ongoing and due to be completed May 2012. 23.01.12 - A new location and facilities have been sourced for the fracture clinic. A refurbishment programme is due to commence in February 2012 with completion due in May 2012. 10.11.11 Additional seating now in place on back corridor to A&E, plans for new fracture clinic now in progress. 01.10.11 Awaiting feedback from fire dept regarding the placement of additional seating.	MOD	DIV	28/09/2012
2314	14/09/2009	Provide safe, high quality care	Trustwide	Risk of Hyponatraemia	Risk of hyponatraemia when administering IV fluids to children aged 14 - 16 years when cared for on adult wards. Risk of loss of Trust reputation and loss of confidence in the organisation Risk of litigation to the Trust.	All Solution 18 removed from wards and any attempt to order Solution 18 is alerted to Director of Pharmacy. Trained and competent paediatric medical staff available on CAH + DHH site 24/7 to provide support in relation to prescribing, monitoring and reviewing IV fluid therapy. DHSSPS wall charts are displayed in all adult and paediatric areas where children and young people aged 1 month to 16 years may be treated.	17.04.12 - Approximately 80% of SEC staff trained with follow up sessions arranged for May 2012. 23.01.12 - ongoing within Governance Team with good uptake from SEC. 01.10.11 Competency framework has now been commenced for target wards. All staff undergoing refresher training. SEC attained 98.1% of all staff trained. Ongoing audit to capture under 18 yr olds to ensure all cared for appropriately.	LOW	DIV	17/10/2013
2501	10/11/2009	Provide safe, high quality careBe a great place to work	Trauma Ward	Isolation of the Trauma Ward	Trauma ward has no adjoining ward therefore no medical/nursing support from other close by wards. Isolated staff especially on night duty and lack of support for staff in the event of an emergency.	Staff awareness of teams available.	01.10.11 Ward has access to relevant teams where required for assistance in complex situations.	LOW	DIV	23/01/2012
2500	10/11/2009	Provide safe, high quality careBe a great place to work	Trauma Ward	Moving of Night Staff from Trauma Ward to support other wards	Unsafe staffing levels left on ward for type and dependency of patients. Staff unable to get tea breaks, increased stress, decreased patient care and in the event of an emergency inadequate staffing support.	Adverse incident forms completed. Bed Flow Manager informed re safety issues. Clinical Lead/Lead Nurse informed.		MOD	DIV	05/09/2011
2499	10/11/2009	Provide safe, high quality careBe a great place to work	Trauma Ward	Inappropriate staffing levels for dependency of patients in Trauma Ward	Inappropriate staffing levels leads to compromise in patient safety/care and staff safety. This results in increased clinical incidents, increased number of falls, staff unable to get breaks, potential for decreased staff morale, increased staff sickness levels, breach of Terms and Conditions for employment, poor documentation, not able to maintain NMC Guidelines. Potential for increased complaints and litigation.	Bank staff - unreliable bank staff or bank staff not available to cover shifts. Additional hours for permanent staff. Clinical Lead and Lead Nurse informed re risk.	08.06.10 - temporary staff now made permanent and risk closed.	MOD	DIV	08/06/2010
2390	11/11/2009	Safe, High Quality and Effective Care	Orthapaedic Ward CAH	Due to the Isolation of Orthopaedic Ward ensure adequate staffing levels at all times to maintain health and safety of patients.	Due to isolation of orthopaedic ward and Elective Admission Ward especially on night duty inadequate staffing levels when staff are moved to deal with emergency for example on 17-11-09 patient had a respiratory arrest cardiac team called staff felt there was a delay in the arrival of team some members of the team were unsure where Orthopaedics was located. Staff did not get their break. On 19-11-09 Staff nurse and auxiliary off sick nurse bank had no cover day staff had to stay until 2230 for a nurse to cover the shift from 4 south the auxiliary was then moved to 4 south which left only 2 nurses this was unsafe as a patient went into atrial fibrillation and SBAR call was made for medical assistance. Staff were not relieved for breaks and therefore did not get their breaks. Clinical incident forms are being completed on a regular occurrence with no effect. Isolated staff especially on night duty. Lack of support for staff in event of emergency. Potential re-occurrence of incident previously occurred. Decreased no's of staff allowing for inadequate	Completion of adverse incident forms. Highlighted re concerns to nurse lead and head of Trauma and Orthopaedics and bed manager that staff should not be moved from wards as there is no adjoining ward for support. No dependency levels tool carried out in the hospital as per nurse lead. Ward manager to ensure as far as possible that ward is safely covered. In circumstances where this is not possible, report to Nurse Manager in hours/ Site manager out of hours to assist in getting assistance from other areas within division, or to commence protocol to get bank / agency staff.		MOD	DIV	05/09/2011
2415	11/11/2009	Provide safe, high quality careSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of	Orthapaedic Ward CAH	Patient cancellations due to inadequate information given to patients in pre-op assessment	Patients cancelled due to not being informed to stop medication eg aspirin or if patient is still on oral contraceptive pill. Patients condition may have changed and may require further investigations eg echo which was not carried out at pre-op assessment. Patient not seen face to face by consultant at pre-op on day of admission consultant decides patient not to have surgery. Pre-op assessment bloods out of date. Patients not having their operation have to have their operation re-scheduled and become upset. Trust Waiting list has to be altered to other people are cancelled to facilitate the cancelled patients. Complaints will increase. Patients taken time off work to come into hospital for their operation. Risk of litigation. Loss of reputation. Extra work for nursing staff on the wards and secretarial staff.	Clinical incident forms completed. Consultants clinical lead and nurse lead aware of situation. Pre-op Manager aware. Protocols to be in place re medication advise. Pre-op staff sent to Musgrave Park pre-op assessment in orthopaedics for developing the service in Craigavon. Pre-op meetings action plans never followed up as problem continues.	24.02.10 - actions on going	LOW	DIV	05/09/2011
2416	11/11/2009	Provide safe, high quality careBe a great place to workMake the best use of resources	Orthapaedic Ward CAH	Patient safety and staff safety - Moving of night staff to support other wards.	Unsafe staffing levels left on ward for type and dependency of patients. Staff unable to get breaks. Decreased patient care. In event of emergency inadequate staffing support.	Clinical incident forms completed. Bed Flow Manager informed re safety of patients. Clinical Lead and Nurse Lead informed.		LOW	DIV	05/09/2011

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2425	14/12/2009	Provide safe, high quality care	Pre-Operative Assessment Clinic	Lack of Anesthetic and Cardiology resources for validating Pre-Op ECG's in a timely manner	Patients are at risk of cancellation of surgery secondary to a cardiac condition not being managed or detected. The Trust is at risk of Litigation if it is shown that a patient has been seen within Surgery and Elective care, with a cardiac condition which was evident from pre op ECG, but not detected or managed due to lack of access to adequately trained staff. There is no adequately trained resource within the Pre Operative Assessment Service to interpret and sign off pre op ECG's which are done as per NICE guidelines. A duty of care to have these ECG's reviewed in a timely manner, is not being met. Risk that designated POA Anaesthetist may not have all potential cardiac issues escalated to them due to the lack of expertise and skill at Band 5 and 6. Risks of patient not getting a Anaesthetic chart ECG/review Financial risk to Trust due to the high volume of charts being sent to Anaesthetist for ECG interpretation and not anaesthetic assessment. Potential harm include patients leaving the department with a undiagnosed Cardiac condition which could progress to a significant cardiac event. The lack of timely review results in ongoing risks around the patient's surgery being postponed or cancelled- potential harm due to delay in treatment. In the event that the patient has a abnormality that needs treatment or management theatre may be cancelled at very short notice. End result being theatre underutilisation. Significant financial harm to the Trust will be incurred in this event.	If Nursing staff see abnormal (as per ECG machine print out) on ECG on tracing, the ECG should be escalated to the Band 6 nurses who then highlight it to either Anaesthetist/ OPD Manager or ECG staff. Designated POA Anaesthetist reviews the charts/ECG's of patients who have been escalated to the Anaesthetist.	Reviewed 6.12.10 - Lorraine Adair meeting with D Lilburn to progress. Awaiting outcome in conjunction with direction from B Conway. Risk remains unchanged. Risk Assessment has been updated 22/10/10 to refine issues. Barry Conway, Lorraine Adair, Diane Lilburn and Connie Connolly met on Monday 11th October 2010. Proposal for Dr Rankin to be prepared by Barry Conway and Heather Trouton for consideration. 16.04.10 - The requirement of ECG screening is being reviewed by Mrs Connie Connolly and Dr Neville Rutherford-Jones. There has been no Cardiology resource identified within Medicine and Unscheduled Care. The Staff doing ECG;s at present are dependant on the individual sites. Any ECG's deemed 'abnormal' are been shown to the ECG department, and or Cardiology clinicians only if available. If no availability, or POA is being done out of hours, relevant ECG's may be seen when appropriate staff available. ECG's are being done during face to face as appropriate. ECG;s are not routinely reviewed until F2F or anaesthetic chart review or on day of surgery. Risk reviewed 24.02.10 - additional actions/controls put in place - On going discussions with Anaesthetics to provide safe and effective cover for pre op clinics. 09.11.11 Meeting to be arranged with Anaes, Cardiology, Pre-op Asses to discuss further management, currently all major abnormal ECGs are being referred to A&E as an interm. 01.10.11 Awaiting further progress report.	MOD	DIV	23/01/2011
2424	14/12/2009	Provide safe, high quality care	Outpatients Dept	Infection Control risks due to lack of decontamination facilities, non compliant taps and sinks in the blood room.	High volumes of patients, public and staff working within/accessing General Outpatients are at increased risk of infection secondary to the non compliant taps, sinks and damaged flooring in department and toilets. Risk of infection to patients, public and staff due to poor provision for hand washing and decontamination. Risk of infection due to broken/damaged flooring and/or units around sinks. Risk of loss of reputation secondary to non-compliance with RQIA recommendations. Risk of infection to patients, staff secondary to decontamination of ENT scopes being done in the same room as patients being assessed.	Daily cleaning of department. Patients are taken to other areas for assessment where possible to separate from Endoscopy decontamination.	19.06.12 - Refurbishment programme of Ramone building for additional facilities and upgrade of current area is near completion. Plan to review in 1 month. 26.03.12 - Will be addressed via outpatient works in early Summer 2012. 23.01.12 - Outstanding working remain on hold until current renovations and proposals complete. 19 May 2011 Decontamination Room complete, sink tops in Rooms 4/5/6/7 have been replaced. Awaiting the replacement of flooring in toilets, and taps/sink in blood room. Estates contacted again 19/05/11 by DHH OPD manager. Awaiting response. Continued risk.	LOW	DIV	29/11/2012
2512	08/03/2010	Be a great place to workMake the best use of resourcesBe a good social partner within our local communities	Fracture Clinic	Fracture Clinic stock going missing Department shared by A&E	Patients not receiving appropriate treatment. Risk of complaints. Disharmony between departments. Risk of stock going low for patients. Patients having to go without appliances. Rise in complaints. Inaccurate budget control. Cannot order in bulk due to lack of storage space.	Stock control book. Staff training on staff control. Discussions with A&E Line Manager. Discussions with Fracture clinic Line Manager. Continue stock control. Communicate with A&E staff. Fracture Clinic to monitor stock daily. Educate A&E staff. Lock Fracture clinic at the end of the day. To have ownership.		LOW	HOS	05/09/2011
2520	15/03/2010	Make the best use of resources	1 Surgical EAW	Drugs in Treatment Room [Ward closed at night & weekend]	Room locked but unit not locked. No alarm on Controlled Drug Cupboard - Potential for theft of medication and controlled drugs while ward is unoccupied	Locking preparation room door . Controlled drug & ward keys given to Dermatology Monday to Thursday , Porters safe Friday to Monday am .	Security work has been completed ' - risk closed 08.06.10	MOD	DIV	08/06/2010
2522	15/03/2010	Provide safe, high quality careMaximise independence and choice for patients and clients	4 North Surgical	Poor toilet and shower facilities on 4 North	Increase in infection rates. Poor environment to recover post operatively. Not enough male / female facilities. Shower male side, door allows water to leak through. Showers need general upgrading. Hand rails need to upgraded on all toilets.	Environmental audit. Complaints about facilities from patients expressing poor satisfaction.		MOD	DIV	01/10/2011
2519	15/03/2010	Provide safe, high quality care	1 Surgical EAW	Distance from theatre to EAW for post-op patients	Risk to patients - condition could deteriorate on way back due to distance. Potential for emergency situation to arise whilst patient is not in a clinical environment, post surgery & anaesthetic	Staff take emergency pack with ambubag , airway & facemask with them to recovery ward .		LOW	HOS	05/09/2011
2521	15/03/2010	Be a great place to workMake the best use of resources	1 Surgical EAW	Double Doors outside Dermatology have no automatic button	Potential manual handling risk - Potential manual handling risk to staff whilst trying to get door open and bad through	Staff open manually	Estates have been contacted-await further response	LOW	HOS	05/09/2011

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
2745	22/03/2010	Provide safe, high quality care	Outpatients Dept	Mis-timing of pre operative assessment investigations- extension of patient pathway to 17 weeks in T/O and Urology	Due to the extension of the patient pathway for Urology and T/O patients to 17 weeks, current pre operative assessment validity dates of 13 weeks, will no longer provide accurate pre op assessment. Risks are around having to facilitate patients coming back to the POA service for screening once the TCI date has been issued. Due to limited Band 5 availability for screening there is a risk that there will insufficient time to manage any pre op issues that may arise. Risk that POA clerical staff do not have the resources to ensure the patients pass through assessment twice at a time allowing for any management issues. Risk that patients having screening done too close to TCI, will have to be cancelled at short notice due to not having enough time to resolve any clinical issues. POA then has no capacity to assess patients who may have been selected to backfill at short notice. Risk of inefficient utilisation of bed and theatre capacity if there are persistent day of surgery cancellations due to inappropriate or inadequate screening. Potential harm to patients if surgical procedure is cancelled Financial harm to SHSCT due to poor theatre and bed utilisation secondary to delayed pre op screening. Potential for financial harm if pre op screening is out of date and has to be repeated. Potential for financial harm if patients are being admitted to ward prior to surgery if pre op investigations are incomplete.	Band 5 Nurses in POA to cease preliminary screening in T/O & Urology when patients are added to IPWL immediately. POA clerical team chronologically inviting patients who are listed within the next month, to attend for repeat screening. (done on receipt of theatre lists)PCR testing being done for T/O patients if surgery is within 3 days	Reviewed 3/12/10 - Issue is still valid for Urology (52 weeks) T/O 32 weeks, General Surgery 20 weeks. Awaiting cutting plans within specialties. Currently undertaking review of patient flow through POA and will be creating HSQ by appointment if needed according to Specialty waiting times. Continued pressure on POA capacity due to the additionality being generated secondary to cutting plans and PTL compliance. Reviewed 21/7/10 - Change in processes made to reinstate screening at initial HSQ - this is to ensure suitability for short notice admissions. Reviewed 14/5/10 - Preliminary meeting held with Band 6 working in POA on 13/4/10, will be meeting again to work on establishing and agreeing timeline of investigations for T/O and Urology patients. Ward Managers have been requested to release all NVQ candidates to the Infection To be reviewed/updated again 14/5/10. Reviewed 3/12/10 - NVQ training complete. Reviewed 21/7/10 - Meeting Susan Boyce 5.8.10 re NVQ verification. Remains a persistent risk. Reviewed 14/5/10. Prevention training this month and Carmel Markey has agreed to teach and assess MRSA swabbing. To be reviewed/updated again.	LOW	DIV	19/05/2011
2546	24/03/2010	Provide safe, high quality careBe a great place to workMake the best use of resources		Risk of fire when oxygen cylinders are stored with other consumables	Fire risk from oxygen cylinders being stored along side stationary and electrical equipment. Resulting in major fire, loss of life, litigation. Oxygen should be stored in appropriate fire proof cupboards.	Oxygen cylinders are stored on metal stands attached to the wall. Staff vigilance.	17.04.12 - Medical gas group has re-established and issue being addressed as part of that group. 23.01.12 - An agreed stock has been established for all wards in SEC - suitable storage and signage. Works ongoing.	LOW	TEAM	10/12/2014
2591	15/04/2010	Provide safe, high quality careBest use of resources	Opthamology Clinic	Unable to identify patients at risk of glaucoma from within the back log of review patients	Unable to identify patients at risk of glaucoma from within the back log of review patients - Risk of patients eyesight deteriorating or losing completely resulting in : 1. Patients not receiving a high quality service. 2. Targets breeched. 3 large manpower expenditure to review the backlog.	Initiate an action plan to address the backlog of out patients that require a review and identify those that have a risk of glaucoma.	Backlog review completed	MOD	DIV	21/09/2011
2592	15/04/2010		Trauma Ward	5.19 WTE Registered staff on maternity leave at the same time	Patients receiving a poorer quality service, less safe 5.19 WTE Registered staff on maternity leave at the same time. Audits reflecting clinical indicators at risk of dipping , MEWS, Hygiene etc. Sick levels increasing. Unsafe service, reduced quality of service delivered. Poor morale. Expenditure due to bank and agency.	3 temporary registered staff In situ, however staff off are predominantly experienced staff, therefore ward short of experienced senior cover.	17.04.12 - All E reqs processed and all vacancies and maternity leaves filled as allowed. Issue closed. 23.01.12 - All vacant posts are in the process of being filled. 4 members of staff from the Bank Permanent Staff are dedicated to Trauma due to the high volume of maternity leave. 10.11.11 New staff in recruitment process and vacancies will be filled in Dec 2011. 01.10.11 Additional block bookings have been put in place and rotation program implemented from Orthopaedics and Trauma co-ordinators are undergoing further training.	LOW	DIV	17/04/2012
2593	15/04/2010		4 North Surgical	Cesation of Band 2 staff trained and currently doing clinical observations under the delegation of registered staff	In wards 4 north, 4 south, 3 south, Band 2 staff that have been trained and currently doing clinical observations under the delegation of registered staff having to stop, therefore a large increase in the number of clinical observations for registered staff to carry out, resulting in risk of observations not being timely. Risk of patients condition changing / deteriorating without recognition Patients not getting clinical observations in a timely manner if band 2s stop their current practice. No data available to identify that patients received less than optimum care when band 2s do clinical observations under delegation of registered nurse	Training carried in legacy trust for band 2 doing clinical observations. Requirement for band 2s to have clinical observation module in NVQ level 3 before being able to do clinical observations. This training not in place at present.			HOS	05/09/2011
2743	16/04/2010	Provide safe, high quality careBe a great place to work	Outpatients Dept	Staff Shortages due to implementation of POA without Backfill of Band 5 staff & ACH OPD provide 2.18 wte nursing support for MIU	Due to chronic staff shortages, staff are unable to be release to attend in service and mandatory training. Risk of not being able to fulfil professional development requirements. Risk of staff providing patient care to potentially out of date standards. Due to chronic staff shortages, staff are unable to be release to attend in service and mandatory training. Risk of not being able to fulfil professional development requirements. Risk of staff providing patient care to potentially out of date standards.	Outpatient Managers keeping current training records for all staff, while making priority for designated mandatory training. Allocation for training done according to type of training and date of last attendance when capacity allows. Consideration given to KSF and professional requirements first. Staff asked to do training during extra hours if no alternative available. Lead Nurse has escalated the staffing deficit/ Minor Injuries Unit to Finance, the AD for Surgery and Elective Care and Head of Out of Hours Service	6/12/10- Finance has extracted the MIU SIP out of the staffing allocation and funding from OPD. Review of funding to be done in relation to staff in January 2011 by H Trouton and Dr G Rankin. All risks remain outstanding and unchanged. 21 July 2010- staffing constraints have been highlighted to the AD for SEC and the Interim Director for Acute Services. Awaiting financial summary of overall Outpatient financial position. Review 31 August 2010. 6/12/10- Finance has extracted the MIU SIP out of the staffing allocation and funding from OPD. Review of funding to be done in relation to staff in January 2011 by H Trouton and Dr G Rankin. All risks remain outstanding and unchanged. 21 July 2010- staffing constraints have been highlighted to the AD for SEC and the Interim Director for Acute Services. Awaiting financial summary of overall Outpatient financial position. Review 31 August 2010.	LOW	DIV	19/05/2011
2636	20/04/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of	Female Surgical Ward DHH	Patients for surgery having cancellations due to inadequate information and preparation via pre-operative assessment clinic.	Patients for surgery having cancellations due to inadequate information and preparation via pre-operative assessment clinic. Trust waiting list has to be altered so other people are cancelled to facilitate the cancelled patients. Wastage of theatre time and staff. Resource implications for the Trust. Complaints will increase. Extra work for ward staff and secretaries. Patients taking time off work to come to hospital for their surgery. Risk of litigation, loss of reputation. Patients cancelled due to not being informed to stop taking medications, such as anti-coagulants or insulin, or patient has not taken essential medications which should have been taken. Patients condition may have changed and may require further investigations eg: ECG, echo, which was not carried out at pre-op assessment. Patient not seen face-to-face at pre-admission clinic by a nurse (so patient effectively doing their own assessment) and on day of surgery consultant decides patient is not for surgery. Pre-op assessment bloods out of date, especially Group and Hold, and need to be repeated on day of surgery. Patient pre-assessed in CAH and documentation did not arrive at ward level.	Incident forms to be completed. Communicate with nurse in pre-admission clinic. Inform lead nurse		HIGH	DIV	05/09/2011

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2635	27/04/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of resources	Female Surgical Ward DHH	Lack of staff training DHH, MSW, FSW, HDU, Gynae	Risk of staff not being updated due to lack of resources to facilitate staff to go to training and multiple training schedules at Trust level. Staff will not meet mandatory requirements for registration as specified by their professional regulatory body. Mandatory requirements unable to be facilitated. Risk of harm to patient if staff not adequately trained to provide high quality, safe, effective care. Increased risk of complaints, loss of reputation to Trust. Increased risk of HAI's. Risk of litigation. Low morale, increased sickness level, high staff turnover Staff will be unable to provide a high quality, safe, effective care to patients if not updated adequately. If staff at training, safe staffing levels may not be achievable at ward level. Most training takes place at Beeches CAH, which means at least 2 extra hours for travelling to and from DHH, which in turn reduces the amount of staff we can release from the ward.	Plan off duty rotas to facilitate training. Assess ward dependencies to ensure adequate staffing levels and facilitate training on the day of training as to whether staff can be released for training. Ward Manager to prioritise training needs. Controls discounted - Request more training in Daisy Hill Hospital. Beeches Education Centre not always able to provide training in DHH.		MOD	DIV	08/06/2010
2624	27/04/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of	Trustwide	Risk to health and safety of patients and staff in all SEC wards in CAH and DHH due to inadequate environment.	Increased risk of falls. Increased risk of injury to staff due to inadequate storage. Risk of infection due to inadequate sinks in wards and storage of hoists in bathrooms. Risk of theft of staff property. Increased risk of complaints, risk of litigation, loss of reputation to Trust. Risk of falls due to floors sealed with tape to cover cracks in floor covering. Uneven floor surface also providing a risk of falls. Inadequate number of sinks per bed ratio in main wards - should be 1 sink per 4 beds - presently 1 sink per 6 beds. Inadequate storage for stationary and equipment, eg: hoist being stored in main bathroom as there is no room for it anywhere else in the ward (FSW + MSW). Inadequate changing facilities for staff and inadequate number of handbags lockers for staff.	Environmental audits. Maintaining low stock levels. Endeavour to adhere to current infection control policy. Inform Estates.	07.06.10 - email from K McGoldrick - 'Beatrice as a follow up to a meeting with Heather, Connie and myself last week would you please look at these entries to 27/05/10, SEC risk register 2624 - expand to SEC as a problem across the division'.	MOD	DIV	05/09/2011
2631	29/04/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of resources	Female Surgical Ward DHH	Risk of delay in treatment for patients with fractures awaiting a bed or further management in the regional centre in Belfast.	Poor outcome for the patient. Delay in treatment. Potential for developing complications of bed rest eg: pressure sores, thrombosis, infection. Potential for increased complaints, litigation for the Trust. Patients may develop complications of bed rest and of having a fracture eg: fat embolism, thrombosis, infection. Delays in surgery may mean death or poor fracture healing. Bed flow may be impaired which will have an effect on elective lists and may result in theatre cancellations and breach of PFA targets. Loss of confidence in the Organisation.	Close liaison with Bed Manager who in turn communicates with regional centre. Control measure discounted - Patients should be admitted directly from A+E to RVH. Ensure CT scans and X-Rays are sent to RVH # Clinic or wherever designated, and signed for on receipt to ensure timely treatment. Communication with medical staff in regional centre at least daily when awaiting transfer.	01/10/13:An agreement has been reached that all N+M patients will transfer to RVH for treatment. During out of hours they will wait in DHH and then transfer directly the next morning to RVH. 29/03/13: Current position remains; continued utilisation of CAH Trauma Ward 01.02.13 - Optimum utilisation of CAH Trauma Ward continues in conjunction with RVH. 07.01.13 - Processes in place continue to work well. No escalations of delays in treatment for patients received. 29.11.12 - Current position remains. Case currently going to board and if approved and consultant appointed, fracture patients will come to CAH therefore minimising risk. Timescale uncertain. 28.09.12 - No change on review. 19.06.12 - Processes in place continue to work well with optimum utilisation of CAH Trauma Ward encouraged in conjunction with RVH as required. Plan to review in 2 months. 17.04.12 - Current position remains. 23.01.12 - Processes in place are working well. 10.11.11 Improvements noted in access to Belfast. 01.10.11 Awaiting feedback from patient flow team. Update 27.5.11- Dr Loughran has received correspondence from Dr Tony Stevens RVH re issue: - New rota hoped to improve response - Monitor success of new rota CAH taking patients requiring surgery subject to bed	LOW	DIV	01/10/2013
2628	04/05/2010			Delay in diagnosis, treatment, transfer and discharge of patients due to loss of X-Rays, CT, MRI results	DHH Female Surgical,/Gynae, Male Surgical/ HDU - Delay in diagnosis, treatment, transfer and discharge of patients due to loss of X-Rays, CT, MRI results # Clinic RVH. Delay in diagnosis and treatment - poor outcome for patient - permanent injury, death. Patient may develop complications of bed rest, hospital acquired infection, fat embolus, DVT, PE, pressure damage to skin. Patients treatment delay causing further complication of condition. Risk of complaints, litigation, confidence loss in service. Bad reputation for surgical wards. Delay in patient flow, resulting in theatre cancellations. Delay in discharge, theatre cancellation ,	Documentation available from surgical ward / A + E to be signed by RVH staff when X-Rays delivered. Good communication by nursing staff. Bed manager to communicate with # Clinic with daily or more regular updates.		VLOW	DIV	05/09/2011
2632	04/05/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of	Female Surgical Ward DHH	Patients are at risk of not receiving prescribed drugs at prescribed times, due to 2 nurses to admin and check drugs IV.	Poor outcome for patient, delay in treatment. Potential for deterioration of condition. Increase of clinical incidents, complaints. Patients will not receive prescribed treatment in timely fashion. Bed flow may be impaired - delay in patient discharged, therefore elective lists may be postponed. Nurse could be disciplined for not adhering to guidelines. Litigation for the Trust, loss of confidence in Organisation.	Encourage use of IV antibiotics in community. 2 Staff on duty at all times to check drugs, risk of not being available for administer of drugs due to patient dependency and bed occupancy. Monitor medication errors and adverse incidents. Controls discounted - Dr to give IV drugs. Daily IV antibiotic ward round.		LOW	HOS	23/01/2012

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2633	10/05/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingBe a great place to workMake the best use of	Female Surgical Ward DHH	Safety of staff property due to inadequate supply of handbag lockers at ward level.DHH, FSW, MSW, Gynae, HDU	Risk of staff property being stolen. Risk of litigation. Risk of loss of Trust reputation. Staff safety at risk if personal details stolen with handbags. Staff are at risk of distress and safety at risk if personal details stolen with handbags.	Handbags in unlocked cupboards.		LOW	HOS	23/01/2012
2625	10/05/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingBe a great place to workMake the best use of	High Dependency Unit DHH	Patients at risk due to inadequate staff cover at meal times	Poor outcome to patient. Possible death of patient. Extreme stress for staff. Increased sick leave, low morale. Increase in clinical incidents, increase in complaints. Risk of litigation, loss of Trust reputation, risk of increase in HAI's. Nurse could be at risk of losing her pin no. In the High Dependency Unit there are two staff nurses to cover for 5 ill patients. There is no provision made in the nursing establishment for meal break cover, lunch breaks; staff nurse caring for 5 ill patients. There is a risk of patients not receiving prescribed care, or of patients no receiving adequate pain relief due to only 1 staff nurse. Risk assessments for moving and handling cannot be adhered to due to only 1 nurse I unit. If patients condition suddenly deteriorates one staff nurse may not be able to deal with all five high dependency patients.	When possible, cover given by Male Surgical ward but due to maternity leaves, study leave, sick leave, posts not replaced. This is not adequate. Emergency call bell in HDU. Control measure discounted - Extra staff in HDU establishment. Inadequate funding for same.		LOW	TEAM	04/04/2012
2739	19/05/2010	Make the best use of resources	Pre-Operative Assessment Clinic	Increase in Day of Surgery Cancellations due to inappropriate/inadequate pre op screening. This is secondary to insufficient cle	Due to the reduction in Clerical Support, the POA clerical team are at risk at not being able to monitor the listing of T/O patients and monitor MRSA screening/status. The patient is at risk of having the procedure delayed or cancelled if not enough time has been given to screen and treat any infection pre operatively. Potential impact on theatre scheduling (surgery being postponed or cancelled at short notice) and theatre capacity)y (day of surgery cancellations) if patients aren't selected for screening in a timely manner. Patient harm - delay or cancellation of procedure has potential the length of time patient is exposed to illness/discomfort. Patient could potentially have financial loss due to time taken from work, along with disruption to domestic circumstance. Financial harm to Trust: substantial financial consequence for Trust secondary to loss of theatre capacity, loss of ward capacity and potential to breach waiting time targets. Harm to resources within the Trust - Day of Surgery cancellations potentially causes additional strain on ward staff due to patient distress and need for reorganisation of surgery. This has the potential for the patient to be exposed to additional screening secondary to delay.	Redistribution of workload within POA Clerical Team. Band 4 officer to monitor the T/O chart processing. S Glenny to provide monthly lists of patients due for selection- Band 4 to then monitor the timely arranging of patient attendance. Scheduling Team to populate Theatre lists a month in advance. POA Band 6 Nurses to highlight patients for screening/rescreening once TCI known.	May 28 2010. Escalate to S Glenny/H Trouton if controls are inadequate.	LOW	DIV	19/05/2011
2634	20/05/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of	Female Surgical Ward DHH	Injury to a patient following a fall DHH, MSW, FSW, Gynae, HDU	Client may have a fracture or head injury or laceration due to a fall. Complaints will increase, risk of litigation. Delayed discharge. Patients who are confused, under the influence of drugs or alcohol, elderly, unsteady on their feet, head injuries may be at risk of falling. This risk may be increased if the staff / patient dependency ratio is not at an adequate level. Patient may need transfer to another hospital. Could develop hospital acquired complications. Risk of death.	Monitor slips, trips and falls. Manual handling risk assessment carried out on admission. Individual patient handling assessment carried out on all patients on admission eg; cot sided, history of fall, use of aids etc. Keep bed at low level, mattress on floor, appropriate chair. Ensure call bell for each patient is within patients reach. Remove environmental risks. Contol measures discounted - Getting family to sit with patients and reviewing staffing levels and getting extra staff to sit with patient. Often family not available. Often unable to get bank staff.	07.06.10 - email from K McGoldrick - 'Beatrice as a follow up to a meeting with Heather, Connie and myself last week would you please look at these entries to 27/05/10, SEC risk register 2634 please remove ' - risk closed 08.06.10	LOW	DIV	08/06/2010
2742	22/05/2010	Provide safe, high quality care	Outpatients Dept	Risk to health & safety of patients in ENT due to no access to decontamination equipment on weekends	No access to decontamination equipment on weekends. Additional Clinic Saturday May 22 2010. Cross contamination to patients. Risk to organisation through: litigation; adverse publicity/ complaints;loss of reputation; breach of Hine Review. Recommendations. Inequality of care for patients; Friday (clean scopes); Saturday (wiped and sheathed scopes). Cross infection risk as ENT sinuscopes are not decontaminated in line with DHSSPS recommendations due to lack of sufficient scopes to meet demand. 10 scopes available for clinic with potential to need to access 40 decontaminated scopes as all are new patients.	10 scopes available for potential need to access 40 scopes therefore decontamination between patients is not possible - scopes will be wiped using alcohol wipes and single use sheath applied (in breach of Decontamination Regulations). Arrange for all scopes on other OPD sites to be transported to CAH for the additional clinic. This would mean that the satellite sites would not have access to their scopes for clinics on Monday with a risk of not having them decontaminated for Tuesday. Irrespective if all scopes were recalled, there would not be sufficient numbers to support a clinic of 80	23.01.12 - Requisition away for customisation of transfer boxes and same should be resolved by 29 February 2012. Seeking funding to provide decontamination of new scopes. Contribution to Decontamination staff- ? .2 Wte Band 2	VLOW	HOS	17/09/2013
2626	24/05/2010	Provide safe, high quality careSupport people and communities to live healthy lives and improve their health and wellbeingMaximise independence and choice for patients and clientsBe a great place to workMake the best use of resources	Female Surgical Ward DHH	Staffing levels in Female Surgical/Gynae, Male Surgical/ HDU	Health and Safety of patients and staff could be compromised if staffing falls below safe levels for dependency and high bed occupancy due to staff absence and reduced staffing as a result of bed closures at the weekend. Patients may be at risk of not receiving adequate, safe, high quality and timely care. Risk of increase in accidents, medications not given on time, poor documentation or lack of documentation / not according to NMC code for record keeping. Staff may be placed under stress if staffing levels fall below recommendations for patient dependency / bed occupancy. Patient may be at risk of receiving inadequate care. Adequate maintenance of the ward environment may be compromised if staffing falls below acceptable levels. Increase in complaints. Increased staff sick leave. Risk of increased length of stay due to HAI's. Lower staff morale. Risk o litigation. Risk of loss of reputation.	Monitor staff sickness and absenteeism. Monitor clinical incidents. Monitor complaints. Attend white-board meetings x3 times / week to monitor patient length of stay. Feedback to nurse managers if requesting bank or extra hours. Monitor environmental cleanliness by audits.		LOW	DIV	08/06/2010

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2627	24/05/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of	Female Surgical Ward DHH	Delays in repair of equipment eg: sluice master in FSW, MSW, HDU, Gynae DHH	Delays in repair of equipment eg: sluice master. Increase of infection. Risk of injury to patient and staff from equipment. Equipment eg sluice master not repaired when faulty may cause spread of infection due to body fluids being stored in clinical waste bags. This is high risk for staff and patient including portering staff. Risk of complaints, litigation and bad publicity.	Use equipment as per guidelines. Inform maintenance as soon as equipment faulty. Ensure infection control procedure applies as per policy.		MOD	HOS	23/01/2012
2647	26/05/2010	Provide safe, high quality care	4 South Surgical	Short term storage of large quantaties of oxygen cylinders at ward level on 27th May 2010	Large quantity of oxygen cylinders at ward level due to the mains oxygen supply being unavailable for a period of time on 27th May 2010, thus potential risk of running out of oxygen and hazard from large quantity of stored oxygen in an unprotected area Risk of litigation if staff harmed due to amount of cylinders stored as area cluttered, and cylinders very heavy Risk of poor quality service if oxygen runs out Risk of injury from oxygen cylinder Risk of fire as no dedicated O2 storage area is available at ward level	Estimation of extra oxygen required obtained and at ward level All cylinders on O2 trolley Porters and Pharmacy informed of the loss of mains O2 Management informed	08.06.10 - work complete and risk closed	MOD	DIV	08/06/2010
2681	15/06/2010	Provide safe, high quality careMake the best use of resources	Outpatients Dept	Shortage of (Paediatric) Band 5 Nursing staff due to the implementation of Pre Operative Assessment without backfill of Band 5 s	Potential harm to patients due to not having regular support of Band 5 Paediatric trained Staff Nurse. Potential harm to the reputation of the SHSCT if this issue is highlighted as part or RQIA feedback. Potential for litigation if it is found that a patient received sub standard care due to lack of access to Paediatric trained Staff Nurse. Failure to comply with Child Protection Policy and Procedure. Staff supporting the Paediatric service in Outpatients are at risk of not having sufficient skill and supervision to undertake the assessment of care of patients 16 and under Trust at risk of complaint and litigation. Staff at risk of not meeting SHSCT Child Protection Standards. Children at risk of harm by potential action or inaction by Adult trained nurses/health care assistants Patients and families have to reattend Inpatient services to have Paediatric specific investigations done. (this as a direct result of insufficient specialist skills within General Outpatients.) Increased risk of exposure to HAI and impact on ward staffing resources.	Awaiting the commencement of year long Secondment to Paediatric training for S/N J Doogan Health Care Assistants and Nursing Auxiliaries allocated to support Paediatric clinic with Band 7 Paeds Trained Department Manager on site. Band 5 staff nurses allocated to Paeds clinic when staffing levels allow. Control measures considered but discounted: Increase Band 5 Staff Nursing allocation-Unable to secure funding for POA backfill due to financial constraints Band 7 OPD Manager, covers Child Protection support-Band 7 Paeds trained Department Manager currently on sick leave Band 5 Paeds Nurse allocated to Paeds OPD- The one Band 5 Paeds trained staff nurse is current on Band 6 secondment in POA.	25 June 2010- Meeting held with Mrs Geraldine Maguire, Mrs Grace Hamilton, Mrs Heather Trouton and Mrs Connie Connolly regarding the transfer of funding from General OPD to the Paediatric Directorate. It was agreed that funds equivalent to 1.0 Wte at one Band 5 and 1.0 Wte at one Band 2, would be transferred from OPD to Paeds. Email request regarding this change was sent to Mrs Carol Cassells. It was agreed that current custom and practice would continue until the Paeds Directorate was able to recruit staff accordingly. 3 June 2010. Meeting held with Grace Hamilton and Bernie McGibbon. Actions: Connie Connolly to amend and escalate Risk Assessment to Heather Trouton/Beatrice Moonan. Done 3/06/10. Connie Connolly to approach Dean Faloon in Finance and Dr Mike Smith regarding information regarding funding for Paeds OPD. Consideration was given to OPD funding being transferred to Paediatric Directorate. Connie Connolly to escalate proposed transfer of funding from OPD to Paeds to H Trouton. Connie Connolly to discuss the commissioning position for Paediatric training in 2010/11 with Heather Trouton. 14 June 2010 -Meeting with Bernie McGibbon, Dawn Connolly and Connie Connolly Due to chronic shortage of Band 5 Paediatric trained Staff Nurses, these actions have been agreed. Actions: Paediatric Outpatients children who require the application of EMLA crème with have to attend 3 North to have EMLA crème applied in advance of having blood taken. Memo to be circulated 15 June 2010 To await outcome of meeting with Mrs Maguire and Mrs Trouton regarding the transfer of funding for Nursing support from General Outpatients to Paediatric Services. 6.12.10 - Paediatric funding transferred to CYP in July 2010. October 2010 - staff rotating from Paediatric ward initially for induction, with a view of supporting the complete service by November 2010. 6/12/10- CYP managing the Paediatric Outpatient	LOW	DIV	06/12/2010
2746	21/07/2010	Provide safe, high quality care	Outpatients Dept	Risk of contamination while using Welch Allen sigmoidoscopes (rigid or flexible) with Welch Allen light source etc.	Risk of contamination has been identified while using Welch Allen sigmoidoscopes (rigid or flexible) with Welch Allen light source, reusable eye pieces, reusable bellows with the disposable proctoscope & disposable filter. There is a risk of cross contamination from the equipment to the patient if the bellows are reusable. Currently in Outpatients staff would not have access to sufficient numbers of reusable eye pieces, to replace the eye piece with every examination. There are only 9 sets of bellows across the Trust and the MDA health alert stipulates that the eye piece, filter and bellows are changed with every examination. The Trust currently has disposable proctoscopes and filters in use. Risk of cross contamination between patient and sigmoidoscope equipment. (the reusable bellow has the potential to cross contaminate the reusable eye pieces irrespective of the disposable filter)Potential harm to patient if secondary infection is contracted. Could potentially delay or change management Risk of litigation	Urgently seek the view of the Assistant Director regarding the financial implications of remaining partially compliant with manufacturer's advice. Collate financial estimates for changing to a Single Use system or enhancing stock of current equipment. Manually cleaning bellow in between examinations, while awaiting investment. Not feasible given the number examinations done and the timing between patients. Cannot insist on the changing of eye pieces or bellows until financial resources are released.	6.12.10 - Requisition has been placed to purchase 6 light sources to support the new disposable system. To be supplied by 31.3.11. Integration of new single use MDA compliant system to be in place by 31.3.11. 6.12.10 - Requisition has been placed to purchase 6 light sources to support the new disposable system. To be supplied by 31.3.11. Integration of new single use MDA compliant system to be in place by 31.3.11.	MOD	DIV	19/05/2011
2740	27/07/2010	Provide safe, high quality careMake the best use of resources	Pre-Operative Assessment Clinic	Staff Shortages due to sick leave within Band 6 POA nurses providing Face to Face Assessment	Due to chronic staff shortages, there is not enough capacity on the two above mentioned sites for Face to Face assessment to be done in a timely manner. This results in an insufficient number of pre op fit patients available for listing for elective procedure. Risk of Day of surgery cancellations and decreased theatre utilisation due to patients being suspended or cancelled at late notice. Due to lack of capacity, there is limited provision for any patients being booked at late notice due to cancellation, or red flag/urgent status. Potential harm to patients following cancellation of surgery due to untimely or no pre operative assessment. Potential financial harm due to inappropriate theatre utilisation- not enough patients pre op fit. Potential to harm to reputation of SHSCT due to potential breech of waiting times	Patients having surgery in the next 4 weeks are given priority for Face to Face assessment. POA clerical staff allocate appointments in chronological order of TCI dates. All Band 6 POA staff have staffed additional clinics during time which was usually allocated for the reviewing of investigative results. Close monitoring of sickness and absence/referrals to Occupational Health.		MOD	DIV	17/08/2010

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2744	27/07/2010	Be a great place to workProvide safe, high quality care	Outpatients Dept	Staff Shortages due to the implementation of Pre Operative Assessment without Backfill of Band 5 staff	Due to chronic staff shortages, staff are unable to be release to attend in service and mandatory training. Risk of not being able to fulfil professional development requirements. Risk of staff providing patient care to potentially out of date standards. Potential harm to patients and staff due to not being able to be updated with mandatory and in service training. Potential harm to the reputation of the SHSCT if this issue is highlighted as part or RQIA feedback. Potential to delay progression through KSF framework , secondary to lack of attendance re agreed training needs. Potential for litigation if it is found that a patient received sub standard care due to lack of access to training.	Outpatient Managers keeping current training records for all staff, while making priority for designated mandatory training. Allocation for training done according to type of training and date of last attendance when capacity allows. Consideration given to KSF and professional requirements first. Staff asked to do training during extra hours if no alternative available	6/12/10 - Current position remains unchanged and will potentially deteriorate in January due to Maternity leave(22/10/10). Block bookings have been utilised where possible with Nurse Bank at Band 5 (1.0 Wte) and Band 2 1.44 Wte). This was arranged following Meeting with H Walker, H Trouton and C McGoldrick. All staff on long term sickness are under occupational health review. Difficulty in staffing additional clinics Trust Wide. 21 July 2010 Awaiting Financial Summary to illustrate the overall Outpatient status. AD for SEC and Interim Director of Acute Services aware of staffing issues. Nurse Bank being utilised to cover gaps. Review August 31 2010	VLOW	DIV	19/05/2011
2741	27/07/2010	Provide safe, high quality care	Outpatients Dept	No provision for Bariatric patient- patients over 25 stone in weight	No bariatric examination couches available on the above mentioned sites. Unable to provided Outpatient service to patients over 25 stone at these sites. Potential to breech waiting time targets as patient may not be able to be seen close to their home or by the relevant specialty. Risk of injury to patient and staff if furniture is not fit to provide support for patient weighing over 25 stone. Risk of inadequate examination due to limitations of non bariatric furniture. Potential harm to patient if the patient cannot be seen on the above mentioned sites, due to lack of appropriate examination couches- potential for increase in severity of disease/illness. Potential for delay in Outpatient appointment if living near one of these site. Potential harm to both patient and staff if patient was seen on inappropriate furniture- potential for inadequate examination due to limitation of furniture. Potential discomfort and embarrassment to patient if department not prepared to meet patient need.	Medical records will book any know bariatric patient to the Daisy Hill site.	6.12.10 - All General Outpatients Departments now have one Bariatric couch and one Bariatric chair in the waiting room. Remove from Register - no longer a risk. 6.12.10 - All General Outpatients Departments now have one Bariatric couch and one Bariatric chair in the waiting room. Remove from Register - no longer a risk. Caroline Doyle in Finance has asked that Helen OHare was contacted regarding updating the status of all E&G accounts. Email sent 15/04/10.	LOW	DIV	06/12/2010
2820	25/11/2010	Provide safe, high quality careBe a great place to workMake the best use of resources	3 South Surgical	Significant WTE staff levels less than agreed compliment due to sick leave, maternity leave and vacancies.	Patients receiving poor quality care. Clinical Audits reflecting reduction in standards. Staff sick leave increasing. Poor moral, staff feeling over worked. Increase in complaints. Risk to reputation of Trust . Due to reduction in ward compliment of staff, along side normal activity there is a risk that systems and processes will breakdown. Staff, patients and Trust reputation at risk. Escalation in level of sick leave. Training opportunities not able to attend due to ward shortage of staff Mentoring of students compromised.	Bank staff to back fill as bank system and financial climate will allow. Encourage staff to be flexible with off duty rota. Control measures considered but discounted and why: Temporary staff appointed, not feasible due to the current recruitment challenges and the time scale involved.		HIGH	DIV	05/09/2011
2821	26/11/2010	Provide safe, high quality care	Outpatients Dept	Risk to health & safety of patients in ENT attending additional clinics on November 20 2010	No access to decontamination equipment on weekends. Additional Clinic Saturday May 29 2010. Cross contamination to patients. Risk to organisation through: litigation, adverse publicity/complaints,loss of reputation, breach of Hine Review Recommendations. Inequality of care for patients - Friday (clean scopes), Saturday (wiped and sheathed scopes). Cross infection risk as ENT sinuscopes are not decontaminated in line with DHSSPS recommendations due to lack of sufficient scopes to meet demand. 10 scopes available for clinic with potential to need to access 40 decontaminated scopes as all are new patients.	10 scopes available for potential need to access 40 scopes therefore decontamination between patients is not possible - scopes will be wiped using alcohol wipes and single use sheath applied (in breach of Decontamination Regulations)	Seeking funding to provide decontamination of new scopes	MOD	DIV	19/05/2011
2824	07/12/2010	Provide safe, high quality careBe a great place to work	Outpatients Dept	Risk of inadequate staffing levels due to long term sick leave resulting in poor or inadequate nursing care and chaperoning	Staff and patients are at risk of error, poor quality care, insufficient chaperoning. Trust is at risk of not meeting SABA levels, secondary to not having enough staff to support additional clinics. Risk of inadequate staffing levels due to long term sick leave resulting in poor or inadequate nursing care and chaperoning. Risk of decreased efficiency and capacity in Outpatient clinics secondary to low staffing levels. Risk of loss of reputation due to increased waiting times and increase risk of error due to increased workload of remaining staff. Potential for a further increase in sick leave due to high demand on remaining staff. Potential for increased complaints due to lack of staffing and staff workload. Extensive Long Term Sick Leave at Bands 5,3 and 2.Band 5 SIP 11.80 Wte 6.75 Wte staff on sick leave, secondment, acting up. Band 3 SIP 7.59 Wte. 3.63 Wte staff on sick leave. Band 2 SIP 2.19 Wte. 1.26 Wte staff on sick or maternity leave. Sickness Rate approx 49% - not withstanding annual leave and mandatory training and casual sick leave. Maternity Leave at Band 6 to be filled by . 90 Wte Band 5	Staff work extra hours when possible Band 5 1.1 Wte Bank block booking. Band 2 1.44 Wte Bank block booking. Staff working between multiple services, instead of single service. CTP has taken over support for Paeds OPD Rheumatology clinics are in DCC in CAH. Requisition has been approved for 2 POC testing for Coagulation Clinic (will release 2 staff)Staff from other Outpatients support when possible		LOW	DIV	19/05/2011
2823	07/12/2010	Provide safe, high quality care	ENT Clinic, Surgical Outpatients	Non Compliance with RQIA Environmental Cleanliness Audit 14/09/10	Health and Safety Risks to all patients attending ENT OutpatientsHealth and Safety Risks to all staff working within ENT Outpatients due to poor conditions of environment. Trust is Corporately at risk of loss of reputation if not compliant with RQIA recommendations. Infection control risk due to the type of flooring. Infection control risk due to lack of facilities to do initial decontamination of equipment. Risk of loss of reputation if not compliant with RQIA recommendations. Infection control risk due to poor condition of flooring in public toilets in ENT Department. Risk of patient injury due to inadequate space to conduct phlebotomy	Carpet is cleaned daily. Blood room is kept uncluttered. Toilets cleaned daily. ENT scopes are taken to CSSD for all cleaning (increasing processing time)	11/11/11 No progress with minor works, duplicate request sent to provide costs for all repair work. Remains a risk 14.11.11 Note link with Risk 2989	MOD	HOS	17/10/2013
2898	01/02/2011	Provide safe, high quality care	Outpatients Dept	No screens surrounding the examination couches in the Consultation rooms	Staff are unable to secure privacy and dignity of patient without adequate resources. Patient does not have any dignity or privacy to change for an examination. Potential for litigation to Trust secondary to inadequate changing facilities and potential for violation of patient privacy during an examination/consultation.	Clinician leaves the room to allow patient for privacy Changing cubicles are in use, and patients then walk in front of waiting are in hospital gown	23.01.12 - Screens have been ordered, awaiting delivery. 11/11/11 J McCaghey has been contacted and measurements have been taken. No cost estimate as yet. 10.11.11 Screens ordered from Jan 2011, awaiting delivery of same to progress with J Austin.	LOW	DIV	27/03/2012
2899	01/02/2011	Provide safe, high quality careBe a great place to work	Outpatients Dept	Non compliance with Infection Control and Health and Safety Standards in relation to patients, staff using this multi purpose ro	Non compliance with Infection Control and Health and Safety Standards in relation to patients, staff using this multi purpose room. Potential harm to patients and staff of hospital acquired infection. Potential of litigation to the Trust secondary to Hospital Acquired Infection.	Potential harm to patients and staff of hospital acquired infection. Potential of litigation to the Trust secondary to Hospital Acquired Infection.	25.10.11 Reviewed and closed by Connie Connolly	MOD	HOS	23/01/2012
2943	07/04/2011	Provide safe, high quality careMake the best use of resources	Urology Clinic	Urology cancer pathway delays (also on CCS Divisional Risk Register ID 2942)	Patients on haematuria and prostate cancer pathways. Delays in first appointments, investigations and treatments. Patients with cancer being delayed in diagnostics and treatment pathways. Patients may be late diagnosed and have further advanced disease leading to poorer outcome. This may mean that a patient changes from potentially curative to palliative during the waiting period.	Identification of patients at risk ongoing. Detailing of capacity and demand ongoing to identify needed capacity and resources. Further reconfiguring of services required to support the change required in the service to reduce delays. Further resources required to support the volume of work within both cancer and non cancer urology work.	23.01.12 - one stop prostrate clinic is fully operational, hence no delays at present. See Risk 2942 10.11.11 We will update figures early December 2011 01.10.11 One stop prostate clinic commences 1 October 2011 and One stop Haematuria clinic commences 6 October 2011	LOW	DIV	23/01/2012
2968	21/04/2011	Provide safe, high quality care	4 South Surgical	Risk to staff and patients of the spread of HCAI due to condemned Bedpan Washer Ward 4 South	Condemned Bedpan Washer Ward 4 South. Risk of the spread of Health Care associated Infections [HCAI] to staff and patients. The Bedpan washer is broken and has been condemned on the Male side sluice room of Ward 4 South. This poses significant risk to the patient and the staff re: the spread of HCAI.	At present staff are using the Bedpan Washer on the Female side of the ward to decontaminate bedpans and urinals	A visit is taking place to another facility to view an HTM compliant bedpan washer in April 2011. As an interim measure a temporary Bedpan washer is being installed week commencing 13th June 2011	MOD	DIV	05/09/2011
2990	19/05/2011	Provide safe, high quality care	Outpatients Dept	No hand washing facility in clinical Outpatient consultation rooms Room 63 and room adjacent	This risk assessment is being measured on the basis that currently these clinical rooms are being used by Speech and Language only. This specialty by its nature is non-invasive and does not traditionally create a high decontamination risks. If these rooms were to be allocated in the future to other specialties, the risk to the Trust would be substantially higher.** Staff and patients do not have access to any hand washing facilities in the clinical consultation room. Risk to Health and Safety- Risk of infection, cross infection and hospital acquired infection to patients. Risk to Health and Safety Risk of infection and cross infection to staff utilising this clinical area. Environment will not have access to timely cleaning as there is no water or washing/cleaning facilities available. Risk to Health and Safety - infection to staff, and patients. Risk of Litigation, secondary to hospital acquired infection. Risk of Loss of Reputation to Trust with hospital acquired infection rate. Risk of non compliance with RQIA	Cleansing wipes and alcohol jells are used in between patients and to wipe equipment Equipment cleansed at the end of clinics with soap and water from other clinical area.		LOW	DIV	23/01/2012

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2989	19/05/2011	Provide safe, high quality care	Outpatients Dept	Inappropriate flooring Consultation rooms not compliant with Health and Safety/Infection Control	Carpet flooring will need replaced with a washable surface. Risk of infection/injury to staff, patients and Clinicians. Risk of litigation to Trust secondary to Hospital Acquired Infection Unable to achieve waiting time targets regarding Outpatient Capacity. Risk of financial penalty for not meeting Outpatient Capacity and Demand.	Daily cleaning of carpet by domestic staff.	11/11/11 No progress with minor works, duplicate request sent to provide costs for all repair work Remains a risk. 14.11.11 Note link with Risk 2823	MOD	HOS	23/01/2012
2998	31/05/2011	Provide safe, high quality care	Outpatients Dept	Unable to safely store sterile ENT equipment	Patients will not have access to a sterile nasopharyngeal scope, and appointment for examination will have to be rescheduled. This will directly result in a delay in diagnoses and an increased review backlog. Patients will not have timely access to sterile ENT nasopharyngeal scoped during ENT consultation. Patient at risk of delayed diagnoses. Risk of Hospital Acquired Infection. Risk of Litigation. Risk of Loss of Reputation secondary to RQIA non compliance. Risk of Loss of Reputation secondary to increased Review Backlog	Staff are currently supporting the Outpatient clinic and decontaminating equipment.		HIGH	DIV	05/09/2011
3006	21/06/2011	Provide safe, high quality careBe a great place to work		Environmental works at 4 North, 4 South & 3 South wards pose threat to management of HCAI;compliance with fire and disability	Outstanding Environmental works at 4 North, 4 South and 3 South wards pose threat to management of HCAI;compliance with fire and disability regulations. Each of the wards have the following areas which need a minor works programme to include: Toilet facilities upgraded; Bathroom / shower facilities upgraded; Installation of sinks in bays; Painting and plastering; Various Ceiling tiles replaced; Nurses station to be upgraded; The facilitation of a waste room in 4N; Floor tiles.	All reasonable measures are in place at present; cleaning schedules; decluttering; good housekeeping practices.	01.08.12 - Programmed of works completed in 4 North and 4 South. Awaiting funding to commence 3 south. 19.06.12 - Programme of works completed 4 south, programme of works near completion 4 North, awaiting funding to commence 3 south. 17.04.12 - Programme of works has commenced in Wards 4 North and 4 South. 3 South no date as yet - awaiting funding. 23.01.12 - Funding has been approved and refurbishment programme commencing February 2012. 10.11.11 Funding has now been allocated and a workable program for dates is being progressed. 01.10.11 Awaiting costing from Estates for refurbishment have walked the wards. Awaiting feedback. Review July 2011	MOD	DIV	28/09/2012
3027	08/09/2011	Safe, High Quality and Effective Care	Pre-Operative Assessment Clinic	PRE OP BAND 6 STAFFING	Patients are at risk of not receiving timely Pre-Operative Assessment by Band 6 POA Nurses Staff are at risk of overlooking patient management issues secondary to dramatic increase in workload Patients are at risk of delay in immediate pre-operative management re medicines management secondary to decrease in workforce. Decreased capacity to Pre Operatively assess patients 6 weeks in advance of surgery Increased risk of day of surgery cancellation or late cancellation secondary to insufficient pre-operative assessment Potential risk for theatre under-utilisation Potential for unnecessary use of staff resource on ward/unit due to unnecessary admission Potential for delay in patient treatment, patient distress, and disruption to patient work/home arrangements Potential for litigation to Trust re potential for delay in patient recovery due to insufficient pre-operative preparation	Patients with dates for admission have been made immediate priority All patients with dates for admission, needing Warfarin management, has been delegated to POA Project Leader Clinic templates have been adjusted to only include patients with dates for admission, and additional time has been allocated for processing results and managing queries Clinical Sister in CAH OPD has been supporting the Band 5/6 triage issues, and has been managing same All long term staff are being actively managed via Occupational Health Temporary replacement of Band 6 Sister has been provided with immediate effect .73 Wte All associated specialties and staff have been notified of temporary staffing issue	25.10.11 Reviewed and closed by Connie Connolly. 01.10.11 Situation should be resolved when full staffing in place by November 2011.	MOD	TEAM	23/01/2012
3048	23/11/2011		Outpatients Dept	Portable suction within CAH ENT OPD now obsolete, and no longer fit for purpose	Patients are at risk of not receiving high quality examination secondary to poor visibility for the Clinician. Potential for increase in waiting times for patients secondary to the extended period of time being needed for examination-may result in delay in diagnoses. Clinician at risk of overlooking clinical finding due to poor visibility. Patient at risk of auditory damage if suction control is inadequate during examination. Potential for inconclusive examination secondary to poor visibility during examination. Potential for patient harm secondary to inadequate suction-may result in needing additional treatment.	Patient examinations have been prolonged to allow for inadequate suction.	22.11.11 Direct Nursing support during every examination during ENT Clinics.	MOD	HOS	18/09/2013
3069	23/01/2012	Safe, High Quality and Effective Care	Trustwide	Wards and Departments not meeting their mandatory requirements for Right Patient Right Blood training.	Risk of no staff or minimal staff at ward level who can competently erect and monitor a blood transfusion. Risk of harm to patient and loss of Trust reputation as well as confidence.	Close liaison with the Haemovigilance Practitioner. Additional inhouse training has been commissioned. Staff have been issued with desist notices if relevant. Patient Flow team are aware of issues and how to manage same if situation arises out of hours.	01/10/13: Situation improving; focus remains at ward level and the Training matrix is monitored closely. 29.03.13: Training matrix is monitored very closely; focus remains at ward level to ensure training is booked in advance of expiry dates. 01.03.13 - Focus remains at ward level to ensure training is booked in advance; position is improving. 01.02.13 - All mechanisms remain in place to monitor position. 07.01.13 - Processes and monitoring mechanisms remain in place. 29.11.12 - SEC position improved. Monitoring mechanisms in place to avoid recurrence.	LOW	DIV	17/10/2013
3071	23/01/2012	Safe, High Quality and Effective Care	Trustwide	Risk of Point of Care Testing at Ward Level	Risk of staff not competent in use of machine and machine not maintained properly. Potentially inaccurate readings resulting in potential harm to patients, increased complaints and litigation.	Close liaison with laboratory staff, particularly Consultant Chemical Pathologist. Discussed with all Ward Sister to cascade to all staff the importance of quality control/cleaning/competency of users.	01/10/13: continue to monitor progress and address any issues that are identified by Laboratories. 29/03/13: continue to await roll out to all wards and departments 01.03.13 - Position remains unchanged. 01.02.13 - Continue to await roll out to all wards and department. 07.01.13 - All wards sisters in SEC have had awareness training. Pilot ongoing in CEAW, awaiting roll out of training via labs staff. 29.11.12 - In service training ongoing. Awareness increased and await outcome of pilot. 28.09.12 - A pilot in conjunction with the Laboratories is commencing at ward level to identify and address issues. 19.06.12 - Staff aware of responsibilities - ongoing work in relation to equipment and point of care testing at ward level. Plan to review in 2 months. 17.04.12 - All wards issued with folders in SEC containing list of all equipment and staff responsibilities. Ward Sisters to continue to reinforce same. 23.01.12 - discussed with all Ward Sisters to cascade to all staff the importance of quality control/cleaning/competency of users.	LOW	DIV	17/10/2013

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3184	17/08/2012		Fracture Clinic	Fracture Clinic Referral Waiting Times	Due to capacity problems the Fracture Clinic waiting times have the potential to increase significantly for new and review appointments.	Additional clinics are being organised where capacity allows and assistance being sought from other specialities/departments.	29.11.12 - Clinics up to date. 28.09.12 - Up to date at week ending 8 October 2012. However numbers have risen again. Assistance being sought for additional clinics.	HIGH	HOS	17/10/2013
3193	06/09/2012		Trauma Ward	Isolation of Trauma and Orthopaedic Wards	Due to the location of the Trauma and Orthopaedic Ward especially in the Out of Hours Period this can result in isolation for staff and patients.	Staffing levels are always maintained at a safe level to ensure safe standards of care at all times; Handover of sick / ill patients forwarded to Patient Flow Team twice daily; Staff have access to a Site Manager and Clinical Co-Ordinator in the Out of hours Period; Staff have access to all grades of Medical Cover via the bleep and escalation policy.	28.09.12 - All measures are in place at all times to ensure safety of staff and patients - review on a 3 monthly basis.	MOD	HOS	17/10/2013
3200	17/09/2012			Wards and Departments not meeting their mandatory requirements for Right Patient Right Blood training.	Risk of no staff or minimal staff at ward level who can competently erect and monitor a blood transfusion. Risk of delay and harm to patient; risk of loss of reputation of Trust.	Additional training sessions for theory in particular have been requested; awaiting assistance from Haemovigilance Practitioner and HSC Education Centre. Staff have been issued with desist notices if relevant. All Sisters are aware that staff may have to transfer to other wards / departments to assist. Patient Flow Team are also aware.			DIV	28/09/2012
3208	27/09/2012		3 South CESU	Infection control risks due to poor shower and toilet facilities on Ward 3 South.	Threat to management of HCAI. Compliance with fire and disability regulations.	All reasonable measures are in place at present, cleaning schedules, decluttering and good housekeeping practices.	29/03/13: Meetings have taken place with Contractors regarding other Minor works programme and work will commence within two weeks. 01.03.13 - Minor works scheme commencing March 2013 to upgrade treatment rooms in the first instance. A project team has been established to plan for a full refurbishment of 3 South and the other areas 4North and 4 South; working progress. 01.02.13 - Programme of works to commence prior to March 2013. 07.01.13 - Await start date for approved programme of works. 29.11.12 - funding has been approved and refurbishment to commence in January 2013. 28.09.12 - bid for funding has been completed - awaiting update.	MOD	DIV	17/10/2013
3210	27/09/2012		Outpatients Dept	Unable to provide full traceability and decontaminatino of Naso Pharyngeal scopes in SHSCT ENT and General OPD.	Risk of infection/injury to staff, patients and Clinicians Risk of litigation to Trust secondary to Hospital Acquired Infection and inability to trace scopes to patients. Unable to achieve waiting time targets regarding Outpatient Capacity- patient may need additional appointment for examination. Risk of financial penalty for not meeting Outpatient Capacity and Demand. Risk of RQIA non-compliance relating to the timing and decontamination of ENT Scopes and litigation Patients may not have access to decontaminated scope during assessment. Risk of litigation to Trust as scope decontamination process does not facilitate traceability	Scopes are cleaned by a variety of staff in CAH and STH without traceability. Insufficient staffing in CSSD for timely decontamination.	03.04.13: Funding has now been approved and recruitment is imminent. Re-training re Drying cabinet is commencing 8 April. 15 scopes awaiting asset tagging. 07.01.13 - Funding has been approved for ATICS to appoint Decontamination support. Retraining re dying cabinet has been arranged. SOP to be finalised 11 Jan 13 re OPD processes. Process to be implemented w/c 4 February 2013 29.11.12 - Standard operating procedures due to be completed by end November 2012. 28.09.12 - Meeting to take place with CSSD Manager and software company re needs and cost of compliance.	MOD	DIV	17/10/2013
3209	27/09/2012		Outpatients Dept	Urology project cannot proceed without the decant of OPD blood room	Urology project will not be completed by 31 March 2013. Urology will not receive new accommodation. Risk of loss of capital funding due to project not commencing on time.	None.	01/10/13: works programme has commenced; awaiting completion 29.11.12 - works programme commenced November 2012. 28.09.12 - completion of estates minor works for rooms 16 and 17 to be adapted to accommodate decant.	VLOW	DIV	07/01/2013
3211	27/09/2012		Outpatients Dept	CAH OPD environment in poor condition.	CAH OPD environment in poor condition- walls need painting/flaking paint needs removed and holes filled. Water stained ceiling tiles in examination rooms need replaced. Carpeted flooring which is worn and stained. Window blind fitting are worn and cannot be repaired- light is not being excluded. Non- compliance with Infection Control and Estates standards. Poor performance against RQIA standards-cleanliness inspections. Loss of reputation in relation to on-compliance Domestic services can no longer clean the aged and damaged surfaces. Risk of infection due to broken and flaking wall surfaces. Risk of infection due to stained/damaged ceiling tiles due to repeated water leaks. Risk of infection due to repeatedly stained carpet which can no longer be rejuvenated.	Regular and repeated cleaning by domestic services.	7 August 2013 Series of 8 emails since 4/11/12 to C Spiers re placement on the estates schedule. A Metcalfe has advised that the minor works budget is to be reviewed in Sept 2013. A Carroll to petition to have this work included in programme by 2014. this work has been outstanding since 2010 following RQIA inspection. 03.04.13: Works were costed and funding declined in March 2013. For consideration of works schedule for 2013/14. 07.01.13 - Series of 4 emails since 4 November 2012 to C Spiers re placement on the estates schedule. No reply as yet. This work has been outstanding since 2010 following RQIA inspection 29.11.12 - Re-requisitioned in September 2012, awaiting approval for commencement date. 28.09.12 - Submit minor works request with risk assessment to AD and Director of Acute Services. 03.09.12 ENT OPD works identified as priority for 2012/13 funding via HCAI Pgs10/11	VLOW	HOS	22/10/2013

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3299	31/12/2012		Anaesthetics, Theatres & Intensive Care Services	CAH Main Theatre Staffing Risk	Due to increase in sick leave/maternity leave within Main Theatres CAH, this has led to being unable to provide additionally with consequence risk to ENT and Urology access targets.	Avenues explored 1. Cross site working of all staff difficulties, can be stabilised through redeployment of staff nurse from Female Surgical to DPU. 2. Extra hours offered to all staff Trustwide -email to be re-circulated to al ward sisters. 3. Increased hours for parttime staff working within Trust across all sites. 4. Contacted staff on secondment. 5. Contacted staff on Maternity Leave for keeping in touch days. 6. Bank- unfortunately unable to provided the necessary number of requests. 7. Block bookings requested - staff starting who are only out of University and will be under 24 week preceptorship. 8. Staff moved from other areas to fill core sessions in CAH. 9. Excalated to line management.	28/3/19 to be closed and amalgamated with risk 3802. 4.10.18 Unsuccessful recruitment drive. Continue with cross site working bank, agency and inhouse additionality to cover gaps. 8.8.18 Interviewing 5 x Band 5 late Aug 18. After Belfast Telegraph recruitment ad. Use of agency and ODP staff in the departments. 12.6.8 Unchanged. Recruited only 1 theatre nurse from nursing recruitment fair. Presently trying to secure agency staff. 10.4.18, 28.02.18 Remains unchanged. 7.11.17 monthly staffing meeting with lead nurses identifying e-reqs established. Weekly theatre rota meetings ongoing to ensure cross site working. Bank and agency staff still employed to cover core sessions 30/5/17 - Theatre staff rota meeting offers cross site working. Bank, agency and additionality continue to cover core sessions. E-req has been completed for all vacant posts	LOW	HOS	28/03/2019
3300	07/01/2013	Safe, High Quality and Effective Care		Transfer or Patients to Independent Sector	There is a risk to the patients in terms of extended waiting times associated with the treatment and care with IS providers. There is associated risk of reputation to the Trust with the transfer of patients to IS Provider , there is a risk to the IS Team being able to deal with the volumes in the expected timeframes, financial risk to the Trust if Providers breach contract.	To minimise the risk we have set up regular governance meetings with the Providers, have robust contracts in place and monitoring of activity and performance by the IS team against these contracts.	12.5.16 - Funding for IS up to end of March 16, any pts left out in the IS are 'paused' awaiting further funding from HSCB. If the patients extend in house waiting times, to be brought back. 23.02.16 - Funding provided by HSCB for some surgical specialties , however the IS , while initially accepting volumes have had difficulty delivering the capacity originally offered. Senior management and HSCB aware of risks - HSCB provided funding for endoscopy patients to be treated by IS to reduce waiting times. Due to the downturn of the IS in December 2014, there is an ongoing risk that they may not be able to deliver the volumes required. Continue to have bi weekly meetings with ISP regarding contracts.		DIV	25/07/2016
3377	21/03/2013		Outpatients Dept	Lack of Clinical Space to assess Ophthalmology patients and store new visual fields analyser and JAG laser.	Patients are at risk of delay in assessment and provision of care. Risk of cost of recalibration of new equipment due to inadequate storage space. Risk of litigation to the Trust in relation to delayed treatment.	Equipment currently unpacked on fallow floor in CAH - unable to use.	01.03.13 - close entry way behind reception desk in STH OPD. Create door way adjacent to clinical room 9. Discussions ongoing.	HIGH	DIV	08/10/2013
3466	29/07/2013		Outpatients Dept	Lack of clinical space to assess opthalmology patients and store new visual fields analyser and JAG laser.	Delay in outpatient treatment and access for patients needing opthalmology assessment. Risk of litigation to Trust in relation to delayed treatment/assessment. Risk of damage to new equipment without adequate storage facilities.	Equipment currently unpacked on fallow floor in CAH. Unable to use.	01.03.13 - Close entry behind reception desk in STH OPD reception area to create doorway adjacent to clinical room 9.	LOW		18/09/2013
3496	01/10/2013		Trustwide	Wards and Departments are not meeting mandatory requirements for Hyponatraemia Training due to unavailability of training dates.	Risk of having no staff, at ward level that can competently erect and monitor IV Fluids. Particularly in the 14-16year old age group. Risk of harm to patient and staff.	Close liaison with assistant director of Nursing Workforce development and training to secure additional dates from CEC.	01/10/13: Some dates have been organised awaiting confirmation of more. All ward sisters encouraged to prioritise.		DIV	17/10/2013
3498	01/10/2013		Fracture Clinic	Fracture Clinic Referral waiting Times and waiting times for Fracture Theatre	Fracture Clinic referral times have increased significantly for new and review appointments. Risk of harm, to patients by unmanaged monitoring of condition in a timely manner. Potential of litigation and reputation, of Trust due to potential lack of adequate patient management.	Additional clinics are being organised where capacity allows and assistance being sought.	01/10/13: Increased provision of fracture clinics. Paper to HSCB highlighting the risk and requirement for additional funding to staff demand. Demand highlighted in IPT for expansion of T/O service within SHSCT.	MOD	HOS	10/12/2014
3690	08/06/2015			Increased waiting time for New out-patients and Elective Surgery	Surgery & Elective Care: Breast Surgery, General Surgery, Endoscopy, ENT, Urology, Orthopaedics Urgent Out-Patients: Waiting times have been growing across the specialties, in some cases exceeding clinically accepted waiting times for urgent appointments. Current urgent waiting times for new out-patients are: General Surgery - 21 weeks, ENT - 28 weeks, Urology - 30 weeks, Orthopaedics - 43 weeks Current urgent waiting times for elective surgery are: Breast Surgery - 33 weeks, General Surgery - 54 weeks, Endoscopy - 12 weeks, ENT - 13 weeks, Urology - 87 weeks, Orthopaedics - 56 weeks Delay in treatment plan and diagnosis. Increased waiting time for Routine patients may result on patients being reprioritised as urgent putting increased pressure on existing capacity and bottle-necking available urgent slots	Monitoring measures are being put in place to ensure that patients triaged/categorised as urgent are being seen within the clinically accepted waiting time. Patients exceeding this waiting time will be escalated to management and clinical teams for further advice. Active plans to reduce urgent waits within specialties are on-going Increasing urgent waiting times have been escalated to HSCB and they are aware of limited control due to demand vs capacity mismatch.		LOW	DIV	24/09/2015
3727	01/09/2015	Make the best use of resources	Anaesthetics, Theatres & Intensive Care Services	No equipment store available in Day Surgery Unit CAH	Currently there is a 2 bedded side room unable to be used for patients as it stores the equipment for this unit. This can impact on the availability of beds for the daycase list, particularly when lists are occurring simultaneously. Potential for harm; Potential delay of access to day surgery beds. Limited availability of segregation for patients for IPC reasons and also male/female.	Try to maximise the use of the existing 12 bed spaces. Continues to use the 2-bedded side room for equipment as this reduces the risk to patients and staff of equipment being stored in corridors, this would also be a fire hazard.	19/11/2021- no change 28/06/2021- remains unchanged no funding. 15/02/2021- remains unchanged still no capital funding 11/12/2020 - remains unchanged 20/10/2020 - remains unchanged, no capital funding identified. 10/8/2020 - Still no capital funding, risk remains the same. 18.09.19 Still no capital funding risk remains the same 18/6/19 - still no capital funding identified, risk remains the same. 28/3/19 - as below, risk remains as no capital funding identified. 6/2/19 - no capital funding, therefore risk remains the same.	MOD	DIV	

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3726	01/09/2015	Provide safe, high quality care	Anaesthetics, Theatres & Intensive Care Services	Registered nurses assisting during operative procedures	It has come to light that currently there are registered nurses assisted during operative procedures who have not completed nationally recognised training and this role has never been agreed or approved by the Trust. Risk of potential injury to the patient, risk to staff member in undertaking duties out with their role and job description as registered practitioners.	It has been discussed with Interim Director of Acute Services we cannot cease the practice immediately as this would impact adversely on operating lists, thereby resulting in patient cancellations. In order to reduce the risk we have stopped nurses undertaking assisting duties that would be considered a surgical in nature ie tapping on a chisel in ENT and uterine manipulation for gynae patients not having a hysterectomy. The need has been identified for surgical first assistant role, currently the Trust is working to secure funding for these roles. We are also looking at a dual role for a scrub practitioner for very minor cases only. An interim holding position has been discussed and agreed with gynae, with regards to the duties that the nursing staff can undertake until surgical first assistants are in post.	08/04/2019 - closed following further review by SEC. 6/2/19 - as below MOVE to departmental RR 20/11/18 - ongoing risk, MOVE TO Departmental ATICS risk register. Job plan is being finalised for possible advertisement in the near year. Discussion to take place with Mr Carroll re progression banding. 4/10/18 Ongoing keep on RR until recruited. 8.8.18 Research completed meeting arranged to discuss findings with BK and plan to move forward with recruitment. 10.4.18 Ongoing research 28.02.18 Risk remains the same 7.11.17 Funding to be transferred from SEC to ATICS. To research posts before recruitment commenced. 30/5/17 - Money identified for 2 x surgical practitioners. For follow up and recruitment once processes agreed 7.3.17 Unchanged	HIGH	HOS	08/04/2019
3734	24/09/2015	Accessible and Responsive Care		At intervals, the Trust does not have the capacity to meet the demands of the outpatient and inpatient trauma and orthopaedic se	Poor patient outcomes.	Discussions ongoing with HSCB regarding additional resources. Additional outpatient clinic and theatre lists organised where possible.	12.5.16 - Ongoing 'at risk' additional fracture sessions being undertaking from April 16 onwards to meet demand. Additional funding received for orthopaedic IP long waiters to reduce waiting time, Orthopaedic NOP and ROP. In process of securing dates. 23.02.16 - Additional clinics and operating lists organised to meet trauma demand as required to meet patient safety standards. HSCB aware of capacity gap. Work ongoing with ED to implement elements of the Glasgow model to meet demand.	MOD	DIV	26/07/2016
3745	30/11/2015	Safe, High Quality and Effective Care	High Dependency Unit DHH	NIV Equipment in DHH HDU is becomming difficult to repairr and 2 of the 4 have recently been condemned.	Risk of being unable to provide non invasive ventilation to patients who require this, adversely affecting patient outcome, e.g., morbidity and mortality.	New NIV 60 ordered on 26 November 2015 and request for additional capital funding requested for further machines. Request sent to finance for approval to lease new equipment until receipt of new order.	29.11.16 New NIV equipment has been replaced. CAH have ordered more, they are both elf contained. 23/10/16 - As below, still outstanding. RC to advise if actioned. 05.08.16 - Still outstanding. Ronan Carroll to advise if actioned. 26/5/16 - Need to communicate with the appropriate staff that this medical device needs to be standardised between both sites. Ronan Carroll to action. 23.02.16 - NIV equipment ordered and will be delivered before 31st March 2016.	MOD	DIV	29/11/2016
3746	30/11/2015	Safe, High Quality and Effective Care	3 South ENT	Paediatric Patients treated in 3 South ENT treatment room - cannot guarantee nurses with up to date paediatric training.	Limited paediatric trained staff includes - paediatric trained nurse may not be with patient in the treatment room - clinical outcomes if patient needs specific paediatric nursing care including resuscitation - poor patient experience and safeguarding issues.	Meeting held with Paediatric Head of Service to discuss issues on 27 November to scope the problem. Data has been requested. Further meetings planned with the aim to have a paediatric nurse with paediatric patients or inform paediatric ward of admissions.	10/8/2020 - take off RR, paeds go to Blossom Unit and 18.09.19 part of rapid access clinic when this moves will resolve the issue 26.06.19, 28/3/19 06/02/19- no change.	LOW	DIV	12/08/2020
3766	24/02/2016	Make the best use of resources		Despite refurbishment of ward areas this financial year, due to winter pressures all work was not completed	Increased risk of infection due to poor bed spacing / inadequate side room availability and inadequate storage. Increased moving and handling risks.	Some wards have had significant refurbishment with plans for further work in the summer of 2016. Significant minor works request in place and mail box requested for some areas.	20/10/2020 - Level 4 refurb is completed. Take off RR 10/8/20 - covid gave the opportunity for maintenance on the 4th floor. 4S works completed, in progress of refurbing 4N. Keep on until all works complete. 18.09.19 Risk remains the same 28/3/19 - 4th floor works remain on the minor works and continued risk with buzzer and oxygen needing placed. 6/2/19 - risk remains that same, no change 20/11/18 - As per below. 4th floor works has never been commenced. In particular buzzer and oxygen require to be replaced. 1/10/18 Risk remains same. 4th floor works has never been commenced. In particular buzzer and oxygen require to be replaced. 8.8.18 Risk remains same. 12/6/18 4th floor still outstanding. 10/4/18 - 4th floor still outstanding. 28/2/18 - No change 30.5.17 No change 7/3/17 - work goings on a phased basis in conjunction with Estates	MOD	DIV	20/10/2020
3764	24/02/2016	Best use of resources		Unexpected vacancies in the scheduling team	Delays in the scheduling of patients for the operational lists in T&O, Gynae, ophthalmology, cardiology and endoscopy. Potential for inefficient use of lists and a higher than average CNA / DNA rate.	Temporary reallocation of duties within the team. Temporary recruitment of bank staff to fill vacancy. Internal permanent recruitment commenced.	27.05.16 - Full compliment of staff now in post. Risk closed. 23.02.16 - New risk.	LOW	DIV	27/05/2016
3772	29/02/2016	Provide safe, high quality care	Trustwide	Use of Hypodermic Needles (not safer sharps) for breast biopsies	Breast biopsies at breast clinic, unsuitable for safer sharps use. The design of the safer sharp interferes with this procedure and patient safety may be compromised. Sharps injuries create potential exposure to hazardous substances as defined in the COSHH Regulations. Cannot comply with Health & Safety (sharp instruments in health care) Regulations (NI) 2013. Non catalogue hypodermic needles to be used.	All staff directly involved to have completed e-learning for sharps awareness. Added to risk register. Key staff to be informed of decision to use original hypodermic needles. Raise awareness of trust policies and procedures in relation to blood, bodily fluids, Health & Safety at work, adverse incident procedure, safe use and disposal of sharps policy. Ensure all staff suitably trained. Staff follow sharps injury flowchart. Practice of re-sheathing needles prohibited. Sharps boxes are readily available in all rooms.	28/3/19 - closed as per Wendy Clayton. 3.10.18 Hypodermic needles currently being used. Safer sharps not adequate for use during FNA procedures. All steps required to minimise risk are in place (as per previous column) Reminder will be given to all Breast Screening staff at next staff meeting. 8.8.18 No update from J Robinson following escalations. 12/6/18 - WC has emailed J Robinson for update, waiting on response before closing. 10.4.18, 28.2.18, 6.6.17 & 24.10.16 J Robinson and F Reddick to provide update or close. 28/2/18 When the newer needles were introduced both radiologists trialled and both found that they were unable to obtain the detail for optimum needle visualisation during FNA, Biopsy procedures.	LOW	DIV	28/02/2019

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3802	27/05/2016	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	Nurse Recruitment for Adult and Paed theatres	Risk of being unable to cover all required theatre sessions with appropriately skilled theatre staff, therefore, there is a risk of sessions not being scheduled or being cancelled if insufficient skilled Theatre staff are not available.	We continue to use the Nursing Team in ATICs across all theatre departments. This includes cross site working, to ensure that we make the best use of our resources to cover the core confirmed sessions.	19/11/2021- no further update. 20/09/2021- Rolling nurse recruitment for Band 6 for paeds theatre is at advert. No paediatric surgery at present due to surge- redeployment of staff to ICU. 28/06/2021- Jan/Feb 2021x8 band 5 staff nurses recruited through peri-operative workstream. June 2021 band 5 applications closed, approx 8 band 5 have been recruited. Waiting on checks and start dates. Delivering of care x 1 Band 7 and 10 x Band 6's funding secured. ATICS going out to advertisement (3x CEPs Band 7- 1 funded and 2 at risk). 15/02/2021- regional peri operative recruitment drive closing date 05/02/2021, awaiting confirmation of applicants and interviews to be processed. ATICS remain with larger number of vacant adult and paediatric theatre nursing posts. 11/12/2020 - request through E&G for a commissioned paediatric nursing course for 21/22. Regional recruitment plans ongoing. HOS ATICS remains on group 20/10/2020 - regional recruitment plans ongoing. HOS ATICS sits on the group. 10/8/2020 - Since the covid-19 pandemic Paediatric theatre presently being used for outpatient ENT AGPs. No paediatric surgery currently on the DHH site. Only 2 paediatric nurses Band 6 at present, out for recruitment with BSO. Continues as risk. Continuing with recruitment drives for adult theatre nursing staff. Vacancies still remain. For retention Band 5 uplift to Band 6 successfully completed. 3/9/19 - only 3 paed nurses at present (1 is 16 hours only). Further nursing gap highlighted to AD and Director - paper attached 18/6/19 - Unfortunately continued high level of vacancies in ATICS. Theatre nursing paper has been submitted to the Acute Director. Continue to run main theatres in CAH and DHH at 30% reduction. Risk remains high. 28/3/19 - Continued high level of vacancies in theatres and risk to staffing main theatre sessions. Continue to run at 30% less theatre sessions for April 2019.	MOD	DIV	
3804	27/05/2016	Safe, High Quality and Effective Care	Outpatients Dept	Pre Op Assessment	Pre-op assessment is currently under resourced to provide the number of assessments required and deal with the increase in demand to the service	Staffing has been structured within pre-op to cover the key areas ensuring the best use of the limited resources. We are currently proactively working to change the existing pre-op processes to ensure that patients are pre-assessed and passed fit before ever being scheduled for surgery. This impacts on the need for additional staffing as we are working to change the processes while having to continue with existing processes.	20/09/2021- Pre-op staffing currently matches the requirements for urgent bookable. Recruitment required. Will update as necessary. 28/06/2021- remains unchanged will discuss way forward with AD. 15/02/2021- remains unchanged. 11/12/2020 - remains unchanged. Internal audit completed and addressing recommendations 2010/2020 - remains unchanged 10/8/2020 - Pre-op assessment demand continues outweigh capacity. Out for recruitment BSO band 6. Requested planners to complete a business case to enhance pre-op service. 10/8/2020 - Pre-op assessment demand continues outweigh capacity. Out for recruitment BSO band 6. Requested planners to complete a business case to enhance pre-op service. 18/9/19 - Lead nurse is interviewing this week for new pre-op nursing staff. Pre-op is one of the projects submitted under demography monies. 18/6/19 - Ongoing works pressures continue in pre-op due to demand. Group met to progress pre-op paper however planners will be not support without confirmed funding stream. To remain on RR. 28/3/19 - Risks continue as below and additionality continues. Agency band 2 part time to start end of April 19 to support the B5/6 nursing staff. 6/2/19 - High sickness rate in pre-assessment at present. Additional hours offered to keep up with demand. Discuss additional admin B2 to be recruited as risk to support the B5/6	MOD	DIV	

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3805	27/05/2016	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	Theatre nursing staff being redeployed during OOH to cover wards, in particularly DHH	Putting at risk the ability to provide an emergency service to theatre and hospital in general	For wards / departments to staff their own areas	28/3/19 - closed as per discussion at SEC Divisional meeting. 6/2/19 - consider removing from directorate RR, discuss with AD. 28/11/18 - Can this be removed as there is a process to follow 1/10/18 Remains unchanged. Due to hospital pressures to remain safe theatre nurses still redeployed during OOH when required. 8.8.18 Remains unchanged. Due to hospital pressures to remain safe theatre nurses still deployed when during OOH when required. 12/6/18 Theatre nursing being redeployed during OOH still occurs on all sites, ongoing risk. 10.4.18 Unchanged 28/2/18 - redeployment is still an issue on both sites 7.11.17 - redeployment of theatre staff at night continues, especially on the DHH site at present 30/5/17 - Action plan still to be developed and agreed. Theatre staff still are redeployed at night 7/3/17 - ADs have met with staff side, action plan to be developed and agreed. Future meeting to be arranged	MOD	DIV	09/04/2019
3800	27/05/2016	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	Anaesthetic cover for maternity services	We currently fail to meet the standards regard to anaesthetic cover for maternity theatres. There is a risk to the Maternity patients from having inadequate cover. The staff is approximately 2.0wte. The nursing levels do not meet the national guidelines. Risk of failing anaesthetic accreditation, currently do not meet the standards.	A paper is being completed with regard to sorting the deficit in both anaesthetic and nursing cover.	19/11/2021- no change 20/09/2021- no change 28/06/2021- no change 15/02/2021- risk remains the same 11/12/2020 - risk remains unchanged, however, in DHH elective c-sections are performed in the main theatres. 20/10/2020 - risk remains unchanged, however, in DHH elective c-sections are performed in the main theatres. 10/8/2020 - no further update. Risk continues. 18.09.19 - HOS & LN's have met and are meeting again in the next month to go through figures for the nursing requirement 18/6/19 - meeting was held between gynae and ATICs, business case to be progressed. To be kept on RR 28/3/19 - Next ATICS business meeting arranged for 19/4/19, await update from Dr Scullion. 6/2/19 - discussed at ATICS business meeting. Dr Scullion investigating the transfer of IMWH maternity theatres	MOD	DIV	
3801	27/05/2016	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	JAG Accreditation	Due to the waiting times for patients having endoscopy procedures, we cannot achieve timeliness of appointments, and therefore, cannot achieve JAG accreditation. This is a regional issue and JAG are aware of same.	JAG is working with HSCB and the Trusts with regard to the revised JAG standards and the potential for 2 levels of accreditation.	12/11/2021 No ATICS business meeting interface 15/09/2021- unchanged. 28/06/2021- unchanged. 15/02/2021- priority given to covid pandemic. Significantly reduced capacity available on all day surgery sites. 11/12/2020 - remains the same, priority being given to covid pandemic 20/10/2020 - Due to covid pandemic remains unchanged, currently going into 2nd surge 10/8/2020 - Dr P Murphy is the Interim Endoscopy lead. Endoscopy waiting times continue to be an issue in achieving JAG accreditation. 18.09.19 Require a led for JAG 28/3/19 - next ATICS Business meeting Fri 19/4/19, to discuss taking JAG off the RR. 6/2/19 - Consider taking off Directorate RR to be discussed at next ATICS Business meeting.	MOD	HOS	

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3803	27/05/2016	Safe, High Quality and Effective Care	Recovery Ward	Post op Surgical Pts in the Recovery Ward	Regularly there are patients kept over night in the recovery ward due to ongoing bed pressures within the Trust. However, this increases the risk within the recovery area due to having post op surgical pts, HDU patients (med or surg), adults male, female and children are all mixed within the area. There are post op pts being fed while pts are still being brought out from theatre intubated and pts that come round from anaesthetic can also be nauseated. Unable to get patients out in a timely manner to the wards the following day which impacts on patients being able to get out of theatres to recovery, which in turn impacts on the operating time available if patients have to be recovered in the Theatre.	ATICs try to ensure as far as possible that a limited number of patients are kept post op in the recovery ward. This is not always adhered to.	06/07/2021- remove from risk register 28/06/2021- recovery continues to work over 3 areas managing covid and non-covid ICU/HDU patients as well as 2-3 urgent bookable list Mon-Fri and emergency/trauma lists. ICU 1 available for AGP recovery when required. 15/02/2021- currently in 3rd surge. recovery continues to work over 3 areas managing covid and non-covid ICU/HDU patients, as well as 1 urgent bookable list Mon-Fri and emergency/ trauma lists. 11/12/2020 - remains unchanged. Recovery are working over 3 areas to accommodate covid pandemic, which is challenging on recovery manpower. 20/10/2020 - remains challenging 2nd surge expected. recovery staffing ICU2, Hub (Urgent bookable elective) and main recovery. Staffing identified daily at communication Hub meetings between ICU, recovery and theatres 10/8/2020 - challenges in recovery due covid-19 pandemic and requirement to segregate patients. Top end of recover for 'red' AGP patients, anaesthetic hub for urgent bookable patients, main recovery for 2 x HDU, emergency and trauma however all at reduced bed capacity due to social distancing. Issue still continues with over night patients and managed locally. 18.09.19 No change it has become the mai stream of covering Mon-Thurs extra 4th nurse, with more often requiring 4th nurse on a Friday. 28/3/19 - due to continued bed pressures, recovery cstsaff with 3rd nurse Tues, Wed and Thursday nights, increasing to 4th nurse when required. Some patients continue to be kept in recovery post op which limits their enhanced recovery on the wards. 6/2/19 - continue to staff with 3rd nurse on Tues, Wed, and Thursday on night duty to cope with capacity. increased to 4th nurse dependent on bed pressures.	MOD	HOS	06/07/2021
3826	19/08/2016	Safe, High Quality and Effective Care		Demand of fracture referrals outweighs fracture capacity.	Fracture patients at risk of late diagnosis and treatment.	The Trust has given permission for "at risk" fracture clinics, however, this still does not meet demand.	10/8/2020 Fracture MSK Hub up and running from June 2019. Take off RR. 17/06/2019 Fracture MSK Hub commenced in CAH on 17/6/19. The principle of the hub is to redirect ED fracture referrals to the right pathway eg physio, OT, face to face, back to ED or discharge. (Keep on RR to see outcome of the Hub before downgrading to department) 28/3/19 - current fracture patient outweighs capacity. 11th T&O consultant part funded which include 1 fracture clinic per week. Q1 2019/20 additionality approved by SMT for fractures new and review 6/2/19 - as below, no change	HIGH	DIV	10/08/2020

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3827	19/08/2016	Safe, High Quality and Effective Care		Due to the move down from level 6 to outpatient department to the current OPD accommodation is not suitable to sustain numbers.	Risk of late diagnosis and treatment. Health and Safety and fire risk to patients and staff.	Reduction in the number of fracture patients that can attend each clinic to be reduced.	12/11/21 Refurbishment in DHH for fracture clinic will not take place within financial year 2021/2022. Await confirmation of funding for 2022/2023. 08/09/2021- accommodation for refurb not available as yet. 28/06/2021- remains a risk. Investigating refurbishing Phase 1 OPD in DHH for fracture clinic. Plans developed at a cost of £60k. Waiting to here if funding is to be approved before commencing work. 15/02/2021- remains a risk. Due to the Covid 19 pandemic DHH fracture clinics remain in CAH however still risk due to no social distancing. One DHH clinic has moved to an evening clinic from November 2020. Requested fracture accommodation in STH, unfortunately no capacity to date. 11/12/2020 - remains a risk. DHH fracture clinics remain in CAH however still risk to no social distancing. One DHH clinic moving to evening clinic from Nov 2020. Requested fracture accommodation in STH, unfortunately no capacity to date. 20/10/2020 - remains a risk. DHH fracture clinics remain in CAH however still risk to no social distancing. One DHH clinic moving to evening clinic from Nov 2020. Requested fracture accommodation in STH 10/8/2020 - Remain on risk register. DHH fracture clinic transferred to CAH due to covid pandemic. Need new accommodation in DHH to transfer service back large number of patients going through CAH on a Mon and Tuesday, CAH is not suitable for 2 consultant led clinics. 18.09.19 Remain on Register until capital allocation 24.06.19 - DHH T&O accomodation is priority 1 on the Trust's capital allocation list. To remain on the RR until new accomodation is complete. This will move the fracture clinic from level 2 SAU. 28/3/19 - fracture clinic in DHH continues to be located on level 3 DHH (SAU room), therefore numbers remain reduced. Remains on the capital allocation list 6/2/19 - as below no change to risk	HIGH	DIV	
4018	15/10/2016	Provide safe, high quality care		Inpatient / Daycase Planned Backlog	Delay in review of patients planned for screening/repeat procedures presenting adverse clinical risk.	INDC planned backlog in the following surgical specialties: urology, general surgery, ortho and chronic pain.	19/11/21 ICU beds are currently sitting at 12.WIthin Elective Theatres there are 16 urgent bookable sessions in CAH and 5 urgent bookable sessions in DHH 16/09/2021- OSL update- continues to monitor backlog. Due to Covid 19 pressures there are reduced theatre sessions and therefore the focus is on red flag. 08/09/2021- Due to the increase in Covid ICU patients, theatres have decreased sessions down to 3 all day urgent bookable in CAH and one AM session per day in DHH. This will result in ongoing backlog in planned and surveillance surgical patients. 28/06/2021- OSL continues to monitor planned IPDC backlog. Theatres sessions has increased with DHH restarting 14/06/2021 with 15 theatre sessions. Only RF and urgent at present. Validating top 10 longest waiters each month. 15/02/2021- Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 due to Covid. Currently one 1 urgent bookable list per day Mond to Friday. clinically urgent and priority 2 patients being scheduled. The Trust is currently facing the 3rd surge. No urgent bookable in DHH. 11/12/2020 - Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 due to COVID pandemic. Currently only clinically urgent and priority 2/3 patients being scheduled. The Trust is currently facing the 2nd COVID surge. 1 urgent bookable each day in CAH and 3 days in DHH 20/10/2020- Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 due to COVID pandemic. Currently only clinically urgent and the red flag priority 2 patients being scheduled. The Trust is currently facing the 2nd COVID surge unsure if elective surgery will continue 10/8/2020 - Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for surgery. Backlog continues to grow at present.	HIGH	DIV	

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
4019	15/10/2016	Provide safe, high quality care		Inpatient / Daycase Planned Backlog for Endoscopy	Delay in review of patients for planned screening/repeat procedures presenting adverse clinical risk.	Endoscopy planned backlog. Papers written and submitted to Director re risk. Requested HSCB funding for planned backlog clearance.	19/11/21 Currently only clinical urgent and red flag priority 2 patients are being scheduled for endoscopy. Planned backlog continues to increase as no planned patients are being booked. Validation of planned endoscopy patients is still ongoing. Endoscopy capacity has decreased due to Covid 19 pressures, the redeployment of theatre based workforce continues to impact on capacity within South Tyrone Hospital (STH). The day clinical centre was redeployed to STH day procedure admission ward during the pandemic which still remains in day procedure. This was a 14 bedded ward historically used to run two endoscopy lists 5 days a week simultaneously. Until they return to CAH it is not possible for STH to return to a 19 planned endoscopy list per week. 16/09/2021- Planned endoscopy backlog validation is still in progress 28/06/2021- planned endoscopy backlog is currently being validated by the Gastro and General Surgical Team. 15/02/2021- Planned IPDC endoscopy backlog continues as a clinical risk. All elective surgery cancelled in March due to the COVID pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for endoscopy. Backlog continues to grow at present. as no planned endoscopy patients are being scheduled. Validation of planned endoscopy patients has commenced. 20/10/2020- Planned IPDC endoscopy backlog continues as a clinical risk. All elective surgery cancelled in March due to the COVID pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for endoscopy. Backlog continues to grow at present. Colon patients being sent Qfit test then prioritised for their colon. Still working on IS contract 10/8/2020 - Planned IPDC endoscopy backlog continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for endoscopy. Backlog continues to grow at present. In process of securing contract to bring IS into the Trust for weekend endoscopy additional sessions	HIGH	DIV	
3880	07/03/2017	Provide safe, high quality care	Trustwide	Patients requiring review at Breast Family History Clinic	Patients requiring review at Breast Family History Clinic not being seen in a timely manner due to review backlog therefore risk that patients may have delay in diagnosis. Patients may not be seen within appropriate review.	Staff have been offered the opportunity to undertake additional sessions to ensure that the waiting time for patients to be seen is reduced and patients are seen in a timely manner . Plan to recruit and additional admin person to book yearly mammograms as a rolling programme.	28/06/2021- remove as per HOS. 11/12/2020 - Downgrade to departmental Risk register please 20/10/2020 - remains unchanged 10/8/2020 - downgrade as per below, all review patients have been risk stratified. 18.09.19 downgraded to departmental 28/3/19 - no update. 6/2/19 - downgrade to departmental risk	VLOW	TEAM	28/06/2021
3900	27/06/2017	Provide safe, high quality care		Breast Fail Safe Band 4.	Breast Fail Safe (Band 4) needs to be recruited within the Trust. Risk to SDA & Breast family history patients not receiving following up mammogram	BOXI report for SDA patients is currently being run once a month. Patients being checked if mammogram request has been entered.	28/2/18 - Recruitment successful and successful applicants commence beginning of April 18. 7.11.17 - recruitment for Breast fail safe with BSO at present, however on hold due to possible redeployment 6.10.17 Failsafe post has now been passed by SMT and with BSO for recruitment June 2017, Ronan to discuss with Esther re recruitment at Risk for B4 Breast Failsafe.	MOD	DIV	10/04/2018
3905	26/07/2017	Provide safe, high quality careMake the best use of resources	4 North Surgical	Oxygen and Suction not central in bay	Patient who is furthest away from O2 and suction ie at entrance of bay. Due to tubing etc being long - implication are that there is a ligature risk and suffocation risk. Call bell system is also at risk of failing due to age and poor condition.	As per email dated 8 July 2017 there are no plans to replace bed heads in 4 North/4 South in the immediate future.	28/3/19 - close and amalgamate with 3766. 1.10.18 High risk remain the same, replacement required in 4N for buzzers and oxygen/suction. 8.8.18, 12/06/18 Situation remains the same. 10/4/18, 28/2/18 - no costs at present, to email Estates. Due to ongoing bed pressures unable to close a bay. 26/7/17 Estates need to provide cost, delayed due to winter pressures 15/16	LOW	DIV	28/02/2019
3920	13/11/2017	Provide safe, high quality care	Intensive Care Unit	ICU Consultant Workforce	Potential for inability to cover the department with appropriate staff for ICU	Advertisement to replace 2 ICU consultants and also 2 general anaesthetic consultants.	18/6/19 - new ICU anaesthetists has commenced ?? further update from HMM. 28/3/19 - no change, still waiting start date and vacancies out for re-advertisement. 6/2/19 - 1 consultant anaesthetist recruited awaiting start date. Other vacancies out for re-advertisement. 20/11/18 - Out to advertisement, awaiting outcome of interviews1.10.18 - With medical staffing for recruitment. 8.8.18 Still awaiting start date. 12/6/18 Consultant anaesthetists has been appointed awaiting start date. 10/4/18 - 1 further consultant anaesthetists retirement. Going out for advertisement again closing date Tuesday 17/4/18. 28/2/18 - 4 consultant anaesthetists have been appointment, waiting checks and commencement date. 7/11/17 - in progress, interviewing in the next few weeks and backfilling with Locums at present.	HIGH	DIV	08/07/2019

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
3930	12/12/2017	Provide safe, high quality careMake the best use of resources	Anaesthetics, Theatres & Intensive Care Services	Discontinuation of guaranteed Service for Drager Oxylog Ventilators	Maintenance Company can no longer guarantee support the Drager Oxylog Ventilator for items that may be required for repair/service. There are no spare machines available to STH.	None in place	20/10/2020 - purchased successfully, however they are being used for covid. Take off risk register 10/8/2020 - Due to covid-19 extra ventilators were purchased. HMM to confirm number of ventilators, remain on RR until confirmed 18.09.19 4 last year and new capital from 19/20 to replace another 4 18/6/19 - Ongoing risk as still 6 machines to be replaced, these are are on the equipment capital list however no confirmed funding 28/3/19 - 3 machines arrived, training and implementation plan ongoing. anaesthetic machines programme to remain. 6/2/19 - 3 machines procured for CAH. Will be delivered pre-31/3/19. Rolling replacement programme in place to procure remaining 9 machines	MOD	DIV	20/10/2020
3962	09/05/2018			The flooring in Theatre 4, CAH has a hole in it. The Siemens Image Intensifier wheel keeps getting stuck in this hole. To date a	The flooring in theatre 4 has a small hole in it. Unfortunately, it is in the vicinity that the radiographers park the Image Intensifier prior to starting a screening case. Recently the machine was parked here and unbeknown to the radiographer one of the wheel of the intensifier had been parked on the hole. When the Radiographer went to move the machine into position at the start of the screening case she found the machine every difficult to move laterally. To move the machine it took a lot of stretching, straining and pulling and unnecessary force. The radiographer eventually moved the machine out of the hole but in the process hurt her back. There is a manual handling and health and safety risk that need addressed immediately. If not dealt with it will increase staffs stress levels and effect their welfare and could leave the Trust open to litigation. Staff have a right to expect a safe and secure working environment.	"Raising Staff Awareness regarding the flooring in theatre 4 to help manage the risk. -Actioned 8/4/18 Round Robin e-mail to be sent to all staff with photos of the area in question. "Staff to attend yearly mandatory manual handling training-Actioned-on going. Incident reported on Datix-Actioned IR1 completed 27/4/18 Siemen's Engineer to be called to check out the intensifier as it seemed very stiff and difficult to move. Machine was out of action until checked - Actioned-Engineer checked out machine on 4.5.18. and the machine was ok'd to work by engineer and put back into action. Lead Radiographers to Liaise with theatre sister regarding the incident---Actioned 4.5.18 Theatre Sister to liaise with Urologists regarding the positioning of the machine-Actioned-Urologists happy that radiographers work to the right of the patient to avoid the area in question (3/5/18) Theatre sister to put up safety awareness signs regarding the flooring and the image intensifier machine-Actioned 4.5.18 Flooring to be fixed-Theatre sister to contact Estates to find out when flooring to be replaced-Actioned 2.5.18-Estates have assured the sister that the floor will be replaced May/June 18 Flooring temporarily mended with a metal covering-Actioned 1/5/18-however there is a "lip" on this that is difficult to push machine over especially laterally. Radiographer advised to go for medical assessment.	28/06/2021- all works completed	VLOW	DIV	28/06/2021
3972	28/08/2018	Provide safe, high quality care	Anaesthetics, Theatres & Intensive Care Services	Inexperience of CT1 for General Anaesthetics in Theatres/OOH/Weekends	ATICS cannot guarantee access for c sections due to CT1 inexperience. Potential for harm to women and babies	On-call Consultants will come into the Trust when c sections is required.	28/3/19 - continued risk. To remain on risk register. 6/2/19 - discussed with Dr Scullion and ATICS Business meeting and remains on Directorate RR 20/11/18 - Dr Scullion to review, keep on Directorate risk 1.10.18 Unchanged, review in November 2018. 7.8.18 Dr Scullion, AMD e-mailed all anaesthetists re CT1 inexperience issue and controls. Competencies of CT1's to be completed in 3 months, revalidate.	HIGH	DIV	26/06/2019
3992	19/11/2018	Provide safe, high quality care	High Dependency Unit DHH	Rostering of 3 level 2 skilled/competent staff per shift not achieved	Reduction of beds available for level 2 patients due to reduced availability of competent staff during induction period. Risk of inappropriate placement of level 2 patients in HDU and risk to staff members in undertaking duties pre completion of induction period due to current to training of pre reg nurses to provide care to 2 level 2 patients	Discussed with HOS/AD and Director of Acute Services and SMT plan to recruit trained staff from agency as block booking to fill gaps in roster with suitable skills in level 2 care	18.09.19 HDU beds are now agreed 8 beds and the B7 & B6 are now permanently in post as per pathfinder. 18/6/19 - Doctors - Recruited 2 additional Consultant Anaesthetists, waiting on references and checks to be completed. Commencing Sept 19. Nurses, recruited B6 however she has left so back out for recruitment. Closing date today 29/5/19, interviews 8/6/19 Pharmacy, new post has started. A&C, Band 4 ICNARC is with BSO for recruitment, training to be completed following recruitment. To remain on the RR until transferred to ATICs 28/3/19 - recruitment challenges continue for DHH HDU, to remain under general surgery. Pathfinder group continue to meet regularly to work through possible solutions. 6/2/19 - discussions ongoing re HDU in DHH recruitment. Pathfinder meetings continue regularly. Recruitment challenges continue. 20/11/18 - pathfinder recruitment for DPU DHH ongoing. Risk assessment being completed	HIGH	DIV	18/09/2019
3994	19/11/2018	Provide safe, high quality care	High Dependency Unit DHH	Change in the concertation of phenylephrine from a 10ml ampule containing (10mg in 1 ml)to (1mg in 10mls) November 2017	The change of strength to 1mg/10 ml vials of phenylephrine is fine for short term use ie., a few hours waiting for a central line to be placed. The difficulty is the delivery of phenylephrine for longer than a few hours this tends to arise when patients are not deemed stable for a central line or where a decision has been made not to go down a more invasive route.	Discussion with pharmacy/anaesthetic staff & medical staff re-introducing high dose phenylephrine. The plan is to hold in pharmacy in a segregated area; it will only be issued to HDU and it will be the only strength that HDU stock. The remainder of the hospital will use the low strength and follow the Trust protocols, and once transferred to HDU, staff will use an HDU protocol. Protocol to be review by medical, pharmacy and nursing staff. Pharmacy staff to liaise with procurement about getting the high strength product back in and appropriately set up within the pharmacy system.	18.09.19 phenylephrime HDU protocol reviewed by Dr Harty and re-issued by for HDU 11.03.19- No update. 12/10/18 MD. A McC & JH to discuss protocol and disseminate to staff nursing and medical staff regarding change over date when established AMcC to discuss with procurement	HIGH	DIV	18/09/2019

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
3993	19/11/2018	Provide safe, high quality care	High Dependency Unit DHH	Agency nursing staff not trained to SHSCT protocols	Agency staff from block booking with appropriate qualifications in level 2 may not complete procedures as per SHSCT processes's. Potential for risk to patient safety and potential for staff who may not follow procedures as per SHSCT process which could influence results potential for low performance reports. Agency staff fulling gaps in roster without skills for level and may not complete procedures as per SHSCT processw.with appropriate qualifications in level 2 may not complete procedures as per SHSCT processess Potential for risk to patient safety and potential for staff who may not follow procedures as per SHSCT process which could influence results potential for low performance reports.	Discussed with HOS/AD agency staff can be issued with codes for e-learning gap until completed and time to roster to complete need to have suitable trained staff with level 2 care priority to manage deteriorating patients. Roster reviewed to have suitable trained staff with level 2 care on roster /priority to manage deteriotating patients.	20/09/2021- update from HOS/Lead Nurse for HDU- this risk is from 2018 and was requested to be removed from the risk register 2021. 28/06/2021- ATICs continue to use agency staff, vetted and monitored. Induction and training provided on site. 15/02/2021- gaps remain filled by agency nursing staff. Induction/training is provided on site 11/12/2020 - Ongoing reliance in block booking and agency staff to fill nursing gaps throughout ATICS/SEC. Require period of induction and training 20/10/2020 - below comment not relevant Ongoing reliance in block booking and agency staff to fill nursing gaps throughout ATICS/SEC 07/09/2020- The old scanner was replaced and modular now in place. Funding sorted until March 22021 but a plan needs to be implemented from April 2021 onwards 18/6/19 - on going reliance in block booking and agency staff to fill nursing gaps. Continues to be a risk throughout ATICS/SEC 28/3/19 - BB agency to complete e-learning and practice audit, ongoing review required. 6/2/19 as below, no further update	HIGH	HOS	20/09/2021
4021	12/04/2019	Provide safe, high quality care		Access Times (Outpatients) - General (not inclusive of visiting specialties)	Increase in access times associated with capacity gaps and emergent demand - Capacity gapin RF, urgent and routine.	ATICs/SEC specialties with New Outpatients >52 weeks; urology, general surgery, Orthopaedics, Chronic Pain	19/11/21 OSL update SEC, New regional guidance has been approved for Outpatient admin validation this will be for ENT, Urology and Trauma and Orthopaedics. From April 19 admin validation has been ongoing, new regional technical guidance has been approved and will commence Jan 2022 and the validation team admin support will increase, recruitment in progress.Capacity reduced due to Covid 19 social distancing guidance which is decreasing the number of booked clinics. IPC guidance is continually reviewed and updated. 160921 OSL update- Within outpatients admin validation is ongoing within the following areas: ENT, BFH and orthopaedics. OSL progressing decision with IPC if clinic sizes can be increased. 08/09/2021 - Currently only red flag and some urgent patients are being booked however demand is still greater than capacity. Redeployment of DSU and Theatre staff to ICU for surgery reduces theatre capacity on CAH, STH and DHH sites. Six urgent bookable sessions in CAH, fourteen trauma sessions and five urgent bookable sessions in DHH with cancellation of day surgery and endoscopy. 28/06/2021- OSL and HOS continue to monitor longest waiters. Currently due to social distancing reduced numbers continue and only red flag and urgent patients being booked. Agreed to contact IPC to see if we can increase numbers at clinics. Admin validation to commence. 15/02/2021New Outpatients backlog waiting times continues as a clinical risk. All outpatient cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for surgery. Backlog continues to grow at present. The trust is facing a 3rd surge at present. All outpatients cancelled again and outpatient staff redeployed. 0/10/2020 - New Outpatients backlog waiting times continues as a clinical risk. All outpatient cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for surgery. Backlog continues to grow at present.	HIGH	DIV	

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
4022	12/04/2019	Provide safe, high quality care		Access Times (In-patient/Day Case) - General	Increase in access times associated with capacity gaps and emergent demand.	ATICs/SEC specialties with New Outpatients >52 weeks; urology, general surgery, Orthopaedics, Chronic Pain	19/11/21 OSL and HOS continue to monitor outpatient stragglers >52 weeks. we are currently booking P2 priority patients due to Covid 19 patients. 16/09/21 OSL update- OSL and HOS continue to monitor top ten longest waiters for inpatient/day case. 08/09/2021 - Due to increase in Covid 19 ICU patients, theatres have decreased sessions down to three all day urgent bookable in CAH and one am session per day in DHH. This will result in ongoing backlog in planned and surveillance surgical patients. 28/06/2021- OSL and HOS continue to monitor. Top 10 longest waiters to be validated on a monthly basis. Theatres sessions have increased with DHH restarting 14.06.2021 with 15 theatre sessions. Only priority 2 elective surgery on CAH site. 15/02/2021- New outpatient long waiting times continues as a clinical risk. Reduced outpatient capacity due to covid. Still only RF and urgent patients being scheduled. Surge 3 all outpatients have been cancelled and staff redeployed to support the Wards 11/12/2020 - New outpatients long waiting times continues as a clinical risk. Reduced outpatient capacity due to covid. Only RF and urgent patients being scheduled. Outpatient accommodation increased slightly from 14/12/2020 but not to full capacity. To continue with reduced numbers due to social distancing 20/10/2020 - New outpatients long waiting times continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag new and review patients being booked at present. Reduced capacity due to outpatient rooms being utilised for new covid processes, reduced patients per clinics for social distancing. New referrals have been reduced from March to June 2020 due to covid pandemic. 10/8/2020 - New outpatients long waiting times continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag new and review patients	HIGH	DIV	
4095	02/06/2020	Provide safe, high quality careBe a great place to work	Trustwide	Mishandling of Patient handover resulting in an Information Governance breach	There is a risk that the handover with patients details could be mislaid anywhere on site or in the community. Patient detail not being managed in a confidential manner thereby reveling the patient's private business and exposing the Trust to a breach in public confidence.	All disciplines of staff have been informed of the recent breaches in Information Governance and the consequence of same. All wards and departments have bins with clearly visible signage indicating they are for the disposal of the confidential handover prior to the end of their shift Regular reminders at patient safety briefings to adhere to Trust governance protocols Representative in Acute have met and agreed the content on the handovers. Incident and meeting note shared with OPPC, Peads and MH directorates.	12/11/20212 An Information Governance audit has taken place and results are pending to ascertain compliance with non identifiable patient from handovers.To await report to ascertain compliance to inform if this risk should remain on register. 20/09/2021- AD to confirm is this can be removed from risk register 28/06/2021- Additional confidential waste bins at doffing, exits and signs were erected re disposing confidential waste appropriately. 24/02/2021- continuously monitored 02/06/2020 Staff regularly reminded of necessity to adhere to Trust governance protocols.	LOW	DIV	
4131	03/12/2020	Safe, High Quality and Effective Care	Trustwide	Reduction in elective capacity due to covid restrictions-Urology ENT, Gen Surgery, Gynae and Orthopaedics	With the Covid-19 pandemic SEC ability to accommodate commissioned levels of activity is not being achieved resulting in increases in waiting times and volumes of patients on the elective and planned waiting list. As a result of increased waiting times and reduced capacity consequently patients may come to harm, increased levels of pain and discomfort and reduced quality of life	Mon-Friday 1x all day Urgent bookable on both sites CAH and DHH Due to limited elective capacity consultants clinically prioritise patients for surgery using the FSSA royal college guidelines, priority to cancer patients. Regional cancer rest meeting working towards equalising waiting times across the province. In house additionally from January 2021 on DHH site Endoscopy- weekend additional sessions in LV	12/11/2021ICU beds are currently sitting at 12.WIthin Elective Theatres there are 16 urgent bookable sessions in CAH and 5 urgent bookable sessionsin DHH. 08/09/2021 - Due to increase in Covid 19 ICU patients, theatres have decreased sessions down to three all day urgent bookable in CAH and one am session per day in DHH. THis will result in ongoing backlog in planned and surveillance surgical patients. Only priority 2 for CAH and DHH sites. 28/06/2021- DHH recommenced elective theatres x 15 sessions on the 07/06/2021. CAH elective sessions continue with reduced theatres- currently 2-3 urgent bookable per staff however this is staff dependent. Agency staff have taken leave July/August 21. 9/6/2021 the ongoing workforce issues will affect our ability to provide core operating sessions. Primarily for in patient theatres. The action in respect to recruitment is in place. advertisements are going out in June and 9 new registered nurses are due to commence work between June and Sept for CAH in patient theatres. we are currently working with the nurse bank and agency to attract theatres nurses and Dps from agency across mainland UK. 15/02/2021- ICU remains open to 16 patients, surge staff from day surgery and theatres/recovery remain in-situ. Currently in surge 3 03/12/2020- full de-escalation of CCaNNi critical care surge plan- this is currently medium surge and difficult to predict. Commencement of in house additionally from Jan 2021 for endoscopy and surgical specialties and the January sessions are currently being agreed. Increase urgent bookable theatre sessions	HIGH	DIV	

Southern Health and Social Care Trust

Quality Care - for you, with you

CORPORATE RISK REGISTER

to Governance Committee

11th September 2012

Summary of Corporate Risks as at September 2012

There are 18 Corporate Risks (6 high level and 12 moderate level) as agreed by the Senior Management Team on 5th September 2012

HIGH RISKS	* Corporate Objective	Risk Rating	Change to Status since April 2012
Ongoing achievement of PfA access targets and review appointments	1	HIGH	Unchanged
Level of Residential Home/Nursing Home/ Domiciliary Annual Reviews not completed	1	HIGH	⇧
Insufficient capital to maintain and develop Trust estate (facilities, equipment etc) to support service delivery and improvement	1	HIGH	Unchanged
RQIA recommendations in relation to the supervision and administration of medication by Trust/independent agency domiciliary care workers, day care workers and Trust staff in Supported Living Accommodation and Residential Homes	1	HIGH	Unchanged
High Voltage capacity limit on electrical supply to Craigavon Area Hospital	1	HIGH	Unchanged
Implementation of Business Systems Transformation Programme	5	HIGH	Unchanged

MODERATE RISKS	* Corporate Objective	Risk Rating	Change to Status Since April 2012
Systems of assessment and assurance in relation to quality of Trust services	1	MODERATE	Unchanged
Compliance with Standards and Guidelines	1	MODERATE	Unchanged
Fire Safety	1	MODERATE	Unchanged
Asbestos – legal compliance with legislation	1	MODERATE	New risk added on 4.7.12
HCAI – risk to achievement of PfA target	1	MODERATE	Unchanged
Risk of harm to patients from water borne pathogens	1	MODERATE	New risk added on 2.5.12
Protection of Vulnerable Adults – inconsistencies in practice and Issues with interagency working	1	MODERATE	Unchanged

MODERATE RISKS	* Corporate Objective	Risk Rating	Change to Status Since April 2012
Implementation of new regional on-call arrangements	**1**	**MODERATE**	Unchanged
Robust Business Continuity Planning	**1**	**MODERATE**	Unchanged
Fully Embedded Appraisal system	**4**	**MODERATE**	Unchanged
Financial Balance – risk in 2012/13 that the Trust will not achieve financial balance in year and not meet requirement for £11m cash release	**5**	**MODERATE**	Unchanged
Management and monitoring of procurement and contracts	**5**	**MODERATE**	Unchanged

Issues downgraded for removal from Corporate Risk Register

Level of unallocated child care cases – will be managed as Directorate risk issue

Note – Red font indicates the changes that have been made to the Register since May 2012

Corporate Objectives

1: Provide safe, high quality care.

2: Maximise independence and choice for our patients and clients.

3: Support people and communities to live healthy lives and improve their health and wellbeing.

4: Be a great place to work, valuing our people.

5: Make the best use of resources.

6: Be a good social partner within our local communities.

Southern Health & Social Care Trust: Summary of Corporate Risks as at September 2012

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
No	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update (September 2012)**	**Lead Director**	**Status**
1	Achievement of Priority for Action access targets and review appointments to secure timely assessment and treatment • A number of inpatient/day case/outpatient waiting times significantly beyond access standards (Acute and Mental Health areas) • Outreach specialties (oral surgery, ophthalmology, etc) not within control of Trust • Outpatient Reviews in a number of specialties significantly beyond clinical review timescales • Plain film X Ray reporting only maintained at current level of Ionizing Radiation Medical Exposure Regulations with unfunded additional capacity and no regional standard for areas appropriate for Ionizing Radiation Medical Exposure Regulations • A number of patients waiting beyond Allied Health Professions access target	• Bi-weekly reporting to Senior Management Team • Monthly reporting to Trust Board • Action plans in place for reductions in waiting times with associated business cases submitted for capacity gaps where defined/agreed. • Bids submitted for non-recurring funding on a quarterly basis • Performance meetings with Health and Social Care Board • Review backlog plan submitted to Health and Social Care Board • Outpatients Review backlog action plan in place and being incrementally implemented. • Bids for additional capacity submitted and secured on a specialty basis	• On-going work with Health and Social Care Board to agree capacity gaps and associated recurrent funding requirements. A number of Investment Proposal Templates (IPTs) submitted and others to be developed after notification of Commissioner intent to proceed. • Quarter 3 and Quarter 4 bids for non recurrent funding submitted to Health and Social Care Board for all specialties with gaps with requirement to maintain access at March 2012 position by March 2013. Capacity increased both in-house and in Independent Sector. • Independent Sector contracts re-let for 2012/13 include mobile MRI capacity, Ophthalmology, Oral Surgery, Orthopaedics and Urology • Business case for Team South Urology approved (July 2011) – commencement dates agreed for 3 Urologists. . • Consultant recruitment for local Ophthalmology service unsuccessful. Currently re-advertised, with interviews mid September 2012. . In discussion with Co-operation and Working Together (CAWT) and Dublin North East. Future potential for small volume of long waits to flow to Dublin North East. • In house additional capacity utilised where possible within funding allocated	Performance and Reform/ Operational Directors	HIGH

			• Risks to maintaining March 2012 access position, including agreed backstops, highlighted at fortnightly Elective Performance meetings with Health and Social Care Board. Plain Film X Ray • Independent Sector and In-house additionality utilised (but unfunded) to maintain reading of non-Ionizing Radiation Medical Exposure Regulations plain film X Rays at 28 days • Phase 1 Action Plan in progress. Phase 2 report received and Action Plan developed. Action Plan sent by Chief Executive to Chief Medical Officer and Health and Social Care Board to seek clarification on timescales and process for regional actions. Response received, but no regional action yet. Outpatient Review Backlog • Whilst significant reduction in volume of review backlog achieved initially, the number of routine waits has shown an increasing trend in 2012 as the system continues to bring in significant volumes of in-house additional new patients to meet access targets. • Of the total waits, 66% of those waiting have only been waiting from 1 April 2012. • The longest waits remain in Urology and Ophthalmology • Work continues to cleanse lists and Specialist Nurses are working with relevant consultants to screen urgent reviews and longest waiters		

			• Cutting plans formalised to monitor steady reduction of review backlog waits in association with non-recurrent funding of in-house additional capacity • Trust anticipates a rolling backlog in reviews until recurrent demand /capacity gaps have been addressed.		
2	Achievement of statutory functions/duties: Level of Older People and Primary Care Domiciliary clients Annual Reviews not completed	• Monthly monitoring of reviews undertaken by Head of Service/Assistant Directors • Group established to examine operational management of the annual review process	• Domiciliary Care Reviews – exercise underway to scope the number of reviews carried out and those outstanding. 63% of all reviews completed at end of June 2012. 38% have been waiting longer than a year to have their reviews carried out • Development of an excel workbook in place for 100% of clients to provide staff with a live register of review dates for Residential and Nursing Home clients, as well as for domiciliary care reviews. • Social work capacity and demand work paper has been presented and additional capacity has been identified and recruitment is ongoing. Further capacity and demand work is being undertaken in the Memory Services. • Additional temporary social work staff remain in post to ensure the Trust reaches compliance with the expected annual review process. The outcome of the capacity and demand work will inform future staffing levels. • Permanent Placement Team in process of establishment. Operational Manager will be in place by September 2012 and service model will be developed to carry out reviews for all clients in Nursing/Residential Homes and contract reviews etc.	Older People and Primary Care	**HIGH**

3	Systems of assessment and assurance in relation to quality of Trust services	• Clinical and Social Care Governance Review completed and new structures and assurance reports being implemented • Update on implementation to Governance Committee on a quarterly basis • Governance Committee, Senior Management Team and Governance Working Body in place and operating to agreed remit • Directorate, Division and Professional Governance Fora in place and reporting to Senior Management Team/ Governance Committee • Caspe Healthcare Knowledge Systems (CHKS) comparative mortality benchmarking tool - contract in place and information extracted for governance information • Review of Specialty Mortality and Morbidity system completed. • Mortality Reports to Governance Committee • Chair/Chief Executive/Director/Non Executive Director programme of visits in place and feedback to Chief Executive • Serious Adverse Incident/Adverse Incident reporting system in place	• New Governance structures/processes embedded • Web-based incident reporting (on Datix) rolled out across the Trust • Reviewing and revising Incident Policy and Serious Adverse Incidents Management Policy • Risk Management Policy to be reviewed by October 2012 • Clinical and Quality indicator programme of work across Directorates • Executive Director of Nursing report to Trust Board in June 2012 showing performance against Nursing Quality Indicators (NFIs) • Executive Director of Nursing report on Allied Health Professions Quality Indicators to Trust Board in April 2012 • Internal Audit of complaints completed and a satisfactory level of assurance achieved • Internal Audit of incidents completed and a satisfactory level of assurance achieved • Governance Working Body in place and meeting regularly. Priority strategic areas agreed and work underway	Chief Executive	MODERATE

	Learning from Adverse Incidents, complaints and user feedback - lack of formal, embedded system of learning	• For Serious Adverse Incidents and appropriate level of Adverse Incidents, investigation/Root Cause Analysis process embedded with reports to Director/Senior Management Team Governance to approve recommendations/actions and ensure shared learning • Governance Committee Senior Management Team, Governance Working Body, Divisional and Directorate Governance Fora, Professional Governance Fora, Patient and Client Experience Committee for shared learning	• 4 issues arising from Serious Adverse Incidents brought to Governance Working Body on 20th January 2012 and being taken forward for organisational learning. Governance Committee updated on progress in September 2012. • Presentation on National Early Warning System (NEWS) to Senior Management Team on 1st August 2012 and decision taken to progress implementation in adult in-patient settings within Acute and Older People and Primary Care. Progress report on implementation to Trust Board on 30th August 2012 • Reviewing and revising Incident Policy and Serious Adverse Incidents Management Policy		
4	Compliance with Standards and Guidelines (S&G) • Due to the volume/ complexity of new S&G being issued to the Trust by external agencies, it is a challenge for the Trust to also monitor and review the compliance status of those S&G that have already met full compliance in order to ensure that this is maintained. Since 1st January 2012, a total of 157 new standards and guidelines have been regionally endorsed from a range of different external agencies. The Trust register now indicates a total of 329 standards have been issued since 1.4. 2010.	• Establishment of six monthly performance/accountability reports for standards and guidelines. • Standard item for discussion at SMT (monthly) and Governance Committee with submission of relevant reports / assurance statements • Standard item for discussion at the Directorate Governance meetings with submission of relevant reports • For those that are 'pharmacy' related a compliance report is also presented by the Trust's Medicines Governance Pharmacist to the Operational Directors and members of the Drug and Therapeutics Committee.	• Since 19 April 2012, the Standards & Guidelines Prioritisation and Risk Review Group has met 9 times to review all of the newly regional endorsed circulars. The outcomes from the group are currently being recorded and a summary register will be made available to Directors from September 2012. • Due to financial constraints, there has not been an ability to provide approval to appoint a temporary Band 6 Senior Patient Safety Officer (initial six month secondment). The primary function of this post is to identify all standards that have been issued prior to April 2010 and determine a risk based approach for ensuring that these are effectively implemented within the organisation and that an assurance framework is in place. However, in July 2012, SMT gave approval for a	Chief Executive	**MODERATE**

	• There is often a time lag between when the external agencies require the Trust to achieve full compliance and when this is actually achieved • Standards and guidelines that have been regionally endorsed prior to January 2009 have not been reviewed / managed in line within the Trust's new assurance processes and as a consequence the level of compliance / required action has not been identified for each. • Since 5th April 2012, the Patient Safety and Quality Service has carried a Band 5 vacancy and this has significantly impacted on service capacity. This post is currently being presented for scrutiny and following approval, will be advertised. Band 3 agency cover has been provided since 27th July 2012 to manage some of the administrative backlog.	• Database has been established and there is system of logging and monitoring standards and guidelines • SABS system in place for Safety Action Bulletins	graduate intern to be appointed to the service on a temporary 6 month basis, funded in Acute Services. The successful applicant will take up post in October 2012. • Discussions will take place in September 2012 on the feasibility of integrating the existing standards and guidelines database into the Trust's *Datix* information system. This would facilitate more effective monitoring of the progress that is being made to ensure that standards and guidelines are implementation within the organisation. • Review of the process map to ensure effective dissemination and management of Safety Action Bulletins is on-going. Initial scoping exercise underway. Target completion date – December 2012		

5	Lack of compliance with RQIA recommendations in relation to the supervision and administration of medication by Trust/independent agency domiciliary care workers, day care workers and Trust staff in Supported Living Accommodation and Residential Homes	Risk management includes • Training programme for domiciliary care staff in place – all staff have received medicines management training by November 2010 • Refresher training underway by Sept 2012 (without competency assessment - OSCE) • Trust Medicines Management policy • Medicines Management Steering Group • Review of operational procedures • Induction training for new Domiciliary Care Supervisors all of whom have now received medicines management training • SH&SCT and RQIA Incident reporting systems in place • Workshop held with Independent Sector Providers • Draft educational and competency framework rolled out to support the delivery and management of training of all Trust domiciliary care workers, day centre and social education centre staff • Risk assessment for transcribing completed • Transcribing procedure developed and implemented • Transcribing training carried out in Day Care, Supported Living and Residential Care	• Issues with achievability of compliance have been raised with the Health and Social Care Board • Risk assessment reviewed by Working Group on 23.7.2012. Outstanding actions are: - Trust Operational Procedures regarding medicines management for domiciliary care workers to be reviewed. Meeting to be held with Director of Older People and Primary Care and Director of Mental Health and Disability Services to agree which professional should/will complete assessment and detail instruction in care plan for domiciliary care workers - Implement interim guidelines for commissioners of domiciliary care services until Trust operational procedures are agreed. Guidance developed, but not yet fully implemented due to Commissioners continuing to work to local/legacy arrangements and a delay in regional workstreams in relation to the production of a pharmacy produced medication administration record. • Trust representatives on regional group. No meeting since 2011. Trust staff to contribute to Health and Social Care Board regional workstreams when they are re-established. • Transcribing competency assessments to be carried out by trained nominated staff for day care, supported living and residential care.	Older People and Primary Care/ Executive Director of Nursing	HIGH

6	Insufficient capital to maintain and develop Trust estate to support service delivery and improvement	• Maintaining Existing Services prioritised investment plan agreed by Trust Board and shared with Department • Recent capital allocations have addressed highest priority risks. This process is on-going. Capital Resource Limit also utilised where possible to address highest risk • Strategic development plans in place for major projects and business cases submitted for highest risk areas • Fire Safety Action Plan in place (see below) • High Voltage capacity limit on supply to Craigavon Area Hospital Identified (see below)	• On-going prioritisation and bidding process for capital in place • Fire Safety Action Plan in place and agreed to inform Maintaining Existing Services investment • Recommendations from RQIA hygiene inspection reports prioritised for Capital Resource Limit/Minor works where no other funding source available • £2.1m Maintaining Existing Services funding secured for 2012/13 • Craigavon Hospital Theatres1-4 in progress and to be completed by November 2012 • Business cases in development to address significant Maintaining Existing Services infrastructure issues requiring investment > £500k including c.£2.2m for structural works to tower block at South Tyrone Hospital • Structural engineer reports commissioned for sites at higher risk to inform action plan	Performance and Reform	HIGH
7	Fire Safety and compliance with Fire Safety Regulations (NI) 2010	• Fire Safety Action Plan in place and to be monitored quarterly • Local Fire Safety Management Arrangements in place • Funding to resolve deficiencies – prioritised within Maintaining Existing Services • Approximately £1.2 million was invested in 2011/12 to improve fire safety by upgrading the fire alarm systems in Craigavon Area Hospital, Rathfriland and Warrenpoint Health Centres, construction of escape bed lifts in Craigavon and Lurgan Hospitals, upgrading fire hydrants at Daisy Hill and	• Additional staff have been recruited to implement highest priorities on action plan including Fire risk assessments and fire audits • Staff training on-going • New methods for delivering mandatory fire training agreed and to be implemented and tested 2012/13 • Programme of fire risk assessments and fire drill exercises in the hospitals are being carried out • Initial Firecode funding allocation from Maintaining Existing Services for 2012/13 c. £500k to be directed to next highest priority risks and further funding continues to be sought	Performance and Reform	MODERATE

		Craigavon Hospitals and the construction of a bin store at Craigavon Area Hospital to remove fire loading from the basement			
8	High Voltage capacity limit on electrical supply to Craigavon Area Hospital • Identified under Maintaining Existing Services scheme • Possible limit to expansion of service provision on the Craigavon Area Hospital site • Increased electrical demand on existing limited supply may exceed capability of supply	• All future development/ expansion of the estates is to be notified to Estate Services • Generator backup • Load shedding • Monitoring current demand • Business Continuity Plans for restabilising electrical service in the event of unplanned interruption	• Developing schemes with Northern Ireland Electricity on options for provision of increased supply capacity. • Independent experts appointed to provide Infrastructure condition report and inform plans for new High Voltage/Low Voltage infrastructure • Mechanical Infrastructure and Electrical Infrastructure Business Cases are being progressed in parallel as both Combined Heat and Power (within Mechanical) and new High Voltage intake (within electrical) Strategic Outline Case are required to manage the onsite risk. • Peak Lopping is progressing following agreement with Northern Ireland Electricity • Phase 1 business case for Low Voltage works to provide short-term mitigation for risks approved in June 12 for £2.5m spend in year.	Performance and Reform	HIGH
9	Asbestos and compliance with Control of Asbestos (N.I.) 2007 • Risk of exposure to asbestos by being unable to identify existing asbestos across all Trust property and from lack of a unified/single asbestos management plan.	• Estates Services Asbestos Management Group • Asbestos Policy in place • Revised Asbestos Management Procedures in place • Refurbishment and Demolition Surveys performed when significant work is required on any facility older than 2000 • Asbestos Registers in two legacy systems plus one on-line system	• Re-survey Armagh and Dungannon and Craigavon and Banbridge Estate and develop an integrated Trust Asbestos Management Plan for complete Trust Estate. • One year's management inspections integrated into the Trust's existing Asbestos Register.	Performance and Reform	**MODERATE**

10	HCAI • Risk to achievement of Priorities for Action target identified	• Dedicated isolation ward on Craigavon Area Hospital site • Comprehensive isolation policy in place and strictly adhered to • Ongoing mandatory and tailored training • Comprehensive governance structure in place, including bi-monthly Strategic Forum and fortnightly Clinical Forum • Outbreak /incident management plan in place • Independent and self-audit programme in place • Extensive action plans in place to deal with trends/prevalent HAIs • Antibiotic stewardship • Root Cause Analysis process in place	• Compliance with DHSSPS Board to Ward assurance • Further development of independent audit functions • Ongoing measurement of compliance against DHSSPS Communiqués including Independent Review of Pseudomonas • Measurement of compliance against NICE - Prevention & Control of HCAI - Quality Improvement Guide on-going. • Revision and re-launch of Trust Root Cause Analysis process for HCAI's	Medical Director	MODERATE
11	Risk of harm to patients from water borne pathogens (i.e. legionella, pseudomonas)	• Water Safety Group in place • Revised Legionella policy and procedures in place • Compliance with PHA and HEIG guidance: HSS(MD)6/12 - Water sources and potential for pseudomonas aeruginosa infection from taps and water systems • Legionella risk assessments, sampling and monitoring regime in place (as per L8, PHA & HEIG), results analysed, appropriate action taken as required • Pseudomonas sampling and monitoring regime in place in Neonatal Unit and Special Care Baby Unit; in progress in augmented care • IPC guidance on environmental cleaning developed and rolled	• Further development of formal water safety plan by September 2012 • Installing a trial system for copper sliver ionisation of Ramone Building water system • Extension of legionella testing areas • Consideration of opportunities to increase automated water temperature and flow monitoring • Review resources needed to manage water quality systems (Microbiology, IPC and Estate Services) and identify to Department of Health, Social Services and Public Safety as part of an overall organisational assessment of the unfunded impact of meeting standards and guidelines.	Director of Performance & Reform/ Medical Director	MODERATE

		out (sinks, equipment, etc.) • Infection prevention and control guidance and procedures are continuously reviewed, modified and issued to address emerging risks • Infection prevention and control audit programme and implementation of appropriate actions based on findings • On-going staff education programme highlighting risks of water borne pathogens • Design of water systems within care facility/ environment; attention is given to designing system that will reduce the likelihood of propagation of water borne pathogens			
12	Protection of Vulnerable Adults – inconsistencies in practice and issues with interagency working	• Lead Director and lead professional for Adult Safeguarding in place and Safeguarding Partnership Board/Forum/structures in place • Specialist Safeguarding Team to provide advice and support • Procedural guidance completed • Training to all managers • Report to Trust Board as part of Statutory Functions Reporting • Director of Social Work Report to Trust Board	• Development of key interfaces underway • The majority of staff across directorates now trained in the Soscare Vulnerable Adults module. A further 5 "mop up" sessions were offered over the summer months with the final session due to complete by the 12.9.12. • All Vulnerable Adults referrals now captured on Soscare with the referrals within the first 4 months of the year to be backdated on the system by 31.3.13. • Adult Safeguarding Dashboard Report became operational in July 2012. Trust wide summary report is sent to the Executive Director of SW and specific divisional/directorate reports sent to HOS and governance leads.	Children and Young People's Services	MODERATE

			• Adult safeguarding research commenced in July 2012. On target for completion date of 31st December 2012. Learning from the research will then be disseminated throughout the Trust. • Trust Adult Safeguarding Policy to Policy and Records Committee in September 2012 for approval. • Annual Report to Trust Board on 31.5.2012 as part of Delegated Statutory Functions Report		
13	Implementation of new regional on-call arrangements. Risks in relation to disruption to services in the 'out of hours' period as a result of staff withdrawing from on-call rotas from 1.10.2011 due to the reduction in on-call payments. The following services are provided by staff who will experience the biggest reductions in on-call payments: • Social Work out of hours service • Pharmacy emergency duty • Radiography out of hours service • Laboratory out of hours service	• Meetings with Directorates and Human Resources are currently ongoing to consider alternative ways of working for example, partial / full shifts, extended days, recruitment of staff to waiting lists where this is possible and appropriate in order to ensure cover can be provided during the out of hours period. • Joint Negotiating and Consultation Forum (JNCF) standing agenda item for discussion with Trade Union colleagues • Director of Social Work & Human Resources collated Out of Hours Social Work information. • Director of Social Work & Human Resources issued letter to all co-ordinators with regular update meetings with the Co-ordinators. • The Regional Out of Hours Review Group has been established of which Trust	• The Trust has been participating in the Regional group to plan for the new service model. Timelines for action are being met and the DHSSPS have agreed an extension of the current on-call rates until 30.9.12. • Regional Group has met on a number of occasions since January 2012. A regional contingency plan for a period of four months (October 2012 to January 2013) will be required until the new regional service commences on 1st February 2013. • Discussions are currently ongoing with NIPSA and the staff affected regarding the contingency arrangements • Options have been explored for shift systems in Radiography and Laboratory. A shift system will be operational in Radiography in DHH and CAH wef 1st October 2012. In relation to Laboratory, discussions are ongoing in relation to seeking agreement in relation to a shift system to be introduced once there are sufficient new staff trained, however in the interim, the oncall circular will be	Children and Young Peoples' Services/ Human Resources	**MODERATE**

		Directors are members. The Project Initiation Document (PID) has been developed and agreed by the Project Board (comprising Executive Directors of Social Work and the Director of HSCB • Collectively Trusts are seeking an extension to the implementation of the proposed new service arrangements • Social Work staff who are willing to continue on the Out of Hours rota beyond 31.03.2012 will receive current on-call payments • Out of Hours Project Team established in the Trust	applied to this service wef 1st October 2012 • Agreement has been reached in Pharmacy in relation to the implementation of the oncall circular from October 2012. • Previous difficulties in relation to the hyperbaric chamber oncall have been worked through and arrangements are being finalised during September in relation to the implementation of the on-call circular to both nursing and technical staff.		
14	Development of robust Business Continuity Planning arrangements	• Business Continuity Plans were developed in most Directorates in preparation for pandemic in 2009. • Performance management arrangements in place between Public Health Agency/ Health and Social Care Board and Trust • Further development of plans for severe weather • Stock take undertaken • Engagement of Consultant • Business Continuity Management Policy • Progress reports provided on a monthly basis by the Business Continuity Manager to the Medical Director • Updates provided to Senior Management Team via Medical Director's report and Governance Committee	• Temporary Business Continuity Project Manager has been working with Directors and their staff to identify key time critical services • Business Continuity Manager currently working with Directorate staff to undertake departmental level business impact analyses which will assist with the review/update of the existing suite of continuity/contingency plans for each service in line with the BS25999	Medical Director/ Operational Directors	**MODERATE**

CORPORATE OBJECTIVE 4: BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE					
15	Fully embedded appraisal system – lack of evidence of compliance	• Succession Planning - established and on-going. Band 7 Programme 'Breaking Through'being finalised • Evaluation • Governance – new arrangements in place and ongoing • Knowledge and Skills Framework (KSF) policy and monitoring system in place • Consultant appraisal policy and monitoring system in place • Mandatory Training	• Personal Development Plans received from over 44% of staff. Directorate aligned Support Staff (from HR)have been meeting with teams and demonstrating the documentation as well as encouraging team leaders to apply the policy fully in their area of responsibility and send the completed PDPs to HR for the record. • Supervision – combining staff supervision/KSF and PDP • E-learning Policy to SMT in September 2012 for approval • E-Learning packages for Moving and Handling, Safeguarding, Infection Prevention & Control, Food Safety and COSHH completed. Fire Safety and Waste Management packages almost completed • Basic ICT Skills training roll-out September-December 2012	Human Resources	**MODERATE**
CORPORATE OBJECTIVE 5: MAKE THE BEST USE OF RESOURCES					
16	Achievement of financial balance in 2012/13 to include requirement for £11m cash release • In year • Recurring Financial impact of Transforming Your Care	• Contingency Plan for 2012/13 in place • Best Care Best Value (BCBV) Project structure • Financial monitoring systems in place • Monthly report to SMT and Trust Board • Transforming Your Care (TYC) project leads in place in all Directorates to take forward implementation of priority	• Trust Delivery Plan, including 2012/13 financial plan, approved by Health and Social Care Board in June 2012. • Initial Draft population plan including indicative financial plans for the period to March 2015 submitted on 22nd June 2012 -	Finance and Procurement/ All	MODERATE