Chapter 6 Non-medical prescribing

The development of independent/supplementary prescribing is a key policy initiative that aims to maximise benefits to patients and the Trust by:

- Providing better access to medicines and:
- Better, more flexible use of the workforce skills.

The Trust Independent/Supplementary Prescribing Governance Framework (link) must be followed when introducing or training a non-medical prescriber. If the Framework has not been followed the prescriber will not be added to the Trust non-medical prescribing register.

The Trust Independent/Supplementary Prescribing Governance Framework is available on the Trust intranet/Sharepoint and covers those registered practitioners that are eligible to become prescribers, either independent, supplementary or community nurse practitioner.

Currently the eligible staff groups are pharmacists, nurses and the Allied Health Professionals (AHP) of podiatry, physiotherapy and radiology.

The Trust Framework covers the following areas:

- The Trust process for selecting suitable staff to commence training as Community Practitioner Nurse Prescribers.
- The Trust process for selecting suitable staff to commence training as Independent/ Supplementary Prescribers.
- The process to be followed before a prescriber will be added to the Trust non-medical prescribing register. Staff may not prescribe until they have been added to the Trust non-medical prescribing register and this has been confirmed with their line manager.
- Registering for and obtaining a community prescription pad on the HSCB on-line NMP register.
- On-going review of non-medical prescribing practice.
- General rules for non-medical prescribing.
- Management and security of prescription pads, including instructions on what to do if a pad is lost or stolen, or the staff member concerned leaves the Trust.
- Professional body registration requirements prior to joining and whilst listed on the Trust non-medical prescribing register.

Chapter 7 Administration of medicines in hospitals

7.1 Authority to administer

Medicines may only be administered to patients in accordance with the written directions of an authorised prescriber or an authorised patient group direction, except:

- as a registered midwife who may administer or supply specified medicines on their own initiative in the course of their practice as specified in the Medicines Act; or
- in an emergency as specified below.

In an emergency such as resuscitation, medicines may be administered in accordance with the verbal directions of a registered doctor/dentist provided that the doctor/dentist is present with the person administering medication to the patient. The person administering the medicine must check the medicine and measured dose with the prescriber and the directions and administration must be recorded in writing as soon as possible after administration.

Giving verbal directions remotely, for example via telephone, is not permitted.

Verbal directions by an independent/supplementary prescriber are not permitted.

7.2 Adrenaline

Any registered healthcare professional can administer adrenaline without direction or prescription in a life threatening emergency situation. However, ideally the Trust prefers that an authorised patient group direction should be in place to support staff in this situation.

7.3 Authorised prescriber

An authorised prescriber is:

- a registered doctor or dentist; or
- a non-medical prescriber approved by the trust Non-medical Prescribing Sub-committee of the Medicines Optimisation Committee and their professional body.

7.4 Patient Group Direction

An authorised patient group direction is one that has been approved by the Trust PGD process and signed by the Chair of the Medicines Optimisation Committee, Executive Director of Nursing and Midwifery and Director of Pharmacy. See Chapter 20 for more information.

7.5 Staff permitted to administer medicines

In general, medicines may be administered to patients by an approved practitioner.

The only exceptions to this are glyceryl trinitrate spray, terbutaline and/or salbutamol inhaler, which may be retained by a patient for immediate relief of symptoms and must be kept about their person. The patient is asked to inform nursing/midwifery staff if a dose is taken.

An approved practitioner for the administration of medicines is a registered nurse, midwife, registered doctor or dentist and where a second practitioner is required, may be a registered pharmacist.

Other registered healthcare staff, for example a podiatrist, may be an approved practitioner for the administration of specified medicines where this is within the course of their practice and they have been trained in the administration of such medicines.

Healthcare Assistants and Nursing Auxiliaries cannot be involved in the administration of medicines in hospitals unless they have received specific training that is approved by the Medicines Optimisation Committee. Medical Assistants and Trauma Aids are required to complete specific training to enable them to administer specified medicines.

Other individuals such as parents, carers, patients and students may be involved in the administration process; however it must be under the direct supervision of an approved practitioner, who retains full responsibility for the administration process. Where a student is administering medication under the direct supervision of an approved practitioner, both the student and the approved practitioner must sign the administration record. Where a second practitioner is required for preparation and administration, parents, carers, patients and students do not replace the need for a second practitioner.

7.6 Student involvement in medicines administration

In the Medicines Code the term student nurses/midwives applies only to nursing and midwifery students undertaking a programme of education leading to professional qualification and primary entry to the Nursing and Midwifery professional register, and to those students undertaking a programme of education that leads to movement within parts, or to another part of the Nursing and Midwifery professional register, for example Adult to Mental Health Nursing.

Student nurses/midwives may administer medications under the supervision of one registered nurse/midwife during a normal medication ward round.

For medicines to be given by IV bolus or IV infusion, the student can be involved in the preparation and administration of the medicine under the supervision of two registered nurses/midwives. The two registered nurses/midwives must be present throughout the preparation and administration of the medicine.

For medicines where a calculation is required, students may be involved, but again two registered nurses/midwives must check and confirm the calculation.

Student nurses /midwives can be involved in the administration of controlled drugs under the supervision of two registered nurses / midwives. The student nurse / midwife must sign the controlled drug register and have it countersigned by the two registered nurses.

Student nurses/midwives must not be involved in the supply or administration of any medicine under Patient Group Direction or midwives exemption.

Where a student midwife is administering a medicine (except controlled drugs) under a midwives exemption it must be under the direct supervision of a registered midwife who is also a 'sign-off' mentor, who countersigns the administration.

Student midwives must not be involved in the supply or administration of any controlled drug under a midwives exemption.

7.7 Second checking

All approved practitioners involved in the administration of medicines are individually accountable for their actions.

Two approved practitioners are required for the preparation and administration of:

- controlled drugs; and
- insulin.

Two approved practitioners are required for the administration of parenteral cytotoxic medicines; the prepared dose must always be supplied from the Aseptic Suite, Pharmacy Department, Craigavon Area Hospital.

Two approved practitioners are recommended, and for nursing and midwifery staff are required, for the preparation and administration of:

- warfarin;
- medicines where a calculation is required for the dose, concentration or rate of administration;
- medicines for neonatal patients;
- intravenous medicines, including bolus injections and intravenous infusions; and
- epidural infusions.

Where a second practitioner is asked to check a calculation, they must perform their own calculation independently before comparing with the first practitioner's answer.
Where a second practitioner is involved in the administration of medicines, they must be involved in the preparation and administration process up to the point that administration is commenced, with the exception of specified areas where there is a specified written procedure approved by the Medicines Management Committee. Involvement of a second practitioner up to the point that administration is commenced includes checking the identity of the patient and the use of any medical devices required for administration, for example setting the rate on an infusion pump. Where the setting on an infusion pump is to be adjusted during an infusion, two practitioners are

recommended, and for nursing and midwifery staff are required, to adjust the setting and make a record on the patient's infusion record. This includes stopping and restarting an infusion after a temporary interruption.

7.8 Patient identity

The approved practitioner must check the identity of a patient using the patient's identity bracelet, which states their full name, Health and Care Number and date of birth and confirming that these details match those details on the prescription. Where possible the patient should also be **asked** to confirm their full name and date of birth using open questions, for example 'What is your name and date of birth?' rather than 'Is your name John Smith and your date of birth 01/06/1943?'

7.8.1 Identity bracelets

All in-patients and day case patients must have an identity bracelet with the exception of patients where an identity bracelet presents a risk to an individual patient, for example:

- where there is a foreseeable risk of patient harm through the patient ingesting the identity bracelet (e.g. some patients with a learning disability, confusion, delirium)
- where the wearing of an identity bracelet would cause the patient distress (e.g. paranoia, delirium, dementia, confusion post head/brain injury, post-operative/post-ictal states)
- where the patient/service user with capacity refuses to wear an identity bracelet and the risks and consequences of his/her decision have been explained, understood and documented in the individual's care record
- where there are physical restrictions to applying an identity bracelet (e.g. severe widespread burns, absence of all four limbs, previous allergic reaction to identity bracelet)

Where an identity bracelet presents a risk to an entire group of patients in a ward or department, photographic identification must be used (see 7.8.2). In all other areas, an alternative method for confirming patient identity must be selected on admission from the list below for any individual in-patient or day case patient where a wrist band cannot or will not be worn:

- asking the patient to independently state their (1) full name, (2) address and (3) date of birth each time medicines are to be administered, ensuring that these details correspond to the prescription, or
- positive identification by relatives/carers who will be asked to state the patient's (1) full name, (2) address and (3) date of birth each time medicines are to be administered, ensuring that these details correspond to the prescription,
- positive identification by two members of staff present with the patient each time medicines are to be administered

The alternative method for confirming patient identity must be documented by the nurse

- in the additional notes section on the front page of the Kardex,
- in nursing notes, and
- recorded on the safety brief/handover for communicating at each handover of patients.

The nursing notes should also document the reason why an identity bracelet is not worn.

7.8.2 Photographic identification

Where an identity bracelet presents a risk to an entire group of patients in a ward or department, for example through the risk of ingestion of the identity bracelet in learning disability settings, that ward or department must employ photographic identification and ensure that appropriate equipment is available to enable confirmation of identity by:

- taking a photograph of the patient on admission,
- writing the patient name and H&CN on the reverse of the photograph
- attaching the photograph securely to the front of the Kardex
- checking the photograph against the patient's face each time medicines are to be administered

The photograph should be reviewed regularly during lengthy admissions and if the patient's appearance changes, a new photograph should be taken as necessary

7.8.3 Outpatient and emergency department settings

Where a patient is not an in-patient or day case patient and does not have an identity bracelet, for example in out-patients or in Emergency Department prior to a decision to admit, the patient identity should be checked by:

- asking the patient to independently state their (1) full name, (2) address and (3) date of birth each time medicines are to be administered, ensuring that these details correspond to the prescription
- if a patient is unable to state this information and emergency treatment is required, the person in charge must take steps to identify the patient and maintain safety until full identification is verified and an identity bracelet attached.

7.9 Patient allergy status

The approved practitioner must confirm that the patient is not allergic to or intolerant of any medicines prescribed (including any constituents of combination medicines). The allergy status documented on the prescription must be checked. In day surgery, the allergy status must be confirmed by checking the anaesthetic sheet and the nursing notes.

Medicines should not be administered to a patient unless the allergy section of the prescription is completed, except in an emergency (see 5.1.3.2).

If there is any reason to suspect that the allergy information documented on the prescription is incorrect this must be drawn to the attention of medical staff.

7.10 Review of prescription

Prior to administering any medicine and at each set medicine administration round, an approved practitioner must review all prescriptions in use, including any supplementary prescriptions, and check:

- That the name on the prescription(s) matches the name of the patient intended to receive the medicine

- That the medicine administration is due
- The date, time, dose, frequency, route of administration and, where appropriate, the dilution and rate of administration of the prescribed medicine
- The duration of therapy
- That the dose(s) of medicine has not previously been administered and that the total dose, where applicable, will not be exceeded
- That the number of time slots circled on the Kardex matchthe prescribed frequency of the medicine
- The signature of the prescriber

When checking the frequency on an in-patient prescription, approved practitioners must always refer to the prescribed frequency to determine medicines due for administration and not follow the pattern of administration signatures from previous days.

Any ambiguities, lack of clarity or doubt as to the accuracy, safety, completeness or appropriateness of a prescription should be referred to the prescriber or a pharmacist, as appropriate, before administering the medicine.

7.11 Selection of the medicine

The approved practitioner must select the medicine required, taking particular care to ensure it is the correct medicine, at the correct strength, in the correct formulation, within the expiry date and is not obviously defective.

If there is any concern that the medicine selected is defective in any way, do not administer the medicine, report this to the Pharmacy Department or the on-call pharmacist and retain the medicine so that it can be forwarded to the Pharmacy Department for further investigation.

Where a medicine has been dispensed for an individual patient, it must be administered only to that patient.

Where a patient is unable to take tablets or capsules for example, due to swallowing difficulty or where an enteral feeding tube is in place, tablets must not be crushed or capsules contents opened unless advised by Pharmacy or Medicines Information.

Where a syringe is required for the preparation and/or administration of an oral liquid medicine, an oral/enteral syringe must be used, in accordance with the Trust oral/enteral syringe policy.

When withdrawing a dose of insulin from a vial, an insulin syringe must always be used. **Never** use an insulin syringe to withdraw a dose of insulin from an insulin pen.

Prior to administering the selected medicine, it is important that approved practitioners have a clear understanding of the main effects, side-effects and usual dose of the medicine and ensure there are no obvious contra-indications to the patient receiving the medicine. It may on occasion be just as important not to administer a medicine that is judged to be inappropriate for the patient's condition, in which case the prescriber must be informed at the earliest opportunity so that the prescription is reviewed, a record of this made on the Kardex and in the patient notes.

7.12 Administration

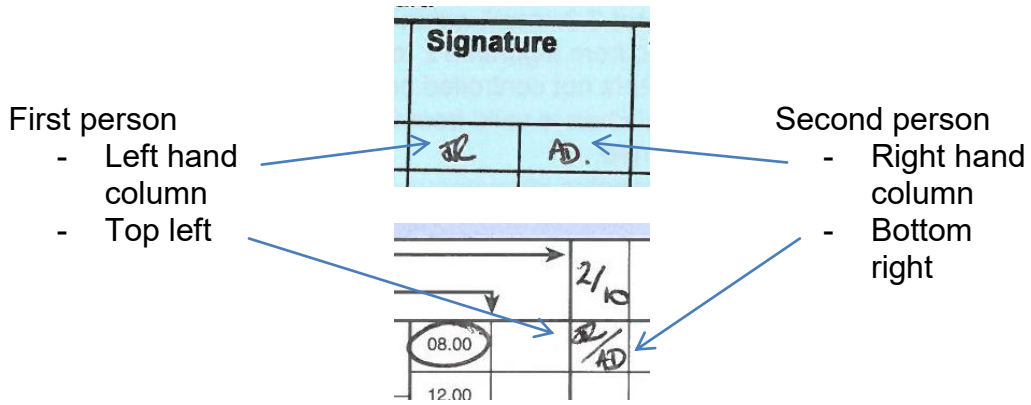
The approved practitioner administering the medicine must ensure that the patient ingests, uses or receives the medicine. Under no circumstance should medicines be left unattended at the patient's bedside except:

- as part of an approved scheme for self-administration; or
- salbutamol inhaler, terbutaline inhaler or glyceryl trinitrate spray, which may be kept about the person of the patient for the immediate relief of symptoms.

7.13 Documentation

The approved practitioner who has administered or supervised the administration of a medicine must record this in black indelible ink on the administration record immediately after administration. Where a continuous infusion is in progress, a practitioner must conduct monitoring of the infusion at the required intervals and record this in black indelible ink on the monitoring record.

Where two practitioners are involved in the administration of medicines, the administration record should be completed as follows:



The first person is the person who prepares and administers the dose. The second person is the person who checks the preparation and administration up to the point of commencement. Both practitioners are accountable for their actions.

7.14 Omitted or delayed doses

If the patient refuses or for any other reason, does not receive a prescribed medicine, the approved practitioner must clearly document this on the administration record using the defined codes. A comprehensive record of such omissions and the action taken must be made in the patient's notes. The medicine not administered must be disposed of in accordance with the Trust waste disposal policy and under no circumstances must it be returned to the original container.

An omitted dose is a dose that has not been administered before the next dose is due. A delayed dose is a dose that is administered two hours or more after the prescribed time and before the next dose is due.

Critical medicines are medicines where the timeliness of administration is crucial. All staff must be familiar with the agreed list of critical medicines in the Trust. While all medicines should be administered in a timely manner, every effort must be made to avoid delayed and omitted doses of critical medicines.

Where a dose has been omitted or delayed, a practitioner must consider if it is appropriate to administer that dose later, for example when a supply becomes available, having due regard for any adjustments that may be required in the timing of subsequent doses and seeking advice from a doctor or pharmacist as required.

If a supply of a critical medicine is unavailable on a ward or department, Pharmacy must be contacted to request an urgent supply and collection and delivery arranged. Outside pharmacy working hours, the on-call pharmacist should be contacted to arrange a supply.

If a dose of a critical medicine is delayed or omitted, the doctor must be informed and the patient reviewed as appropriate. A record of the doctor's advice and review if conducted should be included within the patient's clinical record and an incident report completed.

Patients classified 'nil by mouth' prior to a diagnostic procedure or receiving an anaesthetic must have their prescribed medicines administered to them in accordance with the prescriber's instructions or pre-operative assessment instructions. Any oral medication should be taken with a small quantity of water. It is the responsibility of the prescriber or pre-operative assessment clinic to provide clear instructions to nursing/midwifery staff concerning omission of prescribed medicines.

Patients may also be 'nil by mouth' for other reasons, e.g. vomiting, unable to swallow, ileus, suspected stroke in which case the patient must be reviewed to determine those critical medicines that must be administered via other routes. All patients with a suspected stroke should remain 'nil by mouth' and oral medication not administered until a Speech and Language Therapist or other appropriately trained member of staff has assessed their swallow function.

Where a patient is prescribed a dose of a medicine other than at a set medicine round, appropriate steps should be taken to prompt when administration is due and included in handover.

If a new medicine or a STAT dose of a medicine is prescribed the prescriber must inform a member of nursing & midwifery staff to enable timely administration. The prescriber must consider when the next routine dose of the medicine is due and if necessary prescribe a stat dose to ensure that treatment is started promptly.
When a prescriber informs a nurse that a new medicine has been prescribed the nurse must confirm with the prescriber when the first dose is to be given.

For regular prescriptions, the nurse must:

- Either administer the dose against the regular prescription and record the time on the Kardex
- Or, if there will be a significant time period until the next regular dose is due, ask the prescriber to prescribe a stat dose and administer immediately.

7.15 Medicines requiring preparation

Where a medicine requires preparation prior to administration, for example intravenous medicines, the practitioner must ensure they are aware of the correct method of preparation, diluents and expiry dates of the prepared medicine by referring to the Summary of Product Characteristics, Medicines Information or the on-call pharmacist.

A prepared medicine must be labelled immediately following preparation. Separate labels are available for labelling medicines added to an infusion and for labelling medicines in a syringe for injection or infusion. The only exception to labelling prepared medicines is where there is a single dose to be administered and the prepared dose does not leave the hands of the practitioner until administration. If there is a flush required with this single dose, either the flushing solution or the medicine must be labelled.

Medicines requiring preparation prior to administration must not be prepared in advance of their immediate use, with the exception of a medicine that has been prepared in Pharmacy for a specific patient under the direction of a pharmacist.

Practitioners must only administer medicines requiring preparation where they have been involved in the preparation of the dose, with the exception of:

- an already established infusion;
- where a medicine has been prepared in Pharmacy for a specific patient under the direction of a pharmacist; or
- in an emergency such as resuscitation, where the person administering the dose should take appropriate steps to confirm the medicine and measured dose that has been prepared.

7.16 IV Flushes

When prescribed intravenous medicines are being administered the IV line needs to be flushed with a compatible flush of either sodium chloride 0.9% or glucose 5% as directed in the Injectable Medicines Guide.

Where the nurse or midwife is administering the flush under an appropriate Patient Group Direction (PGD), the volume of flush solution used should be recorded on the fluid balance chart rather than the Kardex.

Any other flush solutions or flushes to be administered other than at the time of intravenous medicine administration must be prescribed separately or administered under a PGD.

7.17 Monitoring

Practitioners must also ensure that any required monitoring associated with the medicine is conducted which may be before, during or after administration of the medicine, for example observing patients for signs of opioid toxicity after administering a dose of a strong opioid to an opioid naive patient.

7.18 Medication incidents

Any events that occur in the administration of medicines, which could have or did lead to patient harm, loss or damage, must be managed and reported in accordance with the Trust Clinical Incident Reporting Policy.

Chapter 8 Administration of medicines in community/primary care

8.1 Administration of medicines in residential care homes, nursing homes, supported living facilities and day care centres

Medicines may only be administered to patients/service users/residents/tenants in accordance with the written directions of an authorised prescriber*.

*An authorised prescriber is:

- a registered doctor or dentist;
- an independent/supplementary prescriber approved by the Non-medical Prescribing Sub-committee of the Medicines Optimisation Committee; or,
- community practitioner nurse prescribers when prescribing within the Nurse Prescribers' Formulary.

Any change to medications must be communicated in a written format (may be by email) before the change is made to the patient/service user/resident/tenant's medication administration record, according to the Trust Transcribing Procedure.

Every effort should be made to obtain written confirmation of **discontinued** medicines, however where this is not possible and is only available verbally e.g. via phone, a written record must be made of the conversation including:

- The name of the person who relayed the information that the medicine was to discontinue
- The name of the GP
- The service user's name and HCN
- The name of the medication
- The date

All prescribed medicines must be recorded on a medication administration record that must be maintained for each patient/service user/resident/tenant that shows:

- full name and date of birth and health and care number of the patient/service user/resident/tenant;
- allergy status of the patient/service user/resident/tenant;
- name, form and, where appropriate, strength of each medicine ;
- dose to be administered;
- time and route of administration ;
- frequency and, where appropriate, the dilution and rate of administration of the prescribed medicine;
- 'As required' medicines must state the minimum interval between doses and maximum frequency or dose within 24 hours;
- the duration of therapy where appropriate;
- any special requirements; and,
- the date prescribed.

The prescriber should be encouraged to verify and sign the medication administration record. Otherwise a designated person who has been trained and deemed competent as a Transcriber, should check the details on the prescribed medication against one of the following sources.

1. Prescription originally written by an 'authorised prescriber'* (HS21);
2. Printed record obtained from the service user's GP detailing current prescribed medication including dosage and directions;
3. Written record obtained from the service user's GP detailing current prescribed medication including dosage and directions and signed by the GP;
4. List of medication obtained from 'Emergency Care Summary' records; or
5. Discharge prescription written in the hospital where the service user has been discharged directly from.

A second transcriber must check and sign the transcription. Anyone involved in transcribing must understand and follow the Trust Transcribing Procedure which is available on the intranet under www.southernguidelines.hscni.net and must be aware of when transcribing is permitted.

Approved Practitioners
In general, medicines may be administered to patient/service user/resident/tenants by an approved practitioner. An approved practitioner for the administration of medicines is a registered nurse, midwife, authorised prescriber and where a second practitioner is required, may be a registered pharmacist. Other registered healthcare staff, for example a podiatrist, may be an approved practitioner for the administration of certain medicines where this is within the course of their practice and they have been trained in the administration of such medicines.

Trained care staff
Non-registered care staff may only be involved in the administration of medicines in residential care homes, nursing homes, supported living schemes and day centres where they have received appropriate training in handling and administration of medicines and following training have been deemed competent in the administration of medicines and are hereafter referred to as trained care staff. This competency must be reviewed yearly as per 'Education and Training Competency Framework for non-nursing staff working in Domiciliary Care and Day Care, Residential Care and Supported Living Settings' (available on the intranet under www.southernguidelines.hscni.net).

Other individuals such as parents, carers, patients and students may be involved in the administration process, however it must be under the direct supervision of an approved practitioner or trained care staff, who retains full responsibility for the administration. Where a second practitioner or trained care staff is required for preparation and administration, parents, carers, patients and students do not replace the need for a second practitioner or trained care staff.

In some instances following a risk assessment, the patient/service user/resident/tenant may be able to self-administer. A consent/agreement form must be signed. The level of self-administration may vary dependent on the assessment.

All practitioners and trained care staff involved in the administration of medicines are individually accountable for their actions.

Two people are required for the administration of controlled drugs in residential care homes, nursing homes, and day centres. In supported living schemes two people should be involved where possible. See 'Standard Operating Procedures for the Safer Management of Controlled Drugs in Domiciliary Care, Day Care, Supported Living Schemes, Residential and Trust Nursing Homes' (available on the intranet under www.southernguidelines.hscni.net).

Where a second person is involved in the administration of medicines, they must be involved in the entire preparation and administration process including checking the actual administration to the patient/service user/resident/tenant.

Where a second practitioner is asked to check a calculation, they must perform their own calculation independently before comparing with the first practitioner's answer. Where a second practitioner is involved in the administration of medicines, they must be involved in the entire preparation and administration process including checking the actual administration to the patient/service user/resident/tenant and the use of any medical devices required for administration, for example setting the rate on a syringe pump.

Trained care staff should not be involved in either conducting or checking calculations.

The identity of the patient/service user/resident/tenant must be confirmed carefully prior to administration of any medicine by asking them to state their name and date of birth (as appropriate) and also by checking photograph on medication administration record (where this is local policy).

It must be confirmed that the patient/service user/resident/tenant is not allergic to or intolerant of any medicines prescribed (including any constituents of combination medicines).

Medicines should not be administered to a patient/service user/resident/tenant unless the allergy section of the medication administration record is completed except in an emergency.

If there is any reason to suspect that the allergy information documented on the medication record is incorrect, this must be drawn to the attention of medical staff. Where appropriate, arrangements should be made with the family/carer to inform the facility of any changes in allergy status.

Prior to administering any medicine and at each set medicine administration time, review the medication administration record in use and check:

- that the name on the medication record(s) matches the name of the patient/service user/resident/tenant intended to receive the medicine;
- that the medicine administration is due;
- The date prescribed, strength, dose, frequency, route of administration;
- the duration of therapy;
- that the dose(s) of medicine has not previously been administered and if 'as and when required' medication that interval between doses is adequate and the total dose, where applicable, will not be exceeded; and,
- any special requirements.

Any ambiguities, lack of clarity or doubt as to the accuracy, safety, completeness or appropriateness of a prescribed medicine should be referred to the prescriber or a pharmacist, as appropriate, before administering the medicine.

Select the medicine required, taking particular care to ensure it is the correct medicine, at the correct strength, in the correct formulation, within the expiry date, is not obviously defective and that the label matches the medication administration record. When administering medicines from a monitored dosage system, for example Medidose®, it is essential that each medicine to be administered is positively identified from the description of the appearance of that medicine provided by the community pharmacy.

[Note: If a Community Pharmacist has dispensed more than one type of tablet or capsule into each blister in the monitored dosage system, they are required to provide a description of each tablet or capsule, so that the individual medicines in each blister may be easily identified]

Where a medicine has been dispensed for an individual patient/service user/resident/tenant, it must be administered only to that patient/service user/resident/tenant.

Where a syringe is required for the preparation and/or administration of an oral liquid medicine, an oral/enteral syringe of the correct size must be used. Where a bung can be inserted (in some bottles a bung will not fit), one should be obtained to make measurement easier. An adequate supply of syringes should be obtained and they should be cleaned and managed in accordance with the Trust Oral Syringe Policy.

If there is any concern that the medicine selected is defective in any way, do not administer the medicine. Report this to the supplying pharmacy and retain the medicine so that it can be forwarded to the pharmacy for further investigation.

Where a medicine requires preparation prior to administration, the practitioner must ensure they are aware of the correct method of preparation, diluents and expiry dates of the prepared medicine by referring to the patient information leaflet inside the packaging, by contacting the supplying pharmacist for advice, or by telephoning Medicines Information in Craigavon Area Hospital ([redacted]).

Trained care staff should not administer medicines that require complex preparation prior to administration, for example, injections. Trained care staff will ordinarily only be involved in the administration of topical and inhaled medicines if they have received specific training that is approved by the Trust Community Medicines Management Committee as per 'Education and Training Competency Framework for non-nursing staff working in Domiciliary Care and Day Care, Residential Care and Supported Living Settings' (available on the intranet under www.southernguidelines.hscni.net).

Where trained staff are required to administer medicines via an enteral feeding tube, an enteral management plan will have been devised and must be strictly adhered to. Appropriate training and assessment of competency must be provided by a qualified health care professional with the relevant knowledge skills and training. Records of training/competency must be retained by the

manager and the health care professional. Competency must be reviewed on an annual basis or more often if required.

Where the setting on a device, for example a syringe pump, is to be adjusted, two practitioners are required to adjust the setting and make a record on the patient's infusion record. This includes stopping and restarting an infusion after a temporary interruption. Trained care staff must not be involved in the administration of medicines requiring use of devices.

Prior to administering the selected medicine, it is important that practitioners have a clear understanding of the main effects, side-effects and usual dose of the medicine and ensure there are no obvious contra-indications to the patient/service user/resident/tenant receiving the medicine. It may on occasion be just as important not to administer a medicine that is judged to be inappropriate for the patient/service user/resident/tenant's condition, in which case the prescriber must be informed at the earliest opportunity so that the prescription is reviewed.

Trained care staff cannot be expected to understand the main effects, side-effects and contraindication of the medicine to be administered however they are expected to ensure the dose being administered corresponds with the medication administration record and raise any concerns that they have about the patient/service user/resident/tenant's condition with a practitioner or the person in charge at the time.

The person administering the medicine must ensure that the patient/service user/resident/tenant takes, uses or receives the medicine. Under no circumstance should medicines be left unattended with the patient/service user/resident/tenant except:

- as part of an approved scheme for self-administration.

The person who has administered or supervised the administration of a medicine must record this in black indelible ink on the drug recording sheet immediately after administration.

If a patient/service user/resident/tenant refuses or for any other reason, does not receive a prescribed medicine, this must be clearly documented on the drug recording sheet. A comprehensive record of such omissions and the action taken must be made in the patient/service user/resident/tenant's notes. The medicine not administered must be disposed of in accordance with the Trust Waste Disposal Policy and under no circumstances may it be returned to the original container.

If a patient/service user/resident/tenant continues to refuse to take their medication this should be escalated to a practitioner or the person in charge, so that appropriate action can be taken, including informing the patient/service user/resident/tenant's General Practitioner.

Any events that occur in the administration of medicines, which could have or did lead to harm, loss or damage, must be managed and reported in accordance with the Trust Clinical Incident Reporting Policy and the requirements of RQIA.

8.2 Administration of medicines by community nursing and midwives

Medicines may only be administered to patients in accordance with the written directions of an authorised prescriber or an authorised patient group direction, except

- in an emergency; or
- as a registered midwife who may administer or supply certain medicines on their own initiative in the course of their practice as specified in the Medicines Act.

An authorised prescriber is:

- a registered doctor or dentist;
- an independent/supplementary prescribers approved by the Non-medical Prescribing Sub-committee of the Medicines Optimisation Committee; or
- community practitioner nurse prescribers when prescribing within the Nurse Prescribers' Formulary.

In an emergency such as resuscitation, medicines may be administered in accordance with the verbal directions of a registered doctor/dentist provided that the doctor/dentist is present with the person administering medication to the patient, the person administering the medicine checks the medicine and measured dose with the prescriber and that the directions and administration are recorded in writing as soon as possible after administration. Verbal directions by an independent/supplementary prescriber or community practitioner nurse prescriber are not permitted.

Any registered healthcare professional may administer adrenaline without direction or prescription in a life threatening emergency situation. However, ideally the Trust prefers that an authorised patient group direction should be in place to support staff in this situation.

In an emergency, where a medicine, that is not a controlled drug, is already prescribed, a doctor/dentist may authorise a change in the prescribed directions without written authorisation, for example a change in dose or frequency. The verbal direction of the doctor/dentist must be given to the designated person in charge, administration recorded immediately and certified by the doctor/dentist preferably within 24 hours. Where the verbal direction is received by telephone, the nurse/midwife must acquaint the doctor/dentist with the names and doses of other medicines currently prescribed, the allergy status and write down the verbal direction before reading back the patient's name, medicine, dose, route and time of administration to confirm details have been correctly understood and recorded. The use of information technology (such as text message or email) may also be used to change prescribed directions for a medicine that is already prescribed, which must be certified by the doctor/dentist preferably within 24 hours.

Verbal directions for changes to previously prescribed controlled drugs are not permitted.

Verbal directions for changes to previously prescribed medicines by an independent/supplementary prescriber or community practitioner nurse prescriber are not permitted.

An authorised patient group direction is one that has been approved by the Trust Medical Director, the Executive Director of Nursing and the Director of Pharmacy.

In general, medicines may be administered to patients by an approved practitioner. An approved practitioner for the administration of medicines is a registered nurse, midwife, authorised prescriber and where a second practitioner is required, may be a registered pharmacist. Other registered healthcare staff, for example a podiatrist, may be an approved practitioner for the administration of certain medicines where this is within the course of their practice and they have been trained in the administration of such medicines.

Non-registered community care staff may only be involved in the administration of medicines where they have received appropriate training in handling and administration of medicines in question and following training have been deemed competent using the agreed Trust framework.

Other individuals such as parents, carers, patients and students may be involved in the administration process; however it must be under the direct supervision of an approved practitioner, who retains full responsibility for the administration process. Where a second person is recommended for preparation and administration, parents, carers, patients and students do not replace the need to use a second practitioner if available. However it is acknowledged that parents, carers, patients and students may be the only available second person to be involved in the preparation and administration. Where a parent, carer, patient or student is the second person involved, the approved practitioner retains full responsibility for the preparation and administration process.

All practitioners involved in the administration of medicines are individually accountable for their actions.

Where possible two practitioners are also recommended for the preparation and administration of:

- Controlled drugs
- Insulin
- Intravenous medicines, including intravenous infusions and bolus injections
- Warfarin
- Medicines where a calculation is required for the dose, concentration or rate of administration
- Medicines for neonatal patients
- Parenteral cytotoxic medicines

However it is acknowledged that two practitioners may not routinely be available in a patient's home. In the case of controlled drugs, NMC guidance recommends that for the administration of Controlled Drugs in a patient's home, where a registrant nurse is administering a Controlled Drug that has already been prescribed and dispensed to that patient, obtaining a secondary signatory should be based on local risk assessment.

Where a second practitioner is asked to check a calculation, they must perform their own calculation independently before comparing with the first practitioner's answer.

Where a second practitioner is involved in the administration of medicines, they must be involved in the entire preparation and administration process including checking the actual administration to the patient and the use of any medical devices required for administration, for example setting the rate on an infusion pump.

Where the setting on an infusion pump is to be adjusted during an infusion, two practitioners are recommended to adjust the setting and make a record on the patient's infusion record. This includes stopping and restarting an infusion after a temporary interruption.

Patients discharged on a continuous subcutaneous syringe pump should be discharged with four days' supply of medication, a discharge prescription and a new 'Prescription and administration record of medicines via subcutaneous CME T34 syringe pump' chart. The chart should be used by community nursing to record preparation and administration of medicines until the four days' supply of medicines runs out or the prescription is changed, whichever is sooner. A new record should then be obtained from the patient's GP together with a new prescription for further supply of medicines. 'Breakthrough medicines' should be administered as required using the discharge prescription as the authorisation to administer. A record of administration should be made on the nursing Medicine Administration Record until the patient's GP is able to write a 'Prescription and administration record of subcutaneous medicines for breakthrough symptoms in primary care'.

Where a second person is recommended for preparation and administration it is acknowledged that within the community setting parents, carers, patients and students may be the only available second person to be involved. Where a parent, carer, patient or student is the second person involved, the approved practitioner retains full responsibility for the preparation and administration process.

The identity of patients should be confirmed prior to administration of medicines.

It must be confirmed that the patient is not allergic to or intolerant of any medicines prescribed (including any constituents of combination medicines).

Prior to administering any medicine, review the Direction to Administer in use and check:

- That the name on the prescription(s) matches the name of the patient intended to receive the medicine
- That the medicine administration is due
- The date, time, dose, frequency, route of administration and, where appropriate, the dilution and rate of administration of the prescribed medicine
- The duration of therapy
- That the dose(s) of medicine has not previously been administered and if 'as and when required' medication that interval between doses is adequate and the total dose, where applicable, will not be exceeded; and
- Any special requirements.

Any ambiguities, lack of clarity or doubt as to the accuracy, safety, completeness or appropriateness of a prescription should be referred to the prescriber or a pharmacist, as appropriate, before administering the medicine.

Select the medicine required, taking particular care to ensure it is the correct medicine, at the correct strength, in the correct formulation, within the expiry date and is not obviously defective.

If there is any concern that the medicine selected is defective in any way, do not administer the medicine, report this to the Pharmacy Department or the on-call pharmacist and retain the medicine so that it can be forwarded to the Pharmacy Department for further investigation.

Where a medicine requires preparation prior to administration, the practitioner must ensure they are aware of the correct method of preparation, diluents and expiry dates of the prepared medicine by referring to the Summary of Product Characteristics, Medicines Information or the on-call pharmacist.

Where a medicine has been dispensed for an individual patient, it must be administered only to that patient.

Where a syringe is required for the preparation and/or administration of an oral liquid medicine, an oral/enteral syringe must be used. A bung should be obtained (where possible) to make measurement easier.

Prior to administering the selected medicine, it is important that practitioners have a clear understanding of the main effects, side-effects and usual dose of the medicine and ensure there are no obvious contra-indications to the patient receiving the medicine. It may on occasion be just as important not to administer a medicine that is judged to be inappropriate for the patient's condition, in which case the prescriber must be informed at the earliest opportunity so that the prescription is reviewed.

The practitioner administering the medicine must ensure that the patient takes, uses or receives the medicine being administered.

The practitioner who has administered or supervised the administration of a medicine must record this in black indelible ink on the administration record immediately after administration.

If the patient refuses or for any other reason, does not receive a prescribed medicine, this must be clearly documented on the administration record. A comprehensive record of such omissions and the action taken must be made in the patient's notes. The medicine not administered must be disposed of in accordance with the Trust Waste Disposal Policy and under no circumstances may it be returned to the original container.

Any events that occur in the administration of medicines, which could have or did lead to patient harm, loss or damage, must be managed and reported in accordance with the Trust Clinical Incident Reporting Policy.

8.3 Student involvement in medicines administration in community/primary care

In the Medicines Code the term student nurses/midwives applies only to nursing and midwifery students undertaking a programme of education leading to professional qualification and primary entry to the Nursing and Midwifery professional register, and to those students undertaking a

programme of education that leads to movement within parts, or to another part of the Nursing and Midwifery professional register, for example Adult to Mental Health Nursing. This excludes existing registrants who are on specialist practice programmes such as DN that lead to a recordable qualification from these restrictions.

Student nurses/midwives may administer medications under the supervision of one registered nurse.

For medicines to be given by IV bolus or IV infusion, the student can be involved in the preparation and administration of the medicine under the supervision of two registered nurses/midwives. The two registered nurses/midwives must be present throughout the preparation and administration of the medicine.

For medicines where a calculation is required, students may be involved, but again two registered nurses/midwives must check and confirm the calculation.

Student nurses /midwives can be involved in the administration of controlled drugs under the supervision of two registered nurses / midwives. The student nurse / midwife must sign the controlled drug register and have it countersigned by the two registered nurses.

Student nurses/midwives must not be involved in the supply or administration of any medicine under Patient Group Direction or midwives exemption.

8.4 Assisting patients/clients to take their medicines in the domiciliary care setting

Only domiciliary care staff who have been trained and deemed competent yearly are permitted to assist service users with their prescribed medicines.

Service users may require assistance with their medicines by trained domiciliary care where a 'face to face' assessment has been carried out by the key worker, all avenues have been pursued and there is no family member/carer/significant other available to support the service user with their medications.

Domiciliary care workers should not agree to family or carer requests to change or add to duties involving medicines until they have been approved by their line manager and documentation in place.

Domiciliary care staff must only assist with medication at the level detailed service user held care plan. If the Domiciliary Care Worker feels that a service user requires more assistance with their medicines than outlined in the care plan then this must be reported to their line manager as soon as possible.

There are two levels of support that domiciliary care staff can facilitate:

Level 2

The Service user **maintains control** of their medications but needs **assistance** in the form of assistance to open bottles/packets due to physical problems e.g. dexterity or mobility difficulties. These tasks must have been consented to and agreed and the Level 2 medication care plan must specify the exact action to be taken by the Domiciliary Care Worker. All tasks must be completed within the presence of the service user and the service user retains responsibility for their medicine management. No medication instruction sheet is required but all assistance given must be recorded in the home documentation.

Level 3

The Service user is **unable to take responsibility** for medications and requires the Domiciliary Care Worker to give medications from a Monitored Dosage System (MDS) or original packaging. A medication instruction sheet must be in the service user held care plan giving the Domiciliary Care Worker permission to administer medicines out of the MDS and detailing the medication to be given out of the original container.

The service user must give their consent (or where he or she is not able to give informed consent, his or her representative) to being given assistance with their medicines.
Non-registered domiciliary care staff may only be involved in assisting service users to take their medicines where they have received appropriate training in handling and assisting service users to take their medicines and following training have been deemed competent to assist service users to take their medicines and are hereafter referred to as trained domiciliary care staff. Domiciliary care staff must have their competency reviewed on an annual basis.

Training/competency arrangements for domiciliary care staff who are required to assist service users with their prescribed medication is outlined in the 'Education and Training Competency Framework for non-nursing staff working in Domiciliary Care and Day Care, Residential Care and Supported Living Settings' (available on the intranet under www.southernguidelines.hscni.net).

All trained domiciliary care staff involved in assisting service users to take their medicines are individually accountable for their actions.

Trained domiciliary care staff may only assist service users to take their medicines in the form dispensed by their community pharmacist i.e. a labelled container of medicines or a sealed MDS (for example a Medidose®) that has been filled by the service user's pharmacist.

Unsealed monitored dosage systems filled by community pharmacists are not acceptable and domiciliary care workers must contact their line manger if they are asked to administer from such a system.

Trained domiciliary care staff may not assist service users to take their medicines from a monitored dosage system that has been filled by the patient/client or a member of the patient/client's family.

Trained domiciliary care staff must not be involved in either conducting or checking calculations.

Where a controlled drug medication is to be administered out of the original container, two domiciliary care workers should be involved where possible. See 'Standard Operating Procedures

for the Safer Management of Controlled Drugs in Domiciliary Care, Day Care, Supported Living Schemes, Residential and Trust Nursing Homes' (available on the intranet under www.southernguidelines.hscni.net).

Where a controlled drug patch is to be applied by domiciliary care staff, the community nurse must carry out an additional checklist with the staff involved.

Trained domiciliary care staff should not assist service users to take medicines that require complex preparation prior to administration, for example, injections. Trained domiciliary care staff will ordinarily only be involved in assisting service users to take oral medicines. They may also be involved in assisting service users with topical and inhaled medicines when they have appropriate training and been deemed competent in the task required.

Where a medicine regime is complex the community nurse will be responsible for liaising with the family/GP/domiciliary care/ community nursing with regard to seeking possible solutions to reduce complexity.

The Trust definition of a complex medicine regime for a domiciliary care worker is;

- medication from a Monitored Dosage System plus more than three medicines from the original container at any administration time,

or

- more than three medicines from the original container at any administration time.

Other factors need to be considered, for example the number of liquid medicines and the stages and complexity in preparation of the medicines. Each scenario requires individual assessment and there may be occasions when it is agreed that Domiciliary Care Workers can assist with medications above this defined level for example if the medicines are low risk.

Domiciliary Care Workers are only permitted to measure up one liquid medicine that requires to be measured up in an oral syringe.

Trained domiciliary care staff must not be involved on the administration of medicines requiring use of infusion devices or syringe pumps and they must not be involved in the administration of insulin.

Trained domiciliary care staff must not be involved in administration of warfarin unless it is in the sealed MDS.

Trained domiciliary care staff may only be involved in administration of an Epipen or buccal midazolam where the Domiciliary Care Worker has had service user specific training by an appropriate qualified Health Care Professional and signed onto to service user's care plan

Trained domiciliary care staff cannot be expected to understand the main effects, side-effects and contraindications of the medicine to be administered however they are expected to ensure the dose being administered corresponds with the medication instruction sheet/medicine label and raise any concerns that they have with their line manager.

Trained domiciliary care staff who are involved in or discover a medication incident should report it immediately to their line manager, who will decide what action is necessary. Domiciliary care workers must not try to manage such an incident themselves; they must contact their line manager.

Domiciliary care line managers must manage and report medication incidents in accordance with the Trust Clinical Incident Reporting Policy and the requirements of RQIA.

8.5 Disposal of medicines

If a service user refuses to take their medication a single dose, such as a capsule or tablet, it may be disposed of by flushing it down the toilet in the house. Any larger quantities of medicines that are no longer required must be returned to the community pharmacy that supplied them. The service user's family or carer should be asked to arrange this. Only in exceptional circumstances and with the agreement of their line manager, should a trained domiciliary care worker return such medicines to a community pharmacist. The domiciliary care worker should sign for quantity of each medicine taken to the community pharmacy.

8.6 Transport of medicines

Trained domiciliary care workers should not be collect medicines from community pharmacies for service users. This is the responsibility of the service user's family or carer. Only in exceptional circumstances and with the agreement of their line manager, should a trained domiciliary care worker collect medicines from a community pharmacy. This activity must also be clearly recorded in the service user's care plan in advance.

Chapter 9 Self-administration of Medicines by patients/residents/clients

The Trust welcomes and supports the self-administration of medicines by patients/residents/clients. Self-administration of medicines is where patients/residents/clients are responsible for storing and administering their own medicines where these would otherwise be administered by trust staff, with practitioners or trained care staff acting as supervisors and monitors of the process. However, the necessary safety, security and storage arrangements must be available together with appropriate records and as such self-administration of medicines should only occur as part of an approved scheme for self-administration, with the exception of glyceryl trinitrate spray, salbutamol inhaler and terbutaline inhaler.

Self-administration of medicines by patients in hospital and by residents/clients in residential care, nursing homes and day care centres may be appropriate in certain circumstances e.g. to increase compliance and understanding by patients with complex regimens, to teach patients how to take their medicines such as inhalers, to preserve independence, to prepare those in short-term care for return to the community or in a move to more independent living arrangements in the community; for example adolescents leaving residential care and moving to independent living.

Self-administration of medicines should not be confused with patients/residents/clients being involved in the administration of their medicines under direct supervision of practitioners for the purposes of training and education for example as part of the discharge process.

Schemes for self-administration of medicines should also not be confused with patients who are attending for day case treatment in the Mandeville Unit or the Renal Unit and are independent with their medication at home. These patients should continue to take their regular medication in accordance with their own doctor's directions and remain independent, provided they can retain personal control of their medication about their person at all times. A record of the patient's medication history should be maintained within the case notes. However should a patient not be independent with their medicines at home and require administration of their regular medicines by staff, any medicines due must be prescribed by an authorised Trust prescriber and administered in accordance with their written directions and any patient's own medicines brought into hospital should be stored securely by staff.
The Medicines Optimisation Committee must approve all procedures for self-administration of medicines by patients.

Chapter 10 Ordering and Receipt of Medicines

10.1 Trust Hospitals

10.1.1 Wards and Departments Stock Medicines Top-Up Service

Each ward/department should have a list specifying which medicines should be held as stock. This list will be specific to each ward/department.

The Ward Pharmacist responsible for the ward/department, the Senior Ward Technician and the Ward/Department Manager will agree the list of medicines and review it at regular intervals. This review will take into consideration all medicines issued in the previous three months.

The Pharmacy Department will provide a top-up service to certain wards/departments at least once weekly (more often where deemed appropriate), based on available resources. Where a pharmacy staff member is not provided to write the top-up, the ward/department manager should appoint a member of ward/department staff to undertake this task.

In departments where a weekly top-up service is not provided then the person responsible for that area may order stock items on a pharmacy requisition.

All documentation should be signed and dated and retained at ward/department level for 3 month. The Pharmacy Department will retain a copy of all top-up requisitions and delivery signature sheets for each ward/department for 2 years.

If the ward/department with a top-up service runs out of stock medicines then a supply can be obtained from the Pharmacy Department by completing a pharmacy requisition.

Craigavon and Daisy Hill Hospitals

All top-up orders shall be delivered to ward/department by the Pharmacy Porter in a secure box with a tamper evident seal on a trolley. The empty trolley will be collected from the ward / department before the next morning.

All top-up orders should have a delivery docket attached to the outside of the box. This docket should be signed and dated by a registered nurse/ midwife upon receipt of the top-up and given back to the Pharmacy Porter immediately.

The ward/department manager should appoint a member of staff to check off the top-up order against the copy order and all discrepancies should be reported to pharmacy stores no later than the next working day.

South Tyrone, Lurgan and St Luke's Hospitals

All top-up orders shall be assembled in the Craigavon Hospital Pharmacy and then delivered in a secure box with a tamper evident seal to secure storage area for pharmacy in the Hospital by the

Trust Transport Department. The sealed boxes will then be delivered to the ward/department by a porter.

All top-up orders should have a delivery docket attached to the outside of the box. This docket should be signed by a registered nurse/ midwife upon receipt of the top-up and posted back to the Pharmacy Department Craigavon Hospital immediately.

The ward/department manager should appoint a member of staff to check off the top-up order against the copy order and all discrepancies should be reported to pharmacy stores no later than the next working day.

10.1.2 Hospital Wards and Departments Non Stock Medicines

Non stock medicines can be ordered using a pharmacy requisition book, ward computer order and Integrated Medicines Management (IMM) patient profiles by the IMM technician, where the ward receives the IMM service.

Medicines not held as stock on wards/departments should be ordered on a pharmacy requisition. The requisition book should be stored in a locked cupboard or drug trolley, as it is controlled stationary. The pharmacy requisition should be completed with all the relevant details according to and signed by a registered nurse / midwife or department manager. For security reasons, the person signing the requisition should draw a line through all unused order lines on the requisition, so that additional items may not be added by an unknown person.

The Pharmacy Department must document the issue of all pharmacy requisition books, recording the ward, requisition numbers and the name of the persons issuing and receiving the requisition book. These records must be kept for two years.

Non stock medicines should be delivered to ward/department by the Pharmacy Porter in a secure box with a tamper evident seal. In the case of South Tyrone, Lurgan and St Luke's Hospitals the Trust Transport department will deliver the non-stock medicines in a secure box with a tamper evident seal to the secure storage area for pharmacy and then the boxes will be delivered to the ward/department by a porter.

All non-stock orders should have a delivery docket attached to the outside of the box. This docket should be signed immediately by a registered nurse / midwife upon receipt of the order and given to the Pharmacy Porter or in the case of South Tyrone, Lurgan and St Luke's Hospitals posted to the Pharmacy Department, Craigavon Hospital.

The ward/department manager should appoint a member of staff to check off the non-stock order against the pink copy of the requisition and all discrepancies should be reported to the Craigavon Area Hospital Pharmacy Dispensary the same day but no later than the next working day. The pink copy of the requisition should be returned to the Pharmacy department Craigavon Hospital as soon as the order has been checked. In Daisy Hill Hospital the yellow copy should be returned to the pharmacy.

Where a ward/department orders pharmacy items using the Ward computer ordering facility, access to pass codes/terminals should be restricted to Designated Persons. Each person will have their own computer user ID and password assigned to them. . It is important that when a member of staff has completed a ward order session they must complete the requisition and log off.

On delivery, the copy of the ward ordering requisition should be signed and returned to Craigavon Pharmacy Dispensary.

10.1.3 Faxed Pharmacy Supplementary Requisitions (South Tyrone, Daisy Hill and Lurgan Hospitals only)

In the case of wards/departments at South Tyrone, Lurgan and ST Luke's Hospitals faxed stock and non-stock orders are accepted by the Craigavon Area Hospital pharmacy. The ward/department should phone the Craigavon Area Hospital pharmacy dispensary prior to faxing the order and then forward the completed pharmacy requisition indicating the date and time the fax was sent. Any ambiguities about the faxed order must be clarified prior to the release of any order from the pharmacy department.

At the weekend, when the Pharmacy at Daisy Hill Hospital is closed, non-urgent faxed stock and non-stock orders will be accepted by the Craigavon Area Hospital pharmacy. The ward/department should phone the pharmacy dispensary at Craigavon Hospital prior to faxing the order and then forward the completed pharmacy requisition to the Craigavon Area Hospital pharmacy indicating the date and time the fax was sent. Any ambiguities about the faxed order should be clarified prior to the release of any order from the Pharmacy department. The ward should then arrange transport to go to the Craigavon Area Hospital pharmacy to collect the item.

If an item is required urgently at the weekend, then the Daisy Hill Hospital on-call pharmacist should be contacted as normal.

10.1.4 Verbal Requests

Verbal requests will only be accepted for stock and non stock orders by the on-call pharmacist when the Pharmacy is closed. A completed signed pharmacy requisition must be given to the on-call pharmacist at the time of delivery/collection of the item.

10.1.5 Borrowing Medicine

(See also Chapter 15 Transfer of Medicines)

During pharmacy opening hours medicines must **NEVER** be borrowed from another ward/department. In the case of wards in South Tyrone, Lurgan and St Luke's Hospitals borrowing of medicines during pharmacy opening hours may only happen in an emergency situation and must be authorised by a pharmacist on site or, if they are not available, the Craigavon Area Hospital Pharmacy Dispensary. That pharmacist will ensure that a replacement supply is organised and forwarded to the ward as soon as possible.

Outside pharmacy opening hours, medicines should be transferred from one ward to another **only in exceptional circumstances**.

Exceptional circumstances include:

- Life threatening emergency
- The dose of the medicine concerned cannot wait until the pharmacy reopens
- When it is not possible to wait 30 minutes for the on-call pharmacist to travel to the hospital to supply the item
- When the on-call duty pharmacist knows that the only stock of the item in the hospital, is being held by another ward

This must only take place when Pharmacy is closed. In such cases the smallest original pack should be supplied. The transfer of any medicine from one container to another, other than by Pharmacy Staff, is forbidden. Borrowing of medicines must be documented using a Drug Transfer Record Form. It is the responsibility of the ward requesting the medicine to complete the form.

All documentation with regard to transferring medicines (borrowing) must be completed and sent to the Pharmacy Department for the attention of the Dispensary Manager or the Pharmacy Patient Services Manager.

Medicines must NEVER be transferred from one container to another, nor should parts of blister packs be borrowed. In the event of an emergency the original labelled container supplied by the Pharmacy Department should be transferred to the borrowing area.

Controlled drugs should NEVER be borrowed. The only exception to this is in a life threatening emergency when the pharmacy is closed, the thirty minutes it will take the emergency pharmacist to get to the hospital will be too long and the transfer has been authorised by the on-call pharmacist.

10.1.6 Obtaining medicines outside normal pharmacy opening hours

When the Trust Pharmacy Departments are closed the Trust pharmacists operate an on-call service for the Trust hospital wards and departments. There are two services provided:

- Daisy Hill Hospital Pharmacy – providing an emergency pharmacy service for the wards and departments in Daisy Hill Hospital; and,
- Craigavon Area Hospital Pharmacy – providing an emergency pharmacy service for the wards and departments in Craigavon Area Hospital, South Tyrone Hospital, Lurgan Hospital and St Luke's Hospital site.

If a medicine is required and cannot wait until the pharmacy reopens, the ward/department Sister/staff nurse/midwife in charge should ask the bed manager/Hospital at Night Coordinator for the hospital concerned to contact the on-call pharmacist, via the hospital switchboard.

For both Craigavon Hospital Service and the Daisy Hill Hospital Service the switchboard telephones the relevant pharmacy on-call mobile phone.

The on-call pharmacist is based at home and carries the on-call mobile phone.

The emergency cover arrangements must only be used when the Pharmacy Department is closed.

The Trust Pharmacy On-call Service may only supply Trust facilities and, in certain circumstances, other Trust Pharmacies and registered community pharmacies. It cannot be used by non-Trust facilities, General Practitioner or the public.

10.2 Trust GP Out of Hours Centres

The Trust GP Out of Hours Centres obtain the majority of their medicines from community pharmacies via the 'stock prescription' system.

In cases where the pack size of the medicine required is not available on the Drug Tariff the stock may be requisitioned from the Pharmacy in Craigavon Area Hospital. Medical and surgical items such as nebuliser chambers and masks are ordered from Supplies in Craigavon Area Hospital.

The Trust GP Out of Hours Centres do not stock controlled drugs.

If the Out of Hours Service requires a medicine that it does not hold in stock or needs to have a prescription dispensed they should contact a community pharmacist as per the Out of Hours Service policy.

However in exceptional circumstances the Trust GP Out of Hours Centres may contact the Trust on-call Duty Pharmacy Service for a supply, for example a medicine required to make up a syringe pump for a palliative care patient in the community at a time when all the community pharmacies are closed.

The on-call pharmacist is not permitted to supply controlled drugs to the GP Out of Hours Service or to any GP under any circumstances. the GP service should contact a community pharmacy, using the list of palliative care support pharmacies and oxygen suppliers available in the Trust GP Out of Hours Centres.

10.3 Trust Residential Homes, Day Care Centres, Supported Living Facilities and Respite Centres

Patients/clients in Trust residential homes, day care centres, supported living facilities and respite centres obtain all their medicines via a prescription from their General Practitioners, which are dispensed by a community pharmacy.

Supplies of medical and surgical items, such as enteral feeding sets may be ordered by Trust facilities from the Craigavon Area Hospital pharmacy or Supplies department using a requisition.

10.4 Trust treatment rooms

The treatment rooms staffed by Trust nursing staff obtain their supplies of medicines and adult vaccines from community pharmacy, via the 'stock prescription' system.

Stocks of vaccines for childhood immunisations are obtained, via the local procedures in place, from the Craigavon Area Hospital Pharmacy using Trust requisitions or standard stock sheets.

Note: Supplies of vaccines for childhood immunisation must not be used for travel or adult immunisations.

Supplies of medical and surgical items, such as enteral feeding sets and masks for nebulisers etc. may be ordered from the Craigavon Area Hospital pharmacy or Supplies Department using a requisition.

10.5 Health Visitors, District Nurses, School Nursing

Stocks of vaccines for childhood immunisations are obtained, via the local procedures in place, from the Craigavon Area Hospital pharmacy using Trust requisitions or standard stock sheets as appropriate.

Note: Supplies of vaccines for childhood immunisation must not be used for travel or adult immunisations.

Supplies of medical and surgical items, such as enteral feeding sets and masks for nebulisers etc. may be ordered, via the local procedures in place, from the Craigavon Area Hospital pharmacy or Supplies Department using Trust requisitions or standard stock sheets as appropriate.

10.6 Trust Community based Podiatrists/clinics

Supplies of medical and surgical items, such as dressings, felts, tofoams, swanfoams etc. may be ordered via the local procedures in place, from the Craigavon Area Hospital pharmacy using Trust requisitions or standard stock sheets/forms as appropriate.

10.7 Trust Community based Dental clinics

Supplies of medicines, such as, antibiotic pastes, local anaesthetics etc. and other items used in dental procedures should be ordered via the local procedures in place, from the Craigavon Area Hospital pharmacy using Trust requisitions or standard stock sheets as appropriate.

10.8 Trust Family Planning Clinics

Supplies of family planning medicines, and other family planning items should be ordered via the local procedures in place, from the Craigavon Area Hospital pharmacy using Trust requisitions or standard stock sheets as appropriate.

Chapter 11 Storage and security of medicines

From the time of receipt to use or removal from the organisation/disposal, all medicines must be kept secure, with access only by authorised personnel. (This includes medicines brought in to a Trust facility by the patient but not required for treatment and held prior to return to the patient or disposal). The legal requirements related to the category of medicine should be applied.

At each stage where a medicine changes hands, there should be clear procedures explaining where the responsibility lies, what should be recorded and how often stock reconciliation should take place.

The Director of Pharmacy is responsible for establishing systems for the safe and secure storage of medicines within the Trust.

11.1 Storage and security of general medicines

The Sister/Charge Nurse/nurse/midwife manager/manager for a ward, department, home, day care centre or other Trust facility is responsible at all times for medicines stored in the ward, department, home, centre or Trust facility. In certain areas, such as radiology departments, specific additional procedures may be drawn up by the responsible manager and agreed by the Medicines Management sub group of the Medicines Optimisation Committee.

All medicines, reagents and disinfectants must be stored in separate locked cupboards, trolleys or others secure receptacles, for example bedside lockers specifically designed to hold medicines securely.

The only exception to this requirement are the storage of intravenous fluids and sterile topical fluids which, because of their bulk, are stored in a secure clean area, as agreed between the nurse manager and the Director of Pharmacy or the Pharmacy Patient Services Manager.

Internal medicines should be stored separately to those for external use. Medicines for internal use must be stored separately from all other medicines, disinfectants and reagents. In addition medicines for epidural use must be kept in a separate cupboard from other parenteral products.

Medicines in current use may be stored in a trolley which must be kept locked and secured to a sturdy wall (i.e. brick, not plasterboard) when not in use. The trolley should not normally be left unattended when not secured but if this is unavoidable the trolley must be left locked.

All such cupboards and trolleys must be kept locked when not in use.

Cupboards and trolleys should be sited where it is most convenient for nursing staff, allowing them adequate space and permitting surveillance to afford maximum security against unauthorised entry.
Medicines cupboards should, when possible, be sited in a clean utility room to which the general public does not have access. If feasible, the room should have keypad access or be kept locked to prevent unauthorised access.

Areas that are unoccupied for any substantial amount of time i.e. overnight or over a weekend must either be alarmed or return their controlled drugs to pharmacy for safe storage when unoccupied. Please contact the Pharmacy for further advice in relation to this issue.

Cupboards should not be sited above or near radiators or major sources of heat, nor above or below sinks where they may be subject to higher than average humidity.

Reagent cabinets should be sited in areas where point of care testing is carried out, but not in areas routinely accessed by patients or members of the public.

The cupboards used must conform to the relevant British Standard or be otherwise approved by the Pharmacy Patient Services Manager. The cupboards used for disinfectants must also be suitable for the products' COSHH categories and any requirements to keep certain disinfectant products apart.

Medicines must not be transferred from one container to another, nor must they be taken out of their container and left loose.

Medicines stocks in the ward, department, home, day care centre or other Trust facility should be reviewed at regular intervals by the Sister/Charge Nurse/nurse manager / manager to ensure that stocks are kept to a minimum. In hospital wards, a member of pharmacy staff may assist the Sister/Charge Nurse/nurse manager in this task.

Expiry date checks should be carried out regularly and any short dated stock should be returned to pharmacy. This ensures that expired stock is not given to or used on patients and also reduces waste as often the stock can be used elsewhere before it expires.

The necessity of checking stock balances of medicines other than controlled drugs should be left to the discretion of the individual Sister/Charge Nurse/ ward manager/manager. If, however, there is a suspicion of medicine abuse this should be reported to the nurse manager, head of service and ward pharmacist or, for community based facilities, to the Director of Pharmacy. If the ward/unit does not have a pharmacist the pharmacy patient services manager should be contacted. The stock balance of the item(s) in question should be recorded and regular checking introduced in a confidential manner without alerting other members of staff. If this shows on-going discrepancies, the Director of Pharmacy, the Director of Nursing and/or the Medical Director may decide to instigate further investigations under the guidance of the police.

Sister/Charge Nurse/midwife/ manager of hospital wards and departments should review the usage of potential drugs of abuse report, provided by the Trust pharmacy department, on a monthly basis. If there are any abnormal usage levels that cannot be explained by the patient population on the ward, their line manager and the Director of Pharmacy should be contacted for advice.

All staff should be aware of the signs that may indicate abuse or diversion of medicines. (e.g. changes in an individual's behaviour such as lack of concentration, regular unexplained absences from work area, a change in character, 'odd' behaviour or other changes such as loss of stock and excessive ordering) and take appropriate action.

Trust staff may not take any medicine stored on a ward for their own or another member of staff's use. See Chapter 17 for more information on this subject.

11.2 Controlled drugs (CDs)

A ward, department or Trust facility may not store CDs unless there is an appropriately qualified person responsible for their storage and use.

All CDs must be kept in a locked metal cupboard specifically designated for that purpose which meets the required specification. No other medicines or items should be stored in this compartment and the lock must not be common to any other lock.

The CD requisition book must be stored in the CD cupboard to prevent unauthorised use.

Areas that are unoccupied for any substantial amount of time i.e. overnight or over a weekend must either be alarmed or return their controlled drugs to pharmacy for safe storage when unoccupied. Please contact the Pharmacy for further advice in relation to this issue.

Details of the receipt, administration and disposal of controlled drugs must be made in the ward, department, home or centre's controlled drugs register. The CD register and the CD requisition book must be retained by the ward, department, home or centre for a minimum period of two years from the date of the last entry in case they are required for inspection by the DHSSPSNI Inspectorate.

The Controlled Drug register must be retained in the clinical area for a minimum period of thirteen years from the date of the last entry in the register. Controlled Drug requisition books must be retained in the clinical area for a minimum period of two years from the date of the last entry in the book. This is the responsibility of the ward/department manager.

Stocks of CDs in wards, departments, nursing/residential homes, day care centres and other facilities must be checked at the morning and evening shift changes. In the hospital setting two registered nurses /midwives must undertake this procedure, the Sister/Nurse in Charge from the outgoing and Sister/Nurse in Charge from the incoming shift. In homes and care centre this may be undertaken by the manager and/or a senior member of care staff. Any discrepancies must be reported immediately to the nurse/midwife or manager in charge, the relevant senior manager/head of service and, in hospital, the pharmacist responsible for the ward/department/facility. Outside normal pharmacy opening hours the on-call pharmacist should be contacted and informed of the discrepancy. A thorough investigation must be carried out and if this fails to identify the cause of the discrepancy this should be reported immediately to the Director of Pharmacy and the relevant senior manager.

In theatres and day surgery unit the controlled drugs must be check at the start and finish of each operating session.
In certain Trust community facilities the shift change only occurs once every 24 hours and in this circumstance it is acceptable to check the controlled drug stock once daily, at the shift handover.

Detailed controlled drug standard operating procedures for hospital based facilities are available on the Trust intranet and from the Trust Pharmacy Departments. Each hospital based ward or facility that uses controlled drugs should have a hard copy of these procedures along with a signature sheet recording the staff who have read and are authorised to apply the standard operating procedures.

11.3 Refrigerators

A separate refrigerator should be used solely for the storage of medicines requiring refrigeration. Food or pathological specimens must not be stored in this refrigerator.

Wards or departments storing intrathecal chemotherapy products must have a dedicated refrigerator for this purpose.

All refrigerators containing medicines must be kept locked at all times.

A maximum/minimum refrigeration thermometer, available from Supplies, must be kept in the refrigerator.

The maximum and minimum temperature achieved by the fridge must be recorded twice daily. Once a reading is taken the thermometer must be reset. The temperature recording sheet, showing the date and time of the reading, the maximum and minimum temperature and the signature of the person who took the reading must be retained on the ward /facility and be available for inspection for a period of five years. This is the responsibility of the ward/facility manager. Such records must be kept for 5 years as they may be requested as during enquiries into product failure, for example vaccine failures.

The acceptable temperature range for a medicines refrigerator is between 2 and 8 degrees centigrade.

All wards, departments, homes, care centres and facilities must have a procedure that outlines the action to be taken if the temperature goes outside this range.

In the event of a problem with a refrigerator, it is the ward manager/ facility manager's responsibility to contact maintenance to arrange repair.

Pharmacy may be contacted for advice on action to be taken in relation to any medicine that has been stored above or below its recommended temperatures.

It is prudent to ensure that the electricity supply to the refrigerator cannot be turned off inadvertently.

11.4 Resuscitation trolley

A Resuscitation trolley should be located where it is readily accessible in an emergency and where surveillance will prevent unauthorised access. The door/lid of the trolley must be secured with a tamper evident seal.

11.5 Stationery used to order medicines

Any stationery used to order medicines is considered controlled stationery. This includes stationery used to order stock medicines, and medicines to be given to patients to take away on discharge or at a clinic – for example requisition books and discharge prescription pads.

The senior nurse or midwife/nurse manager/manager in charge is responsible for the safekeeping of all controlled stationery. Stationary used to order stock and non-stock medicines should be kept under lock and key e.g. in the medicine trolley.

Controlled stationery for ordering controlled drugs must be kept under lock and key to prevent unauthorised use.

Completed order forms and delivery documentation is retained by the Trust pharmacies for two years. In hospital, a copy of the discharge prescription form must be filed in the patient's medical record and an original signed copy is held by Pharmacy.

11.6 Community prescription pads (HS21s)

GPs, Community Nurse Practitioners and community based independent/supplementary prescribers must ensure the security of their prescription pads at all times by adhering to the following guidance:

- Prescription pads must not be left unattended at any time, for example in a patient's home, at receptions desks, etc.
- Prescription pads must not be left in a car where they may be visible.
- When not in use prescription pads must be kept in a locked drawer either in the surgery, the office or at home.
- When new/replacement prescription pads are delivered to a reception area, the staff who will receive them must be told to expect them and how to secure them correctly until the designated person can collect them.
- Prescription pads must never be sent via internal mail.
- It is the prescriber's responsibility to keep a record of the serial numbers of their prescription pads.

If such a prescription pad is missing it must be reported immediately to the prescriber's line manager and then to the Director of Pharmacy, giving details of the pad(s) serial number. The Director of Pharmacy will then inform:

- the CSA (telephone Irrelevant information redacted by the USI); and,
- the Drug Squad (telephone Irrelevant information redacted by the USI).

The line manager is also required to report the incident via the Trust incident reporting system, to investigate the circumstances around the loss of the pad and to produce a report for the Director of Nursing and the Director of Pharmacy, which can be shared with the DHSSPSNI Medicines Inspector.

It is the responsibility of the line manager to ensure that:

- prescription pads are retrieved from prescribers who leave their employment for whatever reason;
- no further prescription pads are ordered for a prescriber who has left his/her employment or who has been suspended from prescribing duties, and all unused prescription forms are recovered, recorded and securely destroyed relating to that prescriber; and,
- prescription pads should be securely destroyed, e.g. by shredding and putting into confidential waste. It is advisable to record first and last serial numbers of the pads destroyed.

11.7 Closure of a ward, department or Trust facility

When a ward, department or Trust facility closes for a short period (seven days or less) the medicines, with the exception of the controlled drugs, may stay in the ward or department provided there is adequate security to prevent unauthorised access to them. This must be agreed by the appropriate Sister/Charge Nurse/nurse manager and the ward's pharmacist or Patient Services Manager, or, in the case of community based facilities, the Director of Pharmacy.

When a ward, department or Trust facility is to be closed for a period longer than seven days all medicines must be returned to the pharmacy department for secure storage. This must be arranged in advance with the Pharmacy Patient Services Manager.

For wards, departments or Trust facilities that hold CDs, the ward or department's Sister/Charge Nurse must hand the CDs personally to the ward pharmacist. With the Sister/Charge Nurse, the pharmacist must check the CDs against the levels stated in the controlled drugs register and then sign the appropriate sections of the register. The CDs must be placed in a secure sealed container along with the register and stored in the pharmacy CD room.

11.8 Custody and loss of medicine cupboard keys

All medicine cupboards must be kept locked at all times when not in use. The keys/key cards must at all times be kept by a registered nurse/midwife, on his or her person. In residential homes and day care centres the keys/key cards must at all times be kept by the manager /senior member of staff in charge of the facility.

The delegation of key holding and control of medicines access to authorised persons within specific departments is permitted only where specific departmental procedures have been approved by the Trust Medicines Management group, a sub-committee of the Medicines Optimisation Committee.

Loss of medicines cupboard keys/key cards must be dealt with according to the Trust procedure for the safe and secure management of medicines cupboard keys/key cards i.e.

- The senior nurse/nurse/midwife in charge/manager will make enquiry of all staff on duty.
- If the key is still missing then staff that have left the premises must be contacted at home. If one of them has the key he or she must return the key immediately.
- If the location of the key is unknown a thorough search of the environment must be carried out.
- If the key remains missing (either assumed lost or with a member of staff unable to return it) then the designated office must be contacted to obtain the duplicate key.
- Security staff, the Directorate Manager or Senior Manager on-call (if outside normal hours) on the site must be contacted. If the key is a controlled drug key then the Pharmacy and, if deemed necessary, the police must be informed.
- If the original key is still missing, the Estates department must be contacted with a view to renewing the lock.
- If the key is a controlled drug cupboard key then nursing and pharmacy personnel must carry out a full inventory check in the clinical area, as soon as possible.
- An incident form must be completed recording all relevant details and submitted to the relevant manager.

In hospital the senior nurse/nurse/midwife in charge is responsible for ensuring key cards for patient medication lockers for individuals are held securely on the ward. Loss of a card must be immediately reported to Pharmacy and the missing card disabled.

11.9 Action in the event of a breach of security

A breach of security includes any deviation from the procedures that causes actual or potential loss or theft of medicines. Examples of such incidents include:

- medicines are found to be missing;
- controlled stationery is found to be missing; and,
- an unauthorised person has used controlled stationery.

Any person who discovers a breach of security is responsible for reporting it immediately to the senior nurse/nurse/midwife in charge/manager in charge and to Pharmacy.
The senior nurse/nurse/midwife in charge/manager in charge is responsible for investigating the breach of security, and for taking the necessary action according to relevant Trust procedures. This includes informing appropriate personnel within appropriate timescales, and ensuring that the relevant incident form is completed.

If the security breach involves a controlled drug or drug liable to abuse then the Trust Accountable Officer must be informed immediatly, in accordance with the Accountable Officer legislation. The Trust Accountable Officer is currently the Director of Pharmacy.

11.10 Voluntary services and medicines security

Voluntary organisation may provide staff or services to the Trust. Voluntary service staff may not be given access to medicines cupboards and cannot carry the medicines cupboard keys in facilities. If a volunteer is to be involved in the medicines administration process, this must be risk assessed and agreed with that Division's Head of Service in advance.

If a voluntary organisation is providing a service that uses products such as essential oils, for example aroma therapy, this must also be risk assessed in advance and the arrangements agreed with the Division's Head of Service. Some essential oils can be extremely toxic if taken orally and therefore their safe storage must be considered to ensure that patients/clients or visitors to the facility cannot access them. (See also Chapter 19)

Chapter 12 Dispensing and supply of medicines

To dispense and supply is to prepare a clinically appropriate medicine directly to a patient for self-administration or, for administration by a parent in the case of a young child or to a ward/department for administration to a patient by a nurse/midwife or appropriate practitioner. It also includes a number of other functions, including checking the validity of the prescription, the appropriateness of the medicine for an individual patient and the assembly of the product. These functions are performed by or under the supervision of a pharmacist.

All dispensed products must conform to Pharmaceutical Society of Northern Ireland Standards and guidance and the Use and Controls of Medicines guidelines for Northern Ireland.

12.1 In Trust hospitals

Ideally dispensing should be undertaken by a member of pharmacy staff.

The filling of compliance aids such as Medidose should always be undertaken by a member of pharmacy staff or the patient/client/resident's own pharmacist. Compliance aids are very time consuming to fill and therefore if one is needed it must be requested before 3pm Monday to Friday. Outside these hours such requests will only be accommodated in exceptional circumstances, such as a palliative care patient being discharged at short notice

Under agreed protocols nursing/midwifery staff may supply a pre-packed, pre-labelled container of medicine to a patient to take home following the approved procedure for the supply of production packs in Emergency Department (ED), day surgery etc. The container must have been dispensed and labelled by the pharmacy department for the specific procedure, which has been agreed by the Director of Pharmacy and the nurse/midwife must obtain a second check from another qualified member of staff.

Ward stocks and medicines dispensed for inpatients must not be given to patients to take home. In the situation where patients have been supplied with fully labelled medicines such as inhalers, creams and eye drops with the directions and information as for discharge medicines these can be issued to patients following a pharmacy check and these items should be sent to pharmacy along with the discharge prescription sheet.

In the case of 'one stop dispensing' wards the nursing staff must follow the procedure for the supply of medicines at discharge by nursing staff outside pharmacy opening hours.

Every effort should be made to ensure that prescriptions are sent to pharmacy during normal opening hours, in preparation for patients' discharges.

Outside pharmacy hours a registered nurse/midwife should only supply enough essential medication for the patient until the pharmacy department is open again - that is a one or two day supply. If there is a problem for the patient or carer returning for a supply the next day then the on-call pharmacist should be contacted. The on-call pharmacist should make arrangements to have the prescription dispensed by pharmacy as soon as possible and delivered to the patient if necessary.

All medicines being transported between departments should be in a secure container, that is sealed in a box or bag with a tamper evident seal or be in the custody of a designated responsible person.

12.2 Aseptically prepared products

Aseptic products such as cytotoxic chemotherapy and total parenteral nutrition must be prepared within the controlled aseptic dispensing facility in the Craigavon Area Hospital Pharmacy.

Reconstitution or preparation of such products must only be carried out by trained pharmacy staff under the direction of a suitably trained and experienced pharmacist.

The Medicines Act stipulates these unlicensed medicines must only be prepared or dispensed against a prescription for a named patient.

12.3 GP Out of Hours Centre

In GP Out of Hours Centres medicines must only be dispensed from the centre when there are no community pharmacies open to dispense the GP's prescription and the medicine cannot wait until a community pharmacy is open again.

Under agreed protocols the GP may supply a pre-packed, pre-labelled container of medicine to a patient. The medicines legislation requires that such packs must be labelled with the patient's name, the directions for taking the medicine, the date, the address of the facility and contain a patient information leaflet. Any dry powder suspensions must be reconstituted correctly by the GP before they are given to the patient or carer.

If it is decided to give the patient a smaller quantity than contained in the original pack then the extra dose units should be removed from the pack and disposed of according to the Trust Waste policy. The original pack with the reduced number of dose units is given to the patient. This ensures compliance with the legislation in relation to labelling and patient information leaflets.

Loose tablets/capsules or unlabelled containers may not be given to patients.

If the medicine has been prescribed and dispensed for the patient to collect at the Out Of Hours Centre, then the patient's identity and date of birth must be confirmed prior to giving the medicines to them. This is to ensure that medicines are given to the right patient.

12.4 Community clinics

Under agreed protocols nursing staff may supply a pre-packed, pre-labelled container of medicine to a patient to take home following the approved procedure or PGD, for example in supplies of the oral contraceptive pill in Trust Family Planning Clinics The medicines legislation requires that such packs must be labelled with the patient's name, the directions for taking the medicine, the date, the address of the facility and contain a patient information leaflet.

Chapter 13 Medicines Issued to Patients on Discharge from Hospital

13.1 Inpatient Discharge prescriptions

Discharge prescriptions should be written by authorised prescribers and assembled by pharmacy staff during pharmacy opening hours. Pharmacy will dispense a minimum of 14 days supply of medicines on discharge unless this is contraindicated, for example known risk of medicines misappropriation or overdose.

Outside pharmacy hours, in exceptional situations, discharge medication may be assembled and supplied in accordance with the procedure for the supply of medication at discharge. Nursing/midwifery staff on 'one stop dispensing' wards must follow the procedure for the supply of medicines at discharge by nursing staff outside pharmacy opening hours. On other wards a registered nurse/midwife should only supply enough medication for the patient until the pharmacy department is open again, that is a one or two day supply. If there is a problem for the patient or carer returning for a supply the next day then the on-call pharmacist should be contacted (see section 12.1). The medication supplied must be in recognised labelled medication container. Envelopes and plastic bags are not suitable for supplies of tablets or capsules. Stocks of containers and blank labels are provided to wards for such a circumstance.

If a nurse/midwife has to provide a supply of medication on discharge a second nurse must check that each individual medicine is:

- for the correct patient being discharged
- prescribed on the discharge prescription
- the correct medicine, form, dose and frequency.

Both nurses must write the quantities of each medicine provided on the discharge prescription and sign the prescription.

On discharge, only medication both prescribed on the discharge prescription and fully labelled for the patient with correct instructions will be issued to the patient following the checks described in the procedure for the supply of discharge medication.

When providing patients with medicines to take home at discharge it is essential that:

- Accurate and up-to-date information of patient's medication on discharge is safely and effectively communicated to the general practitioner/clinical pharmacist

- The patient is clear which medicines they are to take, and is aware of changes made to their medication regimen following inpatient stay.

- The patient is provided with accurate and up-to-date information about their medication at discharge.

- The Pharmacy Department provides a 28 day supply of discharge medication, where it is required, for all inpatients, during pharmacy opening hours.

- The Discharge Summary acts as the prescription and is an accurate record of all items required by the inpatient at the time of discharge.

- Prior to dispensing, a pharmacist will clinically check the inpatient discharge prescriptions and should endeavour to clinically check all discharge prescriptions at ward level irrespective of whether or not a supply is being made.

- All discharge medication will be dispensed in a re-sealable bag along with the prescription. Each bag will be labelled with the patient's name, ward and unit number.

- The pharmacy porter will deliver the discharge medication to the ward/department in a box with a tamper evident seal and then hand the discharge medication to an appropriate member of the ward staff. Ward staff may also collect discharge medication from the Pharmacy Reception, where it is required in advance of the next delivery by the pharmacy porter.

- All discharge medication must be signed for on receipt from Pharmacy Reception or at ward level. The designated member of staff receiving the discharge prescription must sign and print their name on the Discharge prescription Record.

- All discharge medication must be stored at ward level in a locked cupboard until required.

- Nursing/Midwifery staff on discharge will check that the medication listed on the discharge prescription coincides with that prepared by pharmacy. If there are any discrepancies these must be referred to the Pharmacy Department or, outside normal opening hours, the on-call pharmacist

- Where changes are made to an inpatient's prescription after it has been dispensed by pharmacy, all medications previously supplied will be returned to pharmacy with the amended discharge prescription for re-dispensing.

13.2 One Stop Dispensing Wards

- When the inpatient is discharged, only medication both prescribed on the discharge prescription and fully labelled for the patient with the correct instructions may be issued to the patient. Ward stock must not be given to the inpatient.

- The pharmacy team will prepare all discharges prescriptions or impending discharge prescriptions at the earliest opportunity.

- The completed medicines and discharge prescription should be locked in the medicine locker until the patient is discharged.

- Nursing staff, on discharge, should check that the medication listed on the discharge prescription coincides with that prepared by pharmacy. If there are any changes then they must contact a member of the pharmacy team.

- Outside pharmacy hours the nursing staff must follow the one stop dispensing procedure for the supply of medicines at discharge by nursing staff outside pharmacy opening hours.

13.3 Day case patients

Under agreed protocols nursing/midwifery staff may supply a pre-packed, pre-labelled container of medicine to a day case patient to take home.

To make such a supply the nursing/midwifery staff must follow the agreed protocol for the area concerned. In addition the container must have been dispensed and labelled by the pharmacy department for the specific procedure, which has been agreed by the Director of Pharmacy.

The medicines legislation requires that such packs must be labelled with the patient's name, the directions for taking the medicine, the date, the address of the facility and contain a patient information leaflet. Therefore before the pack is given to the patient the details on the label must be completed fully.

Loose tablets/capsules or unlabelled containers may not be given to patients.

If it is decided to give the patient a smaller quantity than contained in the original pack then the extra dose units should be removed from the pack and disposed of according to the Trust Waste policy. The original pack with the reduced number of dose units is given to the patient. This ensures compliance with the legislation in relation to labelling and patient information leaflets.

The nurse/midwife must obtain a second check from another qualified member of staff before giving the pack to the patient.

When providing patients with medicines to take home at discharge it is essential that:

- Accurate and up-to-date information of patient's medication on discharge is safely and effectively communicated to the general practitioner/clinical pharmacist

- The patient is clear which medicines they are to take, and is aware of changes made to their medication regimen as a result of their day case treatment.

- The patient is provided with accurate and up-to-date information about their medication at discharge.

    - The Discharge Summary Sheet acts as the prescription and is an accurate record of the items required by the day case patient at the time of discharge.

13.4 Emergency Department and Minor Injury Unit Attendees

Under agreed protocols nursing staff may supply certain medications for Emergency Department (ED)/ Minor Injuries Unit (MIU) outpatients to take home. These medications must be required by the patient acutely i.e. they cannot wait for the supply to be made via their GP. If the need is not acute then the request for medication must be made via the patient's GP as normal. Medications that are required acutely typically include antibiotics and analgesics.
To make such an acute supply the nursing staff must follow the agreed protocol for the area concerned, which has been agreed by the Director of Pharmacy.

The medications **must** be supplied in accordance with a valid prescription/ PGD documented in the patient's notes.

The medicines legislation requires that the supplied medications must be:

- labelled with the patient's name,
- the directions for taking the medicine,
- the date,
- the address of the facility and
- contain a patient information leaflet.

Therefore before a pack is given to the patient the details on the label **must** be completed fully.

Loose tablets/capsules or unlabelled containers **must not** be given to patients.

Packs suitable for supply include;

- Those which are legal category P and GSL. These are medications which can be purchased from a community pharmacy. Their package has full directions on how to take the medicine for the patient. Examples include paracetamol 500mg tablets and ibuprofen 100mg/ 5ml suspension. They may be supplied from the ED/ MIU if a 'tracer label', complete with the date and the patient's name is applied to the pack
- Those which are legal category POM and have directions already printed on the box by the manufacturer. Examples include some antibiotics and analgesics. They may be supplied from the ED/ MIU if a 'tracer label', complete with the date and the patient's name is applied to the pack
- Those which are legal category POM and come over-labelled from the pharmacy department with the directions for the patient. These may be supplied from the ED/ MIU if the over-label is completed with the date, hospital dept., and patient's name.

All other medications must be prescribed on an outpatient prescription and dispensed by the hospital pharmacy. When the hospital pharmacy is closed, if the medication is required immediately and can't wait until the patient gets a supply from the GP, it may be supplied from ED/ MIU using the blank tablet/ capsule labels supplied from pharmacy to label the medication. These labels must be completed fully and only the smallest appropriate amount of medication should be supplied.

If it is decided to give the patient a smaller quantity than contained in the original pack, then the extra dose units should be removed from the pack and disposed of according to the Trust Waste

policy. The original pack with the reduced number of dose units is given to the patient. This ensures compliance with the legislation in relation to labelling and patient information leaflets.

In every case the nurse must obtain a second check from another qualified member of staff before giving the pack to the patient. Explain to the patient how to take their medication and ensure they are aware of any changes to their existing medications as a result of their ED/ MIU consultation.

Chapter 14 Transport of Medicines

There must be systems in place for the transport of medicines that ensure their security, quality and integrity, and maintain the health and safety of the staff and the public. It is important to ensure that the quality and security of medicines is maintained during transportation and that due attention is paid to health and safety considerations.

14.1 Basic Principles

- A record is kept at each step where a medicine changes hands during its delivery from the pharmacy to destinations within the hospital, or to another hospital or community facility.
- The person responsible for the medicine at each point of the transportation chain can be identified.
- Containers and packages are kept securely or under surveillance whilst awaiting collection or in transit between pharmacy and the final destination.
- Containers and packages awaiting collection or in transit are kept in the appropriate storage conditions to maintain the quality of their contents. This includes maintaining the cold chain where required.
- All medicines are transported in sealed tamper evident containers or packages.
- All containers and packages are clearly labelled with the final destination.
- Pharmacy staff must advise of any health and safety risks and special storage conditions associated with the transport of a medicine at the time of collection.
- Specific arrangements are in place for the transportation of cytotoxic medicines and medical gases.
- Responsibility for security and maintenance of appropriate storage conditions remains with those delivering the sealed container until delivery is made, and documentation is signed for receipt.
- Staff involved in facilitating the delivery of sealed unopened packages containing medicines dispensed by hospital pharmacy by acting as a collection point, should take due diligence in ensuring appropriate steps to assure that the medicines are stored securely and appropriately as per instructions for onward transit to patient or carer. Where appropriate staff should maintain a record of receipt and onward supply of such packages. Due diligence should be taken to ensure the medication is given to the correct person.
- Managers of staff groups responsible for transporting medicines are responsible for ensuring staff are trained to ensure an understanding of the need for security and Trust procedures, including action to be taken in the event of physical threat.
- All incidents involving a breach of security are investigated.

14.2 Maintaining the cold chain

Sensitivity to changes in temperature varies depending on the medicine. The manufacturer's literature must be consulted and other expert advice must be sought if medicines that require to be stored at temperatures outside normal ambient temperatures, i.e. in a fridge or freezer, need to be transported.

If medicines that are sensitive to temperature changes, for example vaccines, are to be transported on a regular basis, the transport system must be validated and monitored for the duration of the transport time.

If medicines that are sensitive to temperature changes are to be transported on an occasional basis, the following good practice should be followed.

- The medicine must be held outside the recommended storage temperature for the minimum time possible. Maximum exposure time allowed depends on the sensitivity of the product.
- Validated cool boxes or containers or a refrigerated van must be used.
- If ice packs are used, they must be evenly distributed. Direct contact with the medicines must be avoided by using layers of card between the medicines and the ice packs. Using partially frozen ice packs further reduces the risk of the medicine freezing.

14.3 Vaccines

- Vaccines are very sensitive to temperature changes.
- Appropriate arrangements must be in place to ensure that vaccines are not adversely affected by the conditions under which they are transported.
- The manufacturers recommended storage conditions must be observed during transport of vaccines.
- Accurate vaccine storage temperature records must be kept by all areas and must be retained for at least 5 years. This will enable staff to prove that vaccines had been correctly stored whilst in the Trust's possession, in the event of a vaccine failure enquiry.
- Maintaining and storing temperature records is the responsibility of the manager of the ward or facility storing the vaccine.

14.4 Cytotoxic medicines

Cytotoxic chemotherapy prepared in the Pharmacy Department must be packaged to avoid escape, leak or spillage during handling and transport. Each item must be individually labelled with the patient name.

- Packaging must be suitable for the product and robust enough to withstand normal conditions of transport and handling.
- Specific Pharmacy procedures exist for the preparation and transport of intrathecal chemotherapy (see Trust Policy for the Administration of Intrathecal Chemotherapy).

Packaging must be:

- Robust;
- tamper proof;
- provide protection for the handler;
- be able to contain any leakage; and,
- labelled to identify the nature of the contents labelled to state the name and address of the sender and recipient.

Procedures must be available for dealing with spillage during transportation. Persons transporting cytotoxic chemotherapy must be trained in the actions to be taken in the event of a spillage.

Any spillage incident must be reported using the Trust incident report form.
Cytotoxic chemotherapy is classified as prohibited or restricted material by the Postal Service and must therefore **never** be sent by routine post. Special arrangements are required and the carrier must be made aware of the hazardous contents. Storage, handling and packaging requirements must be agreed.

Specific Pharmacy procedures have been developed for the transport and delivery of cytotoxic medicines.

14.5 Medical gas cylinders (see Chapter 23 for more detail)

Medical gas cylinders must only be transported using containers and or vehicles which are appropriate for the size and number of cylinders, and which allow all cylinders to be firmly secured either horizontally or vertically.

Transport vehicles for medical gas cylinders must comply with the legal and safety requirements for transport of medical gases.

Medical Gas cylinders must only be moved using approved and maintained equipment clean and free from dirt, grease and oil.

All Trust personnel involved with the transport of medical gas cylinders must be trained in the legal and safety requirements.

14.6 Taxis and couriers

Only hospital transport staff and contract taxis and couriers able to produce identification may be used to transport medicines.

- Taxis and couriers must always be ordered as per Trust procedures.
- Taxis must not carry non -Trust passengers while transporting medicines.
- The driver or courier must sign for collection of medicines to be transported.

14.7 Action in the event of a breach of security

A breach of security includes any deviation from the procedures that causes actual or potential loss or theft of medicines. Examples of such incidents include:

- medicines left unattended at an insecure location;
- signatures are not received when a medicine changes hands; and,
- medicines have been handled by an unauthorised person.

Any person who discovers a breach of security is responsible for reporting it immediately to the manager of the ward, facility or department concerned, and to the pharmacy.

The manager of the ward, facility or department is responsible for investigating the breach of security, and for taking the necessary action according to relevant Trust procedures. This includes informing appropriate personnel within appropriate timescales, and ensuring that a Trust IR1 incident form is completed as soon as possible.

Chapter 15 Transfer of medicines in hospital

When a patient is transferred to another clinical area within the same hospital site, or to a different hospital site, the nurse/midwife responsible for the patient's care must make arrangements to ensure that required doses of medicines are not missed or delayed.

The patient's own medicines, other medicines supplied for the individual patient's use, and other prescribed medicines not immediately available in the receiving clinical area must be transferred. (For information on discharge from hospital into a community facility/own home, please see Chapter 11 - Medicines Issued to Patients on Discharge from Hospital)

Where patients own medicines need to accompany a patient who is being transferred, they must be placed in a closed clear disposable bag. As the responsibility for the patient is transferred from one nurse/midwife or other clinician to another, the responsibility for the safety and security of the medicines is also transferred.

Only **in exceptional circumstances** and the pharmacy is closed, should medicines from ward stock be transferred from one ward to another.

Exceptional circumstances include:

- life threatening emergency
- when it is not possible to wait 30 minutes for the on-call pharmacist to travel to the hospital to supply the item;
- the dose of the medicine concerned cannot wait until the pharmacy reopens; and,
- when the on-call pharmacist knows that the only stock of the item, in the hospital, is being held by another ward.

This must only take place when Pharmacy is closed. In such cases the smallest original pack should be supplied. The transfer of any medicine from one container to another, other than by Pharmacy Staff, is forbidden. Transfer of medicines must be documented using a Drug Transfer Record Form. It is the responsibility of the ward requesting the transfer to complete the form.

Medicines must **NEVER** be transferred from one container to another, nor should parts of blister packs be borrowed. In the event of an emergency the original labelled container supplied by the Pharmacy Department should be transferred to the borrowing area.

Controlled drugs

Controlled drugs should **NEVER** be borrowed. The only exception to this is in an life threatening emergency when the pharmacy is closed, the thirty minutes it will take the emergency pharmacist to get to the hospital will be too long and the transfer has been authorised by the on-call pharmacist.

All documentation with regard to borrowing must be completed and sent to the Pharmacy Department for the attention of the Ward Pharmacist or the Pharmacy Patient Services Manager.

The completed Drug Transfer Record Form must be sent to Pharmacy the next working day.

Pharmacy will replace any stock items transferred through the normal top-up system. If replacement is urgently required, a supplementary order should be sent to Pharmacy as per normal procedures.

In areas where medicines or medicine kits are issued to personnel e.g. midwives, community midwifery managers, community nurses, ambulance drivers, the Senior nurse/nurse in charge is responsible for ensuring that written records of issue and return are maintained.

Chapter 16 Disposal of Medicines no Longer Required

16.1 General principles

Pharmaceutical waste is not to be disposed of via the foul water system down a sink or a sluice, with the exception of **part used** controlled drugs. The disposal of such controlled drugs must be recorded in the Controlled Drug Register (hospitals) or on the patient's administration chart (community), as described in the Trust controlled drug procedures.

With the exception of cytotoxic medicines, part-used infusions or injection containers and anything which may be contaminated with blood or body fluids must be treated as clinical waste and disposed of accordingly.

Waste cytotoxic medicines, including those contaminated with blood or body fluids must be treated as **hazardous** waste and disposed of accordingly.

For further information see Trust Waste Disposal Policy on the Intranet.

16.2 In hospitals

Medicines and pharmaceutical items, which are no longer required by the patient, the ward/department must be returned to the pharmacy by pharmacy staff or ward/department staff. These items will include patients own drugs and ward/department overstock.
All medicines brought into hospital by patients remain the patient's own property. They may be returned to Pharmacy for disposal if they are no longer required. Where ever possible they must only be disposed of with the consent of the patient, or the patient's representative.
A patient's own medicine must never be used by or for another patient.

Out of date items and open containers of loose tablets or capsules that are no longer required can be disposed of at ward level in the appropriate medicines waste container (yellow burn bin with a black lid).

Waste medicines must never be placed in a sharps box.

In the case of South Tyrone Hospital, Lurgan Hospital and facilities on the St Luke's hospital site, medicines (other than controlled drugs) may be returned for disposal to the CAH pharmacy in a locked box.

All returned items should be accompanied with a Pharmacy Returns Requisition. All items returned should be documented on the requisition and signed by a member of ward/department staff according to the Pharmacy Returns Policy.

16.3 GP 'Out of Hours' centres

Medicines and pharmaceutical items which are no longer required or are out of date must be returned to either Craigavon Area or Daisy Hill Hospital Pharmacy.

A patient's own medicine must never be used by or for another patient.

Waste medicines must never be placed in a sharps box or into waste water drainage i.e. down a sink, sluice or toilet.

16.4 In supported living facilities, respite centres and residential homes

Medicines and pharmaceutical items which are no longer required by patients/clients or that are out of date must be returned to the community pharmacy that supplied them. The pharmacy address will be printed on the dispensing label attached to the patients/clients' medicine

A patient's own medicine must never be used by or for another patient.

16.5 In day care centres

Medicines and pharmaceutical items which are no longer required by patients/clients or that are out of date should be given to family member or carer so that they can return the medicines to the community pharmacy that supplied them. This should be recorded in the patient/client's care plan or the centres medicines record book and witnessed by another member of staff or the family member/client. Both people should sign the care plan/book as a record of the medicines being given to the family member/carer.

A patient's own medicine must never be used by or for another patient.

16.6 In domiciliary care

Medicines and pharmaceutical items which are no longer required by patients/clients or that are out of date should be given to family member or carer so that they can return the medicines to the community pharmacy that supplied them. This should be recorded in the patient/client's care plan.

A patient/client's own medicine must never be used by or for another patient/client.

If a patient/client does not take a dose of medicine that has been removed from its packaging, then it should be flushed down the toilet and a record made in the patient/client's care plan

16.7 Treatment rooms/ GP surgeries

Medicines and pharmaceutical items which are no longer required or that are out of date must be returned to the community pharmacy that supplied them.

The only exception to this is vaccines for childhood immunisation, which should be disposed of in purple top burn bins via the community waste disposal contractor, as per HSCB waste guidance. **Waste vaccine must not be returned to the Trust Pharmacies as this contravenes the Special Waste legislation.**

A patient's own medicine must never be used by or for another patient.

16.7 District and community nursing

If a patient has medicines and/or pharmaceutical items which are no longer required by or that are out of date, the patient, a family member or carer should be asked to return the medicines to the community pharmacy that supplied them.

If controlled drugs are no longer required, for example following the death of a palliative care patient, the family or carer should be asked to return them to the community pharmacist. However if the nurse has concerns that the controlled drugs will not be returned to the community pharmacist and may be abused in some way, then they should return the controlled drugs to the community pharmacist themselves. The nurse should record the amount and identity of each controlled drug being removed and if possible get a witness to sign the record as correct. On delivering the items to the community pharmacy, the pharmacist should be asked to sign to confirm that all the items listed have been returned.

A patient's own medicine must never be used by or for another patient.

Chapter 17 Staff Self Administration, Self-Prescribing and Purchase of Medicines

17.1 Staff Self Administration and Self Prescribing

All medicines supplied and dispensed within the hospital are solely for use by patients of the Trust.

Members of staff may not self-medicate using hospital medicines. This constitutes theft of Trust property and contravention of the laws relating to medicines. As such, a member of staff could be liable for prosecution and dismissal.

Authorised prescribers, including registered doctors and dentists, may not self-prescribe medicines or write prescriptions for family or friends.

Ward managers are reminded that they are responsible for the drugs stored on that ward and are therefore obliged to ensure that the intentions of any member of staff requiring access to medicines are honest. Responsibility for medicines is delegated to the Nurse in Charge of a ward or department in the absence of the ward manager.

Members of staff who become ill at work must report to their manager who will direct the member of staff to the Occupational Health Department or Accident & Emergency Department as appropriate.

It is recognised that in an emergency situation, a member of staff may be required to be treated by medical staff in a ward or department.

17.2 Purchase of Medicines

Members of staff cannot purchase medicines from the Trust pharmacy department. The Trust's MHRA license does not permit such sales. Staff who wish to purchase medicines, either for themselves, for family members or for private practice should make arrangements with a community pharmacy.

17.3 Prescriptions for Relatives of Medical Staff

The Pharmacy Department cannot dispense prescriptions for relatives of medical staff unless the family member is a registered patient of the Trust and the prescription has been written by an appropriate member of the medical staff. The Pharmacy Department cannot dispense prescriptions for relatives of staff that live abroad. As in 16.2 above, arrangements should be made with a community pharmacy.

Chapter 18 Use of Unlicensed Medicines

An unlicensed medicine is a medicinal product, which has no UK Product Licence or is being used for an indication, which is not covered by an existing UK Product Licence.

Unlicensed medicines can be classified as follows:

- Medicines prepared by a manufacturer but not on sale in this country.
- Medicines prepared for a specific patient in accordance with a prescriber's instructions, e.g. TPN compounding, cytotoxic reconstitution, extemporaneous dispensing, however these are exempt under "Section 10 Exemption".
- Unlicensed medicines obtained from a hospital or commercial supplier with a manufacturer's "specials" licence.
- Re-packaged medicines – of little significance.

Unlicensed medicines should only be used when there is no equivalent licensed alternative available. Their use should be clearly justified and their clinical/pharmaceutical benefits are considered to outweigh the risks involved.

All those involved in prescribing, distribution or administration of unlicensed medicines must be aware of its unlicensed status and any associated risks.

Prescribers must be aware of the use of medicines outside the product licence/marketing authorisation. Pharmacists will assist in providing information to prescribers with regard to the legal status of the medicines concerned.

Pharmacy staff should ensure as far, as is reasonably practical that the prescriber is aware that the medicine he/she has requested is only available as an unlicensed medicine.

Patients in general, if appropriate should be aware that they are being prescribed an unlicensed medicine. Nursing staff should be aware that they are administering an unlicensed medicine and that the patient has given informed consent to be treated with it where appropriate.

There must be an audit trail for the use of unlicensed medicines. In the Trust unlicensed medicines are classified according to their relative risk and the onward distribution of such medicines depends on this risk classification. The Trust Pharmacy Department will maintain records of unlicensed medicines as appropriate

All adverse drug reactions to unlicensed medicines should be reported through the yellow card scheme to the MHRA and to the pharmacy department.

For further information see the Trust Policy for the Use of Unlicensed Medicines.

Chapter 19 Alternative and complementary medicines

Service users may wish to take or use homeopathic/herbal and complementary/alternative types of therapy.

All members of the team must be made aware of this and review the appropriateness in light of the service user's medical requirements and, taking into account possible interactions with prescribed medication. Information on contra-indications and interactions is available from the Trust Medicines Information service (ext. 63893).

All homeopathic or herbal products being taken by a patient must be recorded on their Kardex and annotated 'patient's own supply'. In nursing homes, residential homes and day care centres all homeopathic or herbal products being taken by a patient/client/ resident must be recorded on their medication record document.

Prior to using a patient/client/resident's own supply of a homeopathic or herbal product it must be assessed for identity and safety by a pharmacist.

Some practitioners may wish to use homeopathic/herbal and complementary/alternative types of therapy to treat patients. Such practitioners must have successfully undertaken appropriate training and be competent to practise such treatments. In addition, prior to commencing such therapies, treatment protocols and procedures must be developed and submitted to the Trust Medicines Management Committee, prior to approval by the Trust Medicines Optimisation Committee.

Chapter 20 Patient Group Directions

The majority of medicines are prescribed on an individual or patient-specific direction (PSD) basis where each individual patient is identified and where direction to administer are often written on a medicines administration chart, e.g., in secondary care settings such as wards.

A patient group direction (PGD) however is a specific written instruction for the supply or administration of a licensed named medicine, including vaccines, to a specific group of patients who may not be individually identified before presenting for treatment.

Medicines may be supplied or administered under PGDs in limited situations where doing so offers an advantage for patient care without compromising patient safety, and where it is consistent with appropriate professional relationships and accountability.

Development of a PGD
The development of a patient group direction must be agreed locally by the

- Clinical Director,
- Head of Service for the area (or their deputy)
- Delegated nurse or professional lead in the staff group providing care under the direction, and
- Pharmacist.

They must consult with all appropriate persons, including Consultants whose patients may be treated under the direction, to confirm that the proposed direction is appropriate, does not compromise patient safety and is consistent with professional relationships and accountability.

All Consultants who have patients who may be treated using the patient group direction must approve its use otherwise the medicine may not be administered under the PGD to these patients. The Clinical Director is responsible for ensuring that all relevant consultants locally approve the direction and that an up-to-date record of signatures confirming approval is maintained.

All new and revised patient group directions must be prepared using the Trust's patient group direction template which is available on the Trust's Intranet (Policies and Procedures – Governance section). A PGD flowchart is also available to assist with the development, review and approval of PGDs within the Trust (flowchart).

The patient group direction must be reviewed at least once every 2 years otherwise it becomes invalid. The review must be undertaken by the Clinical Director Head of Service for the area (or their deputy), delegated nurse or professional lead for the staff group providing care under the direction, and the senior pharmacist. The review must be undertaken in consultation with all appropriate persons.

The patient group direction must contain the following information: -

- The rationale i.e., the reason why the patient group direction offers an advantage to patient care
- The patient group and clinical condition or situation to which the direction applies.

- A description of patient's, clinical conditions or situations excluded from treatment under the direction
- The action to be taken if a patient is excluded from or refuses treatment under the direction
- The medicine which may be supplied or administered, and specific details of the
    - Dose
    - Frequency of administration
    - Form and route of administration
    - Maximum number of doses that may be supplied or administered
    - Maximum period of time for which the medicine may be supplied or administered
    - Warnings, cautions, and contra-indications to treatment with the medicine.
    - Legal status of the medicine (Note: Unlicensed medicines may not be supplied or administered using a PGD)
- Supply and administration must be in line with local guidelines, formularies and protocols
- Instructions on the documentation required to record supply or administration and other records to be kept for audit purposes
- The skills, knowledge and qualifications required by staff approved to authorise supply or administer medicines under the terms of the direction and details of any required training programme
- The action to be taken if an adverse drug reaction is suspected or occurs to a patient being treated under the direction
- Details of any necessary follow-up action that will be taken after supply or administration
- Evidence of approval by the Clinical Director, the Directorate Manager, delegated nurse, or professional lead
- The date that the direction comes into force, and the date that it expires.

Authorisation of a PGD
Before it is introduced into operation, the patient group direction must be authorised by the Medical Director (and Chair of the Medicines Optimisation Committee), the Executive Director of Nursing /AHPs and the Director of Pharmacy.

Review of a PGD
On reviewing a patient group direction should any change be needed to the : -

- patient group
- clinical condition or situation to which the direction applies
- characteristics of staff authorised to supply or administer under the direction, or
- description of treatment available under the direction

then a new version of the patient group direction must be re-submitted for approval.

Minor changes may be made without further approval but the revised version must be posted on the intranet.

Staff support
The ward sister/charge nurse/team leader, or the appropriate manager for other professions, must maintain an up-to-date register of those staff in their area of responsibility who are

approved to supply or administer medicines under the patient group direction. S/he must also ensure that staff have access to relevant training / information and that the patient group direction used by the ward / team is in date and tabled for reviewed as required and that the current patient group direction is listed on the Trust's intranet.

All staff undertaking to administer a medication via a patient group direction **MUST** have completed the required training and / or information sessions on the pharmaceutical product and have signed the associated PGD register.

Chapter 21 Patient's Own Drugs (PODs) in the hospital setting

Patients should be encouraged to bring their medicines with them when coming into hospital as an inpatient. If appropriate a patient's relatives or carers may also be asked to bring a patient's medicines from home. Patient's own drugs can help facilitate an accurate medication history on admission.

Patients own medicines remain the property of the patient. Staff will attempt to obtain written or verbal agreement for the use of Patient's Own Drugs as part of the re-use of Patient's Own Drugs (PODs) and one stop dispensing (OSD) policy. If written or verbal agreement cannot be obtained and no other supply of the prescribed medicine is available or a delay in procuring the medicine will be detrimental to the patient, the patients' own supply of the prescribed medicines may be assessed and re-used in accordance with the Trust's agreed criteria by a member of staff trained in the assessment of patient's own drugs.

PODs will be assessed in accordance with the procedure for the assessment and re-use of Patient's Own Drugs.

PODs assessed as unsuitable for re-use during the in-patient stay will with the patient's/ carer's agreement be disposed of at the point of assessment in accordance with the Trust waste disposal policy at ward level and a new replacement supply of all required items made. Any medication discontinued during the in-patient stay or prior to discharge will with the patient's/ carer's agreement also be disposed of in accordance with the Trust waste disposal policy at ward level.

21.1 Medicine supply

Where PODs have been assessed as unsuitable or are unavailable, pharmacy will supply 28 days of medication in preparation for discharge during pharmacy opening hours. Outside pharmacy opening hours, supplies of medicines will be obtained by nursing staff as described in the procedure for the in-patient supply of medicines outside pharmacy hours.

21.2 Individual patient medicine lockers

In areas using this system each patient is provided with an individual patient medicine locker for medicine storage, which can be accessed by nursing and pharmacy staff only. Key fob access to lockers is the responsibility of both nursing and pharmacy staff as described in the Trust policy for the safe and secure management of medicine key fobs.

Only the PODs and medicines prescribed for that patient will be stored in the individual patient medicine locker. **Patients' own controlled drugs (CDs) will be managed in accordance with the Trust Controlled Drug Policy.**

Individual patient medicine lockers will be reviewed by pharmacy and nursing staff on a regular basis as described in the procedure for the in-patient management of individual patient lockers.

It is the responsibility of the nurse/midwife looking after the patient at the time of transfer/discharge to ensure that the patient's medication locker is emptied and the medicines transferred with the patient or disposed of as appropriate.

During normal working hours, pharmacy will be contacted when no access can be gained to an individual patient medicine locker. Pharmacy will troubleshoot the lock and make new supplies of any prescribed medicine items which would otherwise be missed due to denied access.

Chapter 22 Clinical Trials involving Pharmaceutical Products

All clinical Trials involving medicines must have a Clinical Trial Authorisation (CTA) from the Medicines and Healthcare products Regulatory Agency (MHRA) , Ethics approval from an HSC Ethics Committee, and be approved by the Trust Research Governance Committee. Funding implications must be addressed so that NHS personnel are not inappropriately diverted from the provision of patient care; to this end pharmacy should have input into the financial section of the Clinical Trial Agreement.

All medicines (Investigational Medicinal Products or IMPs) used in Clinical Trials must be subject to the same requirements as other medicines used within the trust and must be supplied by Pharmacy on the written instructions of the prescriber according to legislative standards and best practice guidelines.

This applies to all Clinical trials regulated by the Medicines for Human Use (Clinical Trials) Regulations 2004 including commercial, non-commercial, and investigator – initiated clinical research carried out in the Trust.

All IMPs must be manufactured to Good Manufacturing Practice (GMP) Standards and hospitals hosting clinical trials are subject to MHRA Good Clinical practice inspection.
All IMP'S should be stored and dispensed by the hospital pharmacy and managed to the same standards as licensed medicines.

IMPS must not be stored in offices, clinics or ward areas unless the trial requires immediate access to the IMPs. All IMP storage arrangements must be agreed with the Clinical Trials Pharmacist prior to the trail being submitted to the Trust Research Governance committee for approval. Official guidance concerning the storage and distribution of IMPs is encompassed within the Duthie Report.

Before a clinical trial commences recruitment the pharmacy must have copies of the following regulatory documents:

- The CTA, and approval of any subsequent amendments.
- Ethics approval, and approval of any subsequent amendments.
- Trust Research Governance approval, and approval of any subsequent amendments.
- A final copy of the trial protocol, any amendments and the latest version of the investigator brochure.

Clinical Trial Investigators should delegate responsibility to the pharmacy department for the following functions (as per ICH Harmonised Tripartite Guideline for good Clinical Practice):

- Correct receipt and recording of IMP deliveries by a responsible person.
- Proper safe handling, storage and dispensing of trial medicines.
- Return and disposal of unused products.
- Reconciliation of delivery records with usage and return of unused stock.
- Safe keeping of randomisation code envelopes including 24 hour access in case of emergency.

- Provision of information to trial subjects on how to take study medication.

Study – specific clinical trial prescription forms should be provided by the sponsor and / or pharmacy and signed by the Investigator.

During in-patient stays, (if continued participation in the trial is considered appropriate by the medical team) the IMP must be prescribed on the hospital drug Kardex and the patient's own supply of trial drugs stored in the drug trolley / locker and administered and recorded by nursing staff according to the standards for licensed medicines.

A clinical trials pharmacist must have overall responsibility for the pharmacy clinical trial service and have adequate training and experience to carry out this role. Pharmacy should ensure that adequate resources are available to provide a pharmacy clinical trial service so that research does not inappropriately divert pharmacy NHS resources from the provision of patient care.

Chapter 23 Medical Gases

The safe managment of medical gases is vitally important. Medical gases are prescription only medicines and must be prescribied and administered as per other medicinal products.

In adition they also pose particular safety risks in their use. The have maual handling risks due the size and weight of cylinders. An unsecured cylinder that falls over could cause seroius injury to a patient or a member of staff.
Also If a cylinder falls and fractures the pressurised gas inside will escape with such force that the cylinder will be blown across the room, causing seroius injury to those in its path. Cylinders are also a fire risk, particularly oxygen as it will explode if near an ignition source.

23.1 In the hospital setting

23.1.1 Areas of responsibility

The senior nurse/nurse/midwife in charge, the Director of Pharmacy, the Facilities Manager, the Estates Operational Manager and the relevant laboratory manager should ensure that all staff in their area of responsibility are adequately trained regarding medical gases, both in routine use and in emergency situations.

Medical gases are medicinal products under the provision of the Medicines Act 1968.
Medical gases should be managed and controlled to the same level as other medicinal products with regard to authorisation to prescribe, ordering, administration, storage and security.
Medical gases must be prescribed by a UK registered doctor, dentist or Trust authorised prescriber.
Medical gases are only prescribed on Trust authorised documentation.
Appropriate risk management and operational arrangements are followed for the prescribing, administration, ordering, storage and quality control of medical gas supplies and are compliant with the NPSA Rapid Response Report ' Oxygen Safety in Hospitals' (RRR006).

Medical staff and non-medical prescribers

- Medical staff and non-medical prescribers are responsible for ensuring that medical gases, such as oxygen, are prescribed correctly and according to the current BTS guidelines.

- Medical staff and non-medical prescribers are responsible for requesting the appropriate monitoring for patients prescribed medical gases and that pulse oximetry is used, where appropriate.

Nursing/midwifery staff

- The senior nurse/nurse/midwife in charge is responsible for the safe and secure storage, handling and use of medical gases in his/her area of control. This includes ensuring the availability and maintenance of the necessary equipment.

- The senior nurse/nurse/midwife in charge is responsible for ensuring effective and efficient stock control.

Pharmacy

- The Director of Pharmacy is responsible for the procurement and supply of medical gases and medical gas cylinders. On a day to day basis this responsibility is delegated to the procurement pharmacist in Craigavon Area Hospital.

- The Director of Pharmacy is responsible for the quality of medical gases, and for ensuring that the required quality testing is provided under the Permit to Work System. On a day to day basis this responsibility is delegated to the quality assurance pharmacist in Craigavon Area Hospital.

Portering Services

- Medical gas cylinders are procured by the Pharmacy department and distributed to wards by Facilities and/or Pharmacy portering staff.
- The Facilities Manager and the Director of Pharmacy are responsible for the maintenance, safety, and security of cylinder storage areas.
- The Facilities Manager is responsible for the supply and issue of cylinder trolleys and associated transportation equipment.

Laboratories and other departments

- Laboratories and other departments that use special and industrial gases are responsible for ordering and managing their own supplies of gas cylinders. These cylinders must be segregated from medical gas cylinders.

23.1.2 Storage of medical gas cylinders (wards, departments and other facilities)

The senior nurse/nurse/midwife in charge is responsible for the safe and secure storage of medical gas cylinders in the ward or department, and for ensuring the following:

- Cylinders must be located in a safe position and secured so they cannot fall over. Cylinders must not be stored or used freestanding.
- Cylinders must be located near to an exit so that they can be removed quickly in an emergency such as a fire. However, they must not block the exit, or present any other type of hazard.
- Cylinder storage areas must be well ventilated.
- Cylinders must be sited away from storage areas containing highly flammable liquids and other combustible materials, and from sources of heat or ignition.
- Warning notices must be posted prohibiting smoking and naked lights within the vicinity of the cylinders.
- Cylinders containing liquefiable gases must be stored and used upright with the valve uppermost unless the attached equipment is specifically designed to withdraw liquid from the container.

23.1.3 Trust Cylinder stores

The Director of Pharmacy and the Facilities Manager is responsible for the safe and secure storage of medical gas cylinders in the cylinder stores, and for ensuring the following:

- The cylinder stores must be kept locked when not in use. Access must be restricted to authorised personnel only i.e. pharmacy, portering and technical services personnel.
- Medical and industrial (non-medical) gases must be stored separately.
- Cylinders of size “F” and greater must be stored secured in the vertical position to prevent toppling. Cylinders of size “E” and smaller must be stacked horizontally on racks to prevent damage to the cylinder paintwork.
- Different sizes and types of medical gas cylinders must be stored in separate racks or defined areas.
- Full cylinders must be arranged so that oldest stock is used first. On receipt, cylinders must be positioned in the store such that good stock rotation is maintained.
- Cylinders must not be subject to extremes of temperature.
- Full and empty cylinders must be segregated in clearly defined areas.
- Cylinders must not be defaced by marking with chalk, paint, crayon or other material.
- Cylinders containing oxygen and oxidants must be stored segregated (if possible by a physical barrier) from flammable gases. Flammable gases must not be stored routinely, and if required, quantities must be kept to a minimum.
- The cylinder stores must be kept clean and dry and free from inflammable material. Rubbish must not be allowed to accumulate.
- The area surrounding the stores must be kept free of vegetation or other combustible materials. If weedkillers are required, chemicals which are a potential fire hazard (e.g. sodium chlorate) must not be used.

23.1.4 Safe handling and use of medical gas cylinders

Medical gas cylinders, though robust, should be handled with care and only by personnel who have received training and understand the hazards involved. The details given below are intended to serve as a reminder to staff who regularly handle and transport cylinders and who have received formal training. The guidelines are therefore intended to supplement, and not replace, formal training.

General Guidelines

- Do not smoke or use naked lights in the immediate vicinity of a cylinder or in confined areas where cylinders are kept or stored.
- Do not subject cylinders to temperatures above 45 degrees centigrade.
- Use the appropriate protective clothing (gloves, overalls, safety boots). - Heavy protective gloves (preferably textile or leather) and protective safety footwear must be worn when loading or unloading cylinders. Gloves, protective boots and overalls must be clean and free from oil or grease.
- Ensure cylinders are kept free from dirt, grease and oil.
- Ensure all equipment used to transport cylinders (e.g. trolleys) is clean and free from dirt, grease and oil.
- Handle cylinders with care. - Do not allow them to knock against each other or against other pieces of equipment. Ensure cylinders are secured to prevent them falling or rolling against each other during transport.
- Do not use cylinders as rollers. - Do not roll or drag cylinders along the floor.

- Avoid lifting cylinders by their caps or valves where possible.
- Move cylinders only with the appropriate size and type of trolley. Do not use stretchers or wheelchairs.
- Use medical gas cylinders for medical treatment only (normally associated with respiratory function) and not for other purposes such as welding, laboratory experiments, etc.
- When transporting cylinders attached to medical equipment, ensure that the gas supply is switched off and the cylinder valve is closed, unless the equipment is attached to a patient. When cylinders are moved with apparatus attached always close the cylinder valve first and vent any residual gas to the atmosphere.

23.1.5 Equipment for use with medical gases

All administration equipment must comply with the relevant British Standard and must only be used with the gas for which it is designed.

23.1.6 Precautions for oxygen therapy

- There is a serious risk of fire when patients smoke or are in close proximity to other forms of ignition when receiving oxygen therapy. Oxygen, although not flammable, will increase the burning rate of any combustion. The following precautions must be taken.
- Fire and safety warning signs must be conspicuously displayed in all wards and departments where oxygen is to be administered (available from the Fire Officer).
- Smoking must not be permitted in the room or area where oxygen is being administered or stored. Other sources of ignition e.g. lighters, matches, open fires, cookers must be removed.
- Special consideration needs to be given for oxygen tents and canopies. Only toys approved by the Fire Officer should be given to a child receiving oxygen therapy.

23.1.7 Safe transport of medical gases

- The Facilities Manager must ensure that the risks arising from the transport of gas cylinders around the hospital site are assessed, and appropriate precautions established and applied.

- Gas cylinders must only be transported using containers and or vehicles which are appropriate for the size and number of the cylinders, and which allow all cylinders to be firmly secured either horizontally or vertically.

• Lifts should be used whenever practicable when gas cylinders are taken from one floor to another. Cylinders of sizes G or larger should never be manually handled up or down stairs.

- When transporting a patient receiving oxygen therapy, ensure that the oxygen cylinder is firmly secured and cannot move in transit.
- During transit the patient must be accompanied by a member of staff trained in the use of oxygen cylinders.
- If a patient receiving oxygen therapy needs to be transported home for either a home assessment or home discharge the patient should be transported by ambulance.

- Book an ambulance in the usual way via Ambulance Control and request a two-man ambulance with oxygen.
- Portable oxygen will be required once inside the patient's home and this must be prescribed and provided by the patient's General Practitioner and Community Pharmacist respectively. This must be arranged prior to discharging the patient from hospital. Hospital medical gas cylinders cannot be used in the community as they do not fit community regulators.
- If the patient is to be discharged the doctor arranging the discharge has the responsibility for arranging home oxygen in liaison with the patient's GP. - However, it is important to ensure a suitable quantity of oxygen is available in the home prior to discharge.
- If an oxygen concentrator is ordered the patient may initially require the use of oxygen cylinders or require oxygen cylinders for use in emergencies, again arranged through the patient's GP

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- The managers of departments which require to transport gas cylinders in motor vehicles, must ensure that all such vehicles are equipped so that cylinders can be firmly secured and that drivers are trained in the legal and safety requirements.
- Cylinders must only be carried in motor vehicles if they can be securely fastened in the boot of a car or rear of a van.
- Drivers must carry the appropriate handling information for the gas and be familiar with its contents.
- Any incident that causes a significant impact to a gas cylinder must be reported immediately to the relevant manager and to the pharmacy.

23.1.8 Ordering of medical gas cylinders by hospital wards and departments

During Pharmacy opening hours, routine orders for cylinders must be made by:

- On the Craigavon Area Hospital Site - bleeping the pharmacy porter
- On the Daisy Hill Hospital site – contacting the pharmacy department
- On the St Lukes site - contacting the pharmacy department
- On the Lurgan Hospital site – bleep the hospital porter

Outside Pharmacy opening hours, orders for cylinders must be made by bleeping a porter (all hospital sites).

Each ward/department has an agreed range and stock holding of medical gas cylinders. Cylinders will normally only be replaced on a full for empty basis. Cylinders will only be delivered if the requesting ward or department has appropriate storage facilities and equipment.

Cylinders may be supplied on a temporary basis when usage in a particular ward or department is high or for gases that are not normally stocked. This must be arranged through Pharmacy. When ordering such cylinders the purpose and the expected duration of need must be stated in writing.

The empty/used cylinder must be returned to the cylinder store.

All returned cylinders will be considered "empty" and returned to the supplier at the earliest opportunity.

23.1.9 Faulty Cylinders

Cylinders are described as faulty where the complaint is minor and patient safety is not at risk. Typical complaints that are classified as faulty are:

- faulty valve operation;
- damaged valve outlet; or,
- minor leaks from valve.

If a cylinder is thought to be faulty, the pharmacy staff must be contacted with details of the fault. Arrangements will be made for a replacement.
The label of the faulty cylinder must be marked "FAULTY DO NOT USE". - The faulty cylinder must be segregated from other cylinders. - A faulty cylinder must not be returned to the cylinder store unless it is labelled appropriately.
Pharmacy will contact the supplier to inform them about a faulty cylinder. The supplier will ensure uplift of the faulty cylinder at the next delivery.

23.1.10 Action in the event of fire

In the event of a fire, it is stressed that the safety of all personnel must be the first priority.

- As soon as a fire is discovered, immediately operate the Hospital Fire Procedure and notify the Fire Services, warning them of the presence of pipeline gas or compressed gas cylinders.
- Cylinders involved in the fire that cannot be removed safely may burst due to excessive heat and therefore the immediate area must be evacuated.
- Cylinders in other areas which might become involved in the fire should be moved to a safe location, provided it is safe to do so.
- Do not attempt to fight a fire in which cylinders are directly involved.
- If a cylinder is connected to, but is some distance away from, an apparatus involved in a fire, and it is safe to do so, close the valve and if possible remove the cylinder from the area. Do not take any undue risks.
- Cylinders, which have been involved in a fire, must be identified and segregated from other cylinders. Under no circumstances should their contents be used. The supplier must be informed and the affected cylinders returned for examination.

23.2 Provision of medical gases for home births

The community midwife in charge is responsible for arranging the provision of Entonox and oxygen for home births, with the pharmacy department in Craigavon Area Hospital. Several weeks notice is required to ensure the cylinders are available in the home at the correct time.

23.3 In nursing homes, residential homes, day care centres and in the domiciliary setting

23.3.1 General Guidelines

- Do not smoke or use naked lights in the immediate vicinity of a cylinder or in confined areas where cylinders are kept or stored.
- Do not subject cylinders to temperatures above 45 degrees centigrade.

- Ensure cylinders are kept free from dirt, grease and oil.
- Ensure all equipment used to transport cylinders (e.g. trolleys) is clean and free from dirt, grease and oil.
- Handle cylinders with care. - Do not allow them to knock against each other or against other pieces of equipment. Ensure cylinders are secured to prevent them falling or rolling against each other.
- Do not use cylinders as rollers. - Do not roll or drag cylinders along the floor.
- Avoid lifting cylinders by their caps or valves where possible.
- Move cylinders only with the appropriate size and type of trolley. Do not use stretchers or wheelchairs.

23.3.2 Equipment for use with medical gases

All administration equipment must comply with the relevant British Standard and must only be used with the gas for which it is designed.

23.3.3 Precautions for oxygen therapy

There is a serious risk of fire when patients smoke or are in close proximity to other forms of ignition when receiving oxygen therapy. Oxygen, although not flammable, will increase the burning rate of any combustion. The following precautions must be taken.

- Fire and safety warning signs must be conspicuously displayed where oxygen is to be administered (available from the Trust Fire Officer).
- Smoking must not be permitted in the room or area where oxygen is being administered or stored. Other sources of ignition e.g. lighters, matches, open fires, cookers must be removed.
- Special consideration needs to be given for oxygen tents and canopies. Only toys approved by the Fire Officer should be given to a child receiving oxygen therapy.

23.3.4 Safe transport of medical gases

- Gas cylinders must only be transported using containers and or vehicles which are appropriate for the size and number of the cylinders, and which allow all cylinders to be firmly secured either horizontally or vertically.

• Lifts should be used whenever practicable when gas cylinders are taken from one floor to another. Cylinders of sizes G or larger should never be manually handled up or down stairs.

- When transporting a patient receiving oxygen therapy, ensure that the oxygen cylinder is firmly secured and cannot move in transit.
- During transit the patient must be accompanied by a member of staff trained in the use of oxygen cylinders.
- Portable oxygen, required for the patient/client's own home, in residential/nursing homes or in day care centres must be prescribed and provided by the patient's General Practitioner and Community Pharmacist respectively. This must have been arranged prior to the patient being discharged from hospital. (Hospital medical gas cylinders cannot be used in the community as they do not fit community regulators.)

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- The managers of departments which require to transport gas cylinders in motor vehicles, must ensure that all such vehicles are equipped so that cylinders can be firmly secured and that drivers are trained in the legal and safety requirements.
- Cylinders must only be carried in motor vehicles if they can be securely fastened in the boot of a car or rear of a van.
- Drivers must carry the appropriate handling information for the gas and be familiar with its contents.
- Any incident that causes a significant impact to a gas cylinder must be reported immediately to the relevant manager.

23.3.5 Faulty Cylinders

Cylinders are described as faulty where the complaint is minor and patient safety is not at risk. Typical complaints that are classified as faulty are:

- faulty valve operation;
- damaged valve outlet; or,
- minor leaks from valve.

If a cylinder is thought to be faulty, the supplying community pharmacy must be contacted with details of the fault and arrangements made for a replacement to be provided.
The label of the faulty cylinder must be marked "FAULTY DO NOT USE". - The faulty cylinder must be segregated from other cylinders until it can be collected by the community pharmacy concerned.

23.3.6 Action in the event of fire

In the event of a fire, it is stressed that the safety of all personnel must be the first priority.

- As soon as a fire is discovered, immediately operate the Fire Procedure and notify the Fire Services, warning them of the presence of compressed gas cylinders.
- Cylinders involved in the fire that cannot be removed safely may burst due to excessive heat and therefore the immediate area must be evacuated.
- Cylinders in other areas which might become involved in the fire should be moved to a safe location**, provided it is safe to do so.**
- Do not attempt to fight a fire in which cylinders are directly involved.
- If a cylinder is connected to, but is some distance away from, an apparatus involved in a fire, and it is safe to do so, close the valve and if possible remove the cylinder from the area. **Do not take any risks**.
- Cylinders, which have been involved in a fire, must be identified and segregated from other cylinders. Under no circumstances should their contents be used. The supplier must be informed and the affected cylinders returned for examination.

Chapter 24 Defective Medicines

24.1 Recall of a defective medicine

Official notification of a defective medicine is issued, to the Pharmacy Department, from the DHSSPSNI as a Drug Alert, or from the manufacturer or supplier. Drug Alerts include the required timescale for action.
The Director of Pharmacy is responsible for the systems in place to check if the defective medicine has been issued by the Trust Pharmacies for use in the Trust, and to withdraw from use any defective medicine that has been issued, within the required timescale for action.
In the event of a very serious product defect being identified outside normal working hours, the Chief Pharmacist's office at the DHSSPSNI will contact the Trust's on-call pharmacists and/or the Director of Pharmacy.
The Director of Pharmacy is responsible for informing the Medical Director and the Executive Director of Nursing of any action that is being taken or is necessary in relation to a defective medicine alert.
Other senior Trust staff receiving such alerts from their Professional Officer at the DHSSPSNI should not cascade the alert unless asked to by the Director of pharmacy. This is because in the majority of alerts no action is necessary as the product is not or has not been used by the Trust. Cascade of non-relevant alerts can create unnecessary concern and activity amongst staff.

24.2 Reporting a defective medicine

If any member of staff has reason to believe that a medicine is defective, he or she must inform the Pharmacy Department immediately.
The person who discovers the defect must ensure that the product, container and other packaging are retained. If the defect has been discovered following reconstitution or mixing with another preparation, then the mixture, remaining unmixed constituents, and all containers and other packaging must also be retained. All retained materials must be placed in a sealed container, clearly marked 'Do not use', and returned to the pharmacy as soon as possible. The member of staff returning the product must complete a Trust incident (IR1) form and send a photocopy of the form to the Quality Assurance Pharmacist in the Craigavon Area Hospital Pharmacy.
The Director of Pharmacy is responsible for the systems in place to investigate local reports of defective medicines, to withdraw from use other affected stock if appropriate, and to inform the MHRA Defective Medicines Report Centre if there are implications for the rest of the health service.

Chapter 25 Medication incident reporting

Medication incidents are the most common preventable cause of patient injury and can occur during the prescription, dispensing and administration of medicines.

All staff must adhere to the Trust procedures for the reporting of incidents relating to medicines within each ward, department, residential home, nursing home, day care centre, respite centre and supported living facility in the Trust.

In hospitals, multidisciplinary review of medication incidents must be conducted by medical, nursing and pharmacy staff on a regular basis. Staff should receive feedback from such review and be informed of improvements in practice.

In , residential homes, nursing homes, day care centres, respite centres and supported living facilities a review of medication incidents must be conducted by senior staff on a regular basis. Staff should receive feedback from such review and be informed of improvements in practice.

Chapter 26 Management of Illicit Substances

All unauthorised drugs or other suspicious substances must be handled in accordance with the relevant legislation and with the guidance issuesd by DHSSPSNI.

The member of staff finding the illicit substance(s) should immedeatly inform the manager of the facility where the substance was found.

If the substance is found on a patient:

- In the hospital setting, the manager of the facility should contact the patient's Registered Medical Officer or if not avaialble, the duty Consultant. The Consultant may decide to attend the patient or arrange for another doctor to attend. The Consultant should be kept informed of the situation.
- In the community setting the most senior member of staff available should attend the patient.

A patient found to have illicit substance(s) in their possession should be asked to surrender these and the procedure outlined below should be followed.

Any illicit substance(s) found should be placed in a suitable secure sealed container (e.g. a dry sample bottle) and a label should be placed over the container seal so that it would be evident if the container was opended again. This label **must** be signed and dated by the member of staff who found the and the senior manager/consultant.

Part 1 of the form 'Removal or destruction of Ilegal Substances' must be completed and should be witnessed and signed by the unit manager. The form number should be the pharmacy user code of the facility followed by the date and a sequential letter of the alphabet (e.g. 760 010711 A). If you do not already have copies of the form please contact the pharmacy.

The container should then be placed in a locked controlled Drug Cupboard until it can be collected by a Pharmacist or, in certain circumstances, the Police. A Trust IR1 incident form must also be completed. (In community facilities, if a controlled drug cupboard is not avaible then the most secure locked cupboard must be used and all the keys to that cupboard must be held by the person in charge, until the substance is removed)

The pharmacist assigned to the ward or the Director of Pharmacy should be informed of the situation and they will make arrangements to remove the substance at an appropriate time.

Part 2 of the form 'Removal or destruction of Ilegal Substances' must be completed by the pharmacist and should be witnessed and signed by the unit manager.

The pharmacy department will store the illicit substance(s) until collection by the Misuse of Drugs Inspector or the Police or intrsuted by them to destroy the substance(s). If the pharmacist feels that the quantity is greater than for personal use then the pharmacist should consult the lead professionals dealing with the incident and/or the Misuse of Drug Inspector. The pharmacist will then decide on whether to give the substance(s) to the Misuse of Drug Inspector or the Police. Part 3 of

the form ‘Removal or destruction of Ilegal Substances’ should be completed by the pharmacist and either the Misuse of Drug Inspector or the Police Officer.

A member of the senior managment team or the police liaison officer should be contacted if the incident is sufficently serious to warrant investigation by the Police i.e. a quantity greater than for personal use, supply of drugs whilst on a ward, etc. It is important to seek legal advice and, if necessary, advice from a professional body before making any disclosure withiut the consent of the patient concerned. An agreed management plan involving relevant senior managers and clinicians should clarify what information will be given to the Police and by whom. The patient must be kept informed of any proposed actions.

If Police are called to take possession of the substance(s) then the Police Officer should complete part 2 of the form and be witnessed and signed by the unit manager.

Chapter 27 Reporting adverse drug reactions

Any drug may produce unwanted or unexpected adverse reactions. Rapid detection and recording of adverse drug reactions is of vital importance so that unrecognised hassards of a drug are identified promptly and the appropriate regulatory action is taken to ensure patient safety.

Doctors, dentists, nurses, midwifes and pharmacists are urged to help by reporting adverse drug reactions to the Medicines and Helathcare product Regulatory Agency.

More information on reporting suspected adverse drug reactions via the 'yellow card scheme' is given in the initial pages of the current British National Formulary (BNF).

The simplest way to report an adverse drug reaction is via the 'Yellow Card Scheme' web-site www.yellowcard.gov.uk . 'Yellow cards' for reporting suspected adverse drug reactions can also be found in the back of the current BNF.

New drugs and vaccines
Only limited information is availble from clinical trials on the safety of new medicines. Further understanding about the safety of medicines depends on the availability of information from routine clinical practice. The black triangle symbol (▲) in the BNF identifies newly licensed medicines that are being monitored intensively by the MHRA.

The MHRA asks that all suspected reactions to such product, including those not thought to be serious, are reported through the Yellow Card scheme. An adverse reaction should be reported even if it is not certain that the drug has cuased it, or if the reaction is well recognised, or if other drugs have been given at the same time.

Glossary of terms

Administer means administer to a human being or an animal whether orally, by injection or by introduction into the body in any other way, or by external application, a substance or article either in its existing state or after it has been dissolved or dispensed in, or diluted or mixed with, some other substance used as a vehicle (Medicines Act 1968).

Assisting patients with meidicines Patient/clients in domiciliary care who are unable to self-administer their medicines may require assistance with their medicines. This will be carried out by the domiciliary care worker according to the instructions in patient/client held care plan.

ATO An Assitiant Technical Officer is a member of the pharmacy team, trained to NVQ2 level, who works under the supervision of a pharmacist or pharmacy technician.

Black Triangle Medicines Newly-introduced medicines still subject to special monitoring for potential side effects by the Medicines and Healthcare Products Regulatory Agency (so-called because they are identified by a black triangle symbol)

Clinical Trial A clinical trial is a carefully designed and controlled research study designed to test the safety and/or effectiveness of drugs, devices, treatments, or preventive measures in humans.

Complementary Medicines Complementary therapies, such as herbalism, homoeopathy and aromatherapy, involve the administration of unlicensed products such as herbal medicines, homoeopathic remedies and essential oils (used in aromatherapy)

Controlled Drugs (CDs) Narcotic drugs or other drugs liable to misuse which are subject to special controls under the Misuse of Drugs Act 1971

Dentist A person who is trained and licensed to practice dentistry

Dispense To make up or give out a clinically appropriate medicine to a patient for self-administration or administration by another, usually a professional. In the case of prescription-only medicines, dispensing must be in response to a legally valid prescription. The act of dispensing is combined with advice about safe and effective use

General sales list (GSL) A medicinal product which can be sold or supplied direct to the public

Group Protocol is a specific written instruction for the supply and administration of named medicines in an identified clinical situation. It is drawn up locally by doctors, pharmacists and other appropriate professionals, and approved by the employer, advised by the relevant professional advisory committees. It applies to groups of patients or other services users who may not be individually identified before presentation for treatment.

Licensed medicine A medicine which falls within the definition of a medicinal product and which is granted a marketing authorisation by the Licensing Authority when the safety, quality and efficacy of the product have been satisfactorily demonstrated by the license holder in accordance with EC directives 65/65

Licensed indication Treatment purpose for which a product may be used under the terms of the marketing authorisation granted by the Licensing Authority (see also licensed medicine)

Illicit Substance A substance obtained illegally, that causes addiction, habituation, or a marked change in consciousness.

Independent Prescriber is a person who is registered with the Nursing and Midwifery Council or the Pharmaceutical Society of Northern Ireland and against whose name in that register is recorded an annotation signifying that they are qualified to order drugs, medicines and appliances as an independent prescriber

Medicinal Product Article 1 of Directive 2001/83 EC defines a medicinal product as 'any substance or combination of substances presented for treating or preventing disease in human beings or animals. Any substance or combination of substances which may be administered to human beings or animals with a view to making a diagnosis or to restoring, correcting or modifying physiological functions in human beings or animals is likewise considered a medicinal product'.

MTO A Medical Technical Officer, also known as a Pharmacy Technician, is a member of of the pharmacy team, trained to NVQ3 and BTEC level, who works under the supervision of a pharmacist.

Nurse/Midwife A person how has completed a formal program of nursing education and is registered with the Nursing and Midwifery Council.

Patient any person who receives medical attention, care, or treatment.

Patient Group Direction (PGD) is a document signed by a doctor and agreed by a pharmacist that acts as a direction to a nurse/midwife to supply and/or administer a prescription only medicine to a patient using their own assessment ot patient need, without necessarily refering back to the doctor for an individual prescription.

Pharmacist A person registered with the Pharmaceutical Society of Northern Ireland who is responsible for the safe, effective and efficient use of medicines.

Pharmacy medicine (P) A medicinal product which may only be sold or supplied by a pharmacist.

Practitioner is a physician or other individual licensed in law to practice their profession.

Prescriber is a person authorised under the Medicines Act 1968 to order in writing the supply of a prescription only medicine for a named patient

Prescription only medicines (POMs) A medicinal product which may only be sold or supplied against the signed prescription of an appropriate practitioner, i.e. doctor, dentist, some nurse/midwife (in respect of a specified list of POMs) specified in the Prescription Only Medicines (Human Use) Order 1997

Sister/Charge Nurse is a nurse/midwife in charge of a ward, theatre or other department in a hospital or nursing home or, a caseload holder in a community setting.

Student nurse This term applies to Nursing and Midwifery students undertaking a programme of education leading to professional qualification and primary entry to the Nursing and Midwifery professional register, and to those students undertaking a programme of education that leads to movement within parts, or to another part of the Nursing and Midwifery professional register, for example Adult to Mental Health Nursing.

Supply To provide a medicine to a patient / carer for administration

Trained care staff Non-registered care staff in residential care homes and day care centres, who have received appropriate training in handling and administration of medicines and have been deemed to have the required knowledge and ability to administer certain medicines and/or assist patients/clients/residents with their medicines.

Unlicensed Medicine is the term used to refer to a medicine that has no product licence. If an unlicensed medicine is administered to a patient, the manufacturer has no liability for any harm that ensues. The person who prescribes the medicine carries the liability.

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Southern Health and Social Care Trust

CLINICAL GUIDELINES ID TAG	
Title:	**HOSPITAL CONTROLLED DRUG PROCEDURES**
Author:	Lyn Watt
Designation:	Pharmacy Patient Services Manager
Speciality / Division:	Pharmacy
Directorate:	Acute Services, OPPC Inpatient Wards & MHD Inpatient Wards
Date:	25 / 02 /2019
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Clinical ID:	

Southern Health and Social Care Trust	Craigavon Area Hospital Pharmacy Department	Standard Operating Procedure ID CD Version 4

Title: HOSPITAL CONTROLLED DRUG PROCEDURES

Author:	Lyn Watt	Date:	25/02/19	Review Date: 3 years from approval date	
Approval by:	Dr Tracey Boyce	Date:		Reviewed by:	
Copy Number:	1	Pages:	1 of 47	Next review date:	25/02/22

I the undersigned have read the Southern Health and Social Care Trust Hospital Controlled Drug Procedures and fully understand the points detailed. I am also fully aware of what my responsibilities and those of my colleagues are as a result of this procedure.

NAME	GRADE	WARD/DEPT	SIGNATURE	DATE

Southern Health and Social Care Trust	Craigavon Area Hospital Pharmacy Department	Standard Operating Procedure ID CD Version 4

Title: HOSPITAL CONTROLLED DRUG PROCEDURES

CD01 General Procedure for Controlled Drugs

Author:	Lyn Watt	Date:	25/02/19	Review Date: 3 years from approval date	
Approval by:	Dr Tracey Boyce	Date:		Reviewed by:	
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These procedures are underpinned by the Health Act 2006 and the Controlled Drugs (Supervision of Management and Use) Regulation (Northern Ireland) 2009 as amended by the Controlled Drugs (Supervision of Management and Use) (Amendment) Regulations (Northern Ireland) 2015.

Under The Controlled Drugs (Supervision of Management and Use) Regulations (Northern Ireland) 2009 HSC Organisations and Independent Hospitals must appoint an Accountable Officer to be responsible for a range of measures relating to the monitoring of the safe management and use of controlled drugs and related governance issues within their organisation and take appropriate action where necessary. The day to day discharge of these responsibilities may be undertaken by a Designated Officer who will be responsible for providing appropriate assurances to the Accountable Officer. The Accountable Officer for controlled drugs in the Southern Health and Social Care Trust is Dr Tracey Boyce, Director of Pharmacy.

The Health Act 2006 contains three provisions in relation to the Fourth Report of the Shipman Enquiry to improve and strengthen the management and use of controlled drugs:

- The appointment of an Accountable Officer by Designated Bodies
- A duty to collaborate and share intelligence on controlled drugs between health bodies and other organisations
- A power of entry and periodic inspections by certain authorised persons.

The responsibility for ordering, receipt and storage of controlled drugs on a ward/ clinical area is that of the senior registered nurse/midwife or registered operating department practitioner (ODP) in charge. Tasks can be delegated to another registered nurse/ midwife or another ODP but the responsibility cannot. The ward/ clinical area manager has overall responsibility for ensuring that all staff are aware of the controlled drug procedures and their individual responsibilities within each procedure.

Orders for controlled drugs must be made in chronological order and written in indelible ink so as to be permanent. Controlled drug requisition books must be locked away in the controlled drug cabinet. Controlled drug register should be kept either locked in the controlled drug cabinet or in a designated place which is secure and has restricted access. These books are controlled stationery and obtainable only from the pharmacy department on a controlled drug requisition. Only one book in use shall be held on each ward/ clinical area at any one time except where a second controlled drug register is used for epidural controlled drugs. Each ward / clinical area should have a separate controlled drug requisition book and controlled drug register. Completed controlled drug requisition books must be kept on the ward/ clinical area for two years after the last entry and controlled drug registers must be kept on the ward/ clinical area for eleven years after the last entry (Southern Health and Social Care Trust Records Retention and Disposal Schedule link to https://www.health-

ni.gov.uk/articles/disposal-schedule-section-m If a controlled drug requisition book or register is lost this must be reported immediately to the ward/ clinical area manager and the pharmacy department.

Pages should not be removed from these books (with the exception of the yellow and blue copies of each requisition which will be removed by pharmacy). Entries should not be erased.

It is illegal to exchange or supply controlled drugs between ward / clinical area. If a controlled drug is needed when pharmacy is opened the senior registered nurse/ midwife or ODP in charge must order and obtain this drug from pharmacy. If a controlled drug is needed when pharmacy is closed the nurse/midwife in charge must contact the on call pharmacist to supply the drug. There may be exceptional emergency circumstances when the pharmacist on call may authorise the transfer of one dose of the controlled drug between ward / clinical area e.g. if diamorphine is required for myocardial infarction. One nurse / midwife from the clinical / ward area requesting the controlled drug must go to the clinical/ward area issuing the controlled drug and along with the nurse / midwife from the issuing area both check and sign out the controlled drug. The controlled drug must then be written into the requesting area controlled drug register and must be checked in by a second nurse. This must be followed up the next working day by the on call pharmacist.

If a patient is being transferred from ward / clinical area with an epidural or PCA infusion a set of epidural/ PCA observations including the rate setting and the total volume infused should be documented and signed on the MEWS chart at the point of transfer by the transferring nurse/ midwife and the receiving nurse/ midwife.

Controlled drugs cannot be administered without a prescription.

Controlled drugs must be stored in a controlled drug cabinet. This cabinet is to be reserved solely for the storage of controlled drugs; no other items or medicines should be stored there. The lock should not be common to any other lock in the hospital.

The key for the controlled drug cabinet must be kept on the person of the senior registered nurse/ midwife or registered operating department practitioner (ODP) in charge of the ward/ clinical area or the registered nurse/ midwife or ODP nominated by them. The key must be held separately from other medicine keys. No person should have access to the controlled drug cabinet except in the presence of the nurse officially holding the key. The key may not be handed over to medical staff but may on occasions for the purpose of stock checking be handed to a designated member of pharmacy staff. Spare controlled drug cabinet keys should be handed over to the pharmacy department for safe storage.

If the controlled drug keys cannot be found urgent efforts should be made to retrieve the keys as soon as possible e.g. by contacting staff who have just gone off duty. Loss of controlled drug keys must be reported to the sister/ charge nurse/ registered nurse/ midwife/ ODP in charge who must immediately notify their head of service / departmental manager, their assistant director and the pharmacy department. If pharmacy is closed the on call pharmacist must be notified. The estates department must be contacted to fit new locks on the controlled drug cabinet as soon as possible to preserve the security of the controlled drug stocks. If a spare controlled drug key is held by pharmacy this may be issued to ward/ clinical area until a new lock is fitted to ensure that patient care is not impeded. Wherever possible the controlled drug cabinet should be located in an area where staff is present 24 hours a day. In areas where this is not feasible adequate steps should be taken to securely lock all areas where controlled drugs are stored when not in use. If controlled drugs are stored in a ward/ clinical area that is not staffed 24 hours a day e.g. at the weekend, that area should be alarmed. If

this is not possible then alternative arrangements for storage can be made after discussion with pharmacy.

Each ward/ clinical area should have an agreed list of the controlled drugs to be held as stock. The content of this list should reflect current patterns of usage and be agreed between the pharmacy and the senior registered nurse/ midwife or ODP in charge. This list should be reviewed at regular intervals e.g. at the 4 month controlled drug audit.

For each controlled drug held in a ward/ clinical area a running total of the stock should be maintained in the controlled drug register.

Each page in use in the ward/ clinical area controlled drug register must be titled with the drug name, form, strength / concentration, ampoule/vial size and the proprietary name if appropriate.

Entries in the ward/ clinical area controlled drug register must be in chronological order and be in indelible ink so as to be permanent.

All pages in the ward/ clinical area controlled drug register must be completed in full before transferring stock balances. On reaching the end of a page the balance must be transferred to another page. The new page number must be added to the bottom of the finished page and initialed. The index at the front of the ward / clinical area controlled drug register must be updated to indicate the page number of the current stock recording. The finished page number must be indicated at the top of the new follow-on page. See example 1.

Example 1

Generic Name_Diamorphine___**Brand Name**_____**Strength**__5mg___**Form**____injection____ **Ampoule/Vial Size** ___ 09 (If Applicable)

Amount(s) Obtained from Pharmacy			**Amount(s) removed from CD cabinet**					**Names & signatures of persons making enteries**		Stock Balance	Stock balance confirmed as correct (sign & date)
Date received	Amount Received	Name of Pharmacy & Serial No. of Requisition	Date given	Time given	Patient's name and Unit Number	Amount Given	Amount wasted	Name & signature of authorised person taking receipt of or administering drug or discarding drug wastage	Name & signature of person witnessing receipt of or administration of drug/ witnessing drug wastage		
										Balance of stock 1	Transferred from page_8_
5.4.09	5	CAH 00021	Received from pharmacy D. Toner / G. Corrigan							6	
			6.4.09	1200	Mary Browne 22458888	5mg	-	D. Toner	H. Merryfield	5	
			7.4.09	0900	George Clooney 6781918	5mg	-	T. Holly	J. Rock	4	
7.4.09	5	CAH 00024	Received from pharmacy J. Rock / F. Homer							9	
			7.4.09	1800	Hilda Decon 78453487	5mg	-	T. Holly	W. Evans	8	

Balance transferred to page 10_TH

When a new controlled drug register is started the balance of controlled drugs in stock should be written into the new book promptly by ward staff following the procedure for transferring the balance of controlled drugs in stock into a new controlled drug register (CD07). This transfer should be witnessed by a registered nurse, midwife, ODP or a pharmacist.

For further information see SH&SCT Medicines Code November 2016
http://www.southernguidelines.hscni.net/?wpfb_dl=527

Southern Health and Social Care Trust	Craigavon Area Hospital Pharmacy Department	Standard Operating Procedure ID CD Version 4

Title: HOSPITAL CONTROLLED DRUG PROCEDURES

CD02 Procedure for Ordering Controlled Drugs from the Pharmacy Department

Author:	Lyn Watt	Date:	25/02/19	Review Date: 3 years from approval date	
Approval by:	Dr Tracey Boyce	Date:		Reviewed by:	
Copy Number:	1	Pages:	6 of 47	Next review date:	25/02/22

1. Controlled drugs can only be ordered from the pharmacy department by submitting a requisition in the official controlled drug requisition book.

2. Ordering of controlled drugs is restricted to a registered nurse/ midwife or registered operating department practitioner (ODP) who is deemed suitable by their ward /clinical area manager and are permanent members of staff or temporary staff who has a block booking and whose manager have provided signatures to pharmacy. Agency staff cannot order controlled drugs.

3. The requisition must indicate the hospital, ward or department and the name, form, quantity, strength and ampoule size (if more than one available) of the drug required. Only one drug can be written on each requisition. The quantity should be written as the number of units e.g. number of tablets or ampoules rather than the number of boxes. The requisition must be signed and dated by the person ordering the controlled drug. This information must be complete on all three copies of the requisition (yellow, blue and white copies). See example 2.

4. If an error occurs when ordering a controlled drug, a line should be drawn through the entry and initialed by the practitioner who made the error. Any amendments to an order for a controlled drug must be endorsed by the person ordering the item in both words and figures and initialed. If the pharmacy department amends an order for a controlled drug when supplying the controlled drug e.g. the order is for five ampoules and the drug is only available as a box of ten ampoules, the member of pharmacy staff will bracket the original quantity ordered, write the quantity supplied in words and figures beside this and sign and print his/her name beside the new quantity.

5. The controlled drug requisition book must be reserved solely for ordering controlled drugs.

6. All registered nurses/ midwives or ODPs who may order controlled drugs must provide the pharmacy department with a specimen signature. Specimen signatures are held in pharmacy see appendix 1. The sister/ charge nurse/ ODP in charge of a ward/ clinical area may request from pharmacy the list of specimen signatures for her/ his ward/ clinical area to update the list, to add new staff and to delete staff from the list who no longer work on that ward/ clinical area. The list should be returned to pharmacy as soon as possible after it has been updated. The list must also be reviewed at the 4 month controlled drug audit.

7. A member of ward/ clinical area staff should leave the completed controlled drug requisition book and Envopak® in pharmacy. In South Tyrone hospital, Lurgan hospital and St Luke's hospital the completed controlled drug requisition book should be place in the controlled drug transport box which should then be locked. The locked transport box should then be sent to pharmacy with a SH&SCT transport driver.

8. Each ward / clinical area should have an agreed stock list and stock controlled drugs should be ordered before 11:00am on the ward / clinical area's specified controlled drug stock order days. Controlled drugs should not be ordered on a Saturday or Sunday unless a controlled drug not stocked by the ward/ clinical area has been prescribed. The registered nurse/ midwife or ODP in charge on a Friday must ensure that adequate stocks of controlled drugs are ordered to cover the weekend and prior to Bank Holidays.

Example 2

SOUTHERN HEALTH AND SOCIAL CARE TRUST
MISUSE OF DRUGS ACT
ORDER FOR CONTROLLED DRUGS

123456

Hospital…… ……Craigavon……..……..

Ward or Dept…… ……Ward 4……..….

Each preparation to be ordered on a separate page

NAME OF PREPARATION	FORM	STRENGTH	QUANTITY
Morphine Sulfate	Injection	10mg	10 ampoules

Ordered by: …*G Reid* . …….. G REID…..…… Date……01/11/17…...……
Signature of Registered Nurse / Midwife / ODP Print name

Supplied by: …….. …… ..……..…… Date…….……..
Signature of Pharmacist / Authorised Technician Print name

Issued by / Checked by: ……..…… …….…… Date……..……
Signature of Pharmacist / ACPT Print name

Accepted for Delivery: …… ……..…… Date……..……..
Signature of Messenger Print name

ID Check: Y / N Job Title: ……

Received by: ……..…… ..……..…… Date……..……
Signature of Registered Nurse / Midwife / ODP Print name

Title: HOSPITAL CONTROLLED DRUG PROCEDURES

CD03 Procedure for Collection of Controlled Drugs from the Pharmacy Department

Author:	Lyn Watt	Date:	25/02/19	Review Date: 3 years from approval date	
Approval by:	Dr Tracey Boyce	Date:		Reviewed by:	
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1. A registered nurse/ midwife or ODP or a health care assistant can collect controlled drugs from the Pharmacy Department. Controlled drugs for South Tyrone hospital can be collected by a SH&SCT transport driver. The person collecting the controlled drugs (the messenger) will be asked to present SH&SCT photographic ID when receiving the controlled drugs from pharmacy. A list of specimen signatures for healthcare assistants authorised to collect controlled drugs is held in pharmacy see appendix 2. It is the responsibility of the sister/ charge nurse/ ODP in charge of a ward / clinical area to keep this list up to date. The list must also be reviewed and updated at the 4 month controlled drug audit

2. The messenger must check the correct name, form, strength and quantity of each drug received. These details must agree with the controlled drug requisition. If a box containing a controlled drug is sealed with the manufacturer's tamper evident seal the quantity of drug can be taken as that printed on the box. Tamper evident seals should only be broken when the pack is required for administration. If when the seal is broken the contents do not match the expected amount stated on the pack the senior registered nurse/ midwife or ODP in charge should contact the pharmacy as soon as possible.

3. The member of pharmacy staff supplying the controlled drug must sign, print and date his/her name in the 'Supplied by' section on the yellow copy of the controlled drug requisition. The member of pharmacy staff issuing the controlled drug must sign, print and date his/her name in the 'Issued / Checked by' section on the yellow copy of the controlled drug requisition and confirm ID checked by circling Y or N. The messenger must sign, print and date his/her name in the 'Accepted for delivery' section on the yellow copy of the controlled drug requisition. See example 3. Pharmacy will then remove the yellow copy from the requisition book.

4. The controlled drugs and controlled drug requisition book will then be placed in an Envopak® and sealed with a tamper evident seal. Controlled drugs for wards in South Tyrone hospital, Lurgan hospital and St Luke's hospital will be placed in the ward controlled drug transport box with the controlled drug requisition book. This box will then be locked.

5. On receipt of the drug(s) at ward/ clinical area level a registered nurse/ midwife or ODP breaks the tamper evident seal on the Envopak® or unlocks the controlled drug transport box and removes the controlled drugs. The registered nurse/ midwife or ODP must check the correct name, form, strength and quantity of each drug received in the presence of the messenger. This must agree with the controlled drug requisition. If there is any discrepancy the registered nurse/ midwife or ODP must contact pharmacy immediately.

6. The registered nurse/ midwife or ODP then completes in the presence of the messenger the date received, the amount received, the name of the pharmacy, the requisition serial number and updates the running balance for each drug in the appropriate page of the controlled drug register as shown in example 4. The registered nurse/midwife or ODP must record received from pharmacy and sign this entry. This entry must be countersigned by the 'Messenger' or another registered nurse/ midwife or ODP as the witness. The top of each page in the register must state the name, strength and form of the drug and the brand name if appropriate.

Example 3

SOUTHERN HEALTH AND SOCIAL CARE TRUST
MISUSE OF DRUGS ACT
ORDER FOR CONTROLLED DRUGS

789123

Hospital…… ……DHH……..……

Ward or Dept…… ……Ward 2……..…..

Each preparation to be ordered on a separate page

NAME OF PREPARATION	FORM	STRENGTH	QUANTITY
Fentanyl	Injection	50 micrograms / ml 2ml	20 ampoules

Ordered by:……*L Smith* . ……. …L SMITH…..…… Date……01/11/17…...……..
Signature of Registered Nurse / Midwife / ODP Print name

Supplied by:……*C Scarlett* ……. …C SCARLETT… Date……01/11/17……..…..
Signature of Pharmacist / Authorised Technician Print name

Issued by / Checked by:……*J Sock*……. .....J SOCK……. Date……01/11/17…….
Signature of Pharmacist / ACPT Print name

Accepted for Delivery……*H Brown*…….. ..H BROWN..…… Date……01/11/17……
Signature of Messenger Print name

ID Checked: Y / N Job Title: Registered Nurse……

Received by……*M Jones*……. …M JONES…… Date…01/11/17……..
Signature of Registered Nurse / Midwife / ODP Print name

Example 4

Generic Name_Morphine sulfate__**Brand Name**_____ **Strength**__10mg__F**orm**_injection_ **Ampoule/Vial Size** ___ 02 (If Applicable)

Amount(s) Obtained from Pharmacy			**Amount(s) removed from CD cabinet**					**Names & signatures of persons making entries**		Stock Balance	Stock balance confirmed as correct (sign & date)
Date received	Amount Received	Name of Pharmacy & Serial No. of Requisition	Date given	Time given	Patient's name and Unit Number	Amount Given	Amount wasted	Name & signature of authorised person taking receipt of or administering drug or discarding drug wastage	Name & signature of person witnessing receipt of or administration of drug/ witnessing drug wastage		
										Balance of stock	Transferred from page_1_
1.2.09	5	DHH 00001	Received from pharmacy S. Greene / P. Godfrey							6	
			1.02.17	0900	Joe Getbetter 945310401	10mg	-	L. Smith	H. Brown	5	
			1.02.17	1500	Frank Sickly 906549876	5mg	5mg	L. Brown	S. Greene	4	
2.2.09	10	DHH 00002	Received from pharmacy H. Brown/ J. Sock							14	
			2.02.17	1300	Sam Smith 79581234	10mg	-	L. Smith	L. Brown	13	

7. The registered nurse/ midwife or ODP must then date and sign his/her name in the 'Received by' section on the blue copy of the controlled drug requisition in the presence of the messenger before locking the controlled drug(s) in the controlled drug cabinet. See example 3. The blue copy of the requisition will be removed by pharmacy the next time controlled drugs are ordered from pharmacy.

8. On no account can one registered nurse/ midwife or ODP sign both the 'Accepted for delivery' and 'Received by' sections of a controlled drug requisition.

9. A registered nurse/ midwife or ODP or a healthcare assistant must collect discharge prescriptions containing controlled drugs from pharmacy. On no account can controlled drug discharge medications be supplied from the ward/ clinical area stock, they must be supplied from pharmacy on a patient discharge letter written by an authorised prescriber. Controlled drug discharge prescriptions for South Tyrone, Lurgan hospital and St Luke's patients can be collected by a SH&SCT transport driver.

10. The registered nurse/ midwife or ODP or the healthcare assistant or SH&SCT transport driver must sign for the collection of the controlled drug discharge prescription from pharmacy.

11. The discharge medications must be recorded in the Patients Own Controlled Drug (PODCD) register, Record of Schedule 2 Controlled Drugs Supplied from Hospital on Discharge Prescriptions (yellow pages) according to procedure CD08b Procedure for the Storage of Controlled Drugs supplied on discharge from the hospital pharmacy. They must be locked in the ward/ clinical area controlled drug cabinet and a record made in the nursing notes detailing this. On discharge the discharge medications must be removed from the controlled drug cabinet and checked against the discharge prescription and kardex before being given to the patient. This should be recorded in the nursing notes.

Southern Health and Social Care Trust	Craigavon Area Hospital Pharmacy Department	Standard Operating Procedure ID CD Version 4

Title: HOSPITAL CONTROLLED DRUG PROCEDURES

CD04 Procedure for Checking Stock Levels of Controlled Drugs in a Ward/ Clinical Area

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Approval by:	Dr Tracey Boyce	Date:		Reviewed by:	
Copy Number:	1	Pages:	11 of 47	Next review date:	25/02/22

1. Controlled drugs stock balance at ward/ clinical area level must be checked and reconciled at the morning and evening nursing staff shift changes. Both ward stock and patients own drugs must be checked. Two practitioners e.g. registered nurse/ midwife or ODP must undertake this procedure, one from the outgoing shift and one from the incoming shift. Ideally the two practitioners should be the senior registered nurse/ midwife or ODP in charge of the ward/ clinical area from the outgoing shift and the incoming shift. In exceptional circumstances this can be delegated to a registered nurse/ midwife or ODP nominated by them. It is good practice at the morning staff change to order the controlled drugs needed.

2. The correct name, form, strength and quantity of each drug contained in the controlled drug cabinet must be determined and agreed by both practitioners e.g. registered nurse/ midwife or ODP. The quantity of each drug must agree with the stock level as recorded in the controlled drug register. Discrepancies can arise with liquid controlled drugs as a result of manufacturer's overage, the measurement process or spillage but these should be negligible. Stock balances of liquid medicines may be checked by visual inspection but the balance must be confirmed to be correct on completion of a bottle and before opening a new bottle. When spillages occur a second practitioner should verify the spillage and this should be recorded in the controlled drug register by both practitioners.

3. The two practitioners must also check that all the documentation is complete in the controlled drug register. If there are any missing dates, times, patient's names H&CN's or practitioner's signatures these must be followed up immediately. The two practitioners should review patient notes and have all documentation complete before handing over.

4. Both practitioners e.g. registered nurse/ midwife or ODP must complete the 'Official handing over of controlled drugs' section with the date, time and signature of both practitioners. This section can be part of the controlled drug register or loose sheets filed at the back of the controlled drug register and are available from pharmacy as shown in example 5.

Example 5

Official Handing Over of Controlled Drugs – i.e. Day/Night Staff Night/Day Staff

DATE	TIME		Checked By	Received By	Remarks
	a.m.	p.m.			
01/11/17	07:30		*Lucy Jones*	*Anne Smith*	Correct
01/11/17		20:30	*Anne Smith*	*Jess Martin*	Correct

5. If there are any stock discrepancies this must be documented in the remarks section. The sister/ charge Nurse/ registered nurse/ midwife or ODP in charge must be notified of any stock discrepancies immediately. A Trust incident (IR1) form must be completed on Datix. The relevant page(s) in the controlled drug register and patient(s) kardex(es) if appropriate should be scanned and attached to the incident form on Datix. The sister/ charge nurse/ registered nurse/ midwife or ODP in charge must notify their head of services/ departmental manager, their assistant director and the pharmacy department. If pharmacy is closed the on call pharmacist must be notified. It is the responsibility of the Director of Pharmacy to investigate controlled drug stock discrepancies.

6. In the event of a stock discrepancy check the following:

   - What time was the last correct controlled drug check?
   - Identify all nurses / midwives /ODP's who had custody of the controlled drug keys since the last correct controlled drug check was performed.
   - Identify from patients' prescription charts all instances were controlled drugs were administered since the last correct controlled drug check.
   - Ensure that the controlled drug register has been correctly completed for each administration.
   - Check the stock of all other controlled drugs held on the ward/ clinical area – are they correct?
   - Has the drug administration been recorded on the correct page e.g. if the administration of MST 10mg has been incorrectly recorded on the MST 30mg page there will be one less MST 10mg and one extra MST 30mg tablet in the controlled drug cabinet compared to the stock balances in the controlled drug register.
   - Has an unused drug been discarded prior to administration and not recorded in the register?
   - Where practical, inspect all domestic and clinical waste bags and burn bins in case a full or partially full ampoule has been inadvertently disposed of. This may include locating and inspecting waste before it leaves the site.
   - If no explanation can be found for the discrepancy the sister/ charge nurse/ registered nurse/ midwife or ODP in charge should take written statements from all staff that have had custody of the controlled drug keys since the last correct controlled drug check.
   - The incident should be reported following the Trust's Management of Adverse Incidents Policy. The incident should be reported following the SH&SCT Incident Management Procedure.
     http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/documents/20141106_WorkingDraft_SHSCTIncidentMgmtProcedure_CGO_Nov2014.pdf

7. The index at the front of the controlled drug register should accurately reflect the current pages in use for all controlled drugs that have been ordered by the ward/ clinical area.

8. A designated member of pharmacy staff must check the ward/ clinical area controlled drug records and stock balance at least once every four months. This is carried out using a standard proforma see appendix 3. At this check the pharmacist will sign and date each controlled drug register page checked by pharmacy. The pharmacist will check the correct name, form, strength and quantity of each drug against the controlled drug register. If this is correct the pharmacist will sign and date the 'stock balance confirmed as correct' column. See example 6. Volume checks of liquid controlled drugs will be carried out at this check. The

pharmacist will give the ward manager a copy of the completed proforma and discuss any problems identified. It is the ward manager's responsibility to highlight identified problems to ward staff to improve practice and prevent recurrence. The pharmacist will email copies of the completed proforma to the Ward Manager, Head of Service, Assistant Director responsible for that ward/ clinical area and the Director of Pharmacy.

Example 6

Generic Name_____**Brand Name**_____MST___ **Strength**__30mg____**Form**____tablet___ **Ampoule/Vial Size** ___ 50 (If Applicable)

Amount(s) Obtained from Pharmacy			**Amount(s) removed from CD cabinet**					**Names & signatures of persons making entries**		Stock Balance	Stock balance confirmed as correct (sign & date)
Date received	Amount Received	Name of Pharmacy & Serial No. of Requisition	Date given	Time given	Patient's name and Unit Number	Amount Given	Amount wasted	Name & signature of authorised person taking receipt of or administering drug or discarding drug wastage	Name & signature of person witnessing receipt of or administration of drug/ witnessing drug wastage		
										Balance of stock 5	Transferred from page_49_
			22.3.17	0800	Elizabeth Sloan 8434456	30mg	-	R. Gordon	F. Souness	4	
			22.3.17	2200	Elizabeth Sloan 8434456	30mg	-	A. Harrison	J. George	3	
			23.3.17	0800	Elizabeth Sloan 8434456	30mg	-	F. Souness	N. Loos	2	
23.3.09	60	LG 00079	Received from pharmacy J. Rock / J. George							62	
			23.3.17	2200	Elizabeth Sloan 8434456	30mg	-	J. George	A. Harrison	61	V. Cox 20.4.17

Page checked by Pharmacy Date 20.4.17 Signature V. Cox Balance transferred to page 51 VC

1. Whenever a controlled drug is administered the name, form, strength, batch number and expiry date of the drug must be checked by two practitioners. The two practitioners can be two registered nurses/ midwives or ODPs or a doctor and a registered nurse/ midwife /ODP or a pharmacist. This drug also needs to be checked against the patient's prescription.

2. The date, time, patient's name and health and care number (unit number if health and care number is not available), amount of drug given, the signature of the two practitioners administering and witnessing the administration of the drug and the stock balance must be recorded in the controlled drug register as shown. The practitioner administering the controlled drug must be a registered nurse/ midwife or ODP or a doctor, the practitioner witnessing the administration must be a registered nurse/ midwife or ODP. See example 7. Both practitioners should be present during the whole of the administration process and should witness

    - The removal of the controlled drug from the controlled drug cabinet
    - The preparation of the controlled drug to be administered
    - The controlled drug being administered to the patient
    - The destruction of any surplus drug

3. If a full ampoule is not used the amount discarded must be written in the amount wasted column. See example 7. Partially used controlled drugs e.g. partially used ampoules, PCA devices, epidurals and syringe driver contents can be disposed to the sewer i.e. flushed down a sink or sluice. The Water Authority allows the Trust to put small amounts of controlled drugs into the sewer. The Water Authority may inspect ward controlled drug registers on an annual basis. When a partially used PCA device, epidural or syringe driver is discarded this must be recorded in the controlled drug register. This can either be recorded on the current stock recording page for that drug (see example 7) or on a page at the back of the register reserved solely for the destruction of partially used controlled drugs (see example 8). When discarding the contents of a syringe driver record the original controlled drug concentration of the syringe driver and the volume discarded. See example 7.

4. The contents of one ampoule whatever its size cannot be shared between patients.

5. If more than one ampoule is used for a dose this can be written on one line rather than using one line per ampoule as shown in example 7.

6. Oral liquid controlled drugs must be measured and administered using an oral syringe. The top of all oral liquid controlled drugs must have a press in bottle adaptor of the correct size inserted to ensure that doses can be measured accurately and without spillage.

7. Staff applying controlled drug transdermal patches must ensure that the previous patch has been removed. The used or partially used transdermal patch must be folded in two and placed in the purple lidded burn bin for pharmaceutical waste. Staff must record the destruction in the controlled drug register.

Example 7

Generic Name____Diamorphine__**Brand Name**_____**Strength**__5mg_____**Form**___injection__ **Ampoule/Vial Size** ___ 85 (If Applicable)

Amount(s) Obtained from Pharmacy			**Amount(s) removed from CD cabinet**					**Names & signatures of persons making entries**		Stock Balance	Stock balance confirmed as correct (sign & date)
Date received	Amount Received	Name of Pharmacy & Serial No. of Requisition	Date given	Time given	Patient's name and Unit Number	Amount Given	Amount wasted	Name & signature of authorised person taking receipt of or administering drug or discarding drug wastage	Name & signature of person witnessing receipt of or administration of drug/ witnessing drug wastage		
										Balance of stock 2	Transferred from page_79_
1.4.17	20	CAH 00350	Received from pharmacy S.Greene / O. Marano							22	
			1.4.17	0900	Joe Getbetter 7596464	5mg	-	L. Smith	H. Brown	21	
			1.4.17	1100	Frank Sickly F9256	5mg	-	H. Brown	S. Greene	20	
			2.4.17	1500	Lucy Bloggs 5046768	2.5mg	2.5mg	S. Greene	F. Floss	19	
			3.4.17	2000	John Brown 3359876	10mg		L. Smith	F. Floss	17	
			4.4.17	1530	Syringe driver for John Brown 3359876 10mg/16ml		3ml	J. Rowntree	S. Redburn	17	
Entered in error S. Greene/ F.Floss 5.4.09			(5.4.17	1245	Joe Swail 6738765	5mg)				(16) 17	

Example 8

Generic Name_Morphine PCA_waste_**Brand Name**_____**Strength**__1mg/ml___**Form**_____ **Ampoule/Vial Size** ___ 100 (If Applicable)

Amount(s) Obtained from Pharmacy			**Amount(s) removed from CD cabinet**					**Names & signatures of persons making entries**		Stock Balance	Stock balance confirmed as correct (sign & date)
Date received	Amount Received	Name of Pharmacy & Serial No. of Requisition	Date given	Time given	Patient's name and Unit Number	Amount Given	Amount wasted	Name & signature of authorised person taking receipt of or administering drug or discarding drug wastage	Name & signature of person witnessing receipt of or administration of drug/ witnessing drug wastage		
										Balance of stock	Transferred from page___
			12.3.17	1000	PCA John Smith 1933541		50ml	J. Rowntree	C Blackburn		
			18.3.17	1400	PCA Mavis Strain 8435252		100ml	S. Redburn	S. Greene		
			23.3.17	1915	PCA Seamus O'Hagan R5031		86ml	E. Topley	H Brown		
			1.4.17	2000	PCA Paul Rogers 3427856		74ml	H. Brown	S. Greene		

8. If an error is made in the controlled drug register e.g. an entry is made in the controlled drug register and the drug is subsequently not given, do not attempt to delete or obliterate the entry. Bracket the entry so that the original entry is still clearly legible. Write beside the entry 'entered in error' and correct the stock balance. This must be signed and dated by two practitioners. A pencil line can be drawn through the error but the original entry must still be clearly legible. An ink line cannot be used.

9. If the drug has been drawn up for administration it should be discarded and details of the destruction recorded in the controlled drug register as per point 3. See example 7.

10. The remaining stock of the drug must be counted and checked against the ward stock as recorded in the controlled drug register.

11. To avoid administering a controlled drug to the wrong patient, controlled drugs must be prepared and administered for one patient at a time. The process must be completed from removing the controlled drug from the cabinet, preparation and administering to the patient by the same two practitioners.

12. Any stock discrepancies must be documented in the remarks section of the 'Official handing over of controlled drugs' section (this section can be part of the controlled drug register or loose sheets filed at the back of the controlled drug register and are available from pharmacy). The two practitioners must date and sign this entry see example 5 and CD04 Procedure for checking stock levels of Controlled Drugs in a ward / clinical area.

13. Any stock discrepancies must be reported to the sister/ charge nurse/ registered nurse/ midwife or ODP in charge. A Trust incident (IR1) form must be completed on Datix. The relevant page(s) in the controlled drug register and patient(s) kardex(es) if appropriate should be scanned and attached to the incident form on Datix. The sister/ charge nurse/ registered nurse/ midwife or ODP in charge must notify their head of services/ departmental manager, their assistant director and the pharmacy department. If pharmacy is closed the on call pharmacist must be notified. It is the responsibility of the Director of Pharmacy to investigate controlled drug stock discrepancies.

Southern Health and Social Care Trust	Craigavon Area Hospital Pharmacy Department	Standard Operating Procedure ID CD Version 4

Title: HOSPITAL CONTROLLED DRUG PROCEDURES

CD06 Procedure for the Return of Controlled Drugs to the Pharmacy Department

Author:	Lyn Watt	Date:	25/02/19	Review Date: 3 years from approval date	
Approval by:	Dr Tracey Boyce	Date:		Reviewed by:	
Copy Number:	1	Pages:	17 of 47	Next review date:	25/02/22

1. Unused controlled drugs may be returned to the pharmacy department.

2. When controlled drugs are returned to the pharmacy department a registered nurse/ midwife or ODP must contact the pharmacy department to ask for a pharmacist to collect the controlled drugs from the ward / clinical area. Controlled drugs that have expired must be returned to pharmacy for destruction following the same procedure.

3. The controlled drugs should be transported to pharmacy in an Envopak®.

4. The pharmacist accepting the controlled drug(s) must check the name, form, strength, batch number, expiry date and quantity of each drug returned.

5. The pharmacist must enter the date, the quantity (in words and figures) of drug returned to pharmacy, the reason for return e.g. unused stock or expired stock, the remaining stock balance and sign this entry in the ward controlled drug register. The registered nurse/ midwife or ODP returning the controlled drugs must countersign this entry as shown in example 9.

Example 9

Generic Name_Diamorphine____**Brand Name**_____**Strength**__100mg___**Form**__Injection____ **Ampoule/Vial Size** ___ 08 (If Applicable)

Amount(s) Obtained from Pharmacy			**Amount(s) removed from CD cabinet**					**Names & signatures of persons making entries**		Stock Balance	Stock balance confirmed as correct (sign & date)
Date received	Amount Received	Name of Pharmacy & Serial No. of Requisition	Date given	Time given	Patient's name and Unit Number	Amount Given	Amount wasted	Name & signature of authorised person taking receipt of or administering drug or discarding drug wastage	Name & signature of person witnessing receipt of or administration of drug/ witnessing drug wastage		
										Balance of stock 6	Transferred from page_81__
			12.5.17	1400	David Brown 5486671	100mg	-	P. Roddy	V. Lockley	5	
			14.5.17	Five (5) amps returned to pharmacy– unused stock				D. Robinson	S. Bush	0	

6. The registered nurse/ midwife or ODP must complete in red ink a return requisition in the controlled drug requisition book. The requisition must indicate the hospital, ward or department, be marked as a 'CD return' requisition and the name, quantity, strength, form of the drug(s) being returned and the reason for returning the drug e.g. unused stock or expired stock. If the controlled drug is expired OOD (Out Of Date) should be written beside the drug on

the requisition. The quantity should be written as the number of units e.g. number of tablets or ampoules rather than the number of boxes. More than one drug can be written on a return requisition, however separate requisitions should be used for unused stock and out of date stock.

7. The pharmacist accepting the controlled drug(s) must sign and date the 'ordered by' and the 'Accepted for Delivery' sections of the requisition. The registered nurse/ midwife or ODP returning the controlled drugs must sign and date the 'Supplied by' section of the requisition. This information must be complete on all three copies of the requisition (yellow, blue and white copies). See example 10.

Example 10

SOUTHERN HEALTH AND SOCIAL CARE TRUST
MISUSE OF DRUGS ACT
ORDER FOR CONTROLLED DRUGS

2687941

Hospital…… ……Daisy Hill……..…….

Ward or Dept…… ……Ward 1……..….

Each preparation to be ordered on a separate page

NAME OF PREPARATION	FORM	STRENGTH	QUANTITY
CD RETURN Morphine Sulfate - unused stock	Injection	10mg	9 ampoules

Ordered by: ……*D Robinson* . …(Pharmacist)…….. …D ROBINSON….. Date……07/11/17…..……..
Signature of Registered Nurse / Midwife / ODP Print name

Supplied by: ……*S Bush*……(Nurse) … ……. …S BUSH……. Date……07/11/17……..
Signature of Pharmacist / Authorised Technician Print name

Issued by / Checked by: …. ……. ……. Date……..
Signature of Pharmacist / ACPT Print name

Accepted for Delivery…… *D Robinson* (Pharmacist) .. D ROBINSON…... Date……07/11/17……
Signature of Messenger Print name

ID Checked: Y / N

Received by……*C Scarlett*…(Pharmacist)…… …C SCARLETT…… Date……07/11/17……..
Signature of Registered Nurse / Midwife / ODP Print name

8. The pharmacist will remove the yellow copy of the return requisition and bring this with the controlled drugs to the pharmacy department.

Steps 9 to 13 to be completed in the pharmacy department.

9. When brought to pharmacy the returned controlled drug(s) must be checked by another suitably trained member of pharmacy staff and they must sign and date the 'Received by' section of the yellow copy of the return requisition to confirm what has been returned.

10. Reusable returned controlled drugs must be entered using red ink into the appropriate section of the pharmacy controlled drug register.

11. All controlled drug(s) split pack and full pack returns must be returned to stock via the computer and a label should be produced for each item that is returned, the label(s) must be attached to the yellow copy of the 'CD return' requisition.

12. Any controlled drug(s) that are returned to pharmacy that are out of date or not reusable must be entered in the Controlled Drugs Destruction Register and a label must be attached to the item(s) detailing:

    - Where the item is returned from
    - Who it is returned by
    - When it was returned
    - The page number in Destruction Register on which it is entered

13. Any paperwork that has been used in the return of controlled drugs to the pharmacy must be kept in the CD room in the black file labeled CD Returns Paperwork.

Southern Health and Social Care Trust	Craigavon Area Hospital Pharmacy Department	Standard Operating Procedure ID CD Version 4

Title: HOSPITAL CONTROLLED DRUG PROCEDURES

CD07 Procedure for Transferring the Balance of Controlled Drugs into a New Controlled Drug Register

Author:	Lyn Watt	Date:	25/02/19	Review Date: 3 years from approval date	
Approval by:	Dr Tracey Boyce	Date:		Reviewed by:	
Copy Number:	1	Pages:	20 of 47	Next review date:	25/02/22

1. When a new controlled drug register is started the balance of controlled drugs in stock should be written into the new book promptly by ward staff.

2. The registered nurse/ midwife/ ODP transferring the balance of controlled drugs in stock must enter the date, the quantity of drug being transferred to the new register, the page in the new register to which the drug is being transferred and sign this entry in the ward controlled drug register as in example 11.

Example 11

Generic Name_Morphine sulfate__**Brand Name**__Sevredol____**Strength**__10mg__**Form**___tablets__ **Ampoule / Vial Size** ___96 (If Applicable)

Amount(s) Obtained from Pharmacy			**Amount(s) removed from CD cabinet**					**Names & signatures of persons making entries**		Stock Balance	Stock balance confirmed as correct (sign & date)
Date received	Amount Received	Name of Pharmacy & Serial No. of Requisition	Date given	Time given	Patient's name and Unit Number	Amount Given	Amount wasted	Name & signature of authorised person taking receipt of or administering drug or discarding drug wastage	Name & signature of person witnessing receipt of or administration of drug/ witnessing drug wastage		
										Balance of stock 10	Transferred from page_90_
			14.4.17	0900	John Sickly 7529746	10mg	-	J. Janis	P. Smart	9	
			14.4.17 9 tablets transferred to new register page 10					P. Smart	D. Howth	Nil	

3. The registered nurse/ midwife/ ODP transferring the balance of controlled drugs in stock must enter in the new controlled drug register the date, the quantity of drug being transferred to the new register, the page in the old register from which the drug has been transferred and sign this entry as in example 12.

4. The transfer should be witnessed by a registered nurse, midwife, ODP or pharmacist. The person witnessing the transfer must countersign the transfer entries in the two controlled drug registers as shown in examples 11 and 12.

Example 12

Generic Name_Morphine sulfate__**Brand Name**___Sevredol__**Strength**__10mg__**Form**____tablets__ **Ampoule / Vial Size** ___10 (If Applicable)

Amount(s) Obtained from Pharmacy			**Amount(s) removed from CD cabinet**					**Names & signatures of persons making entries**		Stock Balance	Stock balance confirmed as correct (sign & date)
Date received	Amount Received	Name of Pharmacy & Serial No. of Requisition	Date given	Time given	Patient's name and Unit Number	Amount Given	Amount wasted	Name & signature of authorised person taking receipt of or administering drug or discarding drug wastage	Name & signature of person witnessing receipt of or administration of drug/ witnessing drug wastage		
										Balance of stock	Transferred from page__
14.4.17	9	Transferred from old register page 96						P. Smart	D. Howth	9	

See appendix 4 for the list of controlled drugs, however check the BNF for a drugs legal category as it is subject to change.

1. Patients own controlled drugs that are brought into the hospital should be returned to the patient's representative for safe keeping as soon as possible. If it is necessary to retain them they must be checked by two registered nurses/ midwives and entered into the front (white pages) of the ward Patient's Own Drugs Controlled Drugs (PODCD) Register (see example 13). It must also be recorded in the patient's nursing notes that the drug is retained on the ward and stored in the ward controlled drug cabinet.

2. The entry in the ward Patient's Own Drugs Controlled Drugs (PODCD) Register must state the following (see example 13):
   - The date of entry
   - The patient's name and health and care number (unit number if health and care number is not available)
   - The drug name, form and strength
   - The name and signature of the registered nurse / midwife receiving the drug and the name and signature of the registered nurse / midwife witnessing receipt of the drug
   - The stock balance (the number of dosage units received) e.g. 10 tablets, 5 ampoules, 100 ml

3. The controlled drug(s) must be stored in a tamper evident plastic bag labelled with patients details (specific for the storage of patients own drugs, available from pharmacy see appendix 5). The details on the sealed bag e.g. patient's name, health and care number (unit number if health and care number is not available), name and quantity of each drug and signatures of the two registered nurses/ midwives receiving the drug(s) must be completed. The bag must be sealed and stored in the ward controlled drug cabinet. As long as the bag remains sealed each of the patients own controlled drugs do not need to be checked and counted at the morning and evening nursing staff changes when responsibility for safe custody of controlled drugs is transferred. However at the nursing staff changes it must be checked that the sealed bag is still in the controlled drug cabinet.

4. If the patient is transferred to another ward the patient's own controlled drug(s) must be transferred with them. This must be recorded in the entry in the ward Patient's Own Drugs Controlled Drugs (PODCD) Register by ticking the box 'Transferred to other ward/ area'. Two registered nurses/ midwives, one from the ward the patient is being transferred from and one from the ward the patient is being transferred to must open the plastic bag and confirm that the correct quantity and preparation of the patient's own controlled drug as detailed in the ward

Patient's Own Drugs Controlled Drugs (PODCD) Register and on the sealed bag is being transferred. The registered nurse/ midwife transferring the drug must print and sign his/her name and enter the quantity of the drug transferred. The registered nurse/midwife receiving the transfer of the controlled drug must print and sign his/ her name in the box 'Accepted by box' see example 13.

5. Two registered nurses/ midwives on the ward to which the patient is transferred must enter the details as in point 2 in their ward Patient's Own Drugs Controlled Drugs (PODCD) Register. The controlled drug(s) must be stored in a tamper evident plastic bag labelled with the patient's details (specific for the storage of patients own drugs, available from pharmacy see appendix 5). The details on the bag e.g. patient's name, health and care number (unit number if health and care number is not available), name and quantity of each drug and signatures of the two registered nurses/ midwives receiving the drug(s) must be completed. The bag must be sealed and stored in the ward controlled drug cabinet.

6. On discharge the patient's own drug(s) should be returned to the patient/carer. This must be recorded in the entry in the ward Patient's Own Drugs Controlled Drugs (PODCD) Register, by ticking the 'Returned to patient' box. The quantity of the drug(s) must be checked against the entry in the ward Patient's Own Drugs Controlled Drugs (PODCD) Register and the quantity returned entered. This entry must be dated and signed by a registered nurse/ midwife (see example 13). The patient must print and sign his/her name in the 'Accepted by' box. The return of the drugs must also be recorded in the discharge check list and the nursing notes. On no account should a member of nursing staff transport the drugs to the patient's home.

Example 13

Date 30.5.13	Patient's Name: Joseph Bloggs Hospital Number: 3183181831		Drug – Name, Form, Strength: MST suspension 20mg	Name and signature of: authorised persons receiving/ witnessing drug receipt 1 Jane Brown JBrown 2 Eleanor Smith ESmith	Stock balance 5
	*Quantity administered	Quantity wasted	Name and signature of: authorised person **administering** drug	Name and signature of: authorised person **witnessing** drug administration	
2.6.17	Drugs removed from controlled drug cabinet (tick)		√ Returned to Patient Transferred to other ward/ area Returned to Pharmacy for destruction	Returned/ Transferred by (nurse in charge): A Smith ASmith Accepted by (patient/ ~~staff nurse/ pharmacist~~): Joe Bloggs J Bloggs	Quantity returned 5
Date 30.5.17	Patient's Name: Elsie Getty Hospital Number: 4264261264		Drug – Name, Form, Strength: Sevredol tablets 10mg	Name and signature of: authorised persons receiving/ witnessing drug receipt 1 Jane Brown JBrown 2 Eleanor Smith ESmith	Stock balance 14
	*Quantity administered	Quantity wasted	Name and signature of: authorised person **administering** drug	Name and signature of: authorised person **witnessing** drug administration	
30.5.17	Drugs removed from controlled drug cabinet (tick)		Returned to Patient √ Transferred to other ward/ area Returned to Pharmacy for destruction	Returned/ Transferred by (nurse in charge): Jane Brown JBrown Accepted by (~~patient~~/ staff nurse/ ~~pharmacist~~): D Robinson DRobinson	Quantity returned 14

***POD CDs should not be used routinely, only in exceptional circumstances. Page checked by Pharmacy. Date: Signature:**

7. If the drug is given to a relative or carer to take home either before or at the time of discharge then this must be recorded in the entry in the ward Patient's Own Drugs Controlled Drugs (PODCD) Register, dated and signed by a registered nurse/ midwife (see example 14). The relative/ carer must print and sign his/her name in the 'Accepted by' box

8. If the patient no longer requires the medication at discharge and has given permission for the destruction of the drug(s) or if the patient is deceased the drug(s) must be stored in the Controlled Drug cabinet until a pharmacist is available to return the PODCD to the pharmacy department for destruction following the procedure CD06 Procedure for the return of Controlled Drugs to the pharmacy department. This must be recorded in the entry in the ward Patient's Own Drugs Controlled Drugs (PODCD) Register (see example 14).

9. If a patient is going home in and an ambulance ask the NIAS staff to sign the POD register as having received the patient's medication. If the NIAS staff member refuses to sign then a registered nurses must enter in the register PODCD given to NIAS and another registered nurse from the ward / clinical area to sign as a witness.

Example 14

Date 30.05.17	Patient's Name: June Dowds Hospital Number: 5145141345		Drug – Name, Form, Strength: Longtec 10mg tablets	Name and signature of: authorised persons receiving/ witnessing drug receipt 1 Jane Brown JBrown 2 Eleanor Smith ESmith	Stock balance 20
	*Quantity administered	Quantity wasted	Name and signature of: authorised person **administering** drug	Name and signature of: authorised person **witnessing** drug administration	
2.6.17	Drugs removed from controlled drug cabinet (tick)		√ Returned to ~~Patient~~ Peter Dowds Transferred to other ward/ area Returned to Pharmacy for destruction	Returned/ Transferred by (nurse in charge): A Smith ASmith Accepted by (~~patient/ staff nurse/ pharmacist~~): Peter Dowds P Dowds (carer)	Quantity returned 20
Date 30.5.17	Patient's Name: Elsie Getty Hospital Number: 4264261264		Drug – Name, Form, Strength: Sevredol tablets 10mg	Name and signature of: authorised persons receiving/ witnessing drug receipt 1 Jane Brown JBrown 2 Eleanor Smith ESmith	Stock balance 14
	*Quantity administered	Quantity wasted	Name and signature of: authorised person **administering** drug	Name and signature of: authorised person **witnessing** drug administration	
14.6.17	Drugs removed from controlled drug cabinet (tick)		Returned to Patient Transferred to other ward/ area √ Returned to Pharmacy for destruction	Returned/ Transferred by (nurse in charge): Jane Brown JBrown Accepted by (~~patient/ staff nurse/~~ pharmacist): David Browne D Browne	Quantity returned 14

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Southern Health and Social Care Trust	Craigavon Area Hospital Pharmacy Department	Standard Operating Procedure ID CD Version 4

Title: HOSPITAL CONTROLLED DRUG PROCEDURES

CD08b Procedure for the storage of Controlled Drug supplied on discharge prescription from the hospital pharmacy

Author:	Lyn Watt	Date:	25/02/19	Review Date: 3 years from approval date	
Approval by:	Dr Tracey Boyce	Date:		Reviewed by:	
Copy Number:	1	Pages:	25 of 47	Next review date:	25/02/22

1. On receipt from the hospital pharmacy of a controlled drug prescription at ward/ clinical area level a registered nurse /midwife must check the prescription for the correct name, form, strength and quantity of each controlled drug in the presence of the messenger. This must agree with the controlled drug prescription. If there is any discrepancy the registered nurse / midwife must contact pharmacy immediately and an incident form (IR1) completed on Datix.

2. The registered nurse/ midwife then completes in the presence of the messenger a record of receipt of the controlled drug prescription in the Patients Own Controlled Drug (PODCD) Register, Record of Schedule 2 Controlled Drugs Supplied from Hospital on Discharge Prescriptions (yellow pages).

3. Once this has been completed re-seal the bag containing the controlled drug discharge prescription and place in the controlled drug cabinet, clearly segregated from ward stock in the cabinet.

    - Date received from Pharmacy
    - Patient's name and health and care number (unit number if H&CN not available)
    - Drug name, strength and form
    - Quantity received
    - Name of registered nurse / midwife responsible for secure storage (sign and print name). The entry must be countersigned by the 'Messenger' or another registered nurse / midwife / ODP as the witness.

    See example 15

Example 15

Date received from Pharmacy	Patient's Name Hospital Number	Schedule 2 Controlled Drugs supplied on Discharge Prescription		Staff nurse responsible for secure storage Print Name Signature	Date of Issue	Quantity issued to patient / care	Issued to patient by Staff Nurse Print Name Signature	Patient's / Carer's Print Name Signature	Other comment if not issued include CD return form number
		Name Strength Form	Quantity						
02/11/17	3334567891	MST 10mg Tablets	10	A HART *A Hart* *J Sock* J SOCK	02/11/17	10	J SMITH *J Smith*	D HOBBS *D Hobbs*	

4. When a patient is ready for discharge two registered nurses / midwives should check the controlled drugs out of the cabinet, confirming again that they conform to the controlled drug prescription and checked against the patient's kardex.

5. The following details should be completed in the Patients Own Controlled Drug (PODCD) Register, Record of Schedule 2 Controlled Drugs Supplied from Hospital on Discharge Prescriptions (yellow pages).

    - Date of issue
    - Quantity issued to patient / carer
    - Name of two registered nurses / midwives issuing drugs (sign and print name)
    - Name of the patient / carer receiving the controlled drug prescription (sign and print name).
    - The relationship to the patient of the person receiving the CD.
    - If NIAS refuse to sign the PODCD register make a note in the register.

6. The patient's own controlled drug must be checked at the morning and evening nursing staff changes along with the ward stock of controlled drugs.

7. If the patient no longer requires the medication at discharge or if the patient is deceased the drug(s) must be returned to the pharmacy department for destruction following the procedure for the return of controlled drugs to the pharmacy department. This must be recorded in the entry in the ward Patient's Own Drugs Controlled Drugs (PODCD) Register.

See appendix 4 for the list of controlled drugs, however check the BNF for a drugs legal category as it is subject to change.

1. **Only in exceptional circumstances can a patient's own controlled drugs be used e.g. pharmacy does not stock the item and the dose is required before pharmacy can obtain a supply of the product.** A pharmacist must grant permission to use a patient's own controlled drugs. If pharmacy is closed the pharmacist on call must grant permission. The on call pharmacist must inspect the patient's own controlled drugs to determine if they are suitable for use as in point 4. Verbal permission should be obtained if possible from the patient prior to using his/ her own drugs. This should be recorded in the nursing notes.

2. The patient's own controlled drugs must be checked by two registered nurses / midwives and entered into the front (white pages) of the ward Patient's Own Drugs Controlled Drugs (PODCD) Register as per procedure CD08a. It must also be recorded in the patient's nursing notes that the patient's own controlled drug is retained on the ward, is to be used for that patient and stored in the ward controlled drug cabinet.

3. The entry in the ward Patient's Own Drugs Controlled Drugs (PODCD) Register must state the following (see example 14):
   - The date of entry
   - The patient's name and health and care number (unit number if health and care number is not available)
   - The drug name, form and strength
   - The name and signature of the registered nurse / midwife receiving the drug and the name and signature of the registered nurse / midwife witnessing receipt of the drug
   - The stock balance (the number of dosage units received) e.g. 10 tablets, 5 ampoules, 100 ml

4. A pharmacist must first check that the patient's own controlled drugs are suitable to be used according to the Patient's Own Drugs Procedure that is:
   - easily identifiable
   - labelled for that patient
   - in date
   - dispensed within the last three months
   - have been stored correctly

5. The pharmacist must sign the controlled drug entry indicating that the drugs are suitable to use and may be used for that patient only (see example 16).

6. Each time one of the patient's own controlled drug is administered this must be recorded in the ward Patient's Own Drugs Controlled Drugs (PODCD) Register. The date, quantity of drug administered, quantity of drug wasted the signature and name of the two practitioners administering and witnessing the administration of the drug and the stock balance must be recorded in the Patient's Own Controlled Drugs (PODCD) register as shown in example 16.

7. The patient's own controlled drug must be checked at the morning and evening nursing staff changes along with the ward stock of controlled drugs.

Example 16

Date 30.5.13	Patient's Name: Joe Brown Hospital Number: 1451456133		Drug – Name, Form, Strength: Actiq lozenges 400micrograms	Name and signature of: authorised persons receiving/ witnessing drug receipt 1 Jane Brown JBrown 2 Eleanor Smith ESmith	Stock balance 6
	*Quantity administered	Quantity wasted	Name and signature of: authorised person **administering** drug	Name and signature of: authorised person **witnessing** drug administration	
30.5.17	Drugs checked & can be used for Joe Brown 1451456133			D Gregory (pharmacist) D Gregory	6
30.5.17	400mcg	-	Jane Brown JBrown	Eleanor Smith ESmith	5
1.6.17	400mcg	-	A Smith ASmith		
2.6.17	Drugs removed from controlled drug cabinet (tick)		√ Returned to Patient Transferred to other ward/ area Returned to Pharmacy for destruction	Returned/ Transferred by (nurse in charge): A Smith ASmith Accepted by (patient/ staff nurse/ pharmacist): Joe Brown J Brown	Quantity returned 4
Date	Patient's Name: Hospital Number:		Drug – Name, Form, Strength: 10mg	Name and signature of: authorised persons receiving/ witnessing drug receipt 1 2	Stock balance
	*Quantity administered	Quantity wasted	Name and signature of: authorised person **administering** drug	Name and signature of: authorised person **witnessing** drug administration	
14.6.17	Drugs removed from controlled drug cabinet (tick)		Returned to Patient Transferred to other ward/ area Returned to Pharmacy for destruction	Returned/ Transferred by (nurse in charge): Accepted by (patient/ staff nurse/ pharmacist):	Quantity returned

***POD CDs should not be used routinely, only in exceptional circumstances. Page checked by Pharmacy. Date: Signature:**

8. On discharge the patient's own drug(s) should be returned to the patient. This must be recorded in the entry in the ward Patient's Own Drugs Controlled Drugs (PODCD) Register, dated and signed by a registered nurse/ midwife. This must also be recorded in the discharge check list and the nursing notes. The quantity of the drug(s) must be checked against the entry in the controlled drug register. The patient / carer must print and sign his/her name in the 'Accepted by' box

9. If the patient no longer requires the medication at discharge and has given permission for the destruction of the drug(s) or if the patient is deceased the drug(s) must be returned to the pharmacy department for destruction following the procedure for the return of controlled drugs to the pharmacy department. This must be recorded in the entry in the ward Patient's Own Drugs Controlled Drugs (PODCD) Register.

Southern Health and Social Care Trust	Craigavon Area Hospital Pharmacy Department	Standard Operating Procedure ID CD Version 4

Title: HOSPITAL CONTROLLED DRUG PROCEDURES

CD10 Procedure for Writing a Controlled Drug on a Discharge Prescription

Author:	Lyn Watt	Date:	25/02/19	Review Date: 3 years from approval date	
Approval by:	Dr Tracey Boyce	Date:		Reviewed by:	
Copy Number:	1	Pages:	29 of 47	Next review date:	25/02/22

1. Prescriptions for controlled drugs are subject to the legal requirements of the Misuse of Drugs Regulations 2001 (and subsequent amendments).

2. Prescription can be hand written on prescription pads or can be written using the Electronic Correspondence Module (ECM).

3. All prescriptions must be signed and dated by an authorised prescriber. When using the prescription pads remember to sign the signature for pharmacy on the yellow copy.

4. For controlled drug prescriptions using the Electronic Correspondence Module (ECM) a separate page will be printed out for the controlled drugs. The prescriber must complete in indelible ink.

    - The total quantity of the drug to be issued in words and figures.

5. For prescriptions that are handwritten they must state the following in the prescriber's own handwriting

    a) The name and address of the patient
    b) The preparation, the form and where appropriate the strength of the preparation
    c) The dose and frequency
    d) The total quantity of the preparation to be supplied in both words and figures. Be aware of the different strengths of preparation available. When more than one strength is required to make up the required dose the quantity of all strengths required must be written in words and figures (e.g. MST 40mg will be supplied as MST 10mg and 30mg tablets).

6. **The Misuse of Drugs Regulations stipulates that a pharmacist cannot dispense a prescription for a controlled drug unless it complies with the requirements above.** Therefore failure to comply with the regulations will result in inconvenience to patients and staff and delay in supplying the necessary medication. This may also result in delay of the patient's discharge from hospital.

7. A pharmacist who has been involved in the prescribing of a prescription cannot dispense it.

Southern Health and Social Care Trust	Craigavon Area Hospital Pharmacy Department	Standard Operating Procedure ID CD Version 4

Title: HOSPITAL CONTROLLED DRUG PROCEDURES

CD11 Procedure for Four Monthly Auditing of Controlled Drugs in a Ward / Clinical Area

Author:	Lyn Watt	Date:	25/02/19	Review Date: 3 years from approval date	
Approval by:	Dr Tracey Boyce	Date:		Reviewed by:	
Copy Number:	1	Pages:	30 of 47	Next review date:	25/02/22

Objective

To comply with Controlled Drug regulations pharmacists carry out regular audits of Controlled Drugs, checking the requisition book, register and the stocks. Records of these audits are retained by the Pharmacy Department for 5 years. The audits are carried out every 4 months and at other times when requested by the Ward / Clinical Area Manager or Director of Pharmacy.

Scope:

This procedure applies to all pharmacists working in the Southern Health & SC Trust pharmacy departments with a responsibility for auditing controlled drugs.

Responsibilities:

It is the responsibility of all pharmacists in the pharmacy departments SH&SCT and ward / clinical areas registered nurses/ midwives/ODP with a responsibility for auditing controlled drugs to be knowledgeable of the content of this procedure and comply with the processes as described within the procedure.

The Process

Audit of Controlled Drugs (CD's) in ward / clinical area must be carried out every 4 months. A pharmacist will be assigned to each ward / clinical area and it is their responsibility to organise with the ward / clinical area manager the time and dates for auditing the controlled drugs.

1. Contact the ward / clinical area manager to arrange a suitable date and time to check the CD stocks in each ward / clinical area.
2. Prior to meeting with the ward manager photocopy the current list of authorised signatures for ordering and collecting CD's from pharmacy. Leave the photocopy in the signature file marked with the date and name of the person who has the original.
3. Bring a copy of the Controlled Drug Audit form see Appendix 3 and the signature list. On arrival to the ward / clinical area the Manager or designated person will accompany the Pharmacist to the Controlled Drug Cabinet and commence the audit.
4. Obtain the Controlled Drug register and the Controlled Drug requisition book and complete the following questions on the CD audit form.
    a. The Controlled Drug cabinet keys are held separately from the other medicine keys.
        - The keys must be separate, not on the same keyring or attached to other ward / clinical area keys.
    b. The controlled drug cabinet key is kept on the person of the registered nurse/midwife/ODP in charge.

- The keys must be held by the person in charge as they have overall responsibility for the controlled drugs.

c. Only one set of controlled drug cabinet keys is held in each ward / clinical area
   - For security reasons there must only be one set of keys.

d. The spare set of controlled drug cabinet keys is held in pharmacy.
   - If the keys are misplaced then a set of keys can be retrieved from pharmacy urgently in order for patients to receive medicines and to check the stock levels of CD's.

e. The controlled drug requisition book is stored in the locked controlled drug cabinet
   - For security reasons the requisition book must be kept locked away to prevent access by unauthorised persons.

f. The controlled drug register is stored in the locked controlled drug cabinet or in a designated place which is secure and has restricted access.
   - For security reasons the register must be stored securely to prevent tampering.

g. Where an error occurs in the controlled drug requisition book a line is drawn through the entry and initialled by the practitioner who made the error. Any amendments to an order for a controlled drug are endorsed by the person ordering the item in both words and figures and initialled. When the pharmacy department amends an order for a controlled drug at the point of supply the pharmacist brackets the original order quantity, writes the quantity supplied in words and figures and signs and prints his/her name beside the actual quantity supplied.
   - Original information must not be obliterated and all amendments must be endorsed for audit purposes.

h. Controlled Drug requisitions are correctly filled in
   - Date
   - Ward
   - Name, quantity, strength and form of drug
   - One drug per requisition
   - Registered Nurse/midwife/ODP signature for 'ordered by'
   - Pharmacist / Authorised Technician signature for 'supplied by'
   - Pharmacist / ACPT signature for 'issued / checked by'
   - Registered nurse/midwife/ODP /HCA signature for 'accepted for delivery'
   - ID checked Y/N
   - Registered nurse/midwife/ODP signature for 'received by'
   - The signatures for 'accepted for delivery' and 'received by' are two different people.
   - Take a random sample of ten requisitions and check that all sections are completed. Note any requisitions which are incomplete.

i. Last record of specimen signatures for registered nurses/midwives / ODP's permitted to order and collect controlled drugs (held in pharmacy) updated. Specimen signatures for HCA permitted to collect controlled drugs updated.
   - Ward / clinical area manager is responsible to update these lists and send original to pharmacy and keep a copy in ward / clinical area. See appendix 2 & 3

j. Receipt of controlled drugs correctly entered in controlled drug register (this must be checked against controlled drug requisitions.

- Date
- Amount
- Hospital and Requisition number
- 'Received from pharmacy'
- Entry signed by registered nurse/midwife/ODP and messenger or second registered nurse/midwife/ODP

- Using the ten random requisitions from above check each requisition against the entry in the controlled drug register. Note any incomplete entries. The ward / clinical area manager must follow these up.

k. Top page of the controlled drug register states the name, form and strength of drug.
- Check all pages in the register and take a note of any missing information.

l. Administration of controlled drugs correctly recorded in controlled drug register.
- Date
- Time
- Patient's name
- Patient's health and care number (unit number if H&CN unavailable)
- Amount of drug given / amount discarded
- Signature of two practitioners one of which must be a registered nurse /midwife / ODP.
- Stock is correctly subtracted

- Check all pages in the register and take a note of any missing information.

m. The destruction of partially administered PCA's, epidurals, and syringe drivers is correctly recorded in the controlled drug register:
- Date
- Amount discarded
- Signature of two practitioners one of which must be a registered nurse/midwife/ODP

- Check all pages in the register and take a note of any missing information.

n. Does one practitioner administer controlled drugs more frequently than other practitioners?
- Check all pages of the register and note if there is a worrying trend and discuss with the ward / clinical area manager.

o. Where an error occurs in the recording of the administration of a controlled drug 'entered in error' is written beside the entry, signed by the two practitioners and the stock balance corrected.

- Check all pages of the register since the last audit and take a note of missing any signatures.

p. The stock of all controlled drugs are correct with the stock levels as recorded in the controlled drug register (volumes of oral liquids must be checked using a graduated measure)
- Check all stock where there is a discrepancy check with the ward / clinical area manager patients notes / kardexes to see where the discrepancy may have arisen.
- Check with staff who have been on duty since last hand over check
- If stock missing check around the immediate area.

- If liquid controlled drug volume incorrect check all calculations. Check staff are using the correct bungs and syringes to measure doses.
- If cannot be found complete an IR1 and report to Head of Service and Director of Pharmacy.
- If stock correct on the line directly underneath the last entry for each drug enter the date, 'stock correct checked by' inserting name (printed), signature and registration number of the pharmacist and the nurse/ midwife/ ODP witnessing.

q. All controlled drugs are in date.
   - Controlled drugs which are out of date remove from stock and follow the procedure CD06 Procedure for the Return of Controlled Drugs to the Pharmacy Department.

r. The 'Official Handing Over of Controlled Drugs' sheets are completed at 7:30 and 20:30 at the nursing staff change.
   - Date
   - Time
   - Signature of two registered nurses/midwives/ODP
   - Any stock discrepancies recorded in the remarks section
   - Check all sheets and take a note of any missing information.

s. Where any controlled drugs have been returned to pharmacy (expired and non expired stock) this is correctly entered in the controlled drug register.
   - Date
   - Amount returned
   - Signed by a pharmacist
   - Countersigned by registered nurse/midwife ODP
   - Stock adjusted correctly
   - Reason for return
   - The entry in the controlled drug register corresponds with the CD return requisition
   - Return entered in pharmacy controlled drug register / destruction register
   - Where there is any discrepancy follow up with the ward / clinical area manager /dispensary manager.

t. The ward / clinical area has a copy of the most recent controlled drug procedures

u. Does the ward / clinical area hold high strength opioids (morphine or diamorphine ≥ 30mg)
   - Yes or No
   - If yes and not currently prescribed for a patient remove from stock and return to pharmacy.

v. Is there a record of any controlled drugs having been given to or borrowed from another ward / clinical area?
   - Yes or No
   - If yes was this authorised by pharmacy?

w. Patients own controlled drugs retained on ward / clinical area are correctly entered into the Patients Own Controlled Drugs (PODCD) Register.
   - Date of entry
   - Patient's name and health and care number (unit number if H&CN not available)
   - Drug name, form, strength

- Number of dosage units in figures
- Name and signatures of one registered nurses / midwife receiving the drug and the name of one registered nurses / midwives witnessing receipt of the drug
- Drug stored in POD tamper evident sealed plastic bag
- Details on bag complete
- Bag sealed

- Check register and take a note of any discrepancies. Follow information as point (p).

x. If the patient was transferred to another ward / clinical area their controlled drugs were transferred with them and this is recorded in both ward / clinical areas PODCD Register.

- Check registers and take a note of any discrepancies. Follow information as point (p).

y. If the patient's own controlled drugs were returned to a relative or carer prior to discharge or at discharge to the patient / relative or carer this is recorded in the PODCD Register.

- Date
- Amount returned in figures
- Signature of two registered nurses/midwives

- Check register and take a note of any discrepancies. Follow information as point (p).

z. If the patient's own controlled drugs were returned to pharmacy for destruction this is recorded in the PODCD Register.

- Date
- Amount returned in figures
- Signature if two registered nurses / midwives
- Return entered in pharmacy patients own drug controlled drug destruction register.

aa. Where there any patients own controlled drugs used for administration?

- Yes or No
- If yes
  - Was the drug not stock by pharmacy?
  - Did a pharmacist assess the drug prior to its use?
  - Is the administration of the patients own controlled drug recorded in the PODCD Register?
    - Yes or No

bb. The pharmacist and the ward / clinical area manager must sign the Controlled Drug Audit form.

cc. All discrepancies are to be followed up by the ward / clinical area manager within 7 days.

dd. The pharmacist will send a copy of the completed Controlled Drug Audit form to the ward / clinical area manager, Head of Service, Assistant Director and the Director of Pharmacy.

Southern Health and Social Care Trust

Pharmaceutical Services

Record of Ward/Department Nurses Authorised to Order/Collect Controlled Drugs from the Pharmacy Department

Hospital:
Ward/ Department:
Date completed:

Each registered nurse permitted to order or collect stocks of controlled drugs, from the Pharmacy Department must record their name, grade and signature on the table below.

Full name in block capitals	Grade	Signature

I confirm that the staff listed above are registered nurses my ward and are permitted to order or collect controlled drugs from the Pharmacy Department Craigavon Area Hospital.

Ward/Dept Manager's Name: …….
(Block capitals please)
Signature: ……... Date:…….

Please retain a copy for your own records.

Completed forms should be returned to Dr Tracey Boyce, Director of Pharmacy, Pharmacy Dept. Craigavon Area Hospital.

Appendix 2

Southern Health and Social Care Trust

Pharmaceutical Services

Record of Ward/Department Healthcare Assistants Authorised to Collect Controlled Drugs from the Pharmacy Department

Hospital:
Ward/ Department:
Date completed:

Each registered healthcare assistant permitted to collect stocks of controlled drugs, from the Pharmacy Department must record their name, grade and signature on the table below.

Full name in block capitals	Grade	Signature

I confirm that the staff listed above are HCA on my ward /department and are permitted to collect controlled drugs from the Pharmacy Department Craigavon Area Hospital.

Ward/Dept Manager's Name: …….
(Block capitals please)
Signature: ……... Date:…….

Please retain a copy for your own records.

Completed forms should be returned to Dr Tracey Boyce, Director of Pharmacy, Pharmacy Dept. Craigavon Area Hospital.

Appendix 3

PHARMACY DEPARTMENT, SOUTHERN HEALTH AND SOCIAL CARE TRUST
4 MONTHLY REVIEW OF CONTROLLED DRUGS

Ward / Clinical Area:	Date:			
Assessment Criteria	Yes	No	NA	Comments and action agreed with ward/clinical area manager
1. The controlled drug cabinet keys are held separately from the other medicine keys				
2. The controlled drug cabinet key is kept on the person of the registered nurse/ midwife/ ODP in charge				
3. Only one set of controlled drug cabinet keys is held on the ward				
4. The spare set of controlled drug cabinet keys is held in pharmacy				
5. The controlled drug requisition book is stored in the locked controlled drug cabinet				
6. The controlled drug register is stored in the locked controlled drug cabinet or in a designated place which is secure and has restricted access				
7. Where an error occurs in the controlled drug requisition book a line is drawn through the entry and initialed by the practitioner who made the error. Any amendments to an order for a controlled drug are endorsed by the person ordering the item in both words and figures and initialed. When the pharmacy department amends an order for a controlled drug when supplying the controlled drug the member of pharmacy staff brackets the original quantity ordered, writes the quantity supplied in words and figures and signs and prints his/her name beside the new quantity.				
8. Controlled drug requisitions are correctly filled in: ▪ Date ▪ Ward ▪ Name, quantity, strength and form of drug ▪ One drug per requisition ▪ Registered nurse/ midwife/ ODP signature for 'ordered by' ▪ Pharmacist / Authorised Technician signature for 'supplied by' ▪ Pharmacist / ACPT signature for 'issued / checked by' ▪ Registered nurse / midwife /ODP / HCA signature for 'accepted for delivery' ▪ ID checked Y/N				

PHARMACY DEPARTMENT, SOUTHERN HEALTH AND SOCIAL CARE TRUST
4 MONTHLY REVIEW OF CONTROLLED DRUGS

Assessment Criteria	Yes	No	NA	Comments and action agreed with ward/clinical area manager
▪ Registered nurse / midwife / ODP signature for 'received by' ▪ The signatures for 'accepted for delivery' and 'received by' are two different people				
9. Last date record of specimen signatures for; ▪ Registered nurses/ midwives / ODPs permitted to order controlled drugs (held in pharmacy) is up to date. ▪ Healthcare assistants permitted to collect controlled dugs (held in pharmacy) is up to date.				
10. Receipt of controlled drugs correctly entered in controlled drug register (this must be checked against controlled drug requisitions) ▪ Date ▪ Amount ▪ Hospital and Requisition number ▪ 'Received from pharmacy' ▪ Entry signed by registered nurse/ midwife/ ODP and messenger or second nurse/ midwife/ ODP				
11. Top of page in controlled drug register states the name, form and strength of drug				
12. Administration of controlled drugs correctly recorded in controlled drug register: ▪ Date ▪ Time ▪ Patient's name ▪ Patient's health and care number (unit number if H&CN unavailable) ▪ Amount of drug given / Amount discarded ▪ Signature of two practitioners one of which must be a registered nurse/ midwife/ ODP ▪ Stock correctly subtracted				
13. The destruction of partially PCAs, epidurals, syringe drivers is correctly recorded in the controlled drug register: ▪ Date ▪ Amount discarded ▪ Signature of two practitioners one of which must be a registered nurse/ midwife/ ODP				
14. Does one practitioner administer controlled drugs more frequently than other practitioners?				

PHARMACY DEPARTMENT, SOUTHERN HEALTH AND SOCIAL CARE TRUST
4 MONTHLY REVIEW OF CONTROLLED DRUGS

Assessment Criteria	Yes	No	NA	Comments and action agreed with ward/clinical area manager
15. Where an error occurs in the recording of the administration of a controlled drug 'entered in error' is written beside the entry, signed by the two practitioners and the stock balance is corrected.				
16. The stocks of all controlled drugs are correct with the stock levels as recorded in the controlled drug register (the volumes of oral liquids must be checked using a graduated measure).				
17. All the controlled drugs in stock are in date.				
18. The 'Official Handing Over of Controlled Drugs' sheets are completed at the 0730 and 2030 nursing staff changes. ▪ Date ▪ Time ▪ Signature of two registered nurses/ midwives/ ODP ▪ Any stock discrepancies recorded in the remarks section				
19. Where any controlled drugs have been returned to pharmacy this is correctly entered in the controlled drug register: ▪ Date ▪ Amount returned ▪ Signed by pharmacist ▪ Countersigned by registered nurse/ midwife/ ODP ▪ Stock adjusted correctly ▪ Reason for return ▪ The entry in the controlled drug register corresponds with the CD return requisition ▪ Return entered in pharmacy controlled drug register				
20. Where any controlled drugs have been out of date they have been correctly entered in the controlled drug register: ▪ Date ▪ Amount returned ▪ Recorded 'out of date' in register ▪ Signed by a pharmacist ▪ Countersigned by a registered nurse/ midwife/ ODP ▪ Stock adjusted correctly ▪ The entry in the controlled drug register corresponds with the CD return requisition				

PHARMACY DEPARTMENT, SOUTHERN HEALTH AND SOCIAL CARE TRUST
4 MONTHLY REVIEW OF CONTROLLED DRUGS

Assessment Criteria	Yes	No	NA	Comments and action agreed with ward/clinical area manager
▪ Return entered in pharmacy controlled drug destruction book				
21. The ward has a copy of the most recent controlled drug procedures.				
22. Does the ward hold 30mg or higher morphine and/ or diamorphine ampoules?				
23. If 30mg or higher morphine and/ or diamorphine ampoules are in stock are they in use. Return to pharmacy if not in use				
24. Is there a record of any controlled drugs having been given to or borrowed from another ward? If yes was this authorised by pharmacy?				
25. Patients own controlled drugs retained on the ward are correctly entered into the Patients Own Controlled Drugs (PODCD) Register: ▪ Date of entry ▪ Patient's name and health and care number (unit number if H&CN unavailable) ▪ Drug name, form and strength ▪ Number of dosage units in figures ▪ Name and signatures of two registered nurses/ midwives receiving the drug and the name and signatures of two registered nurses/ midwives witnessing receipt of the drug ▪ Drug(s) stored in PODCD tamper evident sealed plastic bag ▪ Details on bag complete ▪ Bag sealed				
26. If the patient was transferred to another ward their own controlled drugs were transferred with them and this is recorded in both ward / clinical area's PODCD Register.				

PHARMACY DEPARTMENT, SOUTHERN HEALTH AND SOCIAL CARE TRUST
4 MONTHLY REVIEW OF CONTROLLED DRUGS

Assessment Criteria	Yes	No	NA	Comments and action agreed with ward/clinical area manager
27. If the patient's own controlled drugs were returned to a relative or carer prior to discharge or at discharge to the patient/ relative or carer this is recorded in the PODCD Register: ▪ Date ▪ Amount returned in figures Signature of two registered nurses/ midwives				
28. If the patient's own controlled drugs were returned to pharmacy for destruction this is recorded in the PODCD Register: ▪ Date ▪ Amount returned in figures ▪ Signature of two registered nurses/ midwives ▪ Return entered in pharmacy controlled drug destruction book				
29. Where any patient's own controlled drugs used for administration? ▪ Was the drug not stocked by pharmacy? ▪ Did a pharmacist assess the drug prior to its use? ▪ Is the administration of the patients own controlled drug recorded in the PODCD Register?				
30. Send a copy of the completed Controlled Drug Audit form to. ▪ Ward / Clinical Area Manager ▪ Ward / Clinical Area Head of Service ▪ Ward / Clinical Area Assistant Director ▪ Director of Pharmacy				
Pharmacist's signature:	Sister/ charge nurse/ registered nurse/ midwife/ ODP in charge signature:			

Drug	Form	Brand	CD Register Y/N	Safe Custody Y/N	Prescription Handwriting Requirements Y/N
Alfentanil	Injection	Rapifen®	Y	Y	Y
Buprenorphine	Tablet	Natzon®	Y	Y	Y
		Prefibin®			
		Subutex®			
		Temgesic®			
		Tephine®			
		Natzon®			
	Transdermal Patch	BuTrans®	Y	Y	Y
		Bupeaze®			
		Buplast®			
		Butec®			
		Hapoctasin®			
		Panitaz®			
		Prenotrix®			
		Reletrans®			
		Relevtec®			
		Sevodyne®			
		Transtec®			
Cocaine	Nasal Spray		Y	Y	Y
Codeine Phosphate	Injection		Y	Y	Y
Diamorphine	Injection		Y	Y	Y
Dihydrocodeine	Injection		Y	Y	Y
Dipipanone + cyclizine	Tablet		Y	Y	Y
Gabapentin (From 1st April 2019)	Capsules	Neurontin®	N	N	Y
	Tablets		N	N	Y
	Oral Solution		N	N	Y
Fentanyl	Injection	Sublimaze®	Y	Y	Y
	Infusion				
	Spray	Instanyl®	Y	Y	Y
		PecFent®			
	Buccal Tablet	Effentora®	Y	Y	Y
	Sublingual Tablet	Abstral®	Y	Y	Y
		Recivit®			
	Transdermal Patch	Durogesic DTrans®	Y	Y	Y
		Fencino®			
		Fentalis®			
		Matrifen®			
		Mezolar Matrix®			
		Mylafent®			
		Opiodur®			
		Osmanil®			

Controlled Drugs

Drug	Form	Brand	CD Register Y/N	Safe Custody Y/N	Prescription Handwriting Requirements Y/N
Fentanyl cont'd		Tilofyl®			
		Victanyl®			
		Yemex®			
	Lozenge	Actiq®	Y	Y	Y
Hydromorphone	Modified Release Capsule	Palladone SR®	Y	Y	Y
	Capsule	Palladone ®	Y	Y	Y
Ketamine	Injection		Y	Y	Y
	Oral Solution		Y	Y	Y
Methadone	Oral Solution		Y	Y	Y
Midazolam	Injection				Y
	Solution	Buccolam®			Y
		Epistatis®			
Morphine	Modified Release Tablet	MST Continus®	Y	Y	Y
	Tablet	Sevredol®	Y	Y	Y
	Modified Release Capsule	MXL®	Y	Y	Y
		Zomorph®			
	Oral Solution	Oramorph®	Y	Y	Y
	Oral Granules	MST Continus®	Y	Y	Y
	Suppository		Y	Y	Y
	Injection		Y	Y	Y
	Infusion		Y	Y	Y
Morphine + Cyclizine	Injection	Cyclimorph®	Y	Y	Y
Nabilone	Capsules		Y	Y	Y
Oxycodone	Modified Release Tablet	Carexil®	Y	Y	Y
		Leveraxo®			
		Longtec®			
		Onexila XL®			
		Oxeltra®			
		OxyContin®			
		Oxylan®			
		Reltebon®			
		Zomestine®			
	Capsule	Lynlor®	Y	Y	Y
		OxyNorm®			
		Shortec®			
	Oral Solution	OxyNorm®	Y	Y	Y
		Shortec®			
	Injection	OxyNorm®	Y	Y	Y
		Shortec®			
Oxycodone + naloxone	Tablet	Targinact®	Y	Y	Y
Papaveretum	Injection		Y	Y	Y

Controlled Drugs

Drug	Form	Brand	CD Register Y/N	Safe Custody Y/N	Prescription Handwriting Requirements Y/N
Pentazocine	Tablet		Y	Y	Y
	Capsule		Y	Y	Y
Pethidine	Tablet		Y	Y	Y
	Injection		Y	Y	Y
Pregabalin (From 1st April 2019)	Capsule	Alzain®	N	N	Y
		Axalid®			
		Lecaent®			
		Lyrica®			
Remifentanil	Injection	Ultiva®	Y	Y	Y
Sufentanil	Sublingual Tablet	Zalviso®	Y	Y	Y
Tapentadol	Modified Release Tablet	Palexia SR®	Y	Y	Y
Tapentadol	Tablet	Palexia®	Y	Y	Y
	Oral Solution	Palexia®	Y	Y	Y
Temazepam	Tablets		N	Y	Y
	Oral Solution		N	Y	Y
Tramadol	Modified Release Tablet	Invodol SR®	N	N	Y
		Mabron®			
		Maneo®			
Tramadol	Modified Release Tablet	Marol®	N	N	Y
		Oldaram®			
		Tilodol SR®			
		Tradorec XL®			
		Tramulief SR®			
		Zamadol 24hr®			
		Zeridame SR®			
		Zydol SR®			
		Zydol XL®			
	Soluble Tablet	Zydol®	N	N	Y
	Orodispersible Tablet	Zamadol Melt®	N	N	Y
	Modified Release Capsule	Maxitram SR®	N	N	Y
		Tramquel SR®			
		Zamadol SR®			
		Zamadol ®			
		Zydol®			
	Oral Drops		N	N	Y
	Injection	Zamadol®	N	N	Y
		Zydol®	N	N	Y

Appendix 5

Label attached to tamper evident sealed plastic bag for storage of Patients Own Drugs

SOUTHERN HEALTH & SOCIAL CARE TRUST
Controlled Drug Medication Brought into Hospital by Patients

Patient Addressograph
Or
Patient Name

Ward

_____

Date of Birth

Date admitted

H&CN

_____

Record the name , strength and quantity of each controlled drug below:

Signature of 2 registered nurses/midwives _____

Consent for destruction Yes ☐ No ☐ (if yes , obtain patient's /carers signature)

Patient's Name (PRINT) _____ Signature: _____

Supplied by Pharmacy

Improving the quality, safety and timeliness of discharge prescriptions.

Eva McRory., Dr Alexander John, Jillian Redpath with Dr Richard Wright and Aldrina Magwwod at the annual Quality Improvement Event

Project Summary

Discharge prescriptions are a critical part of communication on discharge from hospital, informing the patient's GP of any changes made to medicines during an admission, and directing the medicines to be prescribed following discharge. Previous audits identified that the error rate was higher than a national study. While many prescribing errors are detected at part of the pharmacist clinical check, a proportion of patient are discharged out of hours where the prescription will not checked by a pharmacist and a prescribing error may remain undetected. This project aimed to reduce medication errors on discharge prescriptions by identifying the reasons for prescribing errors, seeking prescribers input into system changes to reduce errors, reviewing education and training on discharge prescriptions and providing specific feedback to prescribers on errors.

Key Findings

A discharge summary checklist was developed for the discharging team to provide key information to the FY1 doctor on diagnosis, follow-up and intended medication.

A model for prescribing feedback was developed for FY1 doctors to receive structured feedback on their prescribing.

Training in discharge prescribing and the electronic discharge system was reviewed and updated.

Outcomes

Use of a discharge checklist resulted in a reduced prescribing error rate in each area where it has been introduced.

The model for prescribing feedback was acceptable and felt to be useful by FY1 doctors and education supervisor. This has now been implemented with the 2016/17 cohort of FY1 doctors and has contributed to an overall reduction in prescribing errors.

Value Added

A reduced error rate reduces the likelihood of prescribing errors being continued in primary care for those discharge prescriptions not clinical checked by a pharmacist before discharge.

A reduced error rate can also contribute to a more timely discharge by reducing the time required to resolve queries.

To Find Out More About This Case Study Contact:

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QI Project – Quality and safety of discharge letters

Jillian Redpath – Medicines Governance Pharmacist
Eva McRory – Lead Clinical Pharmacist Medicine
Dr Alexander John – Respiratory Physician & FY1 Educational Supervisor

Background

- Retrospective audits of prescription errors on discharge letters on 2 medical wards
- All discharge letters processed by pharmacists at ward level over the course of a month.
- Baseline figures:
  - May 2014 –28.3 errors per 100 items prescribed
  - May 2015 – 27.4 errors per 100 items prescribed
  - EQUIP (2009) 6.4 errors per 100 items prescribed (FY1 discharge prescription)

Focus on errors…

- Concern over higher error rates than are present in other studies
- Overall ~ 40% of discharge prescriptions do not go through pharmacy
- Project conceived to look at causes, and try to improve aspects of processes within our control.

QI Project initiated…

- Project team
  - Jilly Redpath – Medicines Governance Pharmacist
  - Eva McRory – Lead Clinical Pharmacist (Medicine)
  - Dr John – Respiratory Physician & Educational Supervisor

  - Sr Maria Hamill – Clinical Ward Manager (Respiratory)
  - Sr Joan Wilson – Clinical Sister (Respiratory)
  - Sr Stephanie Carson – Clinical Ward Manager (Haematology)
  - Sr Eileen McGibbon – Clinical Sister (Haematology)
  - Dearbhla Fox – Pharmacist (Haematology)
  - Dr Liezl McCreadie FY1
  - Dr Jordan McVey FY1
  - Dr Sean McNicholl FY1
  - Dr Rebecca Topley FY1

Staff Engagement & Problem Diagnosis

- QI Tools utilised….
  - Purpose 2 Practice
  - Fishbone Diagrams
  - Questionnaires and discussions (FY1s)
  - Frustrations / Ideas boards (Nursing and Pharmacy staff)
  - Process Mapping of ward level discharge process (Project team)

- Measures identified
  - Errors on discharge letters

Ward level processes

- Process Mapping
  - Query loop – FY1 to medical team
    - Unfamiliarity with patient and flow of information identified as primary issues for FY1s writing discharge letters
  - Query loop – pharmacist to FY1/medical team
    - Training and education on discharge prescriptions and ECM
    - Unfamiliarity with patient and flow of information identified as primary issues for FY1s writing discharge letters

Project Streams

- Training and feedback mechanisms for Foundation Trainees

- Ward level processes at the point of discharge

Training & feedback on prescribing

- Feedback sought from FY1s on..
  - Training received at induction / available resources
  - Feedback given on prescribing throughout year

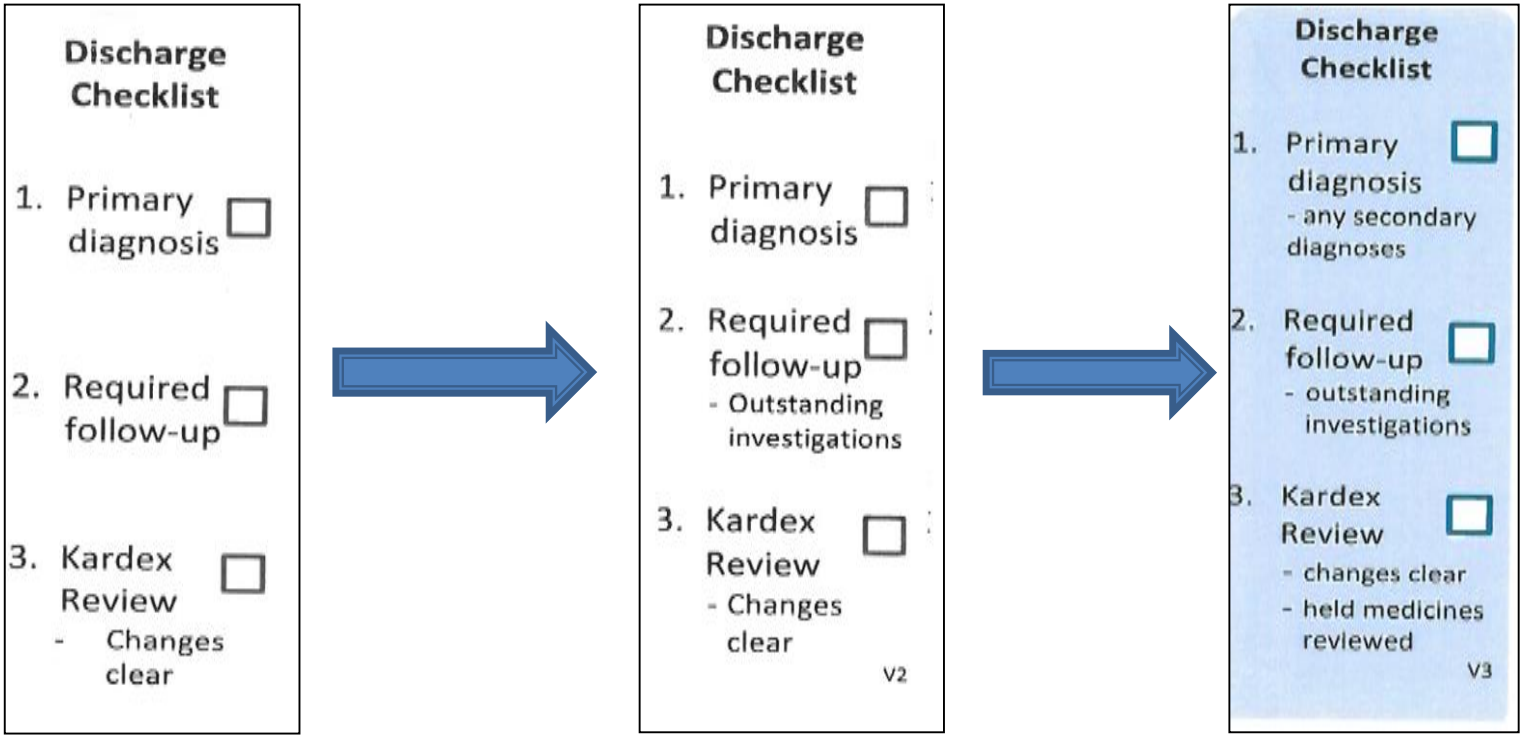
- Training
  - E-learning for ECM system updated and improved
  - 'Quick reference guide' compiled and distributed
  - Revised induction session
  - Additional Q&A sessions

- Feedback on prescribing
  - No structured feedback mechanism previously in place
  - Model for structured feedback developed and piloted with FY1s last year, to positive response.
  - Structured feedback on individual prescribing, from pharmacists and Educational Supervisor will be delivered to FY1s early this year.

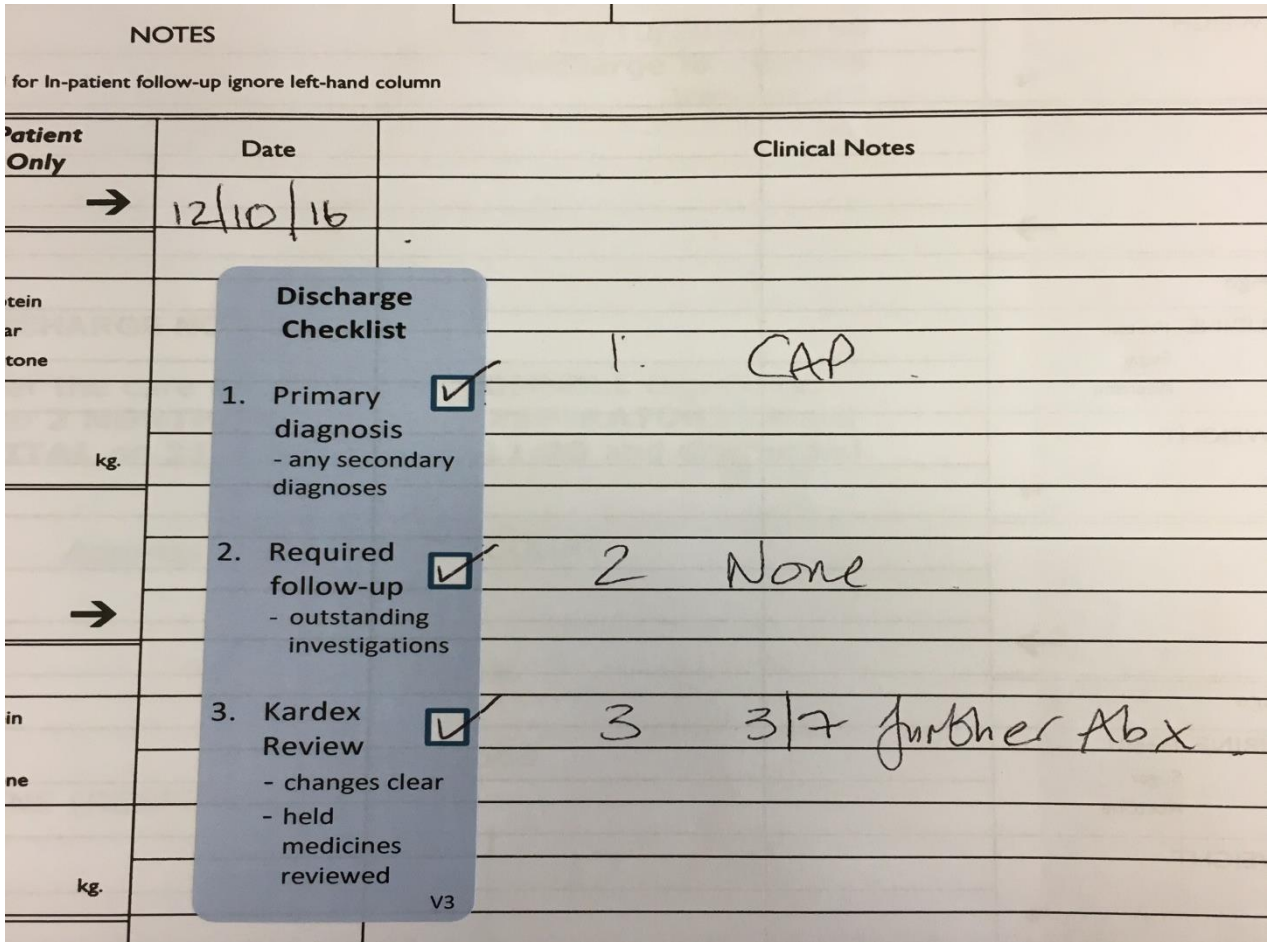
Discharge Checklist

- Initial idea from 2 FY1s in project team
- At point of decision to discharge, medical team completes brief summary of key clinical information
- Kardex review added

Discharge Checklist PDSAs

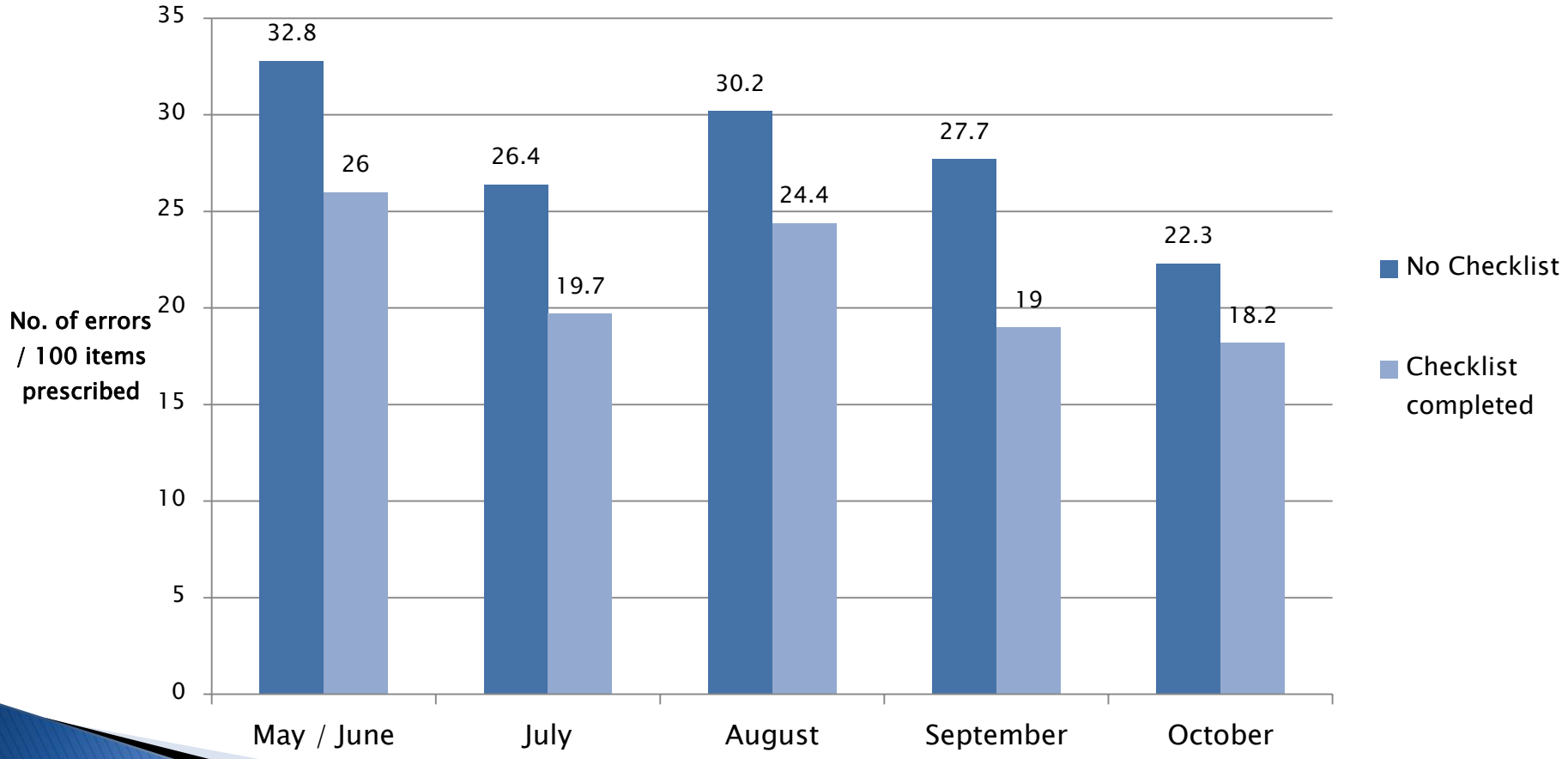


Discharge Checklist



Results

Chart showing number of errors / 100 items prescribed on prescriptions with and without the discharge checklist completed



Summary

- Feedback model developed
- Training revised
- Discharge checklist in place
  - Respiratory and Haematology Wards
  - Rheumatology and Gastroenterology Ward
  - Discussed at Daisy Hill Hospital Medical M+M
  - Initiated in Elderly Care + Acute Medical Unit

- Sustainability and spread

Proposal to expand SHSCT pharmacy coverage to improve the 'discharge before 1pm' rates

Background

In the Southern Trust the dispensing of discharge prescriptions can be delayed on two fronts: getting the discharge summary/prescription written and, on those wards that do not have a pharmacy medicines management team, sending the discharge prescription to the dispensary, rather than having it dispensed on the ward.

Trust discharge documents contain two main sections of information for the patient's GP, a discharge summary (including diagnosis, procedures, etc.) and a medication section. To maintain patient flow through the hospital and avoid long waits for patients in Emergency Department it is critical that inpatient discharges are processed quickly and safely.

After a patient is deemed medically fit there can be substantial delays before a doctor can prepare the discharge summary. This can be due to medical staff attending ward rounds or carrying out other clinical duties.

In the Southern HSC Trust the pharmacy teams have to alter or return approximately 50% of all discharge prescriptions as they require amendment before dispensing can commence. When a problem on a prescription is identified, contacting the prescribing doctor, returning the prescription to the ward for alteration and receiving it back into the dispensary can add an average of 54 minutes to dispensing times.

A recent study undertaken in the Northern HSC Trust (NT) aimed to reduce discharge delays by introducing a prescribing pharmacist into the process.

Initially in the NT study the pharmacist wrote the medication section of the discharge document and the doctor prepared the discharge summary. They found that there was an average delay of over 45 minutes for the discharge summary to be completed. The individual patient delay times ranged from 30mins to over 3hours

The NT Trust study then moved on to the pharmacist completing both the discharge summary and medication section of the discharge paperwork.

This section of the study was carried out over six weeks on a 32-bedded medical ward in Antrim Area Hospital. Time was recorded from the point that pharmacy was informed of the discharge until the discharge summary was written. The time reduced form 127 minutes to 33 minutes when it was prepared by the pharmacist. The time difference was statistically significant and could result in faster discharges. The study showed that in 100% of those letters prepared by the pharmacist all information required was present, that the Consultants involved in the study felt that the standard of the discharge documentation was good and they were positive about the process. The NT are now in the process of extending this work to other wards in the Trust.

Proposals

Dispensing at ward level

The most efficient and fastest way to dispense a discharge prescription is to have it dispensed on the ward by a pharmacy team. A number of wards in the SHSCT do not have a pharmacist and pharmacy technician team therefore all their discharge prescription are sent to the dispensary in the pharmacy.

This adds to patient discharge delays. In addition having pharmacy team at ward level has been shown in previous studies to reduce length of stay, as the team ensure that patients' medication is correct from the point of admission. At the moment the ward based pharmacy staff only see approximately 50% of the patients admitted to SHSCT wards.

To provide each ward with pharmacy team coverage, 9am to 5pm Monday to Friday, the following additional staff would be required:

- Pharmacist (band 7) – 3.5 wte
- Pharmacy Technician (band 4) – 4.0 wte

A breakdown of where these staff would be placed is set out in appendix A.

Discharge Pharmacists

Based on the NT study, the introduction of a team of discharge pharmacists would reduce the time taken for the majority of patients' documentation and prescriptions to be prepared and thus allow earlier patient discharges. The categories of patients whose prescription and discharge summary would be prepared by the pharmacist would be agreed in advance with the consultant leads in each specialty.

To provide a seven day discharge prescription/summary service from 9am to 5pm would require:

DHH - two prescribing pharmacists (band 7)

CAH – four prescribing pharmacists (band 7)

Appendix A

Ward	Pharmacist	Technician
1 North	1.0 wte band 7	1.0 wte band 4
Haematology	-	0.5 wte band 4
CAH level 4& Gynae	1.0wte band 7	1.0wte band 4
DHH Maternity	0.5 wte band 7	0.5 wte band 4
Male Surgical & Female Surgical	1.0 wte band 7	1.0 wte band 4

Southern Health and Social Care Trust

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Southern Health and Social Care Trust

Incident Management Procedure

October 2014

Procedure Checklist

Name of Procedure:	Incident Management Procedure
Purpose of Procedure:	To describe the Trusts systems and processes in relation to Incident Management
Directorate responsible for Procedure:	Corporate Governance, Office of the Chief Executive
Name & Title of Author:	Mrs Margaret Marshall, Interim Asst Director CSCG
Does this meet criteria of a Procedure?	Yes
Trade Union consultation?	No
Equality Screened by:	
Date Procedure submitted to Policy Scrutiny Committee:	
Members of Policy Scrutiny Committee in Attendance:	
Policy Approved/Rejected/ Amended	
Policy Implementation Plan included?	
Any other comments:	
Date presented to SMT	
Director Responsible:	Chief Executive
SMT Approved/Rejected/ Amended	
SMT Comments	
Date received by Employee Engagement & Relations for database/Intranet/Internet:	
Date for further review	

Contents

1.0 Introduction:

The consistent identification, monitoring and review of incidents is central to the Trust"s strategic and operational processes to ensure it can achieve its vision for safe and effective care. As recommended in the document „Safety First: a Framework for Sustainable Improvement in the HPSS" (HPSS 2006) the Trust recognises that incident reporting is a fundamental element of its Risk Management Strategy.

1.1 Purpose:

The purpose of this procedure is to guide all employees of the Trust in the following:

- Identification, reporting, review, monitoring and learning from all incidents which have resulted in or had the potential to result in injury or harm to a person or damage to property or the environment, or a breach of security, confidentiality, policy or procedure.
- Analyse incident trends, root causes, associated costs and to develop appropriate action plans to eliminate or minimise exposure to associated risks.
- Enable staff to participate in, and effect change by ensuring that mechanisms are in place to learn from incidents which occur and that resulting changes in care, policy or procedures are embedded in local practice.
- Notification and recording of incidents from third party organisations from which the Trust commissions services.
- Notification of incidents where appropriate to other relevant agencies, for example the Regional Health and Social Services Board (RHSCB), Regulation Quality and Improvement Authority (RQIA), Department of Health, Social Services and Public Safety (DHSSPS) via appropriate Early Alerts, HM Coroner, Northern Ireland Adverse Incident Centre (NIAIC), Health & Safety Executive Northern Ireland (NIHSE), Police Service of Northern Ireland (PSNI), etc. Please see **Appendix 2.**

1.2 Scope of the Procedure:

The following procedure applies to all employees of the SHSCT. Some aspects, including reporting a serious adverse incident, also applies to independent providers / contractors commissioned or engaged by the Trust. It addresses the Trust's governance responsibilities in relation to incidents and is one element of the Trust's Risk Management Strategy.

2.0 The Roles and Responsibilities:

2.1 Chief Executive:

The Chief Executive is the responsible Officer for the Trust"s statutory duty of quality and is required to drive the delivery of the Trust"s corporate priorities, particularly the priority to provide safe, high quality care. Through the overview of this Trust Policy and Procedure, the Chief Executive will seek to embed the Trust"s corporate values throughout the organisation, to promote the Trust"s values of all staff being open and honest and acting with integrity, to listen and learn and to embrace change for the better.

The Assistant Director for Clinical and Social Care Governance (AD CSCG) reports directly to the Chief Executive and will provide the Chief Executive, Trust Board, Senior Management Team (SMT) and Governance Committee with an on-going overview of this Policy and Procedure through the continuous corporate review and monitoring of Incidents and Serious Adverse Incidents (SAIs).

2.2 Assistant Director of Clinical and Social Care Governance (AD CSCG):

The AD CSCG will provide leadership to ensure a systematic and organisation-wide approach to the reporting of clinical and social care incidents and near misses and will work with SMT to embed a culture of appropriate and timely reporting, analysis and learning across the organisation.

The Assistant Director will participate in monthly meetings with the Clinical and Social Care Governance Coordinators in order that there is a corporate oversight in relation to incidents, risks, trends and learning within the organisation.

It is the responsibility of the AD CSCG to present a trend analysis report quarterly of all incidents reported in the Trust to:

- Senior Management Team (SMT)
- the Governance Committee
- CSCG Working Body

This report will be used by the SMT to inform organisational risk management and governance priorities and will escalate concerns in relation to trends and /or learning.

On behalf of the Chief Executive and SMT, the AD CSCG will provide assurance reports to Governance Committee in relation to the adoption and implementation of procedures relating to incident reporting, monitoring and learning. This includes evidence of cross organisational learning through appropriate forums including the Trust Governance Working Body.

The AD CSCG will act as a conjugate between the Directorates and the Chief Executive, appraising the latter of all major and catastrophic incidents, internal reviews and Serious Adverse Incidents. They will also liaise on behalf of the Trust with the Department, the Public Health Agency (PHA) and the HSCB to ensure the Trust contributes to and is involved in any Regional opportunities for learning.

2.3 Directors:

- Directors are responsible for leading a culture of openness, transparency and learning within their area of responsibility and for ensuring that the actions from any learning are appropriate and the most effective way to minimise risk and provide good care services
- Directors shall ensure that processes are in place to effectively identify, report, review, monitor and learn from all incidents within their Directorate and that the processes are as laid out within this procedure
- They shall ensure that the reviewing, learning from and monitoring of incidents is included on the agenda of all directorate, divisional and team governance meetings
- They shall ensure that action plans and learning to be implemented from incidents are an effective response with an appropriate timescale, prioritised and are reviewed on an on-going basis at directorate governance meetings
- Directors shall consider learning from moderate, major and catastrophic incidents and any trends identified from insignificant / minor incidents to inform directorate governance priorities, education, training and directorate and organisational learning. The latter should be identified through the Directorate Governance forum and be escalated to the AD CSCG for dissemination via the Trust Governance Working Body
- They shall ensure that all current risks recognised from this governance of incidents are considered for the Directorate / Corporate Risk Register
- Training – liaise with the appropriate Executive Directors with responsibility for professional and organisational training

2.4 Assistant Directors & Associate Medical Directors (AMD's for clinical incidents):

All incidents recorded on Datix Web must be reviewed by an ***Incident Review Team*** on a ***weekly*** basis***.*** It is the responsibility of all Assistant Directors / Associate Medical Directors (AMDs) to put in place ***Incident Review Teams*** within their divisions/teams. The membership of an Incident Review Team should include a Head of Service / Senior Manager and an identified Clinician where ***clinical incidents*** are under review.

The Assistant Director / AMDs must also:

- Lead a culture of openness, transparency and learning within their area of responsibility and ensure that the actions from any learning are appropriate and the most effective way to minimise risk and provide high quality care and services

- Include the management, review, monitoring and learning from incidents on the agenda of divisional, service and team governance meetings
- Ensure that action plans and learning to be implemented from incidents are an effective response, appropriately time bound, prioritised and are reviewed on an on-going basis at divisional meetings
- Consider learning from moderate, major and catastrophic incidents and any trends highlighted from insignificant / minor incidents when identifying directorate and divisional governance priorities, education, training and organisational learning in a timely way
- Organisational learning should be identified through to the Directorate Governance forum and be escalated to the AD CSCG for dissemination via the Trust Governance Working Body
- Identify training needs to the appropriate Heads within the Trust
- Ensure through their Heads of Service that any barriers to implementing the learning from moderate, major or catastrophic incidents is risk assessed using the SHSCT risk assessment matrix, highlighted at Directorate Governance Fora and placed on the appropriate risk register if not immediately actioned

2.5 Head of Service/ Team Manager:

It is the Head of Service/Team Manager"s responsibility to:

- Lead a culture of openness, transparency and learning within their area of responsibility and ensure that the actions from any learning are appropriate and the most effective way to minimise risk and provide high quality care and services
- Include the management, review, monitoring and learning from incidents on the agenda of service and team governance meetings
- Ensure that action plans and learning to be implemented from incidents are an effective response, appropriately time bound, prioritised and are reviewed on an on-going basis at team meetings
- Consider learning from moderate, major and catastrophic incidents and any trends highlighted from insignificant / minor incidents when identifying service and team governance priorities, education, training and organisational learning in a timely way
- Escalate any barriers to implementation of action plans relating to incidents to the appropriate Assistant Director and consider if they need to be placed on the appropriate Risk Register
- Ensure through the function of the ***Incident Review Team*** that feedback is provided to the incident reporter on the outcome of incident investigations for all moderate, major and catastrophic incidents

2.6 Incident Review Team:

- The purpose of the ***Incident Review Team*** is to review all incidents, determine any learning from them, make recommendations as to what would constitute an effective response which will minimise risk and communicate this within their teams (and to Heads of Service / Team Manager if they are not part of the Incident Review Team). Learning / effective response to any risks highlighted should then be communicated to the appropriate Head of Service / Team Manager for action within the operational teams. Any barriers to implementation of action plans relating to incidents should be escalated by the appropriate Head of Service to the Assistant Director.

The Review Teams should also consider and review the following:

- The information submitted by the reporter including the incident grade
- Consider the need for additional internal and/or external reporting e.g. Health and Safety, RIDDOR, NIAIC, HSCB, RQIA, Adult Safeguarding (PVA). See **Appendix 2**
- Develop time bound and prioritised action plans as appropriate. All **moderate, major** and **catastrophic** incidents reported will require an action plan which **must** include relevant learning points
- Feedback the outcome of the review of **moderate, major and catastrophic** incidents to the incident reporter
- Inform Assistant Director of any immediate learning which could minimise the risk of further reoccurrence of incident
- Close all incidents following completion of the review process

All Incident Review Teams should adhere to the Datix Web User Guide for Managers/Reviewers which can be accessed from the Trust intranet site. See Hyperlink:

http://vsrintranet.southerntrust.local/SHSCT/documents/DatixWeb_InvestigatorsFinalApproversguidance2012.pdf

2.7 The Directorate CSCG Coordinator:

The CSCG Coordinator will ensure that processes are in place for the recording, reviewing, monitoring and learning from incidents and will provide timely and appropriate information on incidents to the Directorate. Reports will be tailored for Directors, Assistant Directors, Heads of Service and Team Managers.

The CSCG Coordinator will also be responsible for interpreting and analysing incident information to identify risks and/or trends. They will feedback this information to the Directorate through the Directorate Governance structures.

The CSCG Coordinator will provide regular and timely information to the Directorate on the action plans and learning arising from incidents and SAI"s and the progression of these action plans.

On behalf of the Director, the CSCG Coordinator is responsible for monitoring that within each service team, incident information is being acted on appropriately in order to mitigate risk, improve quality of care and patient and client safety and facilitate teams to make any links required from issues identified in incident management to appropriate Risk Registers. They will also ensure that a process is in place to escalate any concerns relating to incidents to the appropriate Director, and that there are appropriate processes in place to identify SAIs in line with the Health & Social Care Board (HSCB) process.

The CSCG Coordinator will participate in monthly meetings with the Assistant Director of Clinical and Social Care Governance in order that there is a corporate oversight in relation to incidents, risks, trends and learning within the organisation.

2.8 All SHSCT Staff:

All SHSCT staff are required to provide safe, high quality care and this includes the reporting of incidents for organisational learning and good risk management as defined below and further in **Appendix 1**, in accordance with this procedure and participate in any subsequent review if required.

3.0 Procedure for the Identifying and Reporting of Incidents – ALL STAFF

3.1 Incident Identification:

A useful definition of an incident is:

"Any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation."

The incident may arise during the course of the business of the Trust or any of its commissioned / contracted services.

However this is not an exhaustive definition and using the incident reporting system specifically for clinical outcomes which are unexpected and / or unexplained, but are not believed to be associated with an adverse incident, is also encouraged by the Trust as a means of triggering a thorough review of such cases. These reviews are a beneficial mechanism of providing assurance to staff, patients, clients, carers and relatives that any learning related to any aspect of the case is sought and acted upon.

3.1.1 Other Systems for Reporting:

An incident can sometimes also be reported through other systems such as Adult Safeguarding, Case Management Review, Mortality and Morbidity meetings, etc.

The Trust mechanism for recording all incidents is **Datix Web** and the electronic incident form (IR1) should be completed as soon as possible after the incident occurs or is discovered to have occurred. Staff should then think through what other reporting systems, such as notifying their Line Manager, may need to be considered.

3.1.2 Incidents Occurring Within Services Contracted or Commissioned by the Trust:

Incidents occurring in contracted / commissioned services which are not observed / witnessed by Trust staff and / or not reported to Trust staff are dealt with under the regional contractual arrangement with independent providers. This states that all incidents occurring within the regulated sector which are notifiable to RQIA will also be notified to the appropriate Trust via a central email. From here they will be distributed to the appropriate Directorate for review as per section 4 of this procedure.

If a member of Trust staff observes or witnesses an incident occurring within a service contracted or commissioned by the Trust or has an incident reported to them by a Trust client and / or their family / carers which relates to care provided by a contracted or commissioned service i.e. domiciliary care services, private nursing home, etc. then the member of staff has a duty to report the incident using the Trust Datix web system. The staff member will also instruct the contracted service to report the incident via their reporting mechanisms (which include notifying RQIA and Trust of significant incidents) and this instruction should be documented by Trust staff. If reported to the Trust by the contracted service the Datix incident reports should be merged by the appropriate governance team. **The original incident should be reviewed as per section 4 of this procedure.**

3.1.3 Immediate Action Checklist Following Identification of an Incident:

When an incident is identified and before it is reported please complete the following **immediate action checklist:**

- The extent of injuries/damages to person(s) or property should be ascertained and a determination made regarding the need for emergency or urgent treatment / action. For patient / client care related incidents, contact the relevant medical team to assess where required. The situation must be made safe
- Appropriate obvious treatment / actions should be taken to minimise the likelihood of the incident recurring
- Any equipment involved in the incident should be removed from use and clearly labeled, “Do not use”, until appropriate checks can be carried out. Do not dispose of equipment involved in an incident
- **The patient/client and/or their relatives / carers** should be informed, as soon as possible of the incident and of any treatment that may be necessary taking into consideration any consent issues and referring to the Trust‟s “Being Open” guidance in **Appendix 4**

- Any incident involving a patient or client, and the action taken, should be recorded in their healthcare record
- If the incident is major or catastrophic and requires an immediate action plan to prevent further harm the line manager (if out of hours, the Senior Out of Hours Manager) should be informed
- For incidents requiring further in-depth investigation e.g. SAIs/Internal Root Cause Analysis (RCA"s) / Reviews, patient/client records should be returned as soon as is practical to the Directorate Governance Coordinator to ensure all recorded information is available for review. Retrospective notes are permitted as long as these are clearly marked as being made in retrospect
- Where appropriate and where it would be beneficial to assist in the investigation of the incident, photographs should be taken and retained as evidence – this is particularly useful in Health and Safety type incidents or where damage had occurred to property
- CCTV footage should be sourced and a copy made for all cases which would be subject to PSNI investigation.
- Security staff and/or the PSNI should be informed where appropriate
- Consideration should also be given to the need to activate site based emergency / contingency plans if necessary (in line with current emergency procedures)

3.2 Reporting an Incident:

Where: All incidents must be recorded electronically via the Datix Web based form (IR1 form) which can be accessed as follows from the Trust intranet site. **(Trust intranet/ useful links/ other useful links and scroll down to click on „Datix Web")**

By Whom: This form must be completed by either the member of staff involved in or who has witnessed the incident, or by the person the incident has been reported to.

When: All incidents should be reported via the electronic reporting form (IR1 form), no later than the end of the working shift or day during which it occurred **or** its occurrence became known.

How: Information concerning the incident must be accurate, complete and factual. The description of the incident should not contain opinions, conclusions, subjective or speculative statements. The following instructions should be followed when filling in the electronic incident form. *See Hyperlink below:*

http://vsrintranet/SHSCT/documents/DatixWebIR1FormUserGuidance_000.pdf

Incidents given an initial severity rating of major or catastrophic (as a minimum) will automatically be triggered to the appropriate Head of Service/Team Manager, relevant Assistant Director and the Assistant Director of Governance in an email via Datix Web.

In circumstances where the incident is considered as a potential **Serious Adverse Incident (SAI),** *(see **Appendix 1** for the definition of an SAI)* immediate telephone contact should be

made to the relevant Head of Service/ Line Manager or Out of Hours Manager if appropriate. They will notify the appropriate Director, Assistant Director/Associate Medical Director and Clinical and Social Care Governance Coordinator at the earliest opportunity. The incident will then be reviewed by the latter group against the HSCB SAI criteria and the DHSSPS Early Alert criteria. This group must complete a major/catastrophic incident checklist for all incidents screened as possible SAIs. This checklist, regardless of the outcome of the screening process, will be held by the Directorate CSCG Coordinator and copied to the Assistant Director of Governance via the Corporate Governance Office**. (**See **Appendix 6)** In the event of the incident meeting the Serious Adverse Incident criteria; **section 5.0** of this procedure should be followed and where appropriate, the Director should brief the Chief Executive on SAIs as soon as possible.

4.0 Procedure for Reviewing, Monitoring and Learning from Incidents:

All incidents are to be reviewed on a weekly basis by the service area‟s Incident Review Team. As indicated earlier the purpose of the Incident Review Team is to undertake a local assessment / review of the incident in a timely manner. This review should include:

- Quality assure the information submitted via the Datix system and the initial severity rating given to the incident. Where the review team believes the severity rating should be changed – the incident reporter should be contacted and this should be discussed and agreed
- Calculate the actual and potential risk rating for the incident using the Risk Grading Matrix and impact Table – this is explained on the Datix screen and also in **Appendix 3**
- Consider the need for additional internal and /or external reporting e.g. RIDDOR, NIAIC, HSCB, RQIA, Vulnerable Adults (PVA), Fire **(See Appendix 2 for guidance on advisory contacts re: these additional reporting routes)**
- If the incident is also an adult safeguarding review (this will be recorded on Datix) then the Incident Review team should link with the adult safeguarding Designated Officer (DO) for that incident. If the incident is proceeding to a safeguarding investigation the Incident Review Team should participate in that or at a minimum, review the learning from that investigation and implement as appropriate
- Develop and agree learning and action plans as appropriate. All **moderate, major** and **catastrophic** incidents reported will require a time bound action plan which **must** include relevant learning points. This learning should be communicated and actioned within teams
- Feedback the outcome of the review of **moderate, major and catastrophic** incidents to the incident reporter
- Inform the Assistant Director of any immediate learning which could minimise the risk of further reoccurrence of the incident
- Any barriers to implementation of action plans relating to incidents should be escalated to the appropriate Head of Service and the Assistant Director

- Close all incidents following completion of the review process

4.1 Incident Review:

The following risk assessment process should be applied to all incidents at the time of occurrence in order to decide what level of investigation is required and at what level within the Trust the investigation should be conducted.

***Step One* – What was the impact of the incident at the time of the incident? (Actual Harm)**

4.1.1 The person reporting the incident should undertake this stage of the assessment, entering it on the IR1 form (DIF1). Based on the actual impact of the incident at the time of occurrence (taking into account psychological as well as physical harm) a judgment is made as to the incident"s severity in the range Insignificant to Catastrophic.

4.1.2 Incidents assessed as causing actual **major** or **catastrophic** harm at the time of the incident must be given immediate consideration for further in depth analysis.

4.1.3 For incidents causing lesser levels of actual harm further questions need to be asked to decide on the level of investigation required.

***Step Two* – What might the impact be if the incident happens again? (Potential harm)**

4.1.4 Where the potential harm of the incident is being considered, staff must ask the following in the context of "if no further action was taken".

- Was the harm caused by a chance happening?
- Could the actual harm caused realistically have been a lot worse?
- How many people might be hurt if it happened again?
- How seriously might someone be hurt if it happened again?
- What are the control measures already in place, today?

4.1.5 It is important that grading on actual harm and potential harm are completed as separate exercises. This will ensure that the most severe incidents where the level of actual harm is higher are dealt with as a priority. All incidents with a lower level of actual harm but with a potential for a higher level of harm must be managed appropriately.

Step one	Deciding what was the impact / harm of the incident today **(actual)**
Step two	Where there is insignificant to moderate actual impact/harm, deciding what might the realistic impact/harm be if the incident were to happen again under similar circumstances. **(potential impact)**
Step three	Decide what are the chances of the incident happening again under similar circumstances. At this stage consideration should also be given

	to reviewing similar incidents that have happened in the past. **(Likelihood)**
Step four	Decide what the overall risk grading for the event is by plotting: **Impact** multiplied by **likelihood = risk grading**

The level of review applied to an incident is determined by the actual severity (impact) of the incident and/or the potential impact and is as follows:

INSIGNIFICANT AND MINOR – These incidents will usually not require detailed review, however the following questions should be asked to establish any learning:

- What happened?
- Did what happened vary from what should have or was expected to happen?
- If so, why?
- What is the learning from this incident?

However, these incidents could be subject to detailed review if similar incidents are found to occur frequently i.e. where there is a trend. It is the review team"s responsibility to identify such trends and advise the appropriate Head of Service/Team Manager or Assistant Director regarding improvements or action plans required if a trend is identified. Heads of Service and Assistant Directors should also be identifying and analysing trends through their Team / Service / Divisional Governance meetings. Action plans and lessons learnt from this trend analysis should be discussed and actions recorded in the notes of team, service and divisional governance meetings.

MODERATE – These incidents **must** be reviewed as part of the incident review process on a weekly basis. The review team must ensure that an investigation is completed within four weeks and that there is a documented action plan and learning points recorded on Datix Web. These actions and the learning should then be reviewed by the team, division and directorate with respect to progress of implementation.

In undertaking a Moderate Incident review the following questions should be answered **as a minimum:**

- What happened?
- Did what happened vary from what should have or was expected to happen?
- If so, why?
- What is the learning from this incident?

Further guidance on incident review is available in **Appendix 7.**

The Heads of Service and Assistant Directors are responsible for reviewing implementation of any actions and learning following an investigation. Action plans and implementation of learning should also be reviewed at the Directorate Governance forum by the Director.

MAJOR AND CATASTROPHIC - This level of incident will, as previously described, have been automatically notified by the Datix system to the Head of Service, relevant Assistant Director and the Assistant Director of Governance at the time of reporting. It is the responsibility of the relevant Assistant Director to inform the Director and Associate Medical Director (AMD) (in the case of clinical incidents) and the appropriate CSCG Coordinator for that area of the incident.

The incident must be considered against the HSCB (October 2013) criteria for a Serious Adverse Incident (SAI) by the relevant Director, Assistant Director, AMD and CSCG Coordinator. This review of the incident should be documented by the CSCG Coordinator on the major / catastrophic incident checklist which must be completed by the group. Regardless of the outcome of the screening, the completed checklist should be shared with the Assistant Director of Governance via the Corporate Governance Office. In the event of the incident meeting the SAI criteria, **section 5.0** of this procedure should be followed.

If the incident does not meet the SAI criteria the relevant Director may either appoint an independent internal team to review the incident using a Root Cause Analysis methodology (the method used to review an SAI -see section 5) or the incident may be reviewed by the service Incident Review Team. **(**See **Appendix 7)**

Whatever the method of reviewing the incident – either as an SAI, an internal review by an independent team within the Trust or by the clinical review team within the division itself, the service team involved in the incident **must** be informed of the decision regarding how the incident is to be reviewed at the earliest opportunity, by the Assistant Director / Associate Medical Director, and **before** the review commences.

Where an incident is to be reviewed internally by an independent team or if it is the subject of an SAI, the patient /client and/or family/carer must be informed of this review at the earliest opportunity (as per the HSCB SAI guidance April 2014) as should the coroner where the case has previously been referred to them. This action forms part of the major / catastrophic incident checklist and should be documented. In exceptional cases where it is not appropriate to share this decision with the patient /client and/or family/carer, the reasons for this decision **must** be documented on the checklist and on the SAI notification form.

The findings and recommendations of the review - irrespective of how it is carried out, will be discussed and documented at relevant team, service, division, Morbidity and Mortality meetings and directorate governance meetings.

The Heads of Service and Assistant Directors are responsible for reviewing implementation of any actions and learning following an investigation.

Action plans and implementation of learning will also be reviewed at the Directorate Governance forum by the Director.

Cross Directorate learning points should be escalated to the Assistant Director of Governance by the CSCG Coordinators when they meet monthly.

The findings and recommendations of an internal review of an incident or an SAI should be shared with the patient / client and/or family / carer, RQIA and the coroner (if previously referred) at the earliest opportunity.

5.0 Procedure for Reporting and Completing a Review of a Serious Adverse Incident (SAI):

Following the review meeting of the relevant Director, Assistant Director, AMD and CSCG Coordinator where it is agreed to report an incident as a SAI, the SAI notification should be electronically reported to the HSCB, via the Corporate Governance Office, as per the HSCB Procedure for the Reporting of SAIs (HSCB October 2013)

See Hyperlink:
http://www.hscboard.hscni.net/publications/Policies/102%20Procedure_for_the_reporting_and_followup_of_Serious_Adverse_Incidents-Oct2013.pdf

The Directorate CSCG Coordinator will populate the HSCB SAI notification form on behalf of the appropriate Director and forward to the Corporate Governance Office for the attention of the Assistant Director of Governance. All SAI notification forms **must** be fully completed and accurate with an appropriate Datix ID number when submitted to the Corporate Governance Office and should be done so **within 72 hours** of the incident occurring. The Director / their designate should also report the SAI to the Chief Executive.

If the SAI concerns the death of a patient and the death has been reported to the Coroner by the appropriate medical professional this will have been recorded on the major/catastrophic review checklist and the SAI Notification. In this case the Corporate Governance Office will automatically inform Litigation (litigation generic email account) of the SAI review and this will on completion be submitted to the Coroner.

Where the SAI notification form indicates that the RQIA should be informed the Corporate Governance Office will automatically share the notification and report (when finalised) with the RQIA.

If the SAI requires an Adult Safeguarding Investigation, the Adult Safeguarding Investigation will inform the SAI process. The PVA Designated Officer will liaise with the appropriate Governance Coordinator, relevant HoS, and a representative from the Adult Safeguarding Team to compose the Adult Safeguarding Investigation review team membership. That review team must be approved by the Director, Assistant Director, and where appropriate AMD. The PVA Investigation Officer will produce an Adult Safeguarding Investigation report which will be submitted to HSCB/RQIA and to the Coroner if appropriate etc as the SAI report.

5.1 Procedure for Conducting a SAI Review (This procedure should also be applied when conducting an Independent Internal Review):

Timescale	Action	Lead
0 -72hrs	Discuss with Director, Assistant Director, AMD and CSCG Coordinator. Consider the incident against HSCB (Oct 2013) definition of a SAI and using the Major/Catastrophic incident checklist.	Director / CSCG Coordinator
0-72hrs	If above group decides the incident is an SAI they will inform the service team involved in the incident of their decision and the patient/client and/or their relatives. This group should identify nominations for the SAI review team including a Chair. (Advice for Chairpersons - see Appendix 8) Those nominated should have had no involvement in the incident for review, should be from another site / team and should be available to participate during the subsequent 12 weeks. There is the option to nominate external independent persons from other organisations onto the review team – this is done via the Director and Chief executive. This option may be useful when there is a need to engage the appropriate expertise, the incident is particularly distressing for staff involved or is particularly sensitive, where carers and relatives have expressed significant dissatisfaction with a service team or the organisation at an early stage, where a service team is small and based on one site only, where the case may be subject to external or legal scrutiny at a later stage or at any other time where it may be deemed to offer a benefit.	Director / AD/AMD/CSCG Coordinator
0-72hrs	Following confirmation of their involvement all review group nominees will receive an email with the following information: • Notification of their nomination and who nominated them. • Membership and Chair of the group • A brief description of the incident • Timescale for completion of the report • Guide to RCA methodology. The relevant A/D will check and ensure the case note /records have been forwarded to the CSCG Coordinator.	CSCG Coordinator
Week 1	CSCG Coordinator and Chair of review group will agree draft terms of reference for the review. Draft terms of reference and a copy of the case note / records will be circulated with potential dates for meeting 1 of the review. All relevant information will be distributed to the group for consideration prior to meeting 1 of the group.	Chair/CSCG Coordinator
Week 2-3	Meeting 1 will take place. This meeting will normally agree a terms of reference – including the scope of the review. The timeline of events will be discussed - and all relevant points for further analysis identified together with any points needing further clarity from the professional team involved in the incident. It is often useful and appropriate to meet with some / all of the staff involved in the incident so they can give their account to the review team in person, indicate their thought processes at the time and clarify any	Review Team

	outstanding issues. The appropriate members of the review can meet those of similar profession from the team involved in the incident.	
Week 3-6	**Actions from meeting 1 will be completed, including follow up meetings with staff involved in the incident and all information can be forwarded to CSCG Coordinator.**	**Review team**
Week 6	**Meeting 2 can take place. It may be appropriate in less complex cases to have Draft 1 of the report tabled at this meeting for further discussion. However this meeting is more likely to pull together all information received and to analyse the incident and make conclusions, recommendations and propose an action plan.**	**Review team / CSCG Coordinator**
Week 7-9	**A complete draft of the report will be prepared by members of the review team and circulated to all for comment.**	**Review team /CSCG Coordinator**
Week 9-10	**Comments from the review team will be reviewed by the Chair and CSCG Coordinator / review facilitator and a final draft agreed and then circulated to the review team.**	**Chair/ CSCG Coordinator**
Week 10-12	**The final draft will be circulated / shared with all members of the service team involved in the incident for factual accuracy checking and information. The Final Draft will then be forwarded to the appropriate Director, Associate Medical Director and Assistant Director for quality assurance prior to presentation at Directorate governance meetings.**	**Chair/CSCG Coordinator**
Week 12	**Following approval by AD CSCG the report will be submitted to HSCB/ RQIA via the Corporate Governance Office. The report may also be submitted to SMT for information sharing / discussion and if a case involves a death being reviewed by the Coroner it will be shared with their office also.**	**CSCG Coordinator / Corporate Governance**

5.2 Points of Best Practice When Undertaking a SAI Review (Applicable when undertaking an Internal Review of an Incident also):

- The service team involved in the incident are provided with support and assistance following the incident and during and after the review. See **Appendix 5**
- The patient / client and/ or relatives are informed of the review taking place, **BEFORE** it commences, to provide assurance to them that any learning related to the incident is identified and acted upon. See **Appendix 4**
- The service team involved in the incident are informed as soon as possible and **BEFORE** it commences how the incident will be reviewed. They are kept informed with respect to review progress and they can interface with the review team to provide additional information and or clarity when required. The draft review report should be shared with the service team involved in the incident for factual accuracy and information
- The review must be chaired by someone with relevant professional experience and expertise from another geographical area of the Trust who has had no involvement in the case or direct line management responsibility for any of the team involved in the incident

- The review team should be multidisciplinary and have the appropriate expertise to review the incident appropriately. They must be independent from being involved in the care and treatment provided to the patient / client
- There is the option of seeking external independent review team members and this should be considered at the outset by the Director, Assistant Director, and Associate Medical Director and CSCG Coordinator. This option can be used at any time throughout the review
- The facts, findings and recommendations from the review will be shared with the patient /client and /or family / carers. See **Appendix 4**
- Where the case has previously been referred to the Coroner, their office will receive a copy of the review report
- Learning and action plans from SAI"s will be managed in the same way as that from other incidents – **see section 4**

(subject to service users consent)

APPENDIX 1:

KEY DEFINTIONS

Definitions: The following terms describe events, which are defined as incidents and will be recorded and reported within the scope of this procedure and through Datix Web.

Terminology	Definitions
Incident/ Near Miss	Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation arising during the course of the business of an HSC organisation / Special Agency or commissioned service (including a breach of security or confidentiality). However this is not an exhaustive definition and using the incident reporting system specifically for clinical outcomes which are unexpected and / or unexplained, but are not believed to be associated with an adverse incident, is also encouraged by the Trust as a means of triggering a thorough review of such cases. These reviews are a beneficial mechanism of providing assurance to staff, patients, clients, carers and relatives that any learning related to any aspect of the case is sought and acted upon.
Near Miss	**Incidents** that do not lead to harm but could have, are referred to as near misses.
Serious Adverse Incident (SAI)	The following criteria will determine whether or not an adverse incident constitutes a Serious Adverse Incident (SAI) **Serious Adverse Incident Criteria:-** serious injury to, or the unexpected/unexplained death (*including suspected suicides and serious self-harm*) of : a service user a service user known to Mental Health services (including Child and Adolescent Mental Health Services (CAMHS) or Learning Disability (LD) within the last two years) a staff member in the course of their work a member of the public whilst visiting an HSC facility. unexpected serious risk to a service user and/or staff member and/or member of the public unexpected or significant threat to provide service and/or maintain business continuity serious assault (*including homicide and sexual assaults*) by a service − on other service users, − on staff or − on members of the public occurring within a healthcare facility or in the community (where the service user is known to mental health services including CAMHS or LD within the last two years). - serious incidents of public interest or concern involving theft, fraud, information breaches or data losses.
Harm	Injury (physical or physiological), disease, suffering, disability or death. In most instance harm can be considered to be unexpected if it is not related to the natural cause of the service user"s illness or underlying harm („Doing Less Harm, National Patient Safety Agency)
Concern	A worry or "gut feeling" about something that could lead to an incident. To highlight a situation which could lead to a full blown incident or suboptimal standards of equipment, practice or performance.

APPENDIX 2:

When and How an Incident Should Also Be Reported To Other Sources

All adverse incidents should initially be reported using the Datix Web incident management system. However some incidents should also be reported to other sources either internally within the Trust and / or externally to other agencies. The following table provides a list of types of incident and where they should be reported to following being recorded as an incident. There is also a list of useful contacts and Web links for additional advice and help.

TYPE OF INCIDENT	WHERE ELSE IT SHOULD BE REPORTED TO	USEFUL CONTACTS AND LINKS ON HOW TO REPORT IT
Potential Adult Safeguarding Incident	Definition available on the link opposite	Info available from Trust Intranet: http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/documents/SAFEGUARDINGVULNERABLEADULTSPROCEDUREGUIDANCEVERSION4.pdf Report form available on: http://vsrintranet/SHSCT/HTML/PandP/documents/PVA1BLANK.pdf
Health and Safety Incident	Via the Datix Web form Incidents should be automatically reviewed by Health and Safety	Contact: (Internal) Health & Safety Dept Number: Irrelevant information redacted by the USI Email: http://vsrintranet.southerntrust.local/SHSCT/HTML/HR/documents/ReportableDiseases.pdf
MHRA	Should be notified (although voluntary) when an Adverse Drug Reaction occurs (ADR)	A paper form can be found in the back of every BNF or alternatively can be completed online at www.mhra.gov.uk/yellowcard
RIDDOR	An Incident is RIDDOR reportable if: **1)**The injury sustained is major, **2)** If a member of the public on Trust premises is killed or taken to hospital **3)** If the injury is sustained is an „Over 3 day injury" **4)** If there has been a Dangerous occurrence	Appropriate information should be completed on the Datix Web IR1 form which alerts the Trust"s Internal Health and Safety Dept. The above department is also contactable on Irrelevant redacted by the USI

	5) If a notification of a reportable work-related disease has been received Further guidance available on Trust Intranet	
SABRE **SHOT**	For adverse blood reactions and events the MHRA (above) has a web based system for reporting known as ***SABRE*** - ****Serious Adverse Blood Reactions and Events**** The hospital blood bank should be informed who will inform a member of the Trust Transfusion Team and the Haemovigilance practitioner will complete online reporting to SABRE. There is an option in the SABRE reporting system also to report to the ***Serious Hazards of Transfusions (SHOT)*** enquiry. All SABRE incidents are discussed at the Hospital Transfusion Committee meetings.	For further information on both SABRE and SHOT please visit www.mhra.gov.uk
CMR	Case Management Review	*New processes have been put in place under Safeguarding Board NI.*
Fire	Relates to all fire Incidents:	An FPN 11 Form should be completed within 24 hours of the Fire Incident. FPN 11 form is available on the Intranet at: http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/PandP.html and should be sent to: Fire Safety Department, Meadowview, Daisy Hill Hospital, when completed.
RQIA	***RQIA are notified about Incidents such as*** -serious injury to, or the unexpected/unexplained death -unexpected serious risk to service user and / or staff member and / or member of the public -unexpected or significant threat to provide service and / or maintain business continuity.	Corporate Governance Office to notify RQIA on receipt of appropriate SAI Notification form.

	-serious assault (*including homicide and sexual assaults*) by a service user -serious incidents of public interest or concern involving theft, fraud, information breaches and data losses	
HM Coroner	There is a general requirement under section 7 of the Coroners Act (Northern Ireland) 1959 that any death must be reported to the coroner if it resulted, directly or indirectly, from any cause other than natural illness or disease for which the deceased had been seen and treated within 28 days of death.	Guidance on reporting a death to the coroner available at: http://www.courtsni.gov.uk/en-GB/Publications/UsefulInformationLeaflets/Documents/Working%20with%20the%20Coroners%20Service%20for%20Northern%20Ireland/Working%20with%20the%20Coroners%20Service%20for%20Northern%20Ireland%20(PDF).pdf and on the Trust Intranet at: http://vsrintranet.southerntrust.local/SHSCT/HTML/clinical_guidelines.html Corporate Governance Office to also notify Coroner on receipt of SAI Notification form
NIAIC	An incident is NIAIC reportable if it relates to a Medical Device	Contact: Specialist Estates Services Dept (internal) Medical Devices Liaison Officer Email: [redacted] i.net
DHSSPS Early Alert	Guidance available on Early Alerts at: http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/PandP.html	Notification sent by Corporate Governance Office
HSCB Early Alert	As above -	Notification sent by Corporate Governance Office

Appendix 3

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Minimal injury requiring no/ minimal intervention. • Non-permanent harm lasting less than one month (1-4 day extended stay). • Emotional distress (recovery expected within days or weeks). • Increased patient monitoring	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Increase in length of hospital stay/care provision by 5-14 days.	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)
	• Minimal disruption to routine activities of staff and organisation.	and organisation, rapidly absorbed.	delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	and organisation - absorbed with some formal intervention with other organisations.	delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

Risk Likelihood Scoring Table

Likelihood Scoring Descriptors	Score	Frequency (How often might it/does it happen?)	Time framed Descriptions of Frequency
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

APPENDIX 4:

Guidelines on being open with patients, service users, families and carers when things go wrong or outcomes are unexpected and /or unexplained

- Any incident involving a service user should be discussed with this individual as soon as is appropriate by a senior member of the service team and preferably the lead professional. If the service user is a child or is unable to give consent due to their physical condition or mental capacity the incident should be discussed with their named next of kin contact. If the service user is able to provide consent and wishes the incident to be discussed with another carer or relative, the service team should facilitate this request.

- Specifically those incidents graded moderate, major and catastrophic should be discussed immediately with the service user and/or their relatives / carers, with consent. Those incidents of an insignificant and minor nature which occur out of hours can be discussed with those required at the most appropriate time within the next 24 hours.

- When discussing an incident with a service user and / or designated relatives / carers, the lead professional should outline the facts of the incident as known, the actual and potential consequences for the service user and how the team will review the incident for future learning. If the service user and/or designated carers / relatives wish to have the outcome of the incident review fed back to them the service team should consider this as good practice and should be conducted with consent of the service user if applicable. These interactions should be documented and attached to the incident report on Datix.

- If an incident meets the criteria for notification as an SAI or internal RCA, (**refer to Section 5**) the service user and / or designated relatives / carers must be informed of this decision before the SAI / RCA review begins. Where possible this should be undertaken by the Lead professional involved in the service user"s care. Where this is not possible to due relations being strained or it is judged to be inappropriate the Chair of the SAI /RCA review group supported by the Directorate CSCG Coordinator will undertake this role. This

individual will continue as the point of contact for the service user and / or designated relatives / carers throughout the period of the review and until the findings have been fed back.

- When an SAI / RCA review is completed and has been approved by the Directorate the point of contact for the service user and / or designated relatives / carers should offer to feed back the factual findings and recommendations of the review. This can include a meeting between parties and / or giving the review document to the service user and / or designated relatives / carers. How this process of review feedback is managed should be guided as far as possible by the wishes of the service user and / or designated relatives / carers.

APPENDIX 5:

Guidance on Support for Staff following an Incident

The Trust promotes an open, honest and participatory culture in which adverse incidents can be reported, discussed and reviewed to enable lessons to be identified, active learning to take place and the necessary changes made to improve our services and practices. A key part of that culture involves the need to support staff when an adverse incident occurs and during its review.

Depending upon the nature and circumstances of an adverse incident the levels of support required by staff will vary. Such support can be provided by line managers in a number of ways, for example:

- Providing immediate assistance/aid if required.
- Contacting the relevant staff member(s) as soon as possible following the incident to discuss.
- Facilitating an immediate informal and/or formal debrief of the staff / team involved in the incident. This should include providing staff with the opportunity to discuss their involvement and/or the circumstances leading up to the incident and how they feel about it. It is usually best to do this in a team setting with all those involved in the incident present.
- Informing staff of the Directorate"s processes in relation to incident review; keeping staff informed of likely next steps in that process and informing staff of who they can contact for advice including the Directorate Governance Office who coordinate all serious adverse incident reviews.
- At any time staff can seek advice from outside their team, for example from Directorate and Corporate Governance Offices, the Trust Litigation Department, Trust Legal Advisors or via the appropriate professional bodies.
- Line managers should be visible to all staff members. Physical presence by line managers post-incidents helps decrease anxiety related to an review and provides an accessible resource for clarification of any issues staff may have.
- Providing information on the Trust and external support systems currently available for staff who may be distressed by incidents. This includes counselling services offered by professional bodies; stress management courses; Occupational Health Services, Carecall or Hospital Chaplains.

APPENDIX 6:

Major / Catastrophic Incident Checklist

Directorate:	
Reporting Division:	
Date of Incident:	
Incident (IR1) ID:	
Grade of Incident:	
If Incident involved the death of a service user, was the coroner informed:	
Names / Designations of those considering Incident: *(Should include Director, Assistant Director, AMD & CSCG Coordinator)*	
Brief Summary of Incident:	
Summary of discussions re SAI / RCA/ Major / Catastrophic incident review:	
Decision on Level Review Type AND rationale for this:	
Nominated Review Team: *(Consider need / benefit of independent external expertise)*	

Is it appropriate to inform the Medical Executive/Executive Directorate of Nursing?	☐ YES ☐ NO
Contact for service user and / or designated relatives / carers:*(Either Lead Professional or Chair of Review)*	
Date and by whom service user and / or designated relatives / carers informed of review taking place:*(If there is an exceptional case where this is inappropriate rationale must be documented):*	
If case referred to the Coroner - Date and by whom coroner informed of SAI / Internal Review :	
(Corporate Governance Office / Litigation to complete) Date and by whom Trust Litigation Dept informed:	
Does this incident meet the DHSSPS Early Alert Criteria including rationale:	
POST REVIEW COMPLETION: Date and by whom and how Review is shared with the service user and / or designated relatives / carers: *(In exceptional cases where this is inappropriate rationale should be documented)*	
Date and by whom and how Review is shared with the Coroner:	

This form once completed, regardless of Outcome, should be shared with the AD of Governance via Corporate Governance Office

APPENDIX 7:

Incident Review Guidance

A key principle of the CSC governance framework is that incidents are reviewed and analysed to find out what can be done to prevent their recurrence. Therefore, a key principle of the incident review is that when an incident occurs the important issue is not „who is to blame for the incident?" but „how and why did it occur?

Although there will be some incidents which require review using methodologies as contained within e.g. individual agency reviews, adult safeguarding reviews, health and safety reviews, the majority of incidents can be reviewed using the National Patient Safety Agency (NPSA) Root Cause Analysis Tools. Nonetheless all incident reviews will ask the core questions of:

- What actually happened? *(The facts)*
- How did what happened vary from what should have or was expected to happen?
- Why did it happen in that way? *(The causes)*
- Is there any learning to share with the team or wider Trust services to minimise the likelihood of recurrence?

The above can be expanded to include where appropriate:

- Was there anything about the task/procedure involved?
- Was there anything about the way that the team works together or perceives each other's roles?
- Was there anything about the equipment involved?
- Was there anything related to the working environment or conditions of work?
- Was there anything about the training and education of the staff in relation to their competence to:-

  (a) provide the care/service required, and

(b) manage the incident when it occurred?

- Was there anything relating to communication systems between individual members of the team, departments, or electronic communications, for example, test results via computer?
- Was there anything about the availability, or quality of any guidance notes, polices or procedures?
- Was there anything about the Trust"s strategy, its strategic objectives and priorities?

Further detailed advice in relation to incident review techniques including Root Cause Analysis (RCA) Methodologies can be sought from the Directorate Governance Coordinators or visiting the NPSA RCA toolkit resource here.

APPENDIX 8

Brief Guidance on the Role and Responsibilities of an SAI Review Chairperson

The Chairperson leads an SAI Review Team. The Chairperson's main aim is to ensure that the SAI Review Team explores in an open, fair and critical manner the circumstances surrounding the incident, and establishes what, if any, lessons arising need to be incorporated into practice in order to prevent or minimise the likelihood of reoccurrence of the incident. The review should identify not only areas for improvement but also areas of good practice. The Chairperson will be assisted by the relevant Governance Coordinator or their nominated review facilitator.

The main responsibilities of the review Chairperson are:

1.0 Prior to the Review

1.1 Reviewing all relevant case notes, statements, synopsis of care reports and relevant sections of policies and procedures related to the incident to enable them to lead the initial meeting of the Review Team.

1.2 In conjunction with the Governance Coordinator, prepare a draft Terms of Reference for consideration by the Review Team at the initial meeting.

2.0 During the Review

2.1 Ensuring that all attendees at the review are introduced to each other and are aware of their role.

2.2 Facilitating a process that is conducive to learning and analysis without interference from personal disagreements, criticisms, perceptions or dissatisfaction.

2.3 Ensuring that the review is open, fair and participative. That if required appropriate members of the Review Team are delegated to meet members of the service team involved in the incident to obtain clarity on events.

2.4 Chairing the Review in a manner which ensures that: all salient facts, a clear chronology of events and interventions, areas of strength/weakness of policy or practice are identified and clear action plans are formulated and agreed.

2.5 Ensuring that Review Team members, service teams and patients / clients and /or relatives and carers are kept informed with respect to the review and its progress as required. See **Appendix 4** and **section 5.**

3.0 Following the Review

3.1 Liaising with the Governance Coordinator to ensure that a comprehensive report with recommendations / action points and timescales (where relevant) is produced and agreed ensuring that the service team involved in the incident are given an opportunity to check the information they have contributed to the report for factual accuracy. The Chairperson should sign off/approve the report prior to it being sent to the AMD /Assistant Director / Director.

3.2 If there are queries / comments raised by the AMD / Assistant Director/ Director following their review of the draft report, the Chair should consider these and reconvene the Review Team if necessary to address same.

3.3 Report practices, systems or other issues which the Review Team feel require immediate attention to the relevant Assistant Director, Head of Service and AMD, where appropriate.

3.4 If the Chairperson is the nominated contact with the patient/client and or family/ carers, they will be responsible for sharing the facts/ recommendations and action plan with them as outlined in **Appendix 4.**

Southern Health and Social Care Trust

15 December 2016

Dear Tracey

As you are aware the SAI review and report in relation to Patient 10 reference number Personal information redacted by USI is complete.

The remit of Patient 10 Serious Adverse Incident was to fully investigate the circumstances which contributed to her clinical incident. The Review Team was comprised Mr Anthony Glackin Consultant Urologist, Dr Aaron Milligan Consultant Radiologist, Mrs Katherine Robinson Booking and Contact Centre Manager, and Mrs Christine Rankin Booking Manager. To provide context, part of the work included a look-back exercise for 7 Urology patients who managed in the same manner as Patient 10 in October 2014. This was to satisfy the panel that there was a management plan in place and no harm had come to the other 7 patient (letters) which were not triaged on the week ending 30 October 2014. The manual look-back was done using the 6 available patient charts on 14 November 2016. These 6 patients all have been discharged or management plans in place. The 7th (patient initia Patient 99 chart was not able to be found on Trust property at this time. Patient 99 hart arrived to the Governance office on week commencing 28 November 2016. The look-back exercise was completed on13 December 2016. There is clinical detail within the dictated letter in relation to the Patient 99 consultation which requires clinical validation. This has been given to Mr Anthony Glackin to review on 15 December 2016.

Upon conclusion, the Review Team agree there are a number of relevant and related issues/themes causing concern for the panel which have been exposed during the SAI investigation. The Panel would like to clarify that all relevant enquiries made while undertaking this report have been solely limited to the information which were independently provided by members of the Review panel in conjunction with Mrs Andrea Cunningham, Service Administrator. There have not been any approaches made directly to the Urology Clerical team, the Urology Head of Service or the Assistant Director of Surgery and Elective Care for any information or evidence of communication.

Issues and Themes of concern include:

- In May 2014, there was an informal process was implemented to monitor/manage Urology letters which had not been returned with management advice (not triaged). It appears that this process was created in an effort to limit risk of harm to the patient. The presence of this process implies that it was accepted that triage non-compliance was to be expected by a minority of consultants within the Urology specialty. On 6 November 2015, an email from the AD of Functional Service formally implementing this process. The Review Panel are anxious that the current process does not have a clear escalation plan which evidences inclusion of the Consultant involved. In addition, this process has not been effective in addressing triage non-compliance. From 28 July 2015 until 5 October 2016, there are 318 patient letters which were not triaged. Currently the Trust cannot provide assurance that the Urology non-triaged patient cohort are not being exposed to harm while waiting 74 weeks for a Routine appointment or 37 weeks for an urgent appointment.

- During the manual look-back exercise on 14 November 2016, Patient 99 [redacted] patient chart could not be found on Trust premises Patient 99 [redacted] chart did appear in the Acute Governance office the week commencing 28 November 2016. After informal queries, it is understood that patient notes are not transported via Trust vehicles to or from Dr 6's outlying clinics (inc SWAH). This could compound efforts to establish any chart location or outstanding dictation. The Review panel acknowledge that processes should not be drafted to address one issue with one specialist team. On balance, the Review team agree there is sufficient cause for concern that Trust documentation may be leaving Trust facilities and the process of record transportation for this Specialty does need urgently addressed.

- There is clear evidence that this patient Patient 99 [redacted] letter was not triaged by week ending 30 October 2014 Patient 99 [redacted] was seen in SWAH by Dr 6 in January 2015. The outpatient letter was dictated 11 November 2016 and typed 15 November 2016. The Review panel have grave concerns that there are other Urology patient letters not being dictated in a timely manner. Upon further investigation, the Panel have found that the Trust does monitor the number charts needing audio-typing of dictation but there does not appear to be a robust process to monitor if post-consultation patient dictation has been completed. This has the potential to be compounded if patient charts are leaving the Trust facilities. The SAI Panel are anxious that assurance is sought that there is reasonable compliance in relation to the timely dictation letters by Dr 6.

Southern Health and Social Care Trust

Root Cause Analysis report on the review of a Serious Adverse Incident

Organisation's Unique Case Identifier: ID [redacted]

Date of Incident/Event: 6 January 2016

HSCB Unique Case Identifier:

Service User Details:
D.O.B: [redacted] Gender: F Age: [redacted] yrs

Responsible Lead Officer: Connie Connolly

Designation: Lead Nurse Acute Governance

Report Author: Review Team

Date report signed off:

Date submitted to HSCB:

Southern Health and Social Care Trust

1.0 EXECUTIVE SUMMARY

Patient 10 is a Personal Inform year old lady with a past medical history of colon cancer in 2010 and breast cancer in 2013.

While Patient 10 was under review and follow up by the Breast Surgeons in June 2014, a Computer Tomograpy Scan (CT Scan) of the abdomen and pelvis was arranged and this was performed on 24 June 2014. This CT scan reported a number of cysts in both kidneys. On the right side, there was a large upper pole cyst, a small lower pole cyst and a cyst on the anterior aspect of the right lower pole which had increased in size with increased complexity from scans completed in 2010. An Ultra Sound Scan (USS) of kidneys was recommended and this was completed on 24 July 2014. A Magnetic Resonance Image with contrast (MRI) was advised, and this was done on 26 September 2014. The MRI report did not comment on the anterior cyst about which concerns were raised, but did confirm a cyst with no abnormal enhancement.

On the basis of this incomplete MRI report, Patient 10's GP made routine referral to the Urology Team in Craigavon Area Hospital (CAH). This GP letter was received by the CAH Booking Centre on 29 October 2014. This letter was given to the Urology Surgeon of the week on 30 September 2014 to triage. There is no evidence that this GP referral letter was triaged or returned to the Booking Centre for processing. As a direct result of triage omission, Patient 10 was managed as a 'New Routine' patient, and waited until 6 January 2016 to be seen by a Consultant Urologist. A wait of 64 weeks.

Patient 10 was diagnosed with a probable cystic renal tumour. Surgery was scheduled for 25 January 2106 but this was postponed due to the recurrence of breast cancer at this same time. Right partial nephrectomy was performed on 31 October 2016.

The Review Panel agree that there are 2 main contributing factors which directly impacted Patient 10's delay in diagnoses. The first contributing factor was the content of the MRI report dated on the 29 September 2014. The wording of the report appears truncated and does not reference the main clinical focus, which was anterior cyst on the right kidney. The Reporter did not grade the cyst. As a result, the Breast Surgeon Dr 3 and the GP Dr 5 reading this report, did not appreciate there was growth in size of the right cyst. This was a significant missed opportunity for clinicians to expedite Patient 10 s referral to Urology.

The second contributory factor is that Patient 10's GP referral letter was not triaged by the Urology Consultant on call. The Review Panel agree that if a Consultant Urologist would have viewed Patient 10's images at triage - Patient 10 would have been upgraded as a Red Flag referral in October 2014. As a direct result of no triage, Patient 10 waited 16 months to be assessed by the Urology Team and diagnosed with renal carcinoma.

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2.0 THE REVIEW TEAM

Mr Anthony Glackin Consultant Urologist

Dr Aaron Milligan Consultant Radiologist

Christine Rankin Acting Booking Manager

Connie Connolly Lead Nurse Acute Governance

3.0 SAI REVIEW TERMS OF REFERENCE

Terms of Reference for the Serious Adverse Incident Investigation are as follows:

- To carry out a review into the care provided to Patient 10 in Craigavon Area Hospital, from 24 June 2014 until 6 January 2016
- To carry out this review into the care provided to Patient 10 using the National Patient Safety Agency Root Cause Analysis methodology
- To use a multidisciplinary team approach to the review
- To provide an agreed chronology based on documented evidence and staff accounts of events
- To identify the key contributory factors which may have had an influence or contributed to Patient 10's delay in treatment.
- To ensure that recommendations are made in line with evidence based practice.
- To set out the findings, recommendations, actions and lessons learnt in an anonymous report
- To adhere to the principles of confidentiality throughout the review.
- To report the findings and recommendations of the review through the Director of Acute Services SHSCT, to the relatives of Patient 10 and the staff associated with Patient 10's management

Southern Health and Social Care Trust

4.0 REVIEW METHODOLOGY

- To carry out a review into the care provided to Patient 10 within the SHSCT from 8 April 2014 until 1 March 2016. Records electronic records available on the Patient Administration System (PAS), Northern Ireland Electronic Care Record (NIECR) the Northern Ireland Picture Archiving and Communication System (NIPACS) will be examined in conjunction with all Clinical and Nursing documentation.

- To carry out this review into the care provided to Patient 10 using the National Patient Safety Agency Root Cause Analysis methodology

- To use a multidisciplinary team approach to the review

- To provide an agreed chronology based on documented evidence and staff accounts of events

- To identify the key contributory factors which may have had an influence or contributed to the timing of Patient 10's clinical management.

- To ensure that recommendations are made in line with evidence based practice. Accompanying appendices to the report will provide evidence of recent researched-based management of

- To set out the findings, recommendations, actions and lessons learnt in an anonymous report

- To adhere to the principles of confidentiality throughout the review.

- To report the findings and recommendations of the review through the Director of Acute Services SHSCT, to Patient 10 and the staff associated with Patient 10's care

This list is not exhaustive

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5.0 DESCRIPTION OF INCIDENT/CASE

Need narrative here re previous medical history

On 18 November 2010 Patient 10 had CT of Abdomen and Pelvis (CTAP) and was reported on 3 December 2010 which stated simple renal cyst particular on the right.

On 13 January 2013 CTAP reported by Dr 10. Bosniak type 1 cyst right kidney noted.

On 24 June 2014, Patient 10 had a CTAP with contrast as ordered by Dr 1. Dr 7's report in relation to the CTAP was issued on 7 July 2014 and reported multiple and bilateral simple cysts. A cyst arising from the anterior aspect of the right lower pole demonstrates subtle layering with high density in its medial aspect. The cyst appears minimally larger. A cyst in the anterior aspect of the right lower pole appears minimally larger and complex with high density in its medial aspect. Localised ultrasound was recommended to ensure no soft tissue component.

On 24 July 2014, Dr 1 ordered at ultrasound of the urinary tract. Dr 2's report on 30 July 2014 concluded a right lower pole complex renal cyst? Solid component. Advised MRI with intravenous (i/v) contrast to determine if the solid component enhances.

On 23 September 2014, Patient 10 seen by Dr 2 who ordered CT of Chest and Abdomen (CT CA).

On 26 September 2014 Patient 10 had a MRI of renal tract done. Dr 2's report on 29 September 2014 compared the previous CT 25/06/14 and USS 24/07/14. There is a large well-defined ovoid cystic mass, arising from the upper pole cortex of the right kidney. Appearances are consistent with cyst.

On 29 October 2014 Patient 10 attended for CT CA with i/v contrast. Dr 4 compared CT on 20/06/14 and on 1 November 2014 reported simple cyst seen in the upper pole. Complex cyst right kidney. On the same day, a routine GP referral was received in CAH Booking Centre from Dr 5 requesting assessment and advice in relation to the MRI findings reported on 26/09/14 re large renal cyst and recent breast cancer.

On 7 November 2014, letter sent to Patient 10 from Dr 3 informing her of unchanged findings of CT CA done on 29 October 2014, and that there would be further Surgical Outpatient review.

On 6 January 2016, Patient 10 was seen by Dr 8 in Urology Outpatients in response to GP referral on 29 October 2014. The MRI images were reviewed by Dr 8 in advance of the consultation. Dr 8 noted that the MRI report from 29/09/14 did not comment on the anterior lower pole of the right kidney. Dr 8 spoke with Dr 7 re the findings. In retrospect, Dr 7 reported the complex cyst on the right kidney had internal solid nodules with one area showing some enhancement with contrast. This raised the possibility of cystic renal cancer. Surgery arranged for 13th January 2016.

On 12th January 2016, Patient 10 was reviewed by Dr 3 with an enlarged left axillary noted on CT. A malignant node in the let axilla with invasive lobular carcinoma was confirmed.

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5.0 DESCRIPTION OF INCIDENT/CASE

15 February 2016 Patient 10 had a left axillary node clearance. Staging and further management of Patient 10's renal cyst has been postponed.

Patient 10 is recovering from a laparoscopic partial nephrectomy for confirmed papillary renal cell carcinoma which was performed on 31 October 2016.

6.0 FINDINGS

The Specialists within the Review Panel individually assessed each of Patient 10's radiological investigations in the timeframe between 24 June 2014 and 6 January 2016. The report by Dr 2 on 29 September 2014 references the findings of the USS and CT images done in June and July 2014. The Panel agree that when Dr 2 mentioned the earlier findings within the 29 September 2014 MRI report, it implied that the ovoid cystic mass noted had been seen and had been investigated. The inclusions of previous imaging findings are ambiguous. The consensus is that Dr 2's reported findings in relation to Patient 10's MRI of both kidneys were misleading and were inappropriately condensed. The Panel contribute this to human error. The Review Panel agree that the absence of a complete right kidney assessment, and the wording of the MRI report, made it extremely difficult for clinicians to detect the missing clinical detail. This provides sufficient rationale to why Patient 10 was not referred to Urology for immediate assessment by Dr 3 or the GP Dr 5.

The Review Panel forensically reviewed the GP Referral Letter management for Patient 10 in October 2014 .In summary, Dr 6 was the Consultant Urologist on-call on 30 October 2014 and was responsible for the triage of the GP letters to Urology for that week. There is hardcopy evidence that Patient 10 was one of eight letters for Triage. The booking centre provided the triage template for Dr 6. The GP letters were all photocopied prior to being sent to the Thorndale Unit for Dr 6 on 30 October 2014.

The Review Team were not able to find any of the original GP referral letters from 30 October 2014. The Triage form for 30 October 2014 was not returned to medical records for processing. After 10 working days, the booking centre e-mailed Dr 6's personal secretary seeking management advice for the 8 patients with outstanding triage. After no reply, a second email request was sent to Dr 6 via his personal secretary seeking management advice which was outstanding from 30 October 2014. At this point the informal booking centre default process for patients with no referral triage, was initiated. The informal default triage management process was introduced in May 2014 to ensure the GP's referrals were allocated to a 'waiting list' in the event of the consultant on-call failing to triage the week's referrals.This was only done once the consultant's personal secretary had been e-mailed requesting management advice. In the event of no response the request for management advice was escalated to the Specialist Service Administrator. The final level of escalation was to the Specialist Head of Service. There is e-mail evidence that the Assistant Director of Functional Services along with Assistant Director of Surgery and Elective Care were aware of ongoing triage omission by Dr 6. The default management process was then formally circulated on 6 November 2015.

The pathway for GP referrals without triage is for the medical records team to accept the GP Grading, code the patient specialty as 'General Urology' and allocate the next

Southern Health and Social Care Trust

6.0 FINDINGS

available new patient appointment. The length of time until assessment is solely dependent on the Urology waiting time- which was minimum of 42 weeks in 2014. The default management process provides an explanation to why Patient 10's 'Routine' referral letter was not upgraded and why Patient 10 was not seen by the Urology Team until 16 January 2016.

Patient 10 is now recovering from a laparoscopic excision of a papillary renal carcinoma which was done on 30 October 2016. This procedure was superseded by breast surgery in 2016 for breast lobular carcinoma on 14 February 2016. It had been agreed by the Oncology and Urology teams that the breast histology was priority and treatment proceeded in advance of renal surgery.

Relevant members of the Review Team completed a 'look-back' exercise in relation to the remaining 7 other GP letters to establish the patient management and outcome. The Panel can confirm that the other 7 patients have been seen by the Urology Team on or before 26 January 2016, and have not been known to have been exposed to significant harm.

7.0 CONCLUSIONS

The MRI report by Dr 2 on 29 September 2014 as previously discussed, was misleading and was inappropriately condensed. The quality of the information resulted in the evolving right renal cyst being overlooked by Drs 3 and Dr 5.

The SHSCT Radiology Team continuously review and audit the quality and accuracy of their reporting. On this occasion, the MRI report irregularities were not detected until viewed by a Urology Consultant.

All available evidence suggests that Dr 6 did not triage Patient 10's GP referral letter on the week ending 30 October 2014. The default triage management process was initiated which resulted in Patient 10 waiting 64 weeks for Urological assessment.

The Review Panel agree that in relation to Patient 10, the opportunity to upgrade the referral to red flag was lost by the omission of triage, this resulted in a 64 week delay to diagnosis of a suspicious renal mass.

While the remit of this Serious Adverse Incident (SAI) Review was to examine the factors in Patient 10's delayed management of papillary renal cancer. The Review Panel were provided evidence that a significant number of letters within Urology are not being triaged by the minority of the Team. It is clear that the default triage management process continues to be initiated secondary to the omission of Triage by individual members of the urology team and not the entire Urology Team

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8.0 LESSONS LEARNED

There will always be an element of human error in the interpretation and reporting of radiological imaging.

Triage of GP referral letters remains a key element in validating appropriate utilisation of specialist services and ensuring patient safety. Triage also serves as an opportunity for early intervention for patients at risk of malignant disease or clinical deterioration.

9.0 RECOMMENDATIONS AND ACTION PLANNING

The fundamental issue of triaging GP referral letter remains a challenge within Urology. This SAI has demonstrated that patients will be at an increased risk of harm when the opportunity for early intervention at Triage is omitted. The Review Panel recommend that the Directors, Managers and Clinicians within Acute Service's Urology amend the method of management and escalation of triage non-compliance.

The method and implementation of the process to address Triage non-compliance will need to be managed by the Urology operational and Medical Management teams as a matter of urgency. Any escalation process should include direct contact with the relevant Consultant after following an agreed pathway.

10.0 DISTRIBUTION LIST

Patient 10

HSCB

SHSCT Litigation

SHSCT Medical Director

SHSCT Director of Acute Services

AMD for Surgery and Elective Care

AMD for Integrated Maternal/Women's Health and Clinical Services

AD's for Surgery and Elective Care, Integrated Maternal/Women's Health/Clinical Services and Functional Support Services

Chair of Surgical Morbidity and Mortality

Southern Health and Social Care Trust

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

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

Reporting Organisation SAI Ref Number:	**ID** Personal Information redacted by	**HSCB Ref Number:**	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, a number of service users or if the SAI relates **only** to a HSC Child Death notification *(SAI criterion 4.2.2)* **Please select as appropriate (✓)**	**Single Service User**	x	**Multiple Service Users***		**HSC Child Death Notification only**		
	Comment: ***If multiple service users involved please indicate the number involved***						
2) Was the Service User[1] / Family / Carer informed the incident was being investigated as a SAI? **Please select as appropriate (✓)**	**YES**	x	**NO**				
	If **YES**, insert **date informed**: 6 January 2016						
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being investigated as a SAI						
	a) No contact or Next of Kin details or Unable to contact						
	b) Not applicable as this SAI is not 'patient/service user' related						
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user						
	d) Case involved suspected or actual abuse by family						
	e) Case identified as a result of review exercise						
	f) Case is environmental or infrastructure related with no harm to patient/service user						
	g) Other rationale						
	If you selected c), d), e), f) or g) above please provide further details:						

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**

Content with rationale?	**YES**		**NO**	

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

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

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

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

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

SECTION 2

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

DATE CHECKLIST COMPLETED	**17 November 2016**

Stinson, Emma M

From: Boyce, Tracey [redacted]
Sent: 09 November 2016 15:39
To: Gishkori, Esther
Cc: Stinson, Emma M
Subject: FW: Emailing: sc of partial SAI
Attachments: sc of partial SAI.pdf

Importance: High
Sensitivity: Confidential

Hi Esther
I had my weekly update with the governance leads today and they shared a draft of an SAI that is nearing completion as they are concerned about its implications - I have attached the first page to give you the gist. I think we may need to discuss this one with Richard as the cause seems to be directly attributable to one of the consultants (AOB)?

Basically this lady's GP sent in a referral in relation to an incidental finding on a CT in relation to her kidneys - it came in as routine.
The urologist consultant of the week collected that week's letters to do triage, as per the urology arrangements but from what the investigation team has found out that letter was never seen again and no instruction were received re triage appointment booking.

Apparently this had happened before with this consultant so the booking team's way of dealing with these type of 'lost letters' was to book them a routine appointment (because letters were lost before they had started keeping copies to work from). As a result there was a 16 month delay in diagnosing this ladies renal carcinoma. The triage consultant is meant to look at the CT as part of triage process but the SAI team found that it hadn't been looked at. The urologist on the SAI team has said if it had been reviewed at triage it would have been immediately obvious it was a tumour. (there was also an issue in relation to the reporting of a subsequent MRI back in 2014 that meant the GP or breast team did not pick up that it was potentially a red-flag or urgent referral was needed)

Although this was an SAI about a single case it has come to light that the other 7 urology referral letters received that week are also missing - as an initial action I have asked Trudy and Connie to try and track them via PAS to check they have been seen and pull their notes if necessary. I haven't asked the question yet whether we know if any more of that consultants weeks triage letters have been lost - but it is probably something we need to discuss.

I am conscious that I haven't spoken to Ronan about this yet as AOB's AD - but I wanted to get your take on it before I shared it with anyone else.

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
[redacted]

Summary of key points of concern – Patient 10 SAI

- Patient 10 was one of 8 patients not triaged during the week in question in Oct 2014. The team reviewed the 7 other patients to check they had been seen and were okay. 6 were found to have had an appointment and not suffered any adverse harm. The 7th patient's notes were missing but had been tracked to the consultant concerned. When asked, the secretary sent another email requesting their urgent return. The notes were returned on 28th November with dictation to be typed in relation to the patients care, requesting that they are booked for an intervention. Mr Glackin is going to review the patient's case urgently.
- As the secretarial team knew triage letters were going missing they kept a copy so that if the letter did not return with a plan, they could add the patient as routine (or as per GPs suggestion). This does seem to have been a known and accepted approach – not just something the secretaries developed themselves? They have kept a log of these cases since the middle of 2015. Between 28 July 2015 and 5th October 2016, there are 318 letters which were not triaged in this specialty.
- Trust notes were being transported via the individual consultant's car, against the Trust procedure. A number of notes seem to be tracked to the individual concerned and not returned – as per the 7th patient above. A report needs to be run to ascertain are any other notes tracked to this person and not on Trust premises.
- The check on the 7 patients above also raised a new concern into the timely dictation of letters. The 7th patient had been seen in January 2015 however the letter was not presented for typing until 11th November 2016. The Trust does monitor the number of charts needing audio-typing, but is there a process to monitor if post-consultation dictation has been completed? Is there a way of checking if this consultant has further patients in the same situation as patient 7?

Southern Health & Social Care Trust

Oversight Committee
22nd December 2016

Present:
Dr Richard Wright, Medical Director (Chair)
Vivienne Toal, Director of HROD
Ronan Carroll, on behalf of Esther Gishkori, Director of Acute Services

In attendance:
Simon Gibson, Assistant Director, Medical Director's Office
Malcolm Clegg, Medical Staffing Manager
Tracey Boyce, Director of Pharmacy, Acute Services Directorate

Dr A O'Brien

Context
On 13th September 2016, a range of concerns had been identified and considered by the Oversight Committee in relation to Dr O'Brien. A formal investigation was recommended, and advice sought and received from NCAS. It was subsequently identified that a different approach was to be taken, as reported to the Oversight Committee on 12th October.

Dr O'Brien was scheduled to return to work on 2nd January following a period of sick leave, but an ongoing SAI has identified further issues of concern.

Issue one
Dr Boyce summarised an ongoing SAI relating to a Urology patient who may have a poor clinical outcome due to the lengthy period of time taken by Dr O'Brien to undertake triage of GP referrals. Part of this SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason. It was noted as part of this investigation that Dr O'Brien had been undertaking dictation whilst he was on sick leave.

Ronan Carroll reported to the Oversight Committee that, between July 2015 and Oct 2016, there were 318 letters not triaged, of which 68 were classified as urgent. The range of the delay is from 4 weeks to 72 weeks.

Action
A written action plan to address this issue, with a clear timeline, will be submitted to the Oversight Committee on 10th January 2017
Lead: Ronan Carroll/Colin Weir

Issue two

An issue has been identified that there are notes directly tracked to Dr O'Brien on PAS, and a proportion of these notes may be at his home address. There is a concern that some of the patients seen in SWAH by Dr O'Brien may have had their notes taken by Dr O'Brien back to his home. There is a concern that the clinical management plan for these patients is unclear, and may be delayed.

Action

Casenote tracking needs to be undertaken to quantify the volume of notes tracked to Dr O'Brien, and whether these are located in his office. This will be reported back on 10th January 2017
Lead: Ronan Carroll

Issue three

Ronan Carroll reported that there was a backlog of over 60 undictated clinics going back over 18 months. Approximately 600 patients may not have had their clinic outcomes dictated, so the Trust is unclear what the clinical management plan is for these patients. This also brings with it an issue of contemporaneous dictation, in relation to any clinics which have not been dictated.

Action

A written action plan to address this issue, with a clear timeline will be submitted to the Oversight Committee on 10th January 2017
Lead: Ronan Carroll/Colin Weir

It was agreed to consider any previous IR1's and complaints to identify whether there were any historical concerns raised.
Action: Tracey Boyce

Consideration of the Oversight Committee

In light of the above, combined with the issues previously identified to the Oversight Committee in September, it was agreed by the Oversight Committee that Dr O'Briens administrative practices have led to the strong possibility that patients may have come to harm. Should Dr O'Brien return to work, the potential that his continuing administrative practices could continue to harm patients would still exist. Therefore, it was agreed to exclude Dr O'Brien for the duration of a formal investigation under the MHPS guidelines using an NCAS approach.

It was agreed for Dr Wright to make contact with NCAS to seek confirmation of this approach and aim to meet Dr O'Brien on Friday 30th December to inform him of this decision, and follow this decision up in writing.
Action: Dr Wright/Simon Gibson

The following was agreed:
Case Investigator – Colin Weir
Case Manager – Ahmed Khan

Boyce, Tracey

From: Glackin, Anthony [redacted]
Sent: 10 January 2017 18:36
To: Boyce, Tracey
Cc: Gishkori, Esther; Carroll, Ronan; Corrigan, Martina
Subject: RE: Sharing of SAI report [redacted]

Sensitivity: Confidential

Dear Tracey,
draft 8 of this report was completed this evening.
I will not be sending the report to Mr O'Brien, I am his colleague and not his manager.

Regards

Tony Glackin

Anthony J Glackin MD FRCSI(Urol)
Consultant Urologist
SHSCT

Secretary: Elizabeth Troughton [redacted]

From: Boyce, Tracey
Sent: 10 January 2017 17:45
To: Glackin, Anthony
Cc: Gishkori, Esther; Carroll, Ronan; Corrigan, Martina
Subject: Sharing of SAI report [redacted]
Sensitivity: Confidential

Hi Mr Glackin

At the oversight meeting today the next steps for this SAI report were discussed.

Dr Wright has asked that you, as chair of the SAI panel, now share the report with the two key consultants involved in the SAI so that they have a chance to comment on the report if they wish.

Would you be able to post a hard copy of the report to AOB with a note requesting that he replies with any comments he has by a certain date – I think two weeks from when you send it would be sufficient? Normally we would email reports to consultants however Martina tells me that the only working email address we have for AOB is a personal one, so cannot be used to send a report such as this.

I understand that the consultant radiologist involved in the SAI has now left the Trust, so I will liaise with Heather Trouton about how they wish to handle that.

Thanks for your help with this, it is much appreciated.

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy/Acute Governance
Personal Information redacted by the USI

Learn more about mental health medicines and conditions on the Choiceandmedication website http://www.choiceandmedication.org/hscni/

From: Connolly, Connie
Sent: 10 January 2017 10:53
To: Glackin, Anthony
Cc: Farrell, Roisin; Reid, Trudy; Boyce, Tracey
Subject: FW: Draft 7 with ammendments from litigation
Sensitivity: Confidential

Good Morning Tony- I know you are under immense pressure but I wanted to ask if you had a chance to do the last edit for this report.
Process for Presentation to SMT ask that we have all reports for circulation by tomorrow
Regards
Connie

Connie Connolly

Southern Health and Social Care Trust
PLEASE NOTE NEW PHONE EXTENTION
Acute Governance | Acute Directorate | Admin Floor | Craigavon Area Hospital | 68 Lurgan Road | Portadown BT63 5QQ |
Tel: Personal Information redacted by the USI | Mob: Personal Information redacted by the USI

From: Connolly, Connie
Sent: 03 January 2017 10:23
To: Glackin, Anthony
Cc: Boyce, Tracey
Subject: Draft 7 with ammendments from litigation
Sensitivity: Confidential

Good Morning Tony. Please see comments from litigation below.
I have amended typos. Can you double check I have all dates correct.
Are you happy that this is presented at SMT 13 January 2017.
Kind Regards
Connie

Connie Connolly

Southern Health and Social Care Trust
PLEASE NOTE NEW PHONE EXTENTION
Acute Governance | Acute Directorate | Admin Floor | Craigavon Area Hospital | 68 Lurgan Road | Portadown BT63 5QQ |
Tel: Personal Information redacted by the USI | Mob: Personal Information redacted by the USI

From: Magill, Lorraine
Sent: 03 January 2017 09:47
To: Connolly, Connie
Cc: Reid, Trudy; Boyce, Tracey; Glackin, Anthony; Muckian, Laura; Wasson, Karen
Subject: Level 2 HSC RCA Report Patient 10 Draft Six for litigation - URGENT
Sensitivity: Confidential

Connie
I refer to your request dated 19th December 2016 and, in the absence of Laura Muckian, ask you to note below the response received from Wendy Begg's in relation to same.
Please advise if you require any further assistance in this matter?
Regards

Lorraine Magill | Litigation Services Co-ordinator
T: Personal Information redacted by the USI Ext: Personal

http://sharepoint/med/home/Litigation/Forms/AllItems.aspx

From: Wendy Beggs [Personal information : Personal Information redacted by the USI]
Sent: 29 December 2016 13:00
To: Muckian, Laura
Cc: Claire Corr; Magill, Lorraine
Subject: RE: Level 2 HSC RCA Report Patient 10 Draft Six for litigation - URGENT
Sensitivity: Confidential

"This email is covered by the disclaimer found at the end of the message."

Dear Laura
I confirm I have reviewed the draft report and note that it is not complete at this stage. I note there are a number of typing and date errors, however I have no comment to make from a legal perspective. I would be happy to review the final draft if required.
Regards

Wendy
Wendy Beggs
Assistant Chief Legal Adviser

From: Muckian, Laura [Personal Information redacted by the USI]
Sent: 20 December 2016 09:44
To: Wendy Beggs
Cc: Claire Corr; Magill, Lorraine
Subject: FW: Level 2 HSC RCA Report Patient 1 Draft Six for litigation - URGENT
Importance: High
Sensitivity: Confidential

Wendy

Please see attached and below.

By way of background the patient [redacted], her husband [redacted] and Dr 6 – Dr Aidan O'Brien's [redacted], this is not an MN case as yet but they anticipate it will be.

The acute governance and the chair Mr Glackin (Chair) has asked that this report is submitted to for validation/review/comments as many of the issues raised are in relation to alleged Consultant non-compliance with Trust policy.
I know this is the holiday period, but we are aiming to have this report presented to SMT on **Friday 13 January 2017.**

I would be grateful if you could review the attached and advise, please note they have requested a response before the 13th January.

Many thanks
Laura Muckian
Litigation Assistant
Nurses Home
Daisy Hill Hospital
Telephone: [redacted]

From: Connolly, Connie
Sent: 19 December 2016 12:58
To: Muckian, Laura
Cc: Reid, Trudy; Boyce, Tracey; Glackin, Anthony
Subject: Level 2 HSC RCA Report [redacted] Draft Six for litigation
Sensitivity: Confidential

Hi Laura- please find attached the final SAI report in relation to [redacted]. I have also attached the inventory.
Mr Glackin (Chair) has asked that this report is submitted to our legal team for validation as many of the issues raised are in relation to alleged Consultant non-compliance with Trust policy.
I know this is the holiday period, but we are aiming to have this report presented to SMT on Friday 13 January 2017.
If you have any queries, do not hesitate to contact me directly
Regards
Connie
Mrs Connie Connolly
Lead Nurse Acute Governance
Mobile Number [redacted]

Received from SHSCT on 21/11/2022. Annotated by the Urology Services Inquiry.

Southern Health & Social Care Trust

Oversight Committee
10th January 2017

Present:
Dr Richard Wright, Medical Director (Chair)
Vivienne Toal, Director of HROD
Esther Gishkori, Director of Acute Services

In attendance:
Simon Gibson, Assistant Director, Medical Director's Office
Siobhan Hynds, Head of Employee Relations
Ronan Carroll, Assistant Director, Acute Services
Tracey Boyce, Director of Pharmacy, Acute Governance Lead

Dr A O'Brien

Dr Wright summarised the progress on this case to date, following the meeting with Mr O'Brien on 30th December, including the following appointments to the investigation:

- John Wilkinson is the Non-Executive Director
- Ahmed Khan is the Case Manager
- Colin Weir is the Case Investigator
- Siobhan Hynds is the HR Manager supporting the investigation

Ronan Carroll summarised the meeting with Urologists, who were supportive of working to resolve the position. Ronan Carroll updated the Oversight Committee in relation to the three issues identified, plus a fourth issue subsequently identified.

Issue one - Untriaged referrals
It was reported that, from June 2015, there are 783 untriaged referrals, all of which need to be tracked and reviewed to ascertain the status of these patients in relation to the condition for which they were referred. All 4 consultants will be participating in this review, which was now commencing.
Action: Ronan Carroll

There are 4 letters which hadn't been recorded on PAS which have been handed over by Dr O'Brien (consultant to consultant referrals).

Issue two – Notes being kept at home
307 notes were returned by Mr O'Brien from his home.
88 sets of notes located within Mr O'Briens office
27 sets of notes, tracked to Mr O'Brien, were still missing, going back to 2003. Work is continuing to validate this list of missing notes. It was agreed to allow an additional seven days to track these notes down, in advance of informing the CEx and SIRO, and Information Governance Team.
Action: Ronan Carroll

It was agreed that Dr Khan would write to Mr O'Brien, informing him who the NED was and, if necessary, asking him whether the 27 sets of notes were still at his house.
Action: Siobhan Hynds to draft letter

Issue three – undictated outcomes
It was reported that 668 patients have no outcomes formally dictated from Mr O'Briens outpatient clinics.
272 From the SWAH clinic
289 From other clinics.
The remaining 107 patients were still being investigated
Action: Ronan Carroll

Issue four – private patients
A review of TURP patients identified 9 patients who had been seen privately as outpatients, then had their procedure within the NHS. The waiting times for these patients appear to be significantly less than for other patients. It would appear that there is an issue of Mr O'Brien scheduling his own patients in non-chronological manner.

Discussion
Following consideration of the above, the Oversight Committee concluded that there were "reasonable and proper grounds" to commence an investigation into Mr O'Brien under the MHPS framework, and that Mr O'Brien would be formally excluded for the period of the investigation.

Draft Terms of Reference were reviewed. It was agreed that these should now be amended to reflect the issues identified as outlined above, and circulated to the Oversight Committee for approval.
Action: Siobhan Hynds

These would then be shared with the Investigating Team and Case Manager to allow the investigation to commence. This would include a meeting with Mr O'Brien to inform him of the decision of the Oversight Committee to move Mr O'Brien from "immediate exclusion" to "formal exclusion"

It was recognised that the Ronan Carroll would continue to lead the operational team in working through the issues identified to reach clear outcomes for all patients. It was agreed by the Oversight Committee that this work would be recognised at WLI rates, with consultants undertaking additional 4 hour sessions to progress the issues identified.
Action: Ronan Carroll

Stinson, Emma M

From: Gibson, Simon < [redacted] >
Sent: 04 January 2017 12:09
To: Gibson, Simon
Cc: Hainey, Lynne; Wright, Richard; Corrigan, Martina; Carroll, Ronan; Gishkori, Esther; Boyce, Tracey; Weir, Colin
Subject: RE: Confidential - AOB

Dear Ronan and Esther

Following discussion with Richard, responses to your queries are below, coloured for ease of reference:

1- What are the ToR for the investigation/review
In line with the MHPS Framework, the TOR will be determined following the 4 week scoping exercise during which the scale of the potential problems are being considered by the Investigating Team

2- How long would you expect the review to last?
As indicated below, the scoping exercise is expected to be completed by 27th January. Once the formal investigation is commenced, it also expected to complete within 4 weeks, but this is dependent upon the complexity of the investigation and could well be extended

3- What was Mr O Brien advised re the undictated outpatient clinics i.e. can he dictate or has he to cease having anything to do with the outstanding backlog
As Mr O'Brien is excluded from work, he is unable to participate in the backlog. As indicated in the action notes from the Oversight Committee on 22nd December, it is expected that a plan for how this backlog will be managed will be presented to the Oversight Committee on 10th January.

4- What is the Trust's position on Mr O Brien undertaking private work and in particular using Trust secretarial staff to type private patient work whilst off?
In line with the MHPS Framework, Mr O'Brien is not completely at liberty to undertake private practice outside the Southern Trust. As his Responsible Officer, Dr Wright advised Mr O'Brien not to undertake private work during the period of this investigation, and to inform any private providers that he was currently excluded from his main employment. The exception to this would be if Mr O'Brien felt there were any patient safety issues; if this was the case, Mr O'Brien was advised that he should arrange transfer of care to a colleague.
However, I would agree with Esthers comments below in relation to secretarial issues.

5- What is the Trust position in regard to notes being transported in staff's private car to and from SWAH? Clinics run twice mthly (2nd & 4th wks)
This should be undertaken in line with Trust procedures; possibly these may need to be reviewed in light of the issues identified

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office

Southern Health & Social Care Trust
Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
DHH: Personal Information redacted by the USI Ext Personal Information redacted

From: Gishkori, Esther
Sent: 03 January 2017 15:17
To: Carroll, Ronan; Gibson, Simon; Corrigan, Martina
Cc: Hainey, Lynne; Wright, Richard; Boyce, Tracey; Weir, Colin
Subject: RE: Confidential - AOB

Ronan,
I'm sure Simon will be able to answer the queries below but I just wanted to comment on point 4. Mr O'Brien is at liberty to do what he wants off ST premises but he cannot use the services of the Trust in the carrying out of his own private work. Not unless
the secretarial staff do the work outside core hours and don't use any facilities of the Trust.
Thanks
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office Personal Information redacted by the USI **Mobile** Personal Information redacted by the USI
Personal Information redacted by the USI

From: Carroll, Ronan
Sent: 03 January 2017 14:49
To: Gibson, Simon; Corrigan, Martina
Cc: Gishkori, Esther; Hainey, Lynne; Wright, Richard; Boyce, Tracey; Weir, Colin
Subject: RE: Confidential - AOB
Importance: High

Richard/Simon/Esther
Colin & Martina & I met with the urology consultants this am, at which we shared with them all the events that had been taking place and the decisions that had been taken.
From this meeting we need to answer a few questions

1- What are the ToR for the investigation/review
2- How long would you expect the review to last?
3- What was Mr O Brien advised re the undictated outpatient clinics i.e. can he dictate or has he to cease having anything to do with the outstanding backlog
4- What is the Trust's position on Mr O Brien undertaking private work and in particular using Trust secretarial staff to type private patient work whilst off?
5- What is the Trust position in regard to notes being transported in staff's private car to and from SWAH? Clinics run twice mthly (2nd & 4th wks)

Mr O Brien contacted Martina and advised that the notes which were not on Trust's premises have been left in his office. Martina has checked and this is confirmed, these notes will be transferred to the med exe office asap to be tracked to Martina on PAS and then a refreshed report will be ran to see if there are any more outstanding.

The Team are going to think/discuss and come back to Colin & I on thurs with how they proposed to complete the actions required associated with review.

Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Personal Information redacted by the USI

From: Carroll, Ronan
Sent: 30 December 2016 12:44
To: Gibson, Simon; Corrigan, Martina
Cc: Gishkori, Esther; Hainey, Lynne; Wright, Richard; Boyce, Tracey; Weir, Colin
Subject: RE: Confidential - AOB
Importance: High

Simon,
Tks – we will now speak with Mr Young (clinical lead) re the plan & then informing the remaining consultants urologist Tuesday am with Mr Weir as CD
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by the USI

From: Gibson, Simon
Sent: 30 December 2016 11:44
To: Corrigan, Martina
Cc: Carroll, Ronan; Gishkori, Esther; Hainey, Lynne; Wright, Richard; Boyce, Tracey
Subject: Confidential - AOB

Dear Martina

The meeting with Mr O'Brien has just concluded. There are a number of operational issues as a consequence:

1. Have discussed a script should anyone ask with Lynne Hainey and we have agreed the following: "Mr O'Brien remains absent from work and this will be kept under review. Staff will be updated when this situation changes"

2. Mr O'Brien is aware that an OH referral is now being made.

3. Mr O'Brien will be delivering charts to your office at 11am on Tuesday. Should you need space, you could use the AMD's office – I will make sure it is clear today.

Ronan – Mr O'Brien was informed that he was being "Immediately excluded" to allow the Trust time to scope the scale of the issues which have been identified in terms of:

- Notes at home
- Untriaged referrals
- Undictated clinics
- Conclusion of SAI
- Any other areas which are identified

As part of your plan, there will need to be a clinical note review of all charts/referral letters returned by Mr O'Brien to assess whether patients have a clinical management plan or require a clinical review with a Urologist. The follow-up meeting with Mr O'Brien will take place in four weeks, so potentially Friday 27th January to discuss the outcome of this scoping exercise, of which the outcome of the clinical note review will be a critical factor. Dr Wright is willing to approve any additional costs incurred for this review to be completed within this timescale.

Happy to discuss if you require any further clarity.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
DHH: Personal Information redacted by the USI Ext Personal Information redacted

Southern Health and Social Care Trust

Quality Care - for you, with you

DIRECTORATE OF ACUTE SERVICES

Interim Director: Mrs Deborah Burns

Tel: Personal Information redacted by the USI

ACUTE DIRECTORATE GOVERNANCE MEETING

Date: Tuesday 4th November 2014
Time: 2.00 pm
Venue: Meeting Room, Admin Floor, CAH

AGENDA

1.0	**Chair's Business** • Infection Control Access Immix Flow System	
2.0	**Patient Safety Programme Report**	**Colum Robinson**
3.0	**Effectiveness & Evaluation**	**Raymond Haffey**
4.0	**Patient Support Update**	**Edele Corr**
5.0	**Complaints Report**	**David Cardwell**
6.0	**Directorate Risk Register**	**Vivienne Kerr**
7.0	**Equipment Management & Medical Device** • Internal Audit Schedules and Performance Reports	**Anne Quinn**
8.0	**Standards & Guidelines:**	**Anne Quinn**
9.0	**SAIs:** • Summary report • New SAIs • Learning • SAI Personal Information redacted by the USI	**Anne Quinn**
10.0	**Incidents** • Summary report • Major and above report	**Tracey Boyce**

11.0	**Medication Incidents** • Summary reports	**Tracey Boyce**
12.0	**Mandatory training compliance**	**ADs**
13.0	**Any Other Business**	
14.0	**Date of next meeting** The next Governance meeting will be held on Tuesday 2nd December 2014 at 2.30 pm in the Meeting Room, Admin Floor, CAH	

Southern Health and Social Care Trust

Quality Care - for you, with you

DIRECTORATE OF ACUTE SERVICES

Interim Director: Mrs Deborah Burns

Tel: Personal Information redacted by the USI

ACUTE DIRECTORATE GOVERNANCE MEETING

Date: Tuesday 7th October 2014

Apologies – Margaret Marshall, Anne McVey (Patricia McStay attending), Heather Trouton (Martina Corrigan attending), Barry Conway.

1.0	**Chair's Business** • n/a	**Action**
2.0	**Patient Safety Programme Report** Colum presented his report. Sepsis audit – outperforming the College of Emergency Physicians audit benchmark which is excellent. Falls now spread to second phase – so every ward will be on-board by December. 1 South has shown a 37% decrease in the incidence of falls. Colum to get Debbie some bench marking data. Ronan to follow up on query re the CT question under stroke. Travel to patient safety collaborative is not possible under the current financial restrictions so they should be tele or video conference.	**Colum** **Ronan**
3.0	**Effectiveness & Evaluation** • Hyponatraemia Audit – the reports were discussed. There has been a great improvement in compliance. • VTE Weekly Audit – the report was discussed. In IWMH the issue with risk assessments is still being progressed. The responsibility for completion of the audit still lies with the medical staff. The next audit level is checking whether the prophylaxis has been prescribed. Anne and Raymond to discuss further.	**Raymond Haffey** **Anne Q, Colum, Margaret & Raymond**
4.0	**Complaints Report –** the report was discussed. There has been excellent progress on the complaints work. The Acute Governance team's involvement in the complaints work was discussed and it was decided that the governance team's role would be to consider the implementation of any learning resulting from the complaints. Current management process would remain the same.	**Tracey**
5.0	**Equipment Management & Medical Device** • Internal Audit Schedules and Performance Reports – Anne discussed an alternative approach. One video conference now with the internal auditors to go ahead – to get the audits back on schedule.	**Anne Q**

6.0	**SAIs:** SAI Investigation Reports as at 6 October 2014 – 5 submitted to HSCB and closed. Four to be circulated for the Friday Clinical Governance meeting, with the AMD to present their SAI. Anne and Debbie to meet to discuss this report further with a view to addressing any backlog. Patient Safety Quality Team Process for SAIs – Anne presented the draft SAI process map circulated. Debbie would like the screening forms regardless of whether the incident turns out to be an SAI or not.	**Anne & Debbie** **Anne Q**
7.0	**Directorate Risk Register –** B/F to next meeting	
8.0	**Standards & Guidelines:** NICE 73 – interim position as at mid November 2014 - Anne Q gave an update and suggested that she would go to AMDs and agree one primary change lead for each item – agreed.	**Anne Q**
9.0	**Incidents** The new draft report on incident management produced by David and Vivienne was considered. The report was very helpful and it was decided that this should go to ADs on a weekly basis, as well as the Acute Governance Team. Tracey to arrange. The large number of 'un-reviewed' and 'under review' incidents were discussed. It was agreed that Connie and Paul would concentrate on the un-reviewed MUSC incidents this week, looking for any of concern and then arrange to meet with Simon and Anne McVey on Monday to discuss and plan action. Next week the focus would move to the 'under-review' category.	**Tracey** **Simon and Anne**
10.0	**Any Other Business** • Reports for monthly Governance meetings – agreed it would be SAI report, incident report, complaints report, Major and above incidents report, patient safety, report, summary Patient Support report and Audit Summary report. • Signing off IR1s under new arrangements	
11.0	**Date of next meeting** The next Governance meeting will be held on Tuesday 4th November 2014 at 2.45 pm in the Meeting Room, Admin Floor, CAH	

Patient Safety Report for Acute Governance Meeting November 2014

SSI Ortho:

- Q2 2014 SSI rates have been released by the PHA. CAH rate was **0%** (0/158 reported procedures). NI rate was **0.16%** (3/1915 reported procedures). Overall CAH SSI rate (Q3 2012 → Q2 2014) **0.18%** (2/1114 reported procedures). Overall NI SSI rate (Q3 2012 → Q2 2014) **0.27%** (44/16595 reported procedures)
- The number of valid surveillance Forms received by HISC in Q2 2014 was **43.3%** (179/413) up from **42.4%** in Q1 2014
- The Annual SSI Audit was undertaken in September 14. Overall Bundle Compliance was **100%** (20/20 patients audited)

SSI C/Section:

- Q2 2014 SSI rates have been released by the PHA. A summary of the data is as follows:

SSI Rates	**Surveillance Forms Returned to the PHA**
CAH **6.28%** up from **3.63%** in Q114	CAH **81.0%** up from **80.5%** in Q114
DHH **4.42%** up from **3.81%** in Q114	DHH **71.1%** up from **70.5%** in Q114
TRUST **5.68%** up from **3.68%** in Q114	TRUST **77.5%** up from **77.2%** in Q114
NI Average **6.76%** down from **6.87%** in Q114	NI Average **74.5%** down from **79.4%** in Q114

- Quarterly SSI C/Section Audit was undertaken in September 14

- Overall Bundle Compliance at CAH **80%** (16/20 patients audited) – down from **90%** in June 14
- Non-compliant elements:
  - Appropriate Use of Antibiotics - In 3 of 20 cases audited antibiotics were not administered prior to the administration of anaesthesia
  - Normothemia – In 1 of 20 cases audited the mother's temperature was under 35.5°C in Recovery & no action taken to address same
- Overall Bundle Compliance at DHH **90%** (18/20 patients audited) – down from **95%** in June 14
- Non-compliant element:
  - Appropriate Use of Antibiotics - In 2 of 20 cases audited antibiotics were not administered prior to the administration of anaesthesia
- The next quarterly Audits will take place in December 2015

VAP:

- Vent Days Between VAP's **2299** (30th April 13 → 30th September 14)
- Calendar Days Between VAP's **519** (30th April 13 → 30th September 14)
- Revised Team Goal for 14/15 **800** Vent Days between VAP's

- The Annual VAP Audit was undertaken in September 14. Overall Bundle Compliance was **100%** (25/25 patients audited)

Central Line:

Bundle Compliance:

Overall Bundle Compliance CAH, excluding ICU **90%** - (9/10 patients audited) – up from **70%** in August 14

- Non-compliant element:
  - Subclavian Site – In 1 out of 10 cases audited the subclavian site was not used nor was a contraindication documented

Infection Rates:

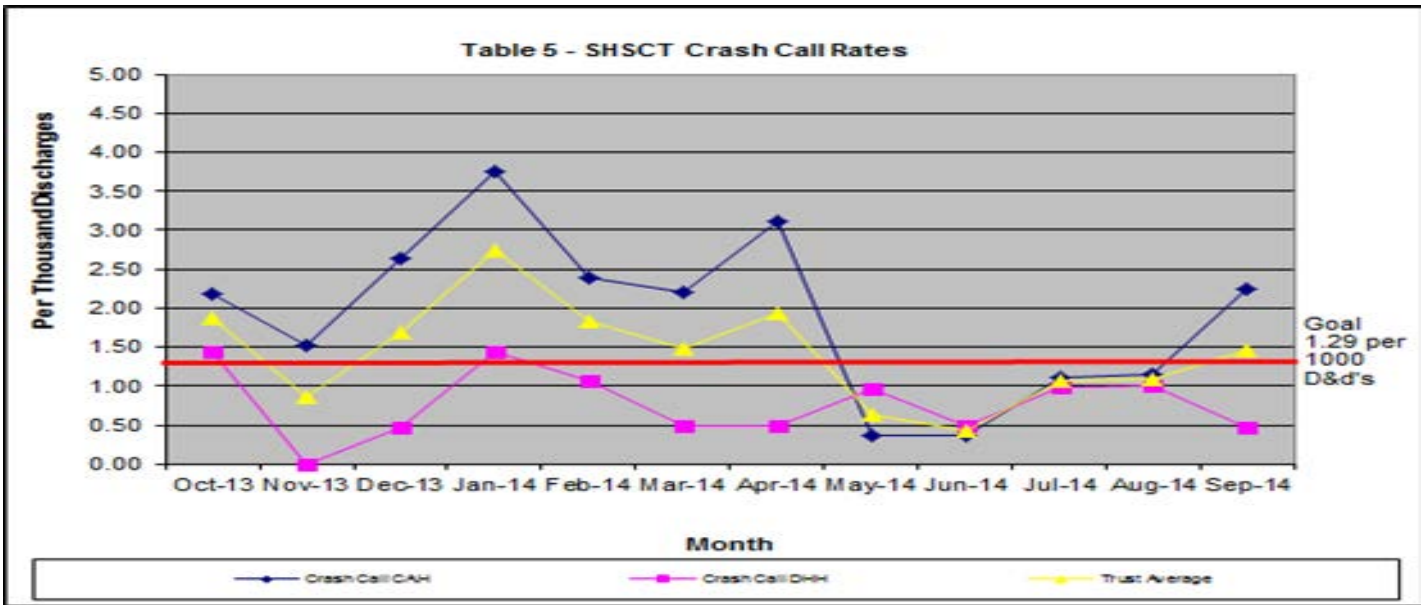
- ICU Infection Free September 14 – cumulative Infection Rate 14/15 is **0** per 1,000 Line Days. Last Reported Infection **May 2010**

- CAH, excluding ICU – Infection Free September 14 - cumulative Infection Rate 14/15 is **0** per 1,000 Line Days. Last reported infection **August 2013**

- DHH Infection Free in September 14 – cumulative Infection Rate 14/15 is **0** per 1,000 Line Days. Last reported infection **December 2012**

- Trust cumulative Infection Rate 14/15 is **0** per 1,000 Line Days (**0** Line Infections) – goal set by Team for 14/15 is **0.50** per 1,000 Line Days.

Crash Calls:



- Trust cumulative Crash Call rate 14/15 stands at **1.11 (31)** per 1,000 deaths/discharges
- Goal for 14/15 – maintain or reduce Trust's 13/14 Crash Call Rate of **1.29 (72)** per 1,000 deaths/discharges
- It is unlikely that the above goal with be achieved as the Number of Crash Calls in the first 6 months of the Financial Year have increased by **35%** compared to the same period last year. The majority of this increase occurred at CAH, where Crash Calls have increased from **15** to **22** in this period **(47%)**, with April & September 14 experiencing rates higher than normal
- The Trust's Resuscitation Officers carry out Chart Reviews on all Crash Calls, with issues identified presented at monthly M&M Meetings & forwarded to the relevant HoS & Lead Nurse

NEWS:

- CAH (all participating wards) - Overall Bundle Compliance **88%** (101/115) – down from **94%** in August 14
- DHH (all participating wards) - Overall Bundle Compliance **91%** (41/45) – down from **93%** in August 14

Emergency Care Collaborative:

Bundle Element	CEM Standard	CAH Apr - Aug 14 (50 pts.)	CAH Sept 14 (10 pts.)	DHH Apr - Aug 14 (29 pts.)	DHH Sept 14 (9 pts.)
Vital Signs measured & recorded in ED Notes	100%	98%	100%	100%	100%
Capillary Blood Glucose measured & recorded on arrival	100%	74%	50%	86%	89%
Evidence in ED notes that high flow O2 was initiated in ED	100%	98%	100%	97%	100%
Evidence in ED Notes that IV Fluids administered with 1 hour of arrival	75%	58%	80% (in 2 other cases IV Fluids given but outside 1 hour)	86%	100%
Evidence that serum lactate measurement obtained	100%	86%	90%	83%	100%
Evidence of Blood Cultures obtained before patient leaves ED	100%	78%	80%	86%	89%
Antibiotics administered within 1 hour of arrival	50% (CEM) 75% (Regional)	44%	70% (in 3 other cases antibiotics given but outside 1 hour)	76%	100%
Urinary Output measured before patient leaves ED	100%	72%	40%	93%	89%
Medical Pick up within 1 hour/ Senior Help Summoned	N/A	86%	100%	93%	100%

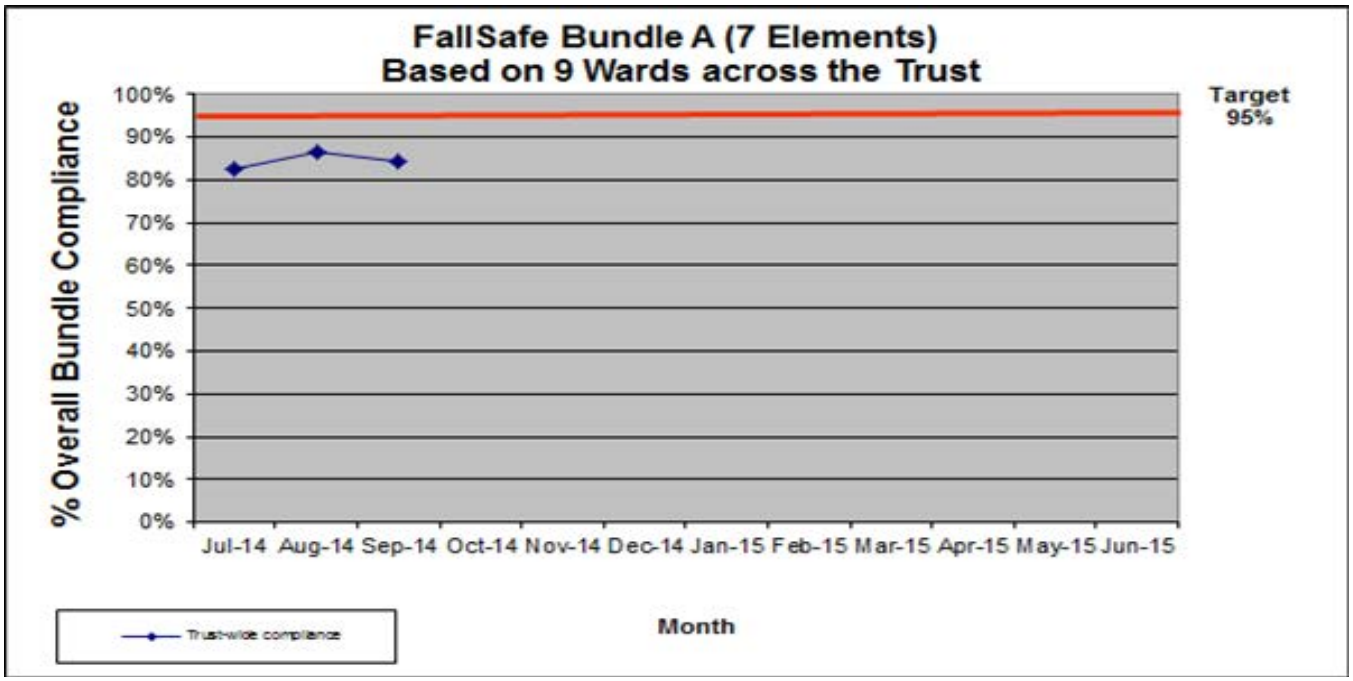
The above table is based on the College of Emergency Medicine Severe Sepsis & Septic Shock NI Audit 13/14

- The latest Regional ED Quality Improvement Collaborative was held on Tuesday 21st October 2014. A draft list of future Improvement Initiatives were agree upon i.e. Pain Management, Communication, Pressure Ulcers & VTE

Falls:

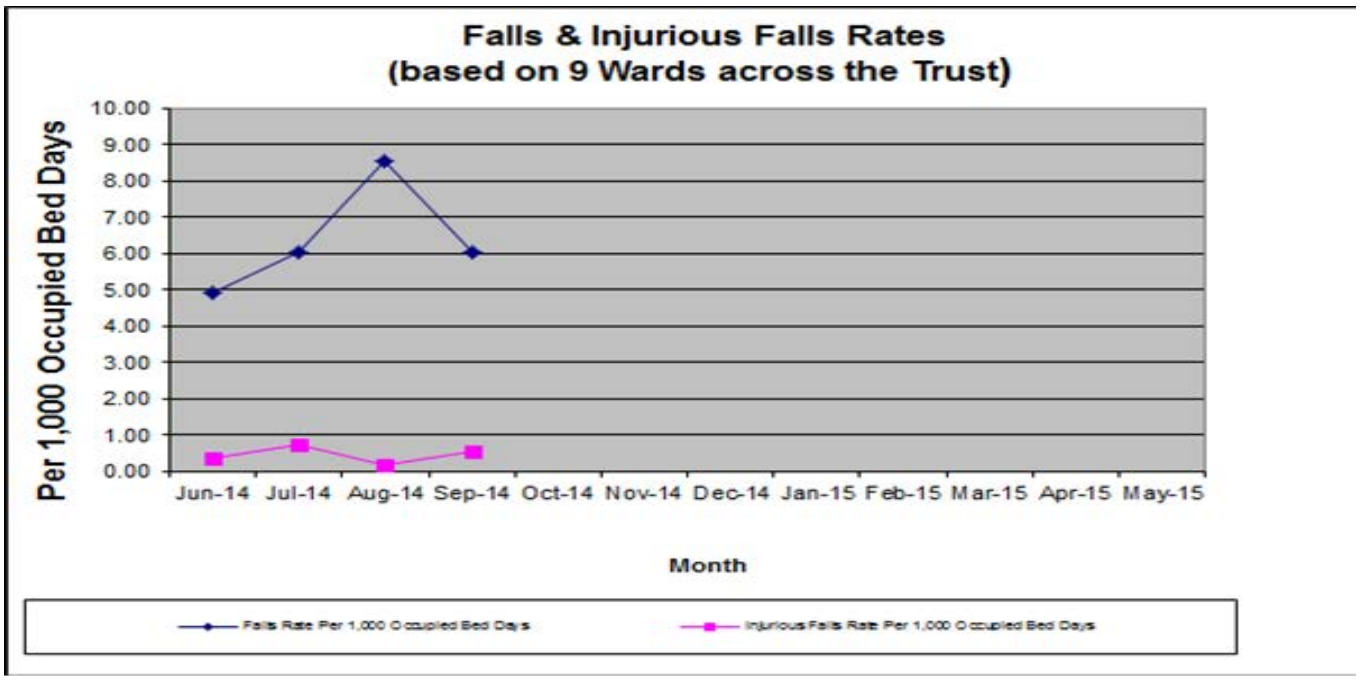
FallSafe Bundle A - Overall Bundle Compliance, with 7 of the Elements of the Bundle – call bell in sight & reach, safe footwear on feet, personal items in reach, no slip /trip hazards (observational), asked about history of falls, asked about fear of falling & urinalysis performed (evidence via Nursing Notes). A further 3 elements are audited (avoidance of prescription of night sedation, assessment & provision of walking aid & mobility status communicated); however they do not form part of Overall Bundle Compliance. Wards also measure 4 elements of FallsSafe Bundle B, cognitive assessment, bed rail risk assessment completed, lying & standing BP & mobility status communicated.

The Run Chart below shows Overall Bundle Compliance with 7 of the Elements of FallSafe Bundle A, based on 9 Wards, where Improvement Work has spread

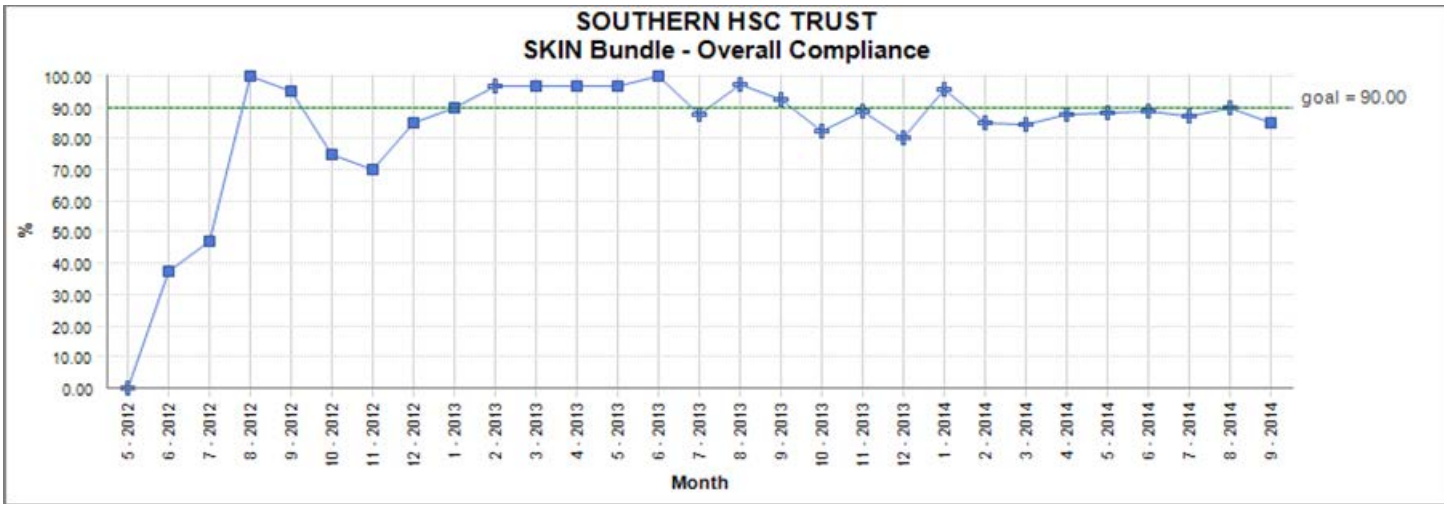


- Nine Wards are now Auditing FallSafe A & B Bundles. Overall Bundle Compliance with 7 Elements of Bundle A (Regional Measure) was **85%** (60/71)
- Non-Compliant Element: Failure to undertake/record urinalysis (11/71 patients audited)
- All Acute & Non-Acute Wards will be completing the Audit by December 14
- The 3rd Falls Workshops was held on Thursday 16th October 14, with 4 Wards in attendance. They will begin monitoring their Falls & Injurious Falls Rates, using the Falls Walking Stick from November 14.

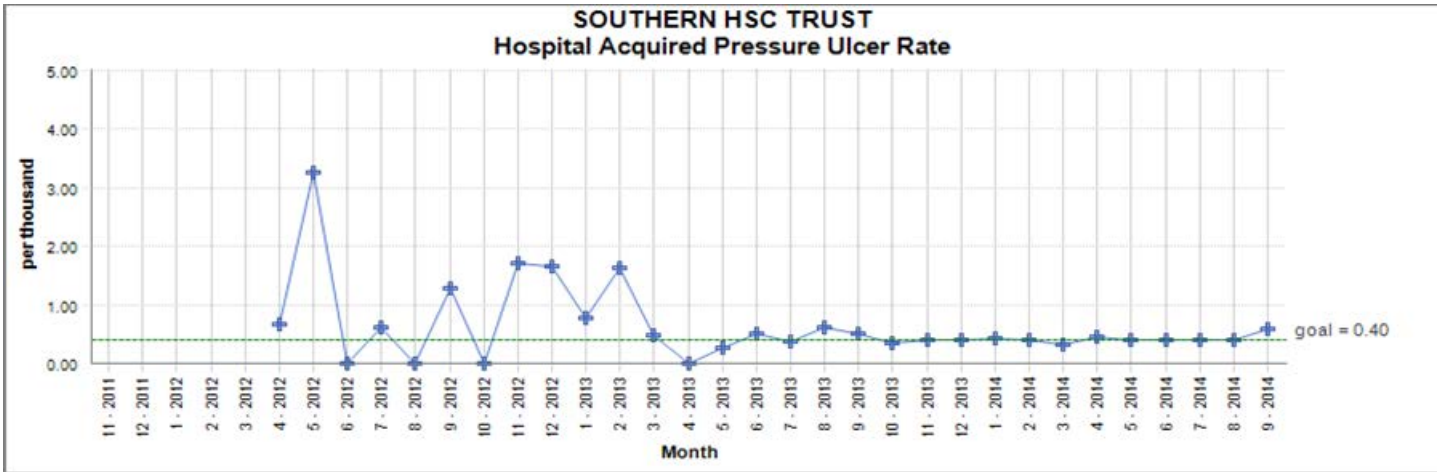
The Run Chart below shows Patient Falls & Injurious Falls Rates per 1,000 Occupied Bed Days based on 9 Wards, where Improvement Work has spread, captured by staff using the Falls Walking Stick & Datix.



SKIN Care (Pressure Ulcer):



- 24 Wards audited compliance with the SKIN Bundle in September14. Overall Compliance was **85%** (115/135) down from **90%** in August 14.



- The Trust's Monthly Hospital Acquired Pressure Ulcer Rate for September14, based on **25** Wards was **0.60** per 1,000 Bed Days up from **0.40** per 1,000 Bed Days in August 14. There were **9** reported Ward Acquired Pressure Ulcers (Ward 4 South, 4 North, 3 South, 2 South Medical, 2 South Stroke, 1 South & MAU, CAH, & Male Surgical & HDU, DHH).
- The Trust's 2014/15 Hospital Acquired Pressure Ulcer Rate, based on **26** Wards stands at **0.44 (40)** per 1,000 Bed Days
- Commissioning Plan Indicator 14/15 **- 10%** reduction of "Hospital Acquired" Pressure Ulcers i.e. **73** to **66** (based on a Baseline of Q2 → Q4 data 13/14)
- It is very unlikely that the Trust will achieve the Commissioning Plan Indicator during 14/15. As it stands the Trust total is likely to be **10%** above 13/14 Baseline rather than 10% below

Maternity Quality Improvement Collaborative:

- The Maternity Collaborative Learning Session 3 was held on Tuesday 14 October, Antrim Civic Centre
- On-going work includes:
  - Regional Dashboard
  - OEWS Chart
  - Sepsis
  - Normality
  - Third Degree Tears
- Dr. Loane, Dr. Adams, Patricia McStay & Wendy Clarke are leading this Improvement Work

Stroke Collaborative:

- Regional agreement to collect data on the following, however only Lysis Data will be reported to the PHA/DHSSPS on a quarterly basis:

	CAH		DHH		TRUST		
Measure	Apr-Aug 14	**Sept 14**	Apr-Aug 14	**Sept 14**	Apr-Aug 14	**Sept 14**	**Commentary Sept 2014**
Patients who are potentially eligible for thrombolysis are assessed by Acute Stroke Team within 30 minutes of arrival	91% (137/151)	**94% (30/32)**	100% (43/43)	**100% (7/7)**	93% (180/194)	**95% (37/39)**	**CAH**: Both cases presented out-of-hours & the time of Assessment was not recorded
Patients who are potentially eligible for thrombolysis receive CT scan within 45 minutes	82% (14/17)	**67% (2/3)**	80% (16/20)	**60% (3/5)**	81% (30/37)	**63% (5/8)**	**CAH:** Case presented out-of-hours. Outside timeframe by 18 mins. 38 min delay between Scan & Report **DHH:** Both cases presented out-of-hours. Outside timeframe by 5 & 15 mins. In latter case issue with ordering CT
Patients deemed suitable for thrombolysis receive first bolus within 60 minutes	82% (9/11)	**100% (2/2)**	54% (7/13)	**75% (3/4)**	64% (14/22)	**83% (5/6)**	**DHH:** Case presented out-of-hours. Outside timeframe by 17 mins. As 2nd case above
Patients transferred to Hyper Acute Stroke Unit (or appropriate environment) within 90 mins	91% (10/11)	**100% (2/2)**	100% (12/12)	**100% (4/4)**	96% (22/23)	**100% (6/6)**	N/A
	CAH		**DHH**		**TRUST**		**AIM 14/15**
Outcome Measure	Apr-Aug 14 (148)	**Sept 14 (28)**	Apr-Aug 14 (58)	**Sept 14 (10)**	Apr-Aug 14 (206)	**Sept 14 (38)**	**(Based on Commissioning Plan)**
Monthly Thrombolysis Rate		**7.1% (2/28)**		**40% (4/10)**		**15.8% (6/38)**	**To ensure that the proportion of thrombolysis administration is at least 12%**
Thrombolysis Rate 14/15	7.4% (11/148)	**7.4% (13/176)**	22.4% (13/58)	**25.0% (17/68)**	11.7% (24/206)	**12.3% (30/244)**	

Please see below Regional Thrombolysis Data, requested at last month's meeting:

	Southern	**Western**	**Northern**	**Southeast**	**Belfast**
Number of Patients who received thrombolysis 13/14	**55**	**47**	**58**	**57**	**95**
Patients deemed suitable for thrombolysis receive first bolus within 60 minutes 13/14	**65% (36/55)**	**57% (27/47)**	**43% (25/58)**	**54% (31/57)**	**100% (95/95)**
Number of Patients who received thrombolysis Apr 14 → Sept 14	**30**	**19**	**30**	**20**	**47**
Patients deemed suitable for thrombolysis receive first bolus within 60 minutes Apr 14 → Sept 14	**70% (21/30)**	**84% (16/19)**	**67% (20/30)**	**55% (11/20)**	**100% (95/95)**

Annual Audits:

WHO Surgical Safety Checklist:

- Compliance measured against the Checklist being fully completed & signed at all 3 stages i.e. before induction, draping & skin incision & patient leaves the operating room and that the checklist has been filed in the patient's Medical Records
- An Audit was undertaken on 20 Trauma & Orthopaedic Charts & Overall Bundle Compliance was **85%** (17/20 charts audited)

Medication Safety (Reconciliation):

In September 12 it was agreed that the Monthly Audit should be replaced by an Annual Audit. The 2nd Annual Audit was conducted in September 14 and the results of the Audit were as follows:

- Medicines Reconciled within 48 hours of admission :
  - Ward 2 North **40**% (4/10 patients audited), down from **100%** in Sept 13
  - Silverwood Ward, Bluestone, **70%** (7/10 patients audited), down from **100%** in Sept 13
- Medicines Reconciled at discharge:
  - Ward 2 North **100**% (10/10 patients audited), same as Sept 13
  - Silverwood Ward, Bluestone, **100%** (10/10 patients audited), same as Sept 13
- Discharge Letter to GP within 72 hours – **40%** (8/20 pts. audited), down from **100%** in Sept 13***
- Discharge Letters which are legible **– 70%** (14/20 pts. audited), down from **85%** in Sept 13***
- Queries raised by GP's in respect of Discharge Letters – **0%** (0/20 pts. Audited), same as Sept 13 ***

*** Data supplied by Dr Peter Beckett, Abbey Court Surgery, and is in respect of a random sample of 20 Discharge Letters received from CAH

Below are comments received in respect of areas of non-compliance in Ward 2 North:

New Medical Model- Direct admissions to the wards mean that fewer patients come via MAU where they would previously have been picked up for Meds Rec by the pharmacists there. In combination with clinical pharmacy staff shortages at the minute the capacity of the resources is reaching its limit. In terms of rec on discharge the new electronic discharge letter classifies the drugs by their reconciliation status, therefore they will always theoretically be reconciled, it's whether it's done accurately is the question; 80% were clinically checked and therefore fully validated by a pharmacist on discharge.

Workload has also increased over the last number of years in terms of patient complexity and polypharmacy, which increases the basic time taken to complete individual medicines reconciliation and prescriptions, but also increases the likelihood and complexity of the errors and problems identified during the process.

Below are comments received in respect of areas of non-compliance at Abbey Court Surgery:

The sample had a large number of ED discharge letters which since before their inception GPs have advised are not fit for purpose. They contain a lot of handwriting often crammed into small spaces. Despite numerous promises of changes this continues. Personally I regard it as one of the Trust's largest risks. The risk is minimised because GPs are spending a lot of time checking on the detail.

The large number of over 72 hours represents a gradual deterioration in the speed of delivery, having said that most are 24 -48 hours over the 72 hours.

Additional Information:

Sepsis6 Workshop:

The HSC Safety Forum led Severe Sepsis Workshop was held on Wednesday 15 October 2014. Two of the three Pilot Wards identified for this Improvement Work were represented (MAU & Female Medical). There was no representation from 4 North.

The next steps will be to form a multiprofessional Improvement Team/s , undertake Baseline Audits and make arrangements for ongoing monthly audits.

Inaugural Northern Ireland Safety Forum Awards 2015:

This will be an opportunity for organisations to showcase their achievements in the field of quality improvement and safety.

The Trust may make one nomination to each category or several to one or more categories up to a maximum of 5 nominations in total. **Applications must be received by 31 March 2015.** Further information can be downloaded from:

www.publichealth.hscni.net (go to Directorates/HSC Safety Forum/News)

Southern Health and Social Care Trust

Acute Directorate

Effectiveness & Evaluation Update

Presentation at Acute Clinical Governance meeting
4th November 2014

Acute Directorate

Effectiveness & Evaluation

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Southern Health and Social Care Trust

Acute Directorate

National Audit Summary

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Southern Health and Social Care Trust

Acute Directorate Governance Meeting:

Effectiveness & Evaluation Summary - November 2014

Audit	Position Statement	Division	AMD/ AD	Clinical Lead	Deadline
NCEPOD Time To Intervene NCCA Cardiac arrest audit and local audit	• Internal audit of cardiac arrests ongoing by Resuscitation Officers. Findings are forwarded to Mrs Burns on a monthly basis. Where educational issues are identified, these are presented at M&M monthly • Data are also submitted to National Cardiac Arrest Audit – 2nd national audit report for DHH & CAH for 1/4/13- 31/3/14 • Report for quarter April – June 2014 circulated 22/9/14. Dr Hinds summary: Older patients being resuscitated, attending more arrests out of hours, resuscitating more patients quite some time after they are admitted to hospital (8 – 30 days, 2 patients had a DNAR in place, only one patient with Return Of Spontaneous Circulation went to ICU?, ROSC and return to a good functional baseline from shockable rhythms is good, ROSC rate from non-shockable rhythms is bad	Acute – All	All	Dr Hinds RTOs	Continuous
NCEPOD Sepsis	• Clinical questionnaire (10 cases - 5 CAH & 5 DHH) • Organisational questionnaire	Acute – All	All	Mr Brown, Mr Lewis Nominated Consultants	Clinical – 30/11/14 Organisational 30/11/14
NI Audit of Dementia Care in Acute Hospitals	• Organisational audit / environmental element • Clinical audit: 20 cases per hospital. Discharge diagnosis of dementia of any type and a hospital stay of ≥ 5 days, discharged between 1 Jan - 30 April 2014. • Awareness at Audit Committee meeting on 29 September 2014 and Acute Governance on 7 October 2014.	MUSC	Dr P Murphy / Mr Gibson	Dr D Craig, Catriona McGoldrick.	Not confirmed

Audit	Position Statement	Division	AMD / AD	Clinical Lead	Deadline
National Heart failure audit	• Audit raised at Cardiology governance / M&M audit meeting re awareness and clarifying the arrangements for quality assuring data & escalating any areas of concern before submission externally. • Awareness at Audit Committee meeting on 29 September 2014.	MUSC	Dr P Murphy / Mr Gibson	Dr D McCall.	Not confirmed
National IBD Organisational & Biologics Reports	• Awareness at Audit Committee meeting on 29 September 2014. Results to Dr S Murphy, Dr Murdock, Ruth Hall 15/10/14 • Organisational key indicators – Trust results poor across key indicators • Biologics – key indicators – response to treatment 0% both sites, remission achieved: 0% both sites, adverse event: CAH 0%, DHH 14%, Crohn's patients with concomitant therapy, 5 ASA at induction: CAH 50% DHH 29%	MUSC	Dr P Murphy / Mr Gibson	Dr S Murphy, Dr A Murdock	Biologics audit Continuous
Inpatient falls pilot site results	• Result to Dr Gormley 8/9/14. Dr Gormley to provide feedback to Interim Director of Acute Services (IDoAS), Dr P Murphy and Mr Gibson.	MUSC	Dr P Murphy / Mr Gibson	Dr Gormley	-
Regional Audit of PPH	• Audit period 1/9/14 – 1/10/14.Awareness at Audit Committee meeting on 29 September 2014. Data approved by Dr Hogan & Mrs McVey.	IMWH	Dr Hogan / Mrs McVey	Dr B Adams Dr Ferguson	7/11/14
GAIN – Healthy Child Healthy Future	• Review records re compliance with professional standards and quality of universal contact provision. Service user survey.	CYP	Mr P Morgan	J McConville	Not confirmed
National SSNAP organisational audit report	• Results to Dr McCaffrey Dr McCormick 15/10/14. Total organisational score CAH 56.6, DHH 64.9. (Median score 73.5.) Domain scores for 6 areas with performance levels A-E. CAH performance levels Bx1, Dx2, Ex3. DHH performance levels Bx1,Cx2, Dx3.	MUSC	Dr P Murphy / Mr Gibson	Dr McCaffrey Dr McCormick	-
Hyponatraemia 14-16 year olds	• SHSCT weekly audit highlights ongoing issues re documentation of output, signature of nurse observing IV fluids, grand totals of input and output • GAIN regional audit of IV fluids in 1month – 16 years. Acute directorate issues were highlighted at 2pm governance meetings during audit	Acute – All	All	ADs to provide ongoing feedback re action plans	Ongoing
VTE	• Compliance with documented VTE risk assessment: 84% (July), 82% (August) and increased to 85% (September). IMWH rep advised audit of VTE is not required in 2W, Delivery Suites CAH & DHH or Maternity Ward, DHH.	Acute – All	All	ADs C Robinson	Ongoing

Southern Health and Social Care Trust

Acute Directorate

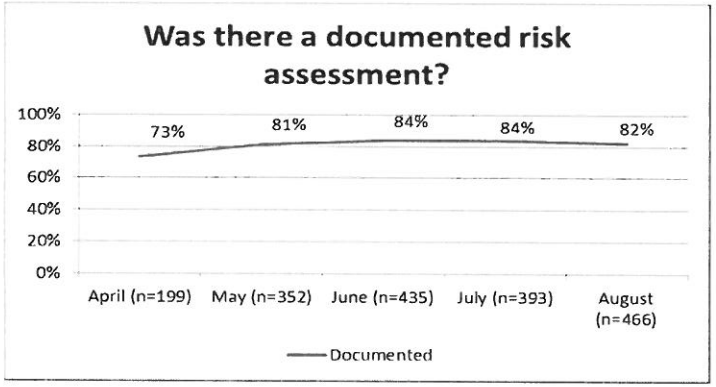
Audit of
Documented VTE Risk Assessment

Audit results 28.07.14 - 31.08.14
01.09.14 – 28.09.14

Presentation at Acute Clinical Governance meeting
4th November 2014

Acute Directorate : Audit Of Documented Risk Asssessment 28.07.14 - 31.08.14

DIVISION	SITE	Ward	w/e 3rd August 2014 Forms Received	w/e 10th August 2014 Forms Received	w/e 17th August 2014 Forms Received	w/e 24th August 2014 Forms Received	w/e 31st August 2014 Forms Received	Up to w/e 31st August: Total number of returns with VTE documented	Up to w/e 31st August: Total number of valid VTE returns	Up to w/e 31st August: Was there a documented risk assessment?	Comment
IMWH	CAH	1 West - Gynae	5	5	5	5	5	24	25	96%	
		2 West								Not required to participate in this current audit	
		Delivery Suite								Not required to participate in this current audit	
	DHH	Delivery Suite								Not required to participate in this current audit	
		Maternity Ward								Not required to participate in this current audit	
M&UC	CAH	1 South	5	5	5	5	5	21	25	84%	
		CCU 1 North	5	5	5	4	5	17	24	71%	
		2N Resp	5	5	Nil return	Nil return	Nil return	9	10	90%	
		2N Haem	Nil return	5	5	5	5	15	20	75%	
		2 South Med	5	5	5	Nil return	4	14	19	74%	
		2 South Stroke	5	4	5	11	Nil return	21	25	84%	
		CDU	5	5	4	4	4	4	22	18%	
		MAU	5	5	5	5	5	25	25	100%	
		Ramone Winter Pressures Ward								Ward closed	
	DHH	Female Medical	5	5	5	5	5	25	25	100%	
		CCU/ Male Medical	5	5	5	5	7	27	27	100%	
		Ger Stoke Ward - L6	5	5	5	5	5	23	25	92%	
		Rehab Ward - L6									
S&EC	CAH	3SSS/ENT/Urology	5	5	5	5	5	2	25	8%	
		4 North CESW	5	5	Nil return	5	5	18	20	90%	
		4 South	5	5	5	5	5	21	25	84%	
		Elective Adm (CEAW)	5	5	5	6	5	24	26	92%	
		Ortho Wd	5	6	4	4	5	22	24	92%	
		Trauma	5	5	5	4	5	21	24	88%	
	DHH	Female Surgical	5	5	5	5	5	24	25	96%	
		Male Surgical/HDU	5	5	5	5	5	25	25	100%	
Total Number of cases audited								**382**	**466**	**82%**	



Summary

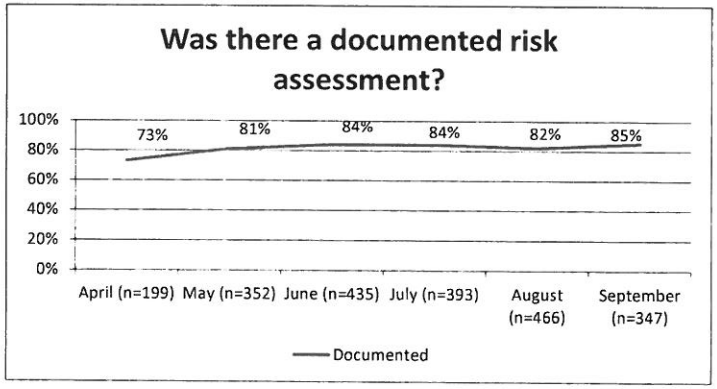
Twenty one wards participating

Outstanding returns for five wards escalated to Nurse managers / Sister

Compliance decreased to 82% from 84%

Acute Directorate : Audit Of Documented Risk Assessment 01.09.14 - 28.09.14

DIVISION	SITE	Ward	w/e 7th September 2014 Forms Received	w/e 14th September 2014 Forms Received	w/e 21st September 2014 Forms Received	w/e 28th September 2014 Forms Received	Up to w/e 28th September: Total number of returns with VTE documented	Up to w/e 28th September: Total number of valid VTE returns	Up to w/e 28th September: Was there a documented risk assessment?	Comment
IMWH	CAH	1 West - Gynae	5	4	1	5	15	15	100%	
		2 West							Not required to participate in this current audit	
	DHH	Delivery Suite							Not required to participate in this current audit	
		Delivery Suite							Not required to participate in this current audit	
		Maternity Ward							Not required to participate in this current audit	
M&UC	CAH	1 South	2	3	5	5	12	15	80%	
		CCU 1 North	5	5	5	5	16	20	80%	
		2N Resp	Nil return	5	Nil return	Nil return	5	5	100%	
		2N Haem	5	5	5	5	16	20	80%	
		2 South Med	Nil return	Nil return	5	5	9	10	90%	
		2 South Stroke	4	4	5	5	15	18	83%	
		CDU	5	5	4	5	8	19	42%	
		MAU	5	5	5	5	20	20	100%	
		Ramone Winter Pressures Ward								
	DHH	Female Medical	5	5	5	5	19	20	95%	
		CCU/ Male Medical	3	5	5	4	17	17	100%	
		Ger Stoke Ward - L6	5	5	5	5	18	20	90%	
		Rehab Ward - L6								
S&EC	CAH	3 South	5	Nil return	5	5	6	15	40%	
		4 North CESW	5	5	5	Nil return	12	15	80%	
		4 South	5	5	5	5	19	20	95%	
		Elective Adm (CEAW)	5	5	5	5	20	20	100%	
		Ortho Wd	4	5	4	5	15	18	83%	
		Trauma	5	5	5	5	18	20	90%	
	DHH	Female Surgical	5	5	5	5	20	20	100%	
		Male Surgical/HDU	5	5	5	5	17	20	85%	
Total Number of cases audited							**297**	**347**	**85%**	



Summary

Twenty one wards participating

Outstanding returns for four wards escalated to Nurse managers / Sister

Compliance increased to 85% from 82%

Southern Health and Social Care Trust

Acute Directorate

Hyponatraemia Audit: 14-16* year olds on IV Fluids (* Day before 16th Birthday)

Audit results 15.09.14 - 12.10.14

Presentation at Acute Clinical Governance meetings
4th November 2014

Southern Health and Social Care Trust	Acute Directorate: High Level Summary

Hyponatraemia Audit: 14-16* year olds on IV Fluids (* Day before 16th Birthday)

15th September – 12th October 2014

(n=14, 13 included in this report, as 1 MUSC patient transferred to other hospital with patient notes)

Division	Audit Compliance	Areas of non-compliance in current period
ATICS (n=5)	100%	
IMWH (n=0)	-	
MUSC (n=4)	0%	Signature of nurse x2, calculation not completed on FBC and total across the page
SEC (n=4)	50%	Signature of nurse, fluid type and total across the page
Total (n=13)	**54%**	

Individual divisional reports have been forwarded to nurse managers for their action plans and timescales, where applicable

Southern Health and Social Care Trust

Acute Directorate

National Cardiac Arrest Audit (NCCA)

Summary for September 2014

Presentation at Acute Clinical Governance meeting
4th November 2014

National Cardiac Arrest Audit (NCAA)
Summary September 2014

Crash Calls Summary CAH September 2014

September 2014	Number
Total number of crash calls logged with switchboard	11
Breakdown of Switchboard Calls	
Cardio Respiratory arrests	6
Respiratory arrests	2
Peri arrests	0
False Alarms	3
Number of forms entered onto NCAA website	6
Number of Charts Reviewed by RO	6
Exclusions*	0

Crash Calls Summary DHH September 2014

September 2014	Number
Total number of crash calls logged with switchboard	10
Breakdown of Switchboard Calls	
Cardio Respiratory arrests	5
Respiratory arrests	0
Peri arrests	2
False Alarms	3
Number of forms entered onto NCAA website	5
Number of Charts Reviewed by RO	1
Exclusions* - 4 x cardio respiratory arrests in ED	4

Criteria for NCAA cases: Individual is an adult or child over 28 day; individual received chest compressions and/or defibrillation; 6666 call logged with switchboard; individual attended by hospital based resuscitation team in response to 6666 call.

*Only the case notes of patients who had a cardio respiratory arrest are reviewed on PFA Target wards by the Resuscitation officers.
Excluded wards/departments are: ICU/HDU/Theatres/ Cardiology 1 North & ED.

Acute Services
Patient Experience Group

Patient Support Enquiries Quarterly Report

2nd Quarter July –September 2014

Paula McAloran
Patient Support Officer

Patient Support Services Report – 2nd Quarter Report 2014

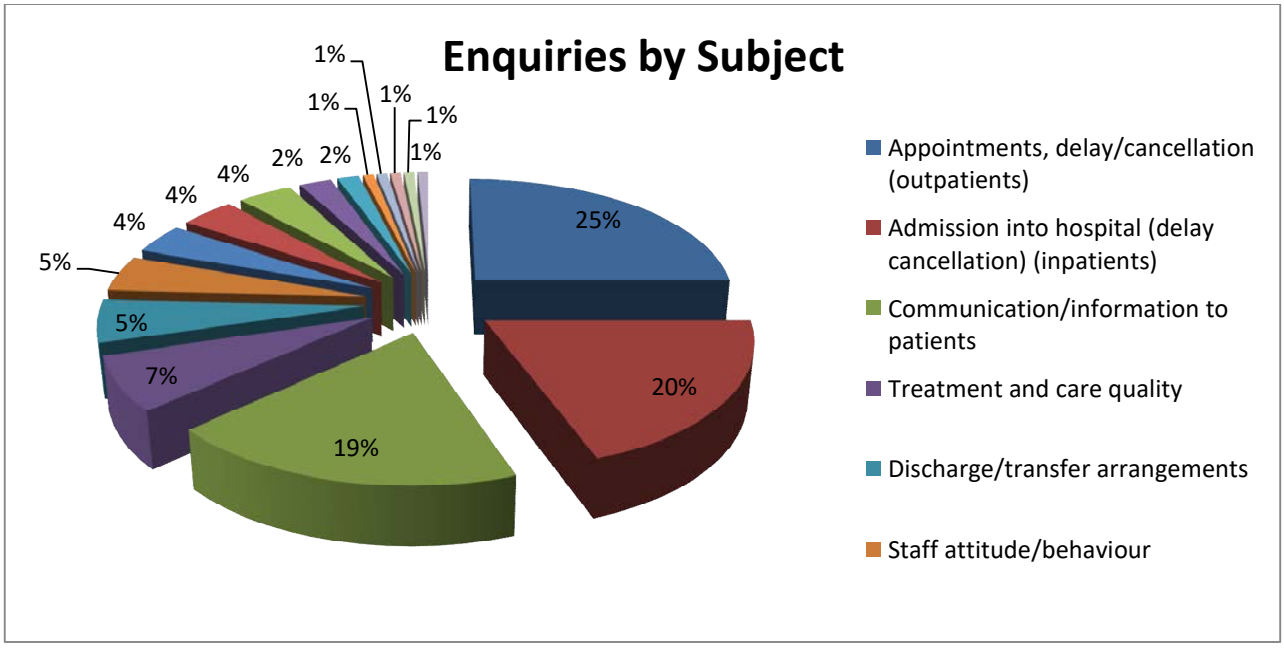
The purpose of this report is to inform senior staff within the Acute Directorate about the Enquiries received by Patient Support within the Directorate in the 2nd Quarter 2014 (July – September) and highlight any key issues or recurring themes.

Summary

- 128 Patient Support Enquiries were received in the 2nd Quarter 2014 compared to 127 Patient Support Enquiries received the same Quarter last year.
- 2 Patient Support Enquiries remain open (98.4% have been responded to and are now closed).

▪ Top 5 Subjects:

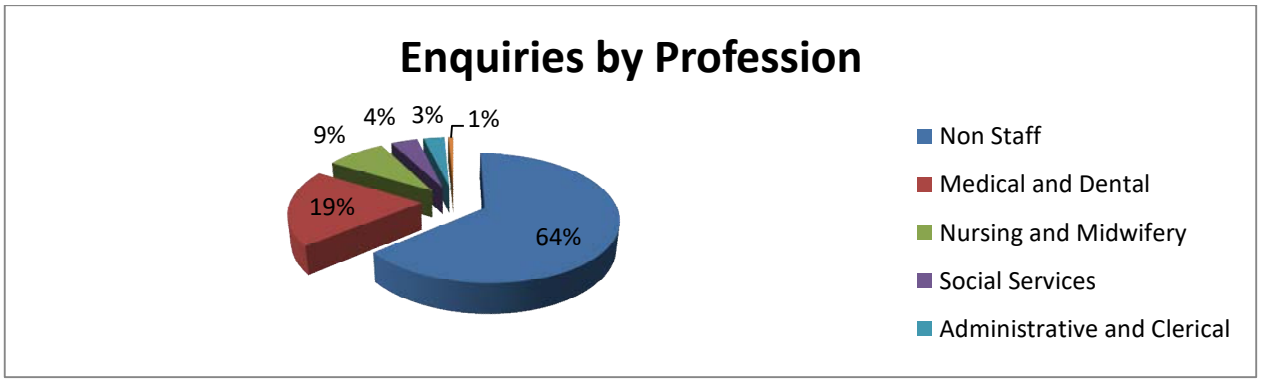
Subject	July- Sept 2013	July –Sept 2014
Appointments, delay/cancellation (outpatients)	19	33
Admission into hospital (delay, cancellation) (inpatients)	13	25
Communication/information to patients	33	24
Treatment and care quality	19	9
Discharge/Transfer arrangements	5	7



- **Top 5 Professions:**

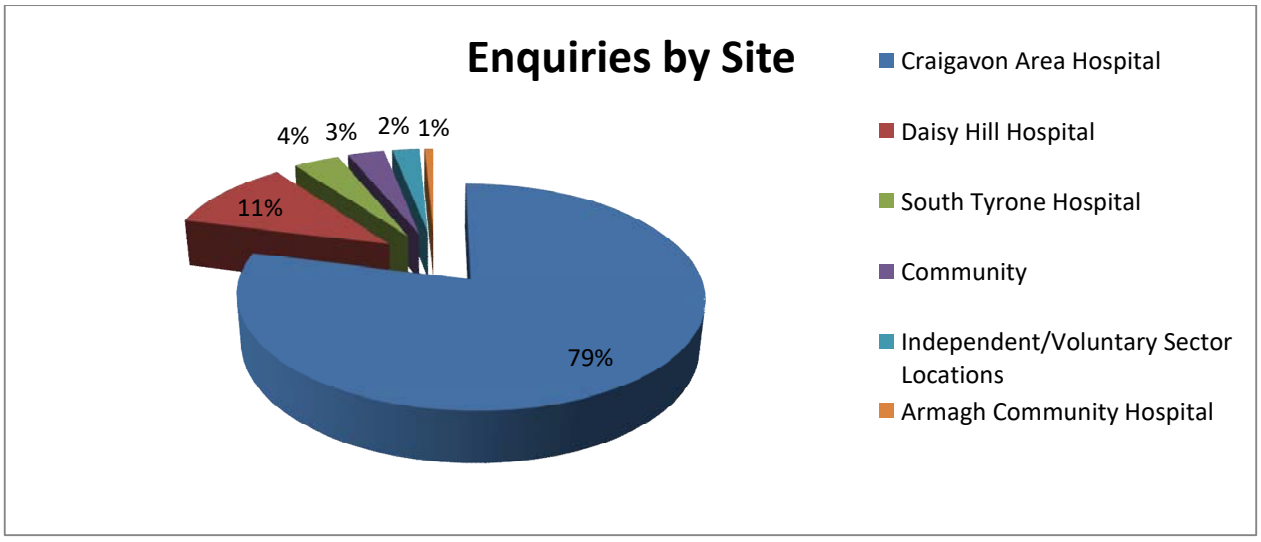
Profession	July – Sept 2013	July –Sept 2014
*Non Staff	67	82
Medical and Dental	34	25
Nursing and Midwifery	11	11
Social Services	3	5
Administrative and Clerical	6	4

*Non Staff refers to enquiries regarding inpatient/outpatient waiting times and general communication /information enquiries that cannot be attributed to any staff group



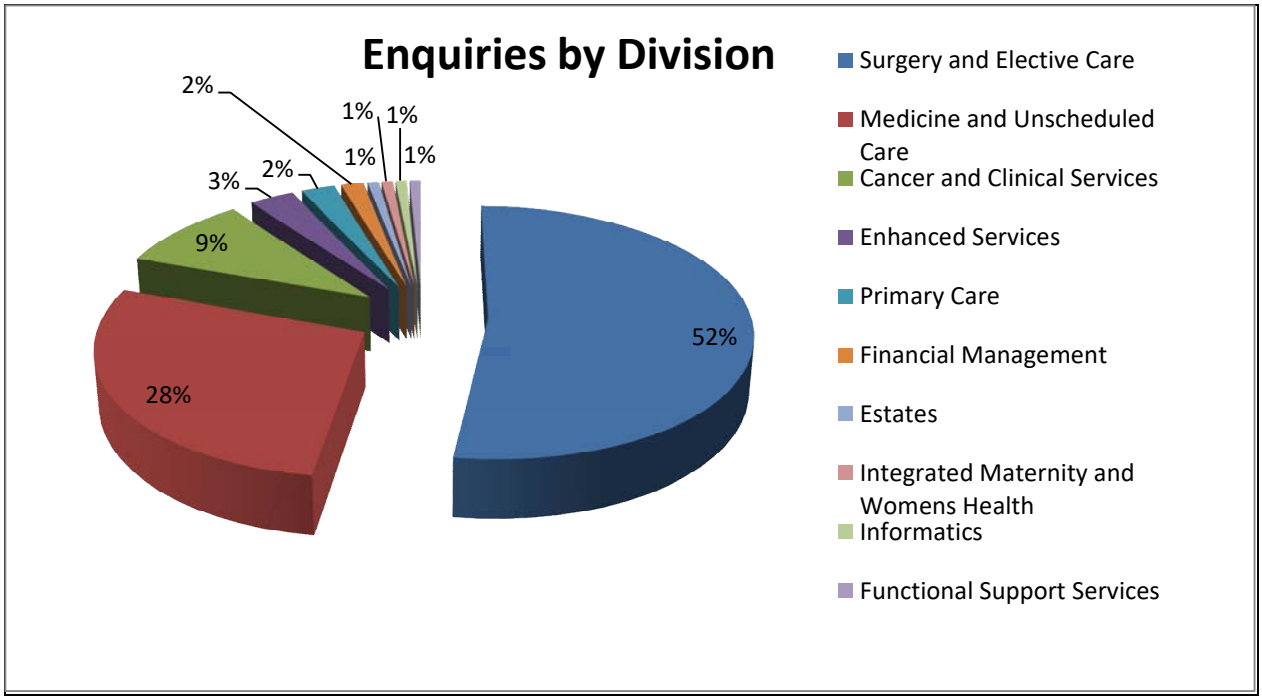
- **Top 5 Sites**

Hospital	July – Sept 2013	July –Sept 2014
Craigavon Area Hospital	95	101
Daisy Hill Hospital	6	14
South Tyrone Hospital	5	5
Community	10	4
Independent/Voluntary Sector Locations	9	3



Enquiries per Division

Enquiries by Division	2nd Quarter 2104
Surgery and Elective Care	67
Medicine and Unscheduled Care	36
Cancer and Clinical Services	12
Enhanced Services	4
Primary Care	3
Financial Management	2
Estates	1
Integrated Maternity and Women's Health	1
Informatics	1
Functional Support Services	1
Grand Total	**128**



Enquiries By Hospital, Division and Subject

Hospital, Division & Subject	2nd Quarter 2014
Craigavon Area Hospital	**101**
Surgery and Elective Care	**55**
Admission into hospital (delay cancellation) (inpatients)	19
Appointments, delay/cancellation (outpatients)	14
Communication/information to patients	8
Theatre/operation/procedure, delay/cancellation	4
Staff attitude/behaviour	3
Treatment and care quality	3
Discharge/transfer arrangements	3

Complaints handling	1
Medicine and Unscheduled Care	**30**
Communication/information to patients	8
Treatment and care quality	6
Appointments, delay/cancellation (outpatients)	4
Other	3
Discharge/transfer arrangements	3
Records/record keeping	3
Theatre/operation/procedure, delay/cancellation	1
Staff attitude/behaviour	1
Transport, late or non-arrival/journey time	1
Cancer and Clinical Services	**12**
Appointments, delay/cancellation (outpatients)	6
Records/record keeping	2
Communication/information to patients	2
Admission into hospital (delay cancellation) (inpatients)	1
Patients' property/expenses/finance	1
Integrated Maternity and Women's Health	**1**
Admission into hospital (delay cancellation) (inpatients)	1
Estates	**1**
Other	1
Functional Support Services	**1**
Hotel/support/security services	1
Informatics	**1**
Communication/information to patients	1
Daisy Hill Hospital	**14**
Surgery and Elective Care	**6**
Appointments, delay/cancellation (outpatients)	3
Admission into hospital (delay cancellation) (inpatients)	2
Clinical diagnosis	1
Medicine and Unscheduled Care	**6**
Staff attitude/behaviour	2
Appointments, delay/cancellation (outpatients)	1
Other	1
Communication/information to patients	1
Discharge/transfer arrangements	1
Financial Management	**2**
Patients' property/expenses/finance	2
South Tyrone Hospital	**5**
Surgery and Elective Care	**3**
Admission into hospital (delay cancellation) (inpatients)	1
Communication/information to patients	1
Appointments, delay/cancellation (outpatients)	1
Enhanced Services	**2**

Communication/information to patients	1
Appointments, delay/cancellation (outpatients)	1
Community	**4**
Primary Care	**2**
Communication/information to patients	2
Enhanced Services	**2**
Transport, late or non-arrival/journey time	1
Appointments, delay/cancellation (outpatients)	1
Independent/Voluntary Sector Locations	**3**
Surgery and Elective Care	**2**
Appointments, delay/cancellation (outpatients)	1
Admission into hospital (delay cancellation) (inpatients)	1
Primary Care	**1**
Professional assessment of need	1
Armagh Community Hospital	**1**
Surgery and Elective Care	**1**
Appointments, delay/cancellation (outpatients)	1
Grand Total	**128**

Enquiries received per Quarter & Year

The Table and Chart below compares the number of Patient Support enquiries received per month compared to the number of Patient Support Enquiries received the same month the previous year.

Quarterly Enquiries Received per Quarter	2013	2014
1st Quarter (1st April – 30th June)	132	119
2nd Quarter (1st July – 30th September)	127	128
3rd Quarter (1st October – 31st December)	99	
4th Quarter (1st January – 31st March)	139	

DIRECTORATE OF ACUTE SERVICES
Weekly Report on Formal Complaints - 3 November 2014

Ref	Record name	Div	Loc (Exact)	Date Received	Response due	Replied due	Current Stage
Personal Information redacted by the USI		SEC	Orthopaedic Ward	19/08/2014	03/09/2014	17/09/2014	To Debbie Burns for signature 20.10.14.
		SEC	General Surgery Clinic	01/09/2014	15/09/2014	29/09/2014	Awaiting response from Amie Nelson.
		SEC	Urology Clinic	10/09/2014	24/09/2014	08/10/2014	Response being drafted.
		MUC	Female Medical, Level 5	18/09/2014	01/10/2014	15/10/2014	To Debbie Burns for signature 03.11.14
		MUC		18/09/2014	02/10/2014	16/10/2014	Awaiting response from Caitriona McGoldrick.
		IMWH	Gynae Clinic	19/09/2014	03/10/2014	17/10/2014	Response being drafted.
		SEC	Orthopaedic Clinic	22/09/2014	06/10/2014	20/10/2014	Response being drafted.
		MUC	1 South Medical	23/09/2014	07/10/2014	21/10/2014	Reminder to Caitriona McGoldrick for response 23.10.14
		MUC	MAU	24/09/2014	08/10/2014	22/10/2014	Reminder to Mary Burke for response 23.10.14.
		IMWH	2 East Midwifery Led Unit	29/09/2014	13/10/2014	27/10/2014	Further input required from P McStay
		MUC	Emergency Department	29/09/2014	13/10/2014	27/10/2014	To Anne McVey for approval 21.10.14.
		SEC	Urology Clinic	30/09/2014	14/10/2014	28/10/2014	Response being drafted.
		MUC	MAU	30/09/2014	14/10/2014	28/10/2014	Reminder to Lorna Cullen for response 23.10.14
		SEC	Urology Clinic	30/09/2014	14/10/2014	28/10/2014	Response being drafted.
		IMWH	Admissions/Assessment Unit	30/09/2014	14/10/2014	28/10/2014	Response being drafted.
		IMWH	Antenatal Clinic	30/09/2014	14/10/2014	28/10/2014	Reminder to Dr Adams for response 27.10.14
		SEC	Oral Surgery Clinic	03/10/2014	17/10/2014	31/10/2014	Reminder to Amie Nelson for response 27.10.14
		SEC	Independent Sector	03/10/2014	17/10/2014	31/10/2014	To Heather Trouton 22.10.14
		SEC	Urology Clinic	03/10/2014	17/10/2014	31/10/2014	Response being drafted.
		IMWH	Delivery Suite	06/10/2014	20/10/2014	03/11/2014	Response being drafted.
		SEC	Orthopaedic Clinic	13/10/2014	27/10/2014	10/11/2014	Response being drafted.
		MUC	Emergency Department	13/10/2014	27/10/2014	10/11/2014	Reminder to Mary Burke for response 27.10.14.
		CCS	Laboratory	14/10/2014	28/10/2014	11/11/2014	Response being drafted.
		CCS	MRI Unit	15/10/2014	29/10/2014	12/11/2014	Awaiting response from R Carroll, T Reid and Dr Bunn
		SEC	Urology Clinic	16/10/2014	30/10/2014	13/11/2014	Response being drafted.
		FSS	Orthotic Clinic	17/10/2014	31/10/2014	14/11/2014	To Debbie Burns for signature 31.10.14
		FSS	Antenatal Clinic	17/10/2014	31/10/2014	14/11/2014	Under investigation
		SEC	3 South	20/10/2014	03/11/2014	17/11/2014	Under investigation
		MUC	Female Surgical/Gynae	20/10/2014	03/11/2014	17/11/2014	Under investigation
		CCS	Laboratory	22/10/2014	05/11/2014	19/11/2014	To Debbie Burns for signature 31.10.14
		IMWH	Delivery Suite, CAH	22/10/2014	05/11/2014	19/11/2014	Under investigation
		SEC	4 South	23/10/2014	06/11/2014	20/11/2014	Under investigation
		SEC	Orthopaedic Ward	24/10/2014	07/11/2014	21/11/2014	Response being drafted.
		MUC	Emergency Department	24/10/2014	07/11/2014	21/11/2014	Under investigation
		MUC	Female Medical, Level 5	27/10/2014	10/11/2014	24/11/2014	Under investigation
		SEC	Independent Sector	27/10/2014	10/11/2014	24/11/2014	Under investigation
		MUC	1 South Medical	28/10/2014	11/11/2014	25/11/2014	Under investigation
		SEC	Urology Clinic	28/10/2014	11/11/2014	25/11/2014	Under investigation

Acute Services Directorate
Directorate Risk Register - November 2014

ID	Opened	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level
3393	22/04/2013	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.	13/5/14 - Application submitted 12/5/14 to UKAS for accreditation. Anticipated inspection Dec 2014. "April 2013 Action Plan to be formulated. 36 non-conformances to be addressed, several of which are critical, Working through non-conformances, however, waiting on new Standards ISO 15189; purchase order has been placed. 26/6/13 - standards have been received and a gap analysis has been completed. Staffing numbers has been sited as a critical non-conformance. additional staff have been recruited since inspection 26/6/13 - full manpower plan has been developed and Laboratory is seeking 5 additional staff to address the balance. Also working with regional group on bid for additional staff for 24/7 Staffing levels - benchmarking to be undertaken. Anticipated total additionality is 11 staff, no funding identified.	HIGH
2594	16/04/2010	Insufficient capacity and resources to manage patients waiting for a review appointment in Acute Services	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.	RVBL teams established to 'cleanse' the lists of patients waiting, ensuring no duplication or incorrect recording of activity. This group will also continue to meet and create effective strategy to manage this chronic gap in capacity. Monthly reports monitoring review waiting lists to give current position. Specialist Nurses working in Consultation with relevant Consultants to screen urgent, and patients waiting the longest length of time. Vacant Outpatient sessions have been backfilled with Review Backlog patients, when Consultant available. Heads of Service are meeting with Relevant Consultants and conveying current provision on a monthly basis.	12/5/14 - with respect to ATICs chronic pain service 9 patients waiting from 12/13 and a further 400 from 13/14. Monies acquired from HSCB, however, this only for consequence of additional new patients. Templates have been amended to meet and New and Review SBA. Further consideration needs to be given to role of Specialist Nurses within this service. 05.05.14 The Trust has received funding to address 700 patients in the Urology review backlog so additional clinics are being organised. 12.02.14 Acute Services continues to manage the review backlog within current resources which are accepted as being insufficient to see the number of review patients that have accrued as a result of additional waiting list clinics / activity required by HSCB to meet access standards. This has been raised to the Regional Commissioning Board but no funding has been made available for the review backlog in 12/13. 31.10.13 - General Surgery Total 2272, ENT Total 2413, T&O Total 369, Urology Total 3258. The Trust is currently seeking funding to re-establish RVBL clinics. 01.03.13: General surgery and Breast position at end of February 2013; no patients to be reviewed prior to 2012; total 1445 01.02.13 - Oral Surgery: 0 patients up to the end of January , Breast Surgery: 0 patients up to the end of January, Breast Family Hist: 53 - DHH 64 - CAH patients up to the end of January not booked or going through the partial booking process, General Surgery: 1189 patients up to the end of January across all sites not booked or going through the partial booking process.	HIGH
3618	04/11/2014	Pathology reporting backlog	There is a backlog of unreported pathology specimens. There is a delay in the diagnosis and treatment to patient.	Every specimen is assessed before it is placed in the backlog, this reduces the chances of cancers etc being delayed, but cannot eliminate the risk	Added to Risk Regiester 4/11/14	MOD

ID	Opened	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level
3528	05/02/2014	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.	13.5.14 A SOC for a new build aseptic suite, co-located with the Mandeville Unit, was sent to the Department in November 2013. Work has commenced on the full business case. The Capita Model for chemotherapy/cytotoxic dispensing has been applied to the current workload in the unit. This has identified a staffing deficit of 3.6wte pharmacists. The capacity planning model shows that the pharmacists are working between 130 and 150% capacity. Based on this review, a paper requesting additional funding has been prepared for the HSCB and Trust representatives met the HSCB on 28/4/14. The additional information requested by HSCB at the meeting is being prepared. A request to HSCB to fund one pharmacist in advance of the final plan was declined. Capital was identified to replace one isolator in October 2012; however it was not possible to raise an order within 2012/13. Additional capital has been identified in 13/14 and one isolator has been ordered, installed and commissioned. A second isolator was ordered in January 2014 and delivered in March 2014 however the company have not been able to install it as their duct work did not fit despite their advance site visit.	MOD
3166	25/06/2012	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.	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 whch 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 01/10/13: Urology access times are currently 80 weeks for inpatients and days. The team are currently focusing on meeting Cancer Targets. 29/03/13: Position has reduced from 86 weeks to 30 weeks for in patients and day cases. 01.03.13: position remains unchanged; working towards reducing waiting times 01.02.13 - All mechanisms in place and work continues to reduce waiting times. 07.01.13 - Position remains unchanged.	MOD
3515	14/11/2013	Ineffective Cardiac Monitoring System in certain Wards/Departments	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.	14.11.13 - Working with Estates Services on an optional appraisal. IPT to be completed.	MOD
2979	13/05/2011	Multiple records/charts per patient e.g. a patient may have South Tyrone, Craigavon, Banbridge and Daisy Hill 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.	11.02.14 This risk continues to be managed appropriately but will not be eliminated until an electronic care record is fully implemented. 07/01/14 Registration now restricted to 2 sites dhh and cah , progress being made on rollout of electronic care record	MOD

ID	Opened	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level
2422	13/10/2009	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.	11.02.14 Training schedules introduced. 25.09.13 - workforce review carried out September 2013 e-learning packages being developed for a variety of mandatory training Sisters continue to prioritise at ward level. 19.10.12 - Still ongoing issues with provision of training. Ward Sisters prioritising. 25.09.12 - Still ongoing. Ward Sisters to prioritise training needs. HOS and Lead Nurse to scope staff training on a monthly basis and identify areas that need escalated.	LOW
3526	17/12/2013	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.	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
3529	05/02/2014	Non compliance to Standards and Guidelines issued to Southern Trust	Poor patient outcomes are a risk due to non compliance with Standards and guidelines issued from extenal agencies Staff are at risk if not practicing safe and effective care outlined in recommendations within standards and guidelines Currently there are 981 standards and guidelines on the Trust's register, 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 received.	There is often a time lag between when the external agencies require the Trust to achieve full compliance and when this is actually achieved This may result in risks to the patient staff and organisation. the delay has potential to expose patient staff and organisation at risk	5/2/14 All newly issued S&G have been reviewed and managed through the new corporate process prior to sending to the nominated Lead Director and Change Lead for action AMD for Standards and Guidelines (Acute Services) in post. 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 on a quarterly basis. Database established and system in place for logging and monitoring	LOW

Southern Health and Social Care Trust	Acute Directorate Surgery & Elective Care

Hyponatraemia Audit: 14-16* year olds on IV Fluids (* Day before 16th Birthday) 15th September – 12th October 2014
Action Plan

No of cases identified by Division for inclusion in the audit in this time period:	4	Audit compliance:	50%

Ward	Issue	Action Proposed by Ward Manager/clinical sister	Person Responsible	Timescale	Confirm action complete or not complete
4 North Date of IV fluids: 19/09/2014	No nursing documentation for: • Type of fluid on FBC	Sister to remind staff of completing Fluid Balance Chart at weekly meeting	Sister Mulligan	Immediate	Done
4 North Date of IV fluids: 19/09/14	No nursing documentation for: • Signature of nurse observing the IVF • Total across the page	Sister to remind staff of completing Fluid Balance Chart at weekly meeting	Sister Mulligan	Immediate	Done
4 North Date of IV fluids: 07/10/14	Audit fully compliant				
Male Surgical Ward (DHH) Date of IV fluids: 08/10/2014	Audit fully compliant				

No of patents with a low NA as identified by the labs system (to 30th September 2014)	0	Audit compliance:	Not applicable

Southern Health and Social Care Trust	Acute Directorate ATICS

Hyponatraemia Audit: 14-16* year olds on IV Fluids (* Day before 16th Birthday) 15th September - 12th October 2014
Action Plan

No of cases identified by Division for inclusion in the audit in this time period:	**5**	**Audit compliance:**	**100%**

Ward	Issue	Action Proposed by Ward Manager/clinical sister	Person Responsible	Timescale	Confirm action complete or not complete
Theatres- CAH	5 cases peer reviewed by Dr K O'Connor Anaesthetics, CAH managed appropriately and appropriate fluids given.				

No of patients with a low NA as identified by the labs system (to 30th September 2014)	**0**	**Audit compliance:**	**Not applicable**

Southern Health and Social Care Trust	Acute Directorate Integrated Maternity & Women's Health

Hyponatraemia Audit: 14-16* year olds on IV Fluids (* Day before 16th Birthday) 15th September – 12th October 2014

Action Plan

No of cases identified by Division for inclusion in the audit in this time period:	**0**	**Audit compliance:**	**Not applicable**

No of patients with a low NA as identified by the labs system (to 30th September 2014)	**0**	**Audit compliance:**	**Not applicable**

Recommendation	Person/s Responsible to take forward	Timescale
1. Central venous catheters (central lines) should not be in situ without clinical indication. 5.		
2. Review policy / procedure regarding the management of central venous lines in accordance with evidence based practice.		
3. Include the management of central venous lines in the newly developed Trust guidelines website.		
4. Provide update training for registered nurses in relation to the management of central venous catheters.		
5 the central line pathway to include a prompt to escalate removal of a central venous catheter when it is no longer fit for purpose or if it is not required.		

Patient Support Enquiries - 2nd Quarter Report
July - September 2014

ID	Received	Site	Division	Location	Subjects	Staff	Description	Outcome	Closed
Personal Information redacted by the USI	10/07/2014	Craigavon Area Hospital	Surgery and Elective Care	Pre-operative Assessment Clinic	Communication/information to patients	Nursing and Midwifery	Enquiry re information provided to patient attending pre-operative clinic. 1. Advised will be seen by Dr X- feels this is misleading as seen by a different doctor 2. Advised to contact scheduler if experiencing pain- feels this suggests they had influence on priority	Enquirer informed patients receive a print out from the savience system and the Medical records manager is to review wording to Consultant's clinic. It is not practise for outpatients staff to give advice re scheduling team and as staff member not identified further action could not be taken but would be reiterated for learning.	24/07/2014
	09/09/2014	Craigavon Area Hospital	Surgery and Elective Care	Orthopaedic Waiting List	Theatre/operation/procedure, delay/cancellation	Non Staff	Enquiry re obtaining date for planned Orthopaedic Surgery. Enquirer has already had surgery cancelled twice	Patient rescheduled for surgery however she chose go to another hospital as a private patient for surgery.	11/09/2014
	09/09/2014	Craigavon Area Hospital	Surgery and Elective Care	Orthopaedic Waiting List	Admission into hospital (delay cancellation) (inpatients)	Non Staff	Enquiry re obtaining date for planned Orthopaedic Surgery. Enquirer has already had surgery cancelled twice	Patient rescheduled for surgery however she chose go to another hospital as a private patient for surgery.	11/09/2014
	28/08/2014	Craigavon Area Hospital	Surgery and Elective Care	Fracture Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	Enquiry re appointment at fracture clinic. Patient is scheduled for an appointment 15/9/14 however her Medical Consultant requests an earlier review. Patient currently an inpatient South Tyrone Hospital.	Orthopaedic Consultant liaised with patient's Medical Consultant re treatment plan.	05/09/2014
	04/07/2014	Craigavon Area Hospital	Surgery and Elective Care	General Surgery Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	Patient awaiting orthopaedic surgery in Musgrave and was referred for Vascular investigations prior to surgery. Patient anxious for review appointment with vascular Consultant.	Patient informed his review appointment with vascular Consultant should be scheduled September/October 2014 and his results have been sent to his Orthopaedic Consultant in Belfast and will be reviewed in due course. Patient Satisfied with advice and information provided.	04/07/2014
	22/07/2014	Craigavon Area Hospital	Surgery and Elective Care	General Surgery Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	Enquiry re date for review appointment at surgical clinic and date for planned surgery. Patient seeks clarification if she she for further investigations or for surgery.	Patient advised she is on the waiting list as routine priority for review at the surgical clinic however no date could be offered due to lengthy backlog. Patient advised to attend her GP should her symptoms change and GP can seek urgent review if appropriate.	23/07/2014
	22/07/2014	Craigavon Area Hospital	Surgery and Elective Care	General Surgery Clinic	Admission into hospital (delay cancellation) (inpatients)	Non Staff	Enquiry re date for review appointment at surgical clinic and date for planned surgery. Patient seeks clarification if she she for further investigations or for surgery.	Patient advised she is on the waiting list as routine priority for review at the surgical clinic however no date could be offered due to lengthy backlog. Patient advised to attend her GP should her symptoms change and GP can seek urgent review if appropriate.	23/07/2014
	04/09/2014	Craigavon Area Hospital	Surgery and Elective Care	Urology Waiting List	Admission into hospital (delay cancellation) (inpatients)	Non Staff	Enquirer seeking date for admission for further Urology surgery. Patient has history of bladder cancer.	Patient unhappy she has not received a date for surgery and has consequently submitted a formal complaint.	06/10/2014
	05/09/2014	Craigavon Area Hospital	Surgery and Elective Care	Orthopaedic Waiting List	Admission into hospital (delay cancellation) (inpatients)	Non Staff	Enquirer seeking date for orthopaedic surgery	Outpatient appointment offered and accepted to meet new Orthopaedic Consultant prior to surgery. Enquirer will discuss surgery at outpatient appointment.	09/10/2014
	15/09/2014	Craigavon Area Hospital	Surgery and Elective Care	General Surgery Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	Enquirer unhappy his scheduled appointment at surgical clinic on 29/9/14 has been cancelled. Patient concerned regarding delay as he is off work and is affected financially by delay in treatment.	Patient outpatient appointment rescheduled for 30/10/14 which he accepted. Contact details provided for Citizens Advice Service for financial advice.	15/09/2014
	22/07/2014	Craigavon Area Hospital	Surgery and Elective Care	Urology Waiting List	Admission into hospital (delay cancellation) (inpatients)	Non Staff	Enquiry re date for admission for planned urology surgery. Added to waiting list as routine priority 6/3/14.	Patient informed she has been prioritised as routine for her surgery and unfortunately due to the lengthy waiting list a date could not be offered at this time. Advised she will receive a letter re date and time for admission 2-3 weeks in advance. Patient advised to attend her GP should her symptoms change.	23/07/2014
	04/08/2014	Craigavon Area Hospital	Surgery and Elective Care	4 South	Treatment and care quality	Non Staff	Patient's daughter anxious for information regarding her father's treatment plan. Patient had CT scan and requires a referral for surgery at Royal Victoria Hospital Belfast.	Meeting between Ward Manager and patient's family who were updated re treatment plan. Await CT results and feedback from RVH. Patient's family satisfied with information provided.	05/08/2014
	04/08/2014	Craigavon Area Hospital	Surgery and Elective Care	4 South	Communication/information to patients	Non Staff	Patient's daughter anxious for information regarding her father's treatment plan. Patient had CT scan and requires a referral for surgery at Royal Victoria Hospital Belfast.	Meeting between Ward Manager and patient's family who were updated re treatment plan. Await CT results and feedback from RVH. Patient's family satisfied with information provided.	05/08/2014
	13/08/2014	Craigavon Area Hospital	Surgery and Elective Care	4 South	Communication/information to patients	Nursing and Midwifery	Patient recently discharged from Craigavon area hospital and referred for assessment at Royal Victoria Hospital Emergency Clinic (vascular). Patient's daughter unhappy with advice and communication re referral arrangements from medical and nursing staff.	Patient's daughter contacted and advised it was the responsibility of RVH to contact her father re date and time of appointment and any further instructions. Patient was contacted by RVH and scheduled for an appointment tomorrow. 15/8/14.	14/08/2014
	13/08/2014	Craigavon Area Hospital	Surgery and Elective Care	4 South	Communication/information to patients	Medical and Dental	Patient recently discharged from Craigavon area hospital and referred for assessment at Royal Victoria Hospital Emergency Clinic (vascular). Patient's daughter unhappy with advice and communication re referral arrangements from medical and nursing staff.	Patient's daughter contacted and advised it was the responsibility of RVH to contact her father re date and time of appointment and any further instructions. Patient was contacted by RVH and scheduled for an appointment tomorrow. 15/8/14.	14/08/2014
	13/08/2014	Craigavon Area Hospital	Surgery and Elective Care	4 South	Discharge/transfer arrangements	Medical and Dental	Patient recently discharged from Craigavon area hospital and referred for assessment at Royal Victoria Hospital Emergency Clinic (vascular). Patient's daughter unhappy with advice and communication re referral arrangements from medical and nursing staff.	Patient's daughter contacted and advised it was the responsibility of RVH to contact her father re date and time of appointment and any further instructions. Patient was contacted by RVH and scheduled for an appointment tomorrow. 15/8/14.	14/08/2014
	22/07/2014	Independent/ Voluntary Sector Locations	Surgery and Elective Care	352 Clinic	Admission into hospital (delay cancellation) (inpatients)	Non Staff	Enquiry re date for planned surgery. Patient has been referred to Independent Sector for hernia repair and was added to the waiting list 18/6/14.	Patient informed he has been added to the waiting list at Kingsbridge Private hospital following his appointment and will receive a letter 2-3 weeks in advance of admission re date and time. Contact details provided for Kingsbridge Private Hospital.	23/07/2014
	08/07/2014	Craigavon Area Hospital	Surgery and Elective Care	Admin Floor/Offices	Communication/information to patients	Administrative and Clerical	Enquirer reports difficulty contacting scheduler to confirm date for admission.	Enquirer informed her mother has been confirmed for surgery 15/7/14 and bowel preparation was posted to her address as agreed with scheduler. Apology offered for any distress caused.	08/07/2014
	12/08/2014	Craigavon Area Hospital	Surgery and Elective Care	General Surgery Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	Enquiry re date for appointment at general surgical clinic.	Patient informed referral received from GP and graded routine priority and he should be scheduled for an appointment September 2014. Added to short notice/cancellation list for appointment.	14/08/2014
	05/08/2014	Craigavon Area Hospital	Surgery and Elective Care	Fracture Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	Enquiry re date for review appointment at fracture clinic. Patient was due review last week however ambulance did not arrive to take patient to appointment. Patient is diabetic and her daughter is concerned re ulceration under plaster of paris.	Patient's daughter informed review appointment scheduled for tomorrow 6.8.14 and transport arranged.	05/08/2014
	21/08/2014	Craigavon Area Hospital	Surgery and Elective Care	Urology Waiting List	Admission into hospital (delay cancellation) (inpatients)	Non Staff	Enquiry re date for admission for planned urology surgery.		

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Personal Information redacted by the USI	23/07/2014	South Tyrone Hospital	Surgery and Elective Care	Orthotic Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	Enquiry re date for appointment at Orthotic clinic. Patient reports difficulty getting through to department despite numerous telephone calls.	Patient contacted and informed she will be scheduled for an appointment in August and will receive a letter to confirm date and time. Satisfied with information provided.	23/07/2014
	23/07/2014	South Tyrone Hospital	Surgery and Elective Care	Orthotic Clinic	Communication/information to patients	Administrative and Clerical	Enquiry re date for appointment at Orthotic clinic. Patient reports difficulty getting through to department despite numerous telephone calls.	Patient contacted and informed she will be scheduled for an appointment in August and will receive a letter to confirm date and time. Satisfied with information provided.	23/07/2014
	28/08/2014	Craigavon Area Hospital	Surgery and Elective Care	4 South	Discharge/transfer arrangements	Social Services	Enquiry re discharge arrangements. Patient has a care package and was allegedly discharged without care package being restarted.	Referred back to complaints as Social Work team currently investigating via formal complaints process.	28/08/2014
	19/08/2014	Craigavon Area Hospital	Surgery and Elective Care	Orthopaedic Waiting List	Admission into hospital (delay cancellation) (inpatients)	Non Staff	Enquiry re date for planned Orthopaedic surgery. Patient is waiting for a hip replacement.	Patient informed he has been added to the waiting list for surgery as routine priority and should be scheduled for surgery October 2014.	19/08/2014
	01/07/2014	Craigavon Area Hospital	Surgery and Elective Care	Urology Waiting List	Admission into hospital (delay cancellation) (inpatients)	Non Staff	Enquiry regarding obtaining a date for urology surgery. Added to urology waiting list as urgent on 14/10/13	Elected Representative informed current waiting time for urology is experiencing severe delays and patient will be scheduled as soon as possible however no date could be confirmed.	21/07/2014
	01/07/2014	Craigavon Area Hospital	Surgery and Elective Care	Urology Waiting List	Admission into hospital (delay cancellation) (inpatients)	Non Staff	Enquiry re date for planned urology procedure.	Patient offered a date for surgery 15/7/14. Patient unable to attend due to holidays and was informed he will be rescheduled in August.	01/07/2014
	09/09/2014	Craigavon Area Hospital	Surgery and Elective Care	Trauma Ward	Discharge/transfer arrangements	Non Staff	Patient is on Trauma ward and is awaiting transfer to RVH for Orthopaedic Surgery.	Patient transferred to RVH and had emergency Orthopaedic surgery.	09/10/2014
	12/08/2014	Independent/ Voluntary Sector Locations	Surgery and Elective Care	Musgrave Park Hospital	Appointments, delay/cancellation (outpatients)	Non Staff	Enquiry re Orthopaedic appointment at Musgrave Park Hospital. Patient has been referred by Orthopaedic Consultant for specialist foot and ankle appointment.	Enquirer informed patient has been admitted to Musgrave Park Hospital and is currently receiving treatment.	04/09/2014
	16/09/2014	Craigavon Area Hospital	Surgery and Elective Care	Orthopaedic Waiting List	Admission into hospital (delay cancellation) (inpatients)	Non Staff	Enquiry re date for planned orthopaedic surgery. Added to waiting list as urgent on 11/3/14	Patient offered and accepted date for surgery for 7/10/14	16/09/2014
	15/09/2014	Daisy Hill Hospital	Surgery and Elective Care	ENT Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	Enquiry regarding a date for a review appointment at ENT clinic. Child was due a 3 month review following insertion of vents in April 2014.	Enquirer informed ENT appointment scheduled for 29/9/14.	16/09/2014
	18/09/2014	Craigavon Area Hospital	Surgery and Elective Care	3 South	Communication/information to patients	Medical and Dental	Enquiry from MLA re inpatient requesting information on her treatment plan. Patient to have MRI today and is awaiting treatment options for Gallstones.	Results of MRI and treatment options discussed with patient . Patient added to waiting list for gallbladder surgery.	18/09/2014
	15/07/2014	Craigavon Area Hospital	Surgery and Elective Care	3 South	Staff attitude/behaviour	Nursing and Midwifery	Feedback from patient who was extremely happy with treatment and care received by all staff at Craigavon Area hospital. Patient requested contact details for Trust Chief Executive as he indicated he would write a letter of thanks.	Contact details provided for Chief Executive and patient thanked for taking the time to express his gratitude. Patient Support Service explained and leaflet provided. Copy of letter to Chief Executive received by Patient Support.	15/07/2014
	15/07/2014	Craigavon Area Hospital	Surgery and Elective Care	3 South	Treatment and care quality	Nursing and Midwifery	Feedback from patient who was extremely happy with treatment and care received by all staff at Craigavon Area hospital. Patient requested contact details for Trust Chief Executive as he indicated he would write a letter of thanks.	Contact details provided for Chief Executive and patient thanked for taking the time to express his gratitude. Patient Support Service explained and leaflet provided. Copy of letter to Chief Executive received by Patient Support.	15/07/2014
	23/09/2014	Craigavon Area Hospital	Surgery and Elective Care	Orthopaedic Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	Enquirer seeking date for Orthopaedic appointment. Referred by GP on 6.8.14	Enquirer advised that current waiting time for routine new referral was 18 weeks.	25/09/2014
	01/07/2014	Daisy Hill Hospital	Surgery and Elective Care	Opthamology Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	Enquiry regarding Ophthalmology outpatient appointment.	Patient informed he has been referred for an Ophthalmology appointment at Mater Hospital Belfast. Patient provided with contact details for Mater Booking centre and Consultant's secretary to enquire re waiting times for an appointment.	03/07/2014
	25/09/2014	Craigavon Area Hospital	Surgery and Elective Care	Orthopaedic Waiting List	Admission into hospital (delay cancellation) (inpatients)	Non Staff	Enquirer seeking date for orthopaedic surgery. Added to waiting list as routine on 5/2/14	Enquirer advised that current orthopaedic waiting time is 37 weeks. Advised to attend his GP if his condition deteriorates or symptoms change.	25/09/2014
	12/09/2014	Craigavon Area Hospital	Surgery and Elective Care	Fracture Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	Enquiry regarding an appointment at fracture clinic. Child sustained a fracture to her leg and has a plaster of paris insitu and was advised she should have a review appointment within one week.	Child scheduled for an appointment at fracture clinic 16/9/14 following review of x-rays by medical staff.	12/09/2014
	24/07/2014	Craigavon Area Hospital	Surgery and Elective Care	General Surgery Clinic	Staff attitude/behaviour	Nursing and Midwifery	Patient unhappy with attitude of member of staff carrying out clinical observations and completing preoperative questionnaire at outpatient clinic. Patient concerned re Blood pressure recorded at time of appointment.	Patient reassured her Blood pressure observations were within normal limits. Staff member identified, apology offered and accepted for any distress caused.	24/07/2014
	16/09/2014	Craigavon Area Hospital	Surgery and Elective Care	Urology Waiting List	Admission into hospital (delay cancellation) (inpatients)	Non Staff	Patient seeks a date for planned Urology surgery. Previous bladder cancer with recurrences January 2012 and August 2013.	Patient advised he is scheduled for planned surgery on 28/10/14.	20/10/2014
	18/09/2014	South Tyrone Hospital	Surgery and Elective Care	General Surgery Waiting List	Admission into hospital (delay cancellation) (inpatients)	Non Staff	Enquirer seeking another date for booked Endoscopy as she has another hospital appointment in RVH the same day as scheduled Endoscopy.	Patient offered and accepted a new date for procedure for the 2/10/14.	18/09/2014
	09/07/2014	Craigavon Area Hospital	Surgery and Elective Care	Orthopaedic Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	Enquirer very unhappy with delay receiving orthopaedic outpatient appointment.	Booking centre confirmed GP referral received 28/5/14 for Orthopaedic appointment and no previous referral received. Patient should be scheduled for an appointment July/ August 2014.	09/07/2014
	01/07/2014	Daisy Hill Hospital	Surgery and Elective Care	General Surgery Waiting List	Admission into hospital (delay cancellation) (inpatients)	Medical and Dental	Enquiry regarding date for admission for planned gallbladder surgery.	Enquirer informed patient is scheduled for an appointment with his Consultant to discuss his treatment plan on 29/7/14.	25/07/2014
	18/09/2014	Craigavon Area Hospital	Surgery and Elective Care	ICATS Orthopaedic Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	Enquiry regarding an appointment at Orthopaedic clinic. Patient has a recurrent knee injury and is anxious for an appointment.	Enquirer informed GP referral received and graded routine priority for which current waiting time is 18 weeks from date of referral.	18/09/2014
	03/07/2014	Craigavon Area Hospital	Surgery and Elective Care	Orthopaedic Ward	Treatment and care quality	Medical and Dental	Enquiry from patient with fractured heel awaiting surgery or transfer to RVH for surgery.	Enquiry forwarded to complaints department for their investigation and action.	07/07/2014
	03/07/2014	Craigavon Area Hospital	Surgery and Elective Care	Orthopaedic Ward	Theatre/operation/procedure, delay/cancellation	Medical and Dental	Enquiry from patient with fractured heel awaiting surgery or transfer to RVH for surgery.	Enquiry forwarded to complaints department for their investigation and action.	07/07/2014

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	10/07/2014	Craigavon Area Hospital	Surgery and Elective Care	Fracture Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	Enquiry re date for review at fracture clinic. Child had long arm plaster of paris applied following diagnosis of fracture and seeks date for review appointment.	Enquirer informed review will be scheduled in 3 weeks which is normal waiting time for this type of fracture. Advised to attend Emergency Department if any problems with plaster of paris.	10/07/2014
	22/09/2014	Craigavon Area Hospital	Surgery and Elective Care	ENT Clinic	Appointments, delay/cancellation (outpatients)	Administrative and Clerical	Enquiry from patient whose 09.00am Outpatient appointment was delayed until 10.00am due to unavailability of hospital notes. Patient had been offered a cancellation appointment only the previous evening, so hospital notes not immediately available at outpatient clinic.	Explanation and apology for reason for delay offered to patient. Issue of unavailability of hospital notes for outpatient appointment raised with relevant medical record staff.	22/09/2014
	31/07/2014	Craigavon Area Hospital	Surgery and Elective Care	Orthopaedic Waiting List	Admission into hospital (delay cancellation) (inpatients)	Non Staff	Enquiry re date for planned Orthopaedic surgery to left knee.	Patient informed she has been added to the waiting list as routine priority and the current waiting time is approximately 26 weeks and should be scheduled for surgery September/October.	01/08/2014
	09/09/2014	Craigavon Area Hospital	Surgery and Elective Care	Cardiac Investigation	Appointments, delay/cancellation (outpatients)	Non Staff	Enquirer seeking date for ECHO and a date for Orthopaedic surgery	Patient had ECHO investigation and has been reinstated on orthopaedic waiting. Scheduled for orthopaedic surgery for 4/12/14	16/10/2014
	09/09/2014	Craigavon Area Hospital	Surgery and Elective Care	Orthopaedic Waiting List	Admission into hospital (delay cancellation) (inpatients)	Non Staff	Enquirer seeking date for ECHO and a date for Orthopaedic surgery	Patient had ECHO investigation and has been reinstated on orthopaedic waiting. Scheduled for orthopaedic surgery for 4/12/14	16/10/2014
	12/09/2014	Craigavon Area Hospital	Surgery and Elective Care	Urology Waiting List	Admission into hospital (delay cancellation) (inpatients)	Non Staff	Enquiry regarding a date for planned urology surgery.		
	21/07/2014	Craigavon Area Hospital	Surgery and Elective Care	4 South	Staff attitude/behaviour	Nursing and Midwifery	Enquirer unhappy with staff attitude when she visited ward outside visiting hours. Enquirer had brought elderly wife of patient who was visiting from Canada.	Ward manager spoke with staff member concerned who refutes the claims she spoke in an aggressive manner however did explain visiting times and reasons for exceptional circumstances. Enquirer rejected reasons for visiting time restrictions. Meeting offered with patient's wife and Ward Manager. Apology offered and accepted for any distress caused.	22/07/2014
	07/07/2014	Craigavon Area Hospital	Surgery and Elective Care	Urology Waiting List	Admission into hospital (delay cancellation) (inpatients)	Non Staff	Enquiry re date for planned urology surgery.	Patient scheduled for urology surgery 30/7/14 which he accepted.	22/07/2014
	25/09/2014	Daisy Hill Hospital	Surgery and Elective Care	General Surgery Clinic	Clinical diagnosis	Medical and Dental	Patient unhappy with clinical diagnosis by medical staff. Patient has attended different surgical Consultants over this past 2 years and had investigations carried out and is anxious regarding "the variance from doctors"as to her diagnosis. Patient seeks appointment with Medical staff.	Patient offered an appointment at the General Surgical Clinic for 29/9/14 to discuss her concerns and receive results of her recent investigations.	25/09/2014
	25/09/2014	Daisy Hill Hospital	Surgery and Elective Care	General Surgery Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	Patient unhappy with clinical diagnosis by medical staff. Patient has attended different surgical Consultants over this past 2 years and had investigations carried out and is anxious regarding "the variance from doctors"as to her diagnosis. Patient seeks appointment with Medical staff.	Patient offered an appointment at the General Surgical Clinic for 29/9/14 to discuss her concerns and receive results of her recent investigations.	25/09/2014
	04/07/2014	Craigavon Area Hospital	Surgery and Elective Care	Orthopaedic Ward	Theatre/operation/procedure, delay/cancellation	Non Staff	Patient was admitted fasting for planned orthopaedic surgery. Surgery cancelled and patient discharged. This was patients second cancellation. Anxious to obtain new date for surgery.	Patient rescheduled for orthopaedic surgery 21/8/14.	07/07/2014
	04/07/2014	Craigavon Area Hospital	Surgery and Elective Care	Orthopaedic Ward	Admission into hospital (delay cancellation) (inpatients)	Non Staff	Patient was admitted fasting for planned orthopaedic surgery. Surgery cancelled and patient discharged. This was patients second cancellation. Anxious to obtain new date for surgery.	Patient rescheduled for orthopaedic surgery 21/8/14.	07/07/2014
	02/09/2014	Craigavon Area Hospital	Surgery and Elective Care	Urology Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	Enquirer seeking Urology Outpatient Clinic review appointment.	Review appointment offered and accepted by patient.	09/09/2014
	10/07/2014	Armagh Community Hospital	Surgery and Elective Care	ICATS Orthopaedic Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	Enquiry is regarding a date and time of appointment at Orthopaedic ICATs.	Patient informed re date and time for his appointment.	10/07/2014
	01/08/2014	Craigavon Area Hospital	Surgery and Elective Care	General Surgery Waiting List	Admission into hospital (delay cancellation) (inpatients)	Non Staff	Enquiry re date for planned bowel surgery. Patient's wife alleges surgery previously cancelled as pre-op nurse failed to carry out blood investigations and requests advice how to make a formal complaint.	Patient contacted by Head of Service and patient rescheduled for surgery following discussion with his Consultant. Patient's wife advised how to make a formal complaint and process involved.	01/08/2014
	01/08/2014	Craigavon Area Hospital	Surgery and Elective Care	Pre-operative Assessment Clinic	Theatre/operation/procedure, delay/cancellation	Nursing and Midwifery	Enquiry re date for planned bowel surgery. Patient's wife alleges surgery previously cancelled as pre-op nurse failed to carry out blood investigations and requests advice how to make a formal complaint.	Patient contacted by Head of Service and patient rescheduled for surgery following discussion with his Consultant. Patient's wife advised how to make a formal complaint and process involved.	01/08/2014
	11/08/2014	Craigavon Area Hospital	Surgery and Elective Care	Orthopaedic Waiting List	Admission into hospital (delay cancellation) (inpatients)	Non Staff	Enquiry re date for planned orthopaedic surgery.	Patient informed her Consultant has left the Trust and an appointment has been scheduled with her new Consultant 21/8/14. Patient scheduled for surgery 18/9/14.	19/08/2014
	02/09/2014	Craigavon Area Hospital	Surgery and Elective Care	3 South	Complaints handling	Medical and Dental	Enquirer seeking information on: how to access deceased grandmothers hospital notes and how to make a formal complaint	Information given to Granddaughter on: How to access deceased grandmothers health records and how to make a formal complaint. Complaints leaflet and Patient Support leaflets given to enquirer.	02/09/2014
	02/09/2014	Craigavon Area Hospital	Surgery and Elective Care	3 South	Communication/information to patients	Administrative and Clerical	Enquirer seeking information on: how to access deceased grandmothers hospital notes and how to make a formal complaint	Information given to Granddaughter on: How to access deceased grandmothers health records and how to make a formal complaint. Complaints leaflet and Patient Support leaflets given to enquirer.	02/09/2014
	08/09/2014	Daisy Hill Hospital	Surgery and Elective Care	General Surgery Waiting List	Admission into hospital (delay cancellation) (inpatients)	Non Staff	Enquiry re obtaining General Surgery Outpatient Clinic appointment	Enquirer advised that he is on waiting list for an urgent scope. Enquirer advised of waiting time for this procedure.	12/09/2014
	17/07/2014	Community	Primary Care	SAUCS (GPOOH) Craigavon	Communication/information to patients	Medical and Dental	Patient unhappy with advice and information provided by GP out of hours. Patient who required hospital admission at night sought advice re care for her brother who has special needs.	Enquirer advised how to contact "On call" duty Social Worker and to contact complaints department for investigation and response.	17/07/2014

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	17/07/2014	Independent/ Voluntary Sector Locations	Primary Care	Non Trust GP premises	Professional assessment of need	Medical and Dental	Hungarian patient alleges GP did not book interpreter for several consultations and seeks advice how to make a formal complaint.	Patient advised her enquiry has been forwarded to complaints who will investigate and respond directly to her. Contact details provided for complaints department.	18/07/2014
	21/07/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	MAU	Communication/information to patients	Medical and Dental	Enquiry from patient's wife who is unhappy with the content of discharge letter to GP which indicates history of drug and alcohol abuse which his family contest.	Patient's wife advised an Elected Representative has already contacted the Trust through the complaints department and a response has been drafted is imminent. Patient Support contact detail provided should she require assistance following response from complaints department.	22/07/2014
	29/07/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	1 South Medical	Communication/information to patients	Medical and Dental	Patient Support assistance requested to attend discharge meeting with Consultant and Social Worker, patient and her daughter. Patient refusing referral for rehab or temporary placement in Nursing Home.	Meeting held between Consultant, Social Worker, patient and her daughter. Consultant explained reasons for temporary placement to which patient agreed. Patient referred for rehabilitation in Lurgan Hospital.	29/07/2014
	29/07/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	1 South Medical	Communication/information to patients	Social Services	Patient Support assistance requested to attend discharge meeting with Consultant and Social Worker, patient and her daughter. Patient refusing referral for rehab or temporary placement in Nursing Home.	Meeting held between Consultant, Social Worker, patient and her daughter. Consultant explained reasons for temporary placement to which patient agreed. Patient referred for rehabilitation in Lurgan Hospital.	29/07/2014
	29/07/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	1 South Medical	Discharge/transfer arrangements	Medical and Dental	Patient Support assistance requested to attend discharge meeting with Consultant and Social Worker, patient and her daughter. Patient refusing referral for rehab or temporary placement in Nursing Home.	Meeting held between Consultant, Social Worker, patient and her daughter. Consultant explained reasons for temporary placement to which patient agreed. Patient referred for rehabilitation in Lurgan Hospital.	29/07/2014
	29/07/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	1 South Medical	Discharge/transfer arrangements	Social Services	Patient Support assistance requested to attend discharge meeting with Consultant and Social Worker, patient and her daughter. Patient refusing referral for rehab or temporary placement in Nursing Home.	Meeting held between Consultant, Social Worker, patient and her daughter. Consultant explained reasons for temporary placement to which patient agreed. Patient referred for rehabilitation in Lurgan Hospital.	29/07/2014
	12/08/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	A&E Resus	Other	Non Staff	Request for Patient Support assistance for patient's son as his mother is critically ill in Resuscitation area Emergency Department.	Support and advice offered to patient's son who was constantly updated re his mother's condition. Support offered when medical staff informed him his mother had died. Chaplaincy service offered. Advised re bereavement counsellor and booklet provided. Process explained regarding transfer to mortuary and collection by undertaker. Ongoing support until relative left for home.	12/08/2014
	24/07/2014	Daisy Hill Hospital	Medicine and Unscheduled Care	General Male Medical, Level 5	Staff attitude/behaviour	Nursing and Midwifery	Patient's family unhappy with attitude of nursing and medical staff on ward as they feel an inconvenience when seeking information. Family request a meeting with relevant medical and nursing staff to discuss discharge plan. Patient's family request discharge to Hospice.	Meeting arranged between Palliative nurse, medical staff and patient's son to discuss discharge plan. Patient's daughter indicated she was satisfied with outcome of meeting and apology accepted for any distress caused.	24/07/2014
	24/07/2014	Daisy Hill Hospital	Medicine and Unscheduled Care	General Male Medical, Level 5	Discharge/transfer arrangements	Medical and Dental	Patient's family unhappy with attitude of nursing and medical staff on ward as they feel an inconvenience when seeking information. Family request a meeting with relevant medical and nursing staff to discuss discharge plan. Patient's family request discharge to Hospice.	Meeting arranged between Palliative nurse, medical staff and patient's son to discuss discharge plan. Patient's daughter indicated she was satisfied with outcome of meeting and apology accepted for any distress caused.	24/07/2014
	24/07/2014	Daisy Hill Hospital	Medicine and Unscheduled Care	General Male Medical, Level 5	Staff attitude/behaviour	Medical and Dental	Patient's family unhappy with attitude of nursing and medical staff on ward as they feel an inconvenience when seeking information. Family request a meeting with relevant medical and nursing staff to discuss discharge plan. Patient's family request discharge to Hospice.	Meeting arranged between Palliative nurse, medical staff and patient's son to discuss discharge plan. Patient's daughter indicated she was satisfied with outcome of meeting and apology accepted for any distress caused.	24/07/2014
	17/07/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	Neurology Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	Enquiry re date for review appointment at Neurology clinic. Patient anxious to discuss her treatment plan with her Consultant as letter to GP indicated patient refused treatment.	Patient scheduled for an appointment at Neurology clinic to discuss treatment plan with Consultant. 2nd Letter to GP amended by Consultant.	24/07/2014
	29/07/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	Gastroenterology Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	Enquiry re date for appointment at Gastroenterology clinic. Patient requested contact details updated on medical records.	Patient informed her GP referral had been received and she is scheduled for an appointment 21/8/14 and will receive a letter to confirm appointment. Medical records staff amended patient contact details.	
	29/07/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	Gastroenterology Clinic	Records/record keeping	Non Staff	Enquiry re date for appointment at Gastroenterology clinic. Patient requested contact details updated on medical records.	Patient informed her GP referral had been received and she is scheduled for an appointment 21/8/14 and will receive a letter to confirm appointment. Medical records staff amended patient contact details.	
	25/07/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	Dermatology Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	General enquiry from Patient & Client Council re waiting times for review appointments at dermatology clinic. Enquirer asks what actions the Trust are taking to address the delays.	Enquirer received a response from Head of Service outlining reasons for delays at dermatology clinics and actions the Trust have taken to address the backlog.	05/09/2014
	21/07/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	1 South Medical	Treatment and care quality	Medical and Dental	Patient's daughter unhappy with treatment and care from medical staff in 1 South. Patient admitted with respiratory arrest and had prolonged resuscitation following cardiac arrest and subsequently developed brain injury. Patient's family seek meeting with senior manager to discuss their concerns. Declined meeting with medical staff.	Meeting with patient's husband and 2 daughters and advised Senior Managers aware of his concerns and a meeting will be arranged in due course. Complaints leaflet and contact details for Patient and Client council provided. On going support for patient's family.	24/07/2014
	11/08/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	1 South Medical	Communication/information to patients	Medical and Dental	Family request for a meeting with patient's Consultant to discuss his treatment and care.	Meeting scheduled between Consultant and patient's family 13.8.14. Family indicated they were satisfied with the outcome of the meeting.	13/08/2014
	29/07/2014	Daisy Hill Hospital	Medicine and Unscheduled Care	General Male Medical, Level 5	Communication/information to patients	Medical and Dental	Enquirer requests information from medical staff about patient whom she alleges is her husband and next of kin. Enquirer lives in USA.	Enquirer informed her husband has not given permission for any information to be shared and does not have her listed as his next of kin therefore due to Data Protection and confidentiality we are unable to share any information.	30/07/2014
	29/07/2014	Daisy Hill Hospital	Medicine and Unscheduled Care	General Male Medical, Level 5	Other	Non Staff	Enquirer requests information from medical staff about patient whom she alleges is her husband and next of kin. Enquirer lives in USA.	Enquirer informed her husband has not given permission for any information to be shared and does not have her listed as his next of kin therefore due to Data Protection and confidentiality we are unable to share any information.	30/07/2014
	27/08/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	Cardiology Clinic	Other	Non Staff	Enquiry re date for appointment at Cardiology clinic. Patient attended A&E with chest pain and was advised she would receive review appointment with Cardiology.	Enquirer informed her aunt has been referred for further cardiac investigations and should receive an appointment in October 2014 and review appointment will be scheduled following outcome of investigations.	28/08/2014
	19/08/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	2 South Medical/Stroke	Communication/information to patients	Nursing and Midwifery	Enquiry re treatment and care. Patient has dementia and her husband is concerned 1.Communication his wife required thickened fluids to avoid choking 2.Dehydration 3.Delay in discharge	Patient's husband contacted by Ward Manager and Assistant Director to discuss his concerns. Ward manager to follow up with staff concerned.	19/08/2014

Personal Information redacted by the USI	19/08/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	2 South Medical/Stroke	Transport, late or non-arrival/journey time	Non Staff	Enquiry re treatment and care. Patient has dementia and her husband is concerned 1.Communication his wife required thickened fluids to avoid choking 2.Dehydration 3.Delay in discharge	Patient's husband contacted by Ward Manager and Assistant Director to discuss his concerns. Ward manager to follow up with staff concerned.	19/08/2014
	19/08/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	2 South Medical/Stroke	Treatment and care quality	Nursing and Midwifery	Enquiry re treatment and care. Patient has dementia and her husband is concerned 1.Communication his wife required thickened fluids to avoid choking 2.Dehydration 3.Delay in discharge	Patient's husband contacted by Ward Manager and Assistant Director to discuss his concerns. Ward manager to follow up with staff concerned.	19/08/2014
	09/07/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	A&E	Other	Non Staff	Patient Support assistance requested to support distressed family of patient admitted to Emergency department.	Patient Support assistance provided throughout the day updating patient's family on his condition and planned transfer to Intensive Care. Hospital Chaplain contacted and phone calls made to family members. Family accompanied to ICU and introduced to staff. Patient Support leaflet and contact details provided should further help and support be required.	09/07/2014
	12/09/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	1 North Coronary Care	Communication/information to patients	Non Staff	Patient seeks update regarding his treatment. Patient also seeks advice and support for his son who has learning disability and his wife who has depression while he is in hospital.	Patient's Consultant to update him regarding his current treatment plan today. Clinical Sister agreed to contact Ward Social worker to meet patient and discuss his concerns regarding support for his family.	12/09/2014
	01/07/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	A&E	Communication/information to patients	Medical and Dental	Enquiry regarding sons treatment and discharge advice following his recent attendance with a dislocated patella. Also requested information on how to make a complaint.	Meeting organised with A & E physio to explain leg splint advice. Appointment offered and accepted for further physio appointment for 7/7/14. Fracture Clinic appointment not required. Physio to discuss with A & E senior nursing staff the need for further staff training on the application of this type of splint and the advice that should be given to patients on discharge. Enquirer satisfied with this intervention. Advised how to make a complaint, provided with contact details and complaints form.	01/07/2014
	01/07/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	A&E	Treatment and care quality	Medical and Dental	Enquiry regarding sons treatment and discharge advice following his recent attendance with a dislocated patella. Also requested information on how to make a complaint.	Meeting organised with A & E physio to explain leg splint advice. Appointment offered and accepted for further physio appointment for 7/7/14. Fracture Clinic appointment not required. Physio to discuss with A & E senior nursing staff the need for further staff training on the application of this type of splint and the advice that should be given to patients on discharge. Enquirer satisfied with this intervention. Advised how to make a complaint, provided with contact details and complaints form.	01/07/2014
	02/07/2014	Daisy Hill Hospital	Medicine and Unscheduled Care	Dermatology Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	Enquiry regarding obtaining a Dermatology clinic review appointment.	Patient informed he is scheduled for an appointment at the Dermatology Clinic 21/7/14. Patient change of address also updated by medical records.	03/07/2014
	18/09/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	1 South Medical	Treatment and care quality	Medical and Dental	Family unhappy that mother has been transferred to another ward due to infection status that required a side room. Mother recently diagnosed with terminal illness and they wished her to remain on the ward were she had been for previous 9 weeks.	Reason for transfer to new ward due to side room availability explained to family. Family reassured that mothers needs would be fully met on new ward. Family introduced to new ward staff and ward layout. Family also spoken to by mothers Consultant. Ongoing Patient Support assistance and support provided until mothers death.	18/09/2014
	04/08/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	2 South Medical/Stroke	Theatre/operation/procedure, delay/cancellation	Medical and Dental	1. Patient's family anxious re delay having OGD. Patient fasted(x2) and procedure cancelled. 2. Patient referred for MRI brain and CT Colonoscopy- family anxious for date for investigations	Patient attended for OGD and MRI Brain 5.8.14. On going discussions between patient's family and medical staff re treatment plan.	05/08/2014
	04/08/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	2 South Medical/Stroke	Treatment and care quality	Non Staff	1. Patient's family anxious re delay having OGD. Patient fasted(x2) and procedure cancelled. 2. Patient referred for MRI brain and CT Colonoscopy- family anxious for date for investigations	Patient attended for OGD and MRI Brain 5.8.14. On going discussions between patient's family and medical staff re treatment plan.	05/08/2014
	26/09/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	A&E	Records/record keeping	Non Staff	Patient seeks advice how to obtain a copy of a letter in her medical notes. Patient unhappy with attitude of nurse in Emergency Department when she attended July 2014 whom she alleges declined Entonox administration and spoke in an aggressive manner.	Patient advised how to obtain a copy of her Medical Records. Access to Records form offered however declined. Patient indicated she would discuss her concerns with her Consultant. Complaints leaflet provided and process explained.	26/09/2014
	26/09/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	A&E	Staff attitude/behaviour	Nursing and Midwifery	Patient seeks advice how to obtain a copy of a letter in her medical notes. Patient unhappy with attitude of nurse in Emergency Department when she attended July 2014 whom she alleges declined Entonox administration and spoke in an aggressive manner.	Patient advised how to obtain a copy of her Medical Records. Access to Records form offered however declined. Patient indicated she would discuss her concerns with her Consultant. Complaints leaflet provided and process explained.	26/09/2014
	11/07/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	General Medicine Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	Patient's GP is concerned re delay receiving letter from medical outpatient clinic and date for review appointment at medical clinic whom the GP alleges had a red flag priority.	GP contacted by Medical Consultant who apologised for delay in letter being sent and explained Consultant who held clinic had left the Trust. Details of clinic letter and treatment plan discussed and agreed letter would be typed and posted today. Concerns raised with Senior Managers re delay in letters to GPs for their attention and action. GP satisfied with response.	11/07/2014
	11/07/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	General Medicine Clinic	Records/record keeping	Administrative and Clerical	Patient's GP is concerned re delay receiving letter from medical outpatient clinic and date for review appointment at medical clinic whom the GP alleges had a red flag priority.	GP contacted by Medical Consultant who apologised for delay in letter being sent and explained Consultant who held clinic had left the Trust. Details of clinic letter and treatment plan discussed and agreed letter would be typed and posted today. Concerns raised with Senior Managers re delay in letters to GPs for their attention and action. GP satisfied with response.	11/07/2014
	06/08/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	MAU	Communication/information to patients	Non Staff	Family of patient who has learning disability and no verbal communication are concerned re treatment and care and that he requires adequate supervision. Patient requires fed at meal times and drinks throughout the day and 1:1 supervision at night.	Meeting between patient's family and Ward Manager to discuss patient specific requirements. 1:1 supervision organised for night time and family agreed to stay during the day with patient. Family satisfied with treatment and care provided.	07/08/2014

Patient Support Enquiries - 2nd Quarter Report
July - September 2014

Personal Information redacted by the USI	06/08/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	MAU	Treatment and care quality	Non Staff	Family of patient who has learning disability and no verbal communication are concerned re treatment and care and that he requires adequate supervision. Patient requires fed at meal times and drinks throughout the day and 1:1 supervision at night.	Meeting between patient's family and Ward Manager to discuss patient specific requirements. 1:1 supervision organised for night time and family agreed to stay during the day with patient. Family satisfied with treatment and care provided.	07/08/2014
	22/09/2014	Craigavon Area Hospital	Medicine and Unscheduled Care	1 South Medical	Discharge/transfer arrangements	Social Services	Enquiry from patient's relatives regarding discharge plans. Patient has learning disabilities and family do not want her discharged back to care home she was admitted to hospital from due to their concerns regarding her treatment and care there. Request a new placement.	Following multidisciplinary assessments of patients needs a new care home was recommended as suitable placement. Patient discharged to new care home.	23/09/2014
	11/08/2014	Craigavon Area Hospital	Integrated Maternity and Womens Health	1 West Gynae	Admission into hospital (delay cancellation) (inpatients)	Non Staff	Enquiry re date for admission for planned Gynaecology procedure.	Enquirer advised patient reluctant to comply with preparation treatment prior to surgery therefore procedure not scheduled and discharged from Consultant's care. Patient requires new referral from GP.	11/08/2014
	10/07/2014	Craigavon Area Hospital	Informatics	Medical Records	Communication/information to patients	Non Staff	Request to update patient medical records re change of GP. Patient received an outpatient letter which had her old GP listed.	Enquirer advised patient medical records had her new GP listed and it is the patients responsibility to inform the Trust of any change in circumstances.	
	12/08/2014	Craigavon Area Hospital	Functional Support Services	Reception/Waiting Area	Hotel/support/security services	Non Staff	Enquirer reports wet floor and absence of toilet paper in public toilets in CAH. Location not identified.	Enquiry forwarded to Senior Managers Support Services for their attention and action. Letter to enquirer to thank her for highlighting her concerns and advise her enquiry was forwarded to Senior Managers.	14/08/2014
	11/08/2014	Daisy Hill Hospital	Financial Management	Cashier's Office	Patients' property/expenses/finance	Non Staff	Patient seeks advice re completion of Health Insurance form. Patient had surgery and requires Consultant's signature and Trust stamp to complete claim form.	Health Insurance form stamped by hospital cashier and signed on behalf of Consultant.	11/08/2014
	18/08/2014	Daisy Hill Hospital	Financial Management	General Surgery Clinic	Patients' property/expenses/finance	Non Staff	Patient seeks reimbursement of travel costs for journey to outpatient appointment. Clinic had been cancelled and patient wasn't notified.	Patient reimbursed for travel expenses.	27/08/2014
	18/09/2014	Craigavon Area Hospital	Estates	Car Park/Grounds	Other	Non Staff	Bereaved family wish to plant a tree at CAH in memory of their loved one who died in CAH.	Due to ongoing estates work in Craigavon hospital grounds and issues re planting additional trees on the site enquirer has been requested to discuss alternative options with bereaved family, i.e. plaque on park bench etc... and to contact hospital again with suggested options.	25/09/2014
	11/07/2014	South Tyrone Hospital	Enhanced Services	Ward 2, Assessment & Rehabilitation (Loane House)	Appointments, delay/cancellation (outpatients)	Non Staff	Enquiry re date for appointment at Belfast hospital. Patient currently an inpatient Loane House,South Tyrone Hospital.	Enquiry referred to Older people and Primary Care Directorate to investigate and respond directly to enquirer.	11/07/2014
	11/07/2014	South Tyrone Hospital	Enhanced Services	Ward 2, Assessment & Rehabilitation (Loane House)	Communication/information to patients	Non Staff	Enquiry re date for appointment at Belfast hospital. Patient currently an inpatient Loane House,South Tyrone Hospital.	Enquiry referred to Older people and Primary Care Directorate to investigate and respond directly to enquirer.	11/07/2014
	10/07/2014	Community	Enhanced Services	Portadown HSSC	Appointments, delay/cancellation (outpatients)	Non Staff	Patient from Private Nursing Home unable to attend for scheduled ultrasound at Portadown Health Centre as family unavailable and patient does not meet the criteria for Ambulance Service and asks if she can have the scan in Craigavon or South Tyrone Hospitals.	Enquirer informed Ultrasounds are carried out in Craigavon Area Hospital and Portadown Health Centre and to contact the Ultrasound scheduler to change booking request. Advised to discuss transport options with Ambulance Service or private taxi.	10/07/2014
	10/07/2014	Community	Enhanced Services	Portadown HSSC	Transport, late or non-arrival/journey time	Non Staff	Patient from Private Nursing Home unable to attend for scheduled ultrasound at Portadown Health Centre as family unavailable and patient does not meet the criteria for Ambulance Service and asks if she can have the scan in Craigavon or South Tyrone Hospitals.	Enquirer informed Ultrasounds are carried out in Craigavon Area Hospital and Portadown Health Centre and to contact the Ultrasound scheduler to change booking request. Advised to discuss transport options with Ambulance Service or private taxi.	10/07/2014
	14/08/2014	Craigavon Area Hospital	Cancer and Clininal Services	Recovery Unit	Patients' property/expenses/finance	Non Staff	Patient admitted for surgical procedure had bottom 2 front teeth damaged during anaesthetic process seeks advice how to make a claim for dental treatment.	Patient advised an IR1 incident form had been recorded and following discussions with anaesthetist involved, a decision was made that no payment would be made in this case. Payment depends on circumstances and there is no automatic entitlement to claim for dental payments. Patient indicated she would discuss treatment plan with her dentist as she may lodge a formal complaint. Complaints leaflet provided and process explained.	11/09/2014
	13/08/2014	Craigavon Area Hospital	Cancer and Clininal Services	Pain Management Clinic	Appointments, delay/cancellation (outpatients)	Medical and Dental	Enquiry re appointment at pain clinic. Patient has chronic pain and has been referred for specialist opinion for pain management and is anxious for a review appointment to discuss treatment plan.	Patient offered an appointment at Pain management clinic 24/8/14 which she accepted.	21/08/2014
	13/08/2014	Craigavon Area Hospital	Cancer and Clininal Services	Pain Management Clinic	Communication/information to patients	Medical and Dental	Enquiry re appointment at pain clinic. Patient has chronic pain and has been referred for specialist opinion for pain management and is anxious for a review appointment to discuss treatment plan.	Patient offered an appointment at Pain management clinic 24/8/14 which she accepted.	21/08/2014
	11/09/2014	Craigavon Area Hospital	Cancer and Clininal Services	MRI Unit	Admission into hospital (delay cancellation) (inpatients)	Non Staff	Patient awaiting a date for a MRI. Currently suspended from surgical waiting list for gall bladder surgery whilst waiting for MRI.	Patient advised that MRI has been requested and she would be notified of date in due course. Following MRI if she was surgically fit for surgery her name would be reinstated on surgical waiting list.	12/09/2014
	11/09/2014	Craigavon Area Hospital	Cancer and Clininal Services	MRI Unit	Appointments, delay/cancellation (outpatients)	Medical and Dental	Patient awaiting a date for a MRI. Currently suspended from surgical waiting list for gall bladder surgery whilst waiting for MRI.	Patient advised that MRI has been requested and she would be notified of date in due course. Following MRI if she was surgically fit for surgery her name would be reinstated on surgical waiting list.	12/09/2014
	23/07/2014	Craigavon Area Hospital	Cancer and Clininal Services	X-ray Dept (Radiology)	Records/record keeping	Non Staff	Enquirer seeks advice how to obtain a copy of his x-rays.	Enquirer provided with Access to Records form and arrangements made for patient to attend X-ray department to obtain a copy of his x-rays.	23/07/2014
	29/07/2014	Craigavon Area Hospital	Cancer and Clininal Services	Glenanne Unit	Appointments, delay/cancellation (outpatients)	Non Staff	Enquiry re date for appointment at Breast Clinic. Referred by GP April 2014.	Patient GP referral confirmed which has been graded routine and current waiting time 20 weeks. Grading of referrals explained to patient. Advised to attend her GP should her symptoms change.	31/07/2014
	01/08/2014	Craigavon Area Hospital	Cancer and Clininal Services	Glenanne Unit	Appointments, delay/cancellation (outpatients)	Non Staff	Enquiry re date for appointment at Breast clinic.	Patient advised GP referral letter received and graded by Consultant as routine. Patient informed re current waiting time for appointment at Breast clinic. Advised to contact her GP should her symptoms change.	01/08/2014

Patient Support Enquiries - 2nd Quarter Report
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Personal Information redacted by the USI	18/08/2014	Craigavon Area Hospital	Cancer and Clininal Services	Glenanne Unit	Communication/information to patients	Non Staff	Patient seeks advice how to make a formal complaint and access her medical records. Patient indicated she would be seeking legal advice re making a claim following surgery for breast cancer.	Patient advised how to make a formal complaint and process involved. Complaints leaflet provided. Access to Records form provided, Patient Support Leaflet provided and contact details for all departments. Advised re Macmillan Service. Patient satisfied with information and advice.	18/08/2014
	18/08/2014	Craigavon Area Hospital	Cancer and Clininal Services	Glenanne Unit	Records/record keeping	Non Staff	Patient seeks advice how to make a formal complaint and access her medical records. Patient indicated she would be seeking legal advice re making a claim following surgery for breast cancer.	Patient advised how to make a formal complaint and process involved. Complaints leaflet provided. Access to Records form provided, Patient Support Leaflet provided and contact details for all departments. Advised re Macmillan Service. Patient satisfied with information and advice.	18/08/2014
	11/08/2014	Craigavon Area Hospital	Cancer and Clininal Services	Pain Management Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	Enquiry re date for review appointment at pain management clinic.	Enquirer informed no date could be offered at this time as clinic behind schedule due to the demand on service. Patient advised to attend his GP should his symptoms change.	11/08/2014
	11/09/2014	Craigavon Area Hospital	Cancer and Clininal Services	MRI Unit	Appointments, delay/cancellation (outpatients)	Non Staff	Enquirer seeking date for MRI. MRI Scan booked when patient was an inpatient and she was given date for MRI however was then discharged and consequently MRI rescheduled as outpatient appointment with longer waiting time for MRI.	New date for MRI offered and accepted by patient for 17/9/14	16/09/2014

Southern Health and Social Care Trust

Acute Directorate: Serious Adverse Incidents

Update for Acute Governance meeting, Tues 4 Nov 2014

Backlog

SAI / ID No.	Initials	Division	SAI Level	Description of SAI	Chair	Current Status	Date of Incident	Date Report Due
Personal Information redacted by the USI		MUSC	2	Insulin medication error	Dr P Murphy	Presented at Acute Clinical Governance on 10 October 2014 by AMD. Revised SAI to be re-presented at 8am in November 14. Meeting with family Nov 2014.	Personal Information redacted by the USI	25/03/14
		MUSC	2	Personal Information redacted by old female admitted via ED, transferred to 1 west and tragically died after cardiac arrest	Dr S Moan	**Coroner URGENTLY awaiting report re making a decision regarding inquest** Report has been completed. Circulated for factual accuracy. Will be presented at the 8am Governance meeting in November 14		20/05/14
		MUSC	2	Patient died after deterioration	Dr P McKeveney	Draft report issued. Will be presented at the 8am Governance meeting in November 14		05/09/14
		OPPC / Acute	2	Patient died from CDiff	Dr B McGleenon	Chair has circulated draft report to SAI review group. Will be presented at the 8am Governance meeting in November 14		27/07/14
		MUSC	1	Personal Information redacted by old F, passed a large blood clot which was queried to be a gestational sac	Mr O'Reilly	Will be presented at the 8am Governance meeting in November 14		xx/11/2014
		MUSC	2	Death of Personal Information redacted by old male in ED (volvulus)	Dr P McGarry	??? To be represented at Acute Clinical Governance on 14 November 2014 by AMD		11/07/14
		IMWH	3	Complicated delivery of baby	Mr Sim	IMWH governance meeting with the senior managers on 05/11/14 and update will be provided after this date.		10/04/14
		SEC	3	Personal Information redacted by old suffered injury post-surgery at CAH – moved to RVH	Mr S Hall	Meetings held with Chair and PSQ. Radiology report received, report being drafted for circulation to review group and external – plan to present at 8am meeting December 14		08/05/14
		CCS	3	Tracheostomy patient bled out and tragically died	Mr S Hall	Meetings held with Chair and PSQ. Report being drafted for circulation to review group and external – plan to present at 8am meeting December 14		27/05/14
		MUSC	1	Patient had Xray in March 2014, later found to have lesion	Mr Tim Doyle	Review team met on 28/10/14 further information required. Loretto following up with Consultant – plan to present at 8am meeting December 14		30/07/14
		MUSC	1	Patient tragically died in theatre before operation	Dr G Magee	Report being drafted and final meeting to be arranged. Meeting held with relatives 30/10/14 - plan to present at 8am meeting December 14		30/07/14

Personal Information redacted by the USI

MUSC	1	Patient admitted to ICU following admission	Dr R McKee	1st meeting 10 October 2014. Follow up meeting planned with Dr McKee 3/11/2014 - plan to present at 8am meeting December 14	Personal Information redacted by the USI	04/09/14
MUSC	1	Smear positive TB in Health Care Worker working in Acute Ward setting	Dr R Convery	Margaret to speak to Dr Convery		04/08/14

SAIs screened in October 2014 (n=7)

Division	SAI Level	Description of SAI	Chair	Current Status	Date of Incident	Date Report Due
MUSC	1	Personal Information old inpatient suffered a fall, 2NH. # NoF	Dr Gormley	Final draft of report has been forwarded to Dr Gormley for approval - plan to present at 8am meeting November 14	Personal Information redacted by the USI	10/11/14
MUSC	1	Pt with acute leukaemia. Unwitnessed fall, 2NH. CT: acute axial collection of mixed attenuation overlying right frontal lobe and right parietal lobe. Patient is deceased	Dr Gormley	Plan to present 8am November 2014. Clinicians advised cause of death was not related to fall. NoK to be engaged with shortly following bereavement.		
Acute	1	Patient fall, MMW, DHH. CT: traumatic subdural and subarachnoid haemorrhage. Patient is deceased		Plan to present 8am meeting November 2014.		24/11/14
MUSC	1	Personal Information admitted for angiography, proceeded to PCI, patient suffered cardiac arrest and died.	Dr Menown	Review Team meeting 13 Nov 2014. NoK have been advised review is underway .		13/11/14
MUSC	1	Patient suffered cardiac arrest in cubicles, ED DHH. Patient is deceased	Mr O'Reilly	The Coroner was satisfied that the cause of death was MI and that death certificate could be issued. Review Team meeting on 19 Nov 2014. NoK to be engaged with shortly.		21/11/14
Acute / CYP	3	Baby death	TBC	IMWH governance meeting with the senior managers on 05/11/14 and update will be provided after this date.		20/01/15
IMWH	1	Baby death		IMWH governance meeting with the senior managers on 05/11/14 and update will be provided after this date.		

Potential SAIs screened / awaiting screening Nov 2014 (n=15)					
SAI / ID No	. Initials	Division	Description of SAI	Current Status of screening	Date of Incident
Personal Information redacted by the USI		SEC	CVP management. Lumen.	Screening meeting on 03/11/14. Level 1 SEA.	Personal Information redacted by the USI
		SEC	Fall, 3S. #NoF. Patient is deceased.	Screening meeting on 03/11/14. Level 1 SEA	
		SEC	PR bleeding. Sigmoidoscopy required but not carried out	Screening meeting on 03/11/14. Level 1 SEA	
		SEC	I/V Antibiotics. Drug allergy	Screening meeting on 03/11/14– Learning Event	
		SEC	Developed fasciitis	Screening meeting on 03/11/14– Level 1 SEA	
		SEC	Missed histology	Screening meeting on 03/11/14– Level 1 SEA	
		SEC	Nephrectomy 2012. CT May 2013 – no disease evident. No OPD review. Reattended GP Aug 2014. CT - widespread mets disease	Screening meeting on 03/11/14 – clarify with Urology usual follow up arrangements at that time	
		Acute/CYP	Baby death. Lifeless at home. CPR by NIAS. Brought to ED	Screening to take place on 06/11/14	
		Acute / CYP	Persistent pulmonary hypertension of newborn. Massive pulmonary haemorrhage.	To be screened	
		CCS	Delay in delivering antibiotics within one hour Neutropenic sepsis	Screening meeting to take place 12/11/14	
		CCS	Delay in delivering antibiotics within one hour Neutropenic sepsis	Screening meeting to take place 12/11/14	
		MUSC	Fall	Awaiting notes. To be screened	
		MUSC	Lysis pump failure	Notes Available. To be screened	
		MUSC	Fall	Notes Available. To be screened	
		MUSC	Fall	Notes Available. To be screened	

Discussion points:

- Arrangements for informing staff that SAI is underway & engagement re factual accuracy of report
- Litigation
- Validate engagement with family / NoK
- Evolving report

From: Fegan, Loretto
Sent: 14 October 2014 15:19
To: Scullion, Damian; McCall, Damian; McGoldrick, Kathleen
Cc: Farrell, Roisin; Gibson, Simon; Carroll, Kay; Murphy, Philip
Subject: FW: DRO Queries: SHSCT SAI Personal Information redacted by the USI HSCB REF: Personal Information redacted by

Hi all

Please see below e-mail from DRO requesting further information /clarification
I would be grateful if you would please review the queries below
Would it be possible to meet on **28 Oct PM for half an hour to pull the response together (Roisin would it be possible to get an agreed time and venue)**
In the meantime, I will put a name against sourcing / reviewing the parts below and would be grateful if you could get back to me before Fri 24 Oct with information or draft responses to the queries

Please find attached report which went to DRO and template for action plan timescale and person/s responsible

Many thanks
Loretto

1. Can the Trust send a copy of the care bundle/care plan/ pathway for Central Venous Catheter (CVC) line

   What is the Trust policy on management and removal of CVC line, as on the 5/3/14 the nursing notes indicate 'grey lumen only one patent'

2. The medical notes indicate 'central line out' on the 7/3/14. Please clarify statement ' this statement could have led to confusion as to whether the CVC was taken out or if this was a directive to take it out'. Direct observation of the patient would have ruled out the former?
3. The patient was found sitting on the side of the bed on the 10/3/14 with the 'central line in his hand'. What Nursing/Medical care was provided in respect of the CVC line from this time until the collapsed a short time after? This is not detailed in the report

4. Would it be possible to have timeline and lead person for each recommendation?

Regards
Loretto

Loretto Fegan
Nursing Governance Co-Ordinator
The Maples
Craigavon Area Hospital

BT63 5QQ
Telephone number Personal Information redacted by the USI
Mobile Personal Information redacted by the USI
Hours of Work Part-time

From: Corporate.Governance
Sent: 14 October 2014 12:31
To: Fegan, Loretto; acute.governance
Cc: Marshall, Margaret
Subject: FW: DRO Queries: SHSCT SAI Personal Information redacted by; HSCB REF: Personal Information redacted by

This incident relates to a Personal Information redacted by the old male patient removed his cardiac monitor. Arrested but did not survive.

Loretto, I await your advices in due course.

Margaret, for your information.

Eileen
From: serious incidents Personal Information redacted by the USI]
Sent: 14 October 2014 12:17
To: Corporate.Governance
Subject: DRO Queries: SHSCT SAI Personal Information redacted by; HSCB REF: Personal Information redacted by

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Blaithnid/Eileen,

The DRO is aware that the above SAI was closed by the HSCB on 2 October 2014, but following discussions with nursing colleagues would be grateful if the Trust could response to the following queries:-

1. Can the Trust send a copy of the care bundle/care plan/ pathway for Central Venous Catheter (CVC) line
2. What is the Trust policy on management and removal of CVC line, as on the 5/3/14 the nursing notes indicate 'grey lumen only one patent'
3. The medical notes indicate 'central line out' on the 7/3/14. Please clarify statement ' this statement could have led to confusion as to whether the CVC was taken out or if this was a directive to take it out'. Direct observation of the patient would have ruled out the former?
4. The patient was found sitting on the side of the bed on the 10/3/14 with the 'central line in his hand'. What Nursing/Medical care was provided in respect of the CVC line from this time until the collapsed a short time after? This is not detailed in the report

5. Would it be possible to have timeline and lead person for each recommendation?

I would be grateful if you would follow-up and provide a response for the DRO as soon as possible please.

Elaine Hyde
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Health and Social Care Board - Southern Office
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LEVEL ONE – SIGNIFICANT EVENT AUDIT REPORT

TITLE:	Personal Information redacted by
DATE OF SIGNIFICANT EVENT:	Personal Information redacted by the USI
DATE OF SIGNIFICANT EVENT MEETING:	29 July 2014
SEA FACILITATOR/ LEAD OFFICER:	Facilitator – Loretto Fegan
TEAM MEMBERS PRESENT:	Dr D Scullion, Consultant Anaesthetist (chair) Dr D McCall, Consultant cardiologist Mrs K McGoldrick, Acting Head of Service, Medicine and Unscheduled Care Mrs Loretto Fegan, Nursing Governance Co-ordinator

WHAT HAPPENED?

Patient Personal Information redacted a Personal Information redacted by the old patient was admitted was Personal Information redacted by the USI to a medical ward from the Emergency Department (ED) in Daisy Hill Hospital (DHH) with shortness of breath, secondary to left ventricular failure (LVF) and a non-ST elevation myocardial infarction (NSTEMI). Personal Inform's previous medical history included, diabetes (type 2), hypertension and benign prostatic hypertrophy. Personal Inform's condition was initially stable.

On Personal Information redacted by the USI, Personal Inform was transferred to High Dependency Unit (HDU) in DHH, where he remained ill, with severe ventricular impairment (EF 20). An arterial line was inserted and Personal Inform continued to have cardiac monitoring.

On Personal Information redacted by the USI, Personal Inform was transferred to CCU (DHH). He developed an unresponsive episode on Personal Information redacted by the USI and returned to HDU, where he was commenced on non-invasive ventilation. Difficulty was encountered in attempting to insert an arterial line as Personal Inform was restless and agitated due to his ill condition, however an arterial line was inserted.

An overall improvement in Personal Inform's condition was noted by the medical team on Personal Information redacted by the USI. However when he developed sepsis secondary to staphylococcus aureus bacteraemia, his condition began to deteriorate again. He was treated with intravenous antibiotics.

However, as Personal Inform was very ill, he was transferred to ICU in Craigavon Area Hospital (CAH) on Personal Information redacted by the USI. He needed continuous invasive monitoring and haemodynamic support. While in ICU, a central venous catheter (CVC) more commonly known as a central line was inserted on Personal Information redacted by the USI through Personal Inform's left jugular vein which provided direct access into the blood stream. This was a necessary medical intervention because IV access was proving difficult and Personal Informat required IV antibiotic and diuretic therapy.

A decision was made to keep the CVC line in situ on transfer to CCU in view of MSSA bacteraemia and inflamed puncture sites. Due to Personal Inform's ill condition, it was reported that he was slightly agitated at times resulting in him trying to climb out of bed, pulling off the oxygen mask and attempting to remove the CVC while in ICU.

Personal Inform was then transferred to the coronary care unit in CAH on Personal Information redacted by the USI where he was

being monitored in a side room. Personal Inform remained in an ill condition and the CVC remained in situ until just before Personal Inform died.

On Personal Information redacted by the USI at 00.00 hours, staff noted that Personal Inform's monitor tracings were not "going through" the patient was checked by nurse 2 and was found sitting at the side of the bed. The monitor leads were on the floor and the central venous line was in Personal Inform's hand. The patient was assisted back to bed and was reported to be agitated at this time. Thirteen minutes from first noting that the monitor tracings were "not going through" to the main monitor, the patient collapsed. Cardiac arrest bleeps were set off, cardio pulmonary resuscitation (CPR) was commenced and air embolism aspiration via the central line attempted. Sadly, Personal Inform died at 02.15 hours on Personal Information redacted by the USI.

The family expressed concern why the CVC was left in situ when blocked and not being used.

The coroner was notified.

WHY DID IT HAPPEN?

The review team undertook a review of the care provided to Personal Inform during the period Personal Information redacted by the USI Personal Information redacted by the USI. Personal Inform's clinical notes were reviewed and a timeline of events was established. The analysis of the events during this time frame focused mainly on the management of the central venous catheter. When Personal Inform was transferred to ICU in Craigavon Area Hospital (CAH) on Personal Information redacted by the USI, a central venous catheter was inserted on Personal Information redacted by the USI through Personal Inform's left jugular vein which provided direct access into the blood stream. This was a necessary medical intervention because IV access was proving difficult and Personal Informat required IV antibiotic and diuretic therapy. The central line was also used for haemodynamic monitoring during his stay in ICU.

The review team endeavoured to determine the following information from the available records:

- Why was a central venous catheter in situ and was it being used for the intended purpose?
- Was the central venous catheter blocked and if so for how long?
- Why was the central line not removed when it was no longer being used for the purpose for which it was inserted / or if it was not patent?
- Why was the patient left in a position to accidently dislodge the central venous catheter?

It was determined by the review team that Personal Inform required a central venous catheter due to the difficulty experienced in getting intra-venous (IV) access and it was also required for the administration of medication and for monitoring purposes. However, it has been established that it was no longer employed for these purposes, as there is evidence that peripheral

access was used for administration of medication from Personal Information redacted by the USI until the patient's death.

From review of the nursing and medical notes which included the "central line insertion record and monitoring chart", the evidence in relation to the patency of the CVC lumen was conflicting. The review team concluded that from examining all the available recorded evidence, all lumens of the CVC were blocked from Personal Information redacted by the USI and a decision was taken to remove the central venous catheter.

The last mention of the CVC in the medical records was on Personal Information redacted by the USI which stated " central line out". The review team are of the opinion that this statement could have led to confusion as to whether the CVC was taken out or if this was a directive to take it out. There was no further mention of the CVC in the medical records over the weekend end period.

The review group considered possible reasons why the central line was not removed when it was no longer being used for the purpose for which it was inserted or if it was not patent. Factors considered included:

- Medical and nursing staff may not have been familiar with the evidence based procedure/s in relation to the removal of the CVC.
- While it is ultimately the responsibility of medical staff to ensure that the CVC is taken out, nursing staff may not have had recent experience of taking out central venous catheters.
- The documentation used when reviewing the central line on a daily basis did not prompt escalation / further action in the event of the lumens not working.

Given the fact that there were occasions when Personal Inform became confused and agitated in the preceding weeks due to his ill condition, the review team discussed the location of Personal Information in a monitored side room in CCU. It was agreed by the review team that the layout of the coronary care unit (CCU) in CAH would not have facilitated a more suitable arrangement. It was also acknowledged that the patient's electrocardiogram was being continuously monitored and that Nurse 4 who cared for Personal Inform on Personal Information redacted by the USI reported that there were no concerns regarding Personal Inform being confused and that he was very lucid and in good form that day.

The review team determined that when the monitoring tracings were not "going through" the patient was checked by nurse 2 and was found sitting at the side of the bed. The monitor leads were on the floor and the central venous line was in Personal Inform's hand. The patient was assisted back to bed and was reported to be agitated at this time. Thirteen minutes from first noting that the monitor tracings were "not going through" to the main monitor, the patient collapsed and help was summoned by setting off the cardiac arrest bleeps. Resuscitation measures were instigated in accordance with the Advanced Life Support Guidelines. On realising that the central venous line was dislodged medical staff attempted to dislodge any potential air embolism by aspirating the CVC. Resuscitation measures were continued until 02.15 hours. The review of the interventions during this time-span confirmed that all possible measures were untaken in a timely manner. Unfortunately despite the best efforts of the team involved in Personal Inform'S care, resuscitation was unsuccessful and sadly Personal Inform died at 02.15 hours on Personal Information redacted by the USI.

The coroner was notified with regard to Personal Inform's death.

As the central venous catheter was dislodged immediately before Personal Inform collapsed, the post-mortem report raised the possibility that air could have entered his bloodstream and this can give rise to the life- threatening condition, known as air embolus. The post-mortem result indicated that there was nothing at autopsy to confirm this diagnosis, however it could not be completely excluded.

WHAT HAS BEEN LEARNED?

This review has highlighted the need to review the management of central venous catheters by reviewing the policies and procedures, training and documentation which supports medical and nursing staff in further developing their knowledge and skills in this critical area of practice.

WHAT HAS BEEN CHANGED?

By sharing the learning, this serious adverse incident has heightened awareness across both acute hospital sites in the Trust with regard to ensuring that central venous catheters are removed on a timely basis.

Preliminary actions have been taken to address identified training requirements with regard to the management of central venous catheters.

RECOMMENDATIONS FOLLOWING THE LEVEL ONE SEA:

The review team have made the following recommendations, which should enhance the safety and quality of the service provided to patients with central venous catheters.

1. Central venous catheters (central lines) should not be in situ without clinical indication.
2. Review policy / procedure regarding the management of central venous lines in accordance with evidence based practice.
3. Include the management of central venous lines in the newly developed Trust guidelines website.
4. Provide update training for registered nurses in relation to the management of central venous catheters.
5. Review the central line pathway to include a prompt to escalate removal of a central venous catheter when it is no longer fit for purpose or if it is not required.

Where a Level two or three investigation is recommended please complete the sections below

THE INVESTIGATION TEAM :

INVESTIGATION TERMS OF REFERENCE:

Timeline of events – Initials [redacted],

Date	Time	Information Source	Event
[redacted]	18.04		Admitted via ED DHH from GP referral with shortness of breath, generally unwell. Background [redacted] Admitted to CCU DHH Diagnosed NSTEMI. Bilateral pleural effusion
	09.10	Medical notes	Post take ward round Working diagnosis NSTEMI / CCF
	16.00		Transfer to HDU DHH. Arterial line inserted. Left radial. Remained ill, on Cardiac Monitoring. Severe left ventricular impairment (EF 20%)
	14.00		Transferred to CCU
	16.15		Unresponsive episode – became rigid Hypoxic – transferred to HDU. Commenced on NIV, attempt to insert Arterial Line unsuccessful as patient agitated and restless Spoke with ICU, Arterial line inserted (R Radial)
	06:00		Dislodged arterial line, nil ordered
	12:00		Arterial line re- inserted (left radial)
	12:45		Seen by Medical Team overall improvement
	16:00		Recommence CPAP
	11.37	Medical notes	Developed Staph aures bacteraemia on IV Flucloxicilin
		Medical notes	Metabolic Acidosis – transfer to ICU in CAH
	19:40		ICU CVC inserted to Left jugular – remains confused pulling oxygen mask off ++
	10:30		To keep CVC line in situ on transfer to CCU in view of MSSA bacteraemia and inflamed puncture sites.

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	02:00		Acutely confused climbing out of bed non-compliant with oxygen attempting to remove CVC , right arm remains red and hot
	7:00		Transferred from ICU to 1North (cubicle 6 for Cardiac Monitoring)
		Nursing notes	Care plan for central line in place
	11.00	Nursing notes	“central line site flushed and dressing renewed”
	16.00	Central line record	All lumens flushed
	12.15	Central line record	All lumens blocked
	15:00	Nursing notes	Patient not tolerating monitoring leads, refusing to have observations taken All Lumen on central line are blocked, peripheral line access unsuccessful JHO bleeped
		Nursing notes	Blue cannula renewed to L arm by phlebotomist
		Central line record	No entry recorded for this date
		Nursing notes	Dr 1(JHO) flushed central line, grey lumen only one patent. Central line to stay in place as per Dr 2 (Reg)
	22.00	Nursing notes	IV flucloxacillin as per kardex this pm
		Medical notes	w/r continuing to improve central line out when not required
	12:00	Nursing notes	central line flushed by JHO, only line flushing is grey lumen
	12.00	Central line record	Entry unclear for this date
	Not timed	Central line record	Another entry made by Nurse 1 stating “ flushed today by F1, only grey working”
	14.10	Nursing notes	Seen by Dr 2 Plan: Refer to Heart Failure Cath ? Monday Post cath for transfer to DHH
	23:55	Nursing notes	No dressing to central line – cleaned and redressed with transparent dressing, ? for removal in am. Patient requesting night sedation, d/w reg – not happy for same to be prescribed, patient aware

Personal Information redacted by the USI

	Nursing notes	Slept poorly, please review today for sleeping tablet
	Medical notes	"central line out"
10.00	Nursing notes	Seen by Dr 3 (Reg) and Dr 4 IV fluc to finish Mon 11th
Night duty	Nursing notes	Central line to be removed tomorrow
	Daily central line chart	Entry unclear and not signed
	Medical notes	Reg Stable (no mention of central line)
19.00	Nursing notes	Urinary Self-Retaining Catheter to come out in am
	Daily central line chart	indicates no Lumen working
11.30		Mobilising around room with no ill effects. Passing urine well since SRC removed. Daily central line chart indicates no Lumen working Seen by Dr 4– Continue IV Flucloxicilin contact microbiology tomorrow, may need full 2/52 (staph aureus in blood culture)
	Medical notes	Reg – Much brighter Feels much improved (no mention of central line)
13.00	Daily central line chart	indicates no lumen working
19.00	Nursing notes	Comfortable evening, no complaints voiced
22:00	Nursing notes	Clinical observation stable NEWS 0 monitor SR 79
Retrospective note made at 01.00 ? time	Nursing notes	Patient noted to be off monitor tracings not coming through, on checking, patient found sitting at side of bed, leads on floor, central line in his hand. Nurse 2 called nurse 3 for help to get patient into bed as he was agitated
Retrospective note made at 01.00	Nursing notes	Patient collapsed, CPR commenced. Arrest bleep set off. PEA arrest. Family and chaplain contacted.

Personal Information redacted by the USI	00.50	Medical Notes	Dr 5 / Dr 6 STs Anaesthetics / ICU Fast bleeped to ward at 00.16, attended immediately On arrival CPR in progress (for 30 mins shocked x 4 as per ALS guidelines) No IV access Intubated Sent for IO needle, while waiting18G inserted in r foot by Dr 6 Drugs administered Central line inserted
	00.50	Medical Notes	Dr 7 likely cause – air embolism aspiration via central line attempted by anaesthetic team no air aspirated. CPR discontinued at 00.44 Family contacted but not yet in attendance
			Retrospective note by Nurse 4 who cared for patient on the Personal Infor [redacted] "no concerns about confusion, very lucid and in good form. Central line was dressed at 13:00 all ports blocked. MO aware that same needed removed. IV drugs over the weekend went through peripheral access."
		Medical notes	Letter to coroner's office written by Cardiology Registrar (*see note to coroner re central line)
	02:15	Medical notes	Dr 7 spoke with family who were concerned why CVC still in and had been blocked and was not being used

Acute Services Directorate - Major and Catastrophic Incidents October 2014

Ref	Incident date	Division	Site	Loc (Exact)	Category.	Sub Category	Adverse event	Severity	Consequence	Description	Action taken (Investigation)	Lessons learned	Approval status	Closed
Personal Information redacted by the USI	Personal Information redacted by the USI	MUC	Craigavon Area Hospital	ED Resus	Implementation of care or ongoing monitoring/review	Possible delay or failure to Monitor	Cardiac arrest	Major	Major	Sudden unexpected death of child Child presented to ED on Personal Information redacted by the USI at 10:30 Cardiac Arrest Standby call from Ambulance Control Child found by mum pale & lifeless CPR commencwed by ambulance crew & continued until death pronunced at 10:53	Personal Information redacted by the USI cc-categorised under failure to monitor as there is nothing else relevant. Remains major. All notes retrieved. Date for SAI screen with Acute and Paeds is 061114.	await	INREV	
Personal Information redacted by the USI	Personal Information redacted by USI	MUC	Craigavon Area Hospital	Cardiac Catheterisation Lab	Treatment, procedure	Arteries and veins	Unintended injury in the course of an operation or clin task	Catastrophic		Patient underwent an elective PCI and stent procedure. Patient suffered complications and died as a result.	case screened 15/10/14 for SIA level 1 using SEA methodology.		INREV	
Personal Information redacted by the USI	14/10/2014	MUC	Daisy Hill Hospital	Stroke / Rehab	Accident that may result in personal injury	Slips, trips, falls and collisions	Suspected fall	Major	Major	I was behind screens when I heard a thud and looked out to find patient lying on his left side on the floor at the bottom of his bed.	151014 08:00cc-to confirm additional information from Sr Harris. Pt on Warfarin 15/10/04 10:33-review of notes reveal CT Brain 14/10/14 Appearances are suspicious for acute/hyperacute on chronic subdural haemorrhage. Follow-up CT is recommended.Discussion with neurosurgery is also advised.Established encephalomalacia inferior left temporal lobe and left occipital lobe secondary to previous contusional change.Left pupil larger than right-new.Family awareBedrails/Manual Handling assessment reviewed 11/10/14. Pt admitted 16/09/14, Falls assessment not done until 19/09/14. Updated 11/10/14. Unwittessed fall Personal Information redacted by the USI notified via email 15/10/14. D/W RVH N/S Reg at 1800hrs.No need for neurolsurgical intervention at present. Follow up scan in 7-10 days. Scan in drop in CNS. 15/10/14 17:00- condition remains stable, d/w Dr,	as above	INREV	
Personal Information redacted by the USI	05/10/2014	IMWH	Craigavon Area Hospital	Delivery Suite, CAH				Major		AT 2045HRS ON THE 5/10/2014, ON CHECKING THE PV LOSS IT WAS DISCOVERED THAT THE PATIENT HAD A BLOOD LOSS OF 300-500 MLS. SISTER MORGAN CALLED DR CALLED AND PPH PROTOCOL COMMENCED. PATIENT TAKEN TO THEATRE AT 2140HRS FOR MANUAL REMOVAL OF CLOTS UNDER GENERAL ANAESTHETIC, DR MORSY CALLED TO COME INTO HOSPITAL. PATIENT STABLE			INREV	
Personal Information redacted by the USI	27/10/2014	IMWH	Craigavon Area Hospital	Delivery Suite, CAH				Major		failed to get iol round to delivery suite following 6hrs pessary, prolonged rupture membranes approx 43 hours due to insufficient staffing and workload in unit at this period			AWAREV	

Ref	Incident date	Division	Site	Loc (Exact)	Category.	Sub Category	Adverse event	Severity	Consequence	Description	Action taken (Investigation)	Lessons learned	Approval status	Closed
Personal Information redacted by the USI	Personal Information redacted by the USI	IMWH	Craigavon Area Hospital	Delivery Suite, CAH				Major		baby delivered at 1549, apgars 1 at 5 and 1 at 9 ph's 7.26 7.36 heart rate less than 60 cpr commenced			AWAREV	
Personal Information redacted by the USI	Personal Information redacted by the USI	MUC	Daisy Hill Hospital	ED Majors	Clinical assessment (investigations, images and lab tests)	Administration of assessment	Lack of clinical or risk assessment	Catastrophic		PT ATTENDED ED DHH BY NIAS@ 17:07 TRIAGED @ 17:15- NO OBSERVATIONS NO SPACES IN MAJORS STANDBY COMING INTO RESUS GCS 3 PT WAITED ON NIAS TROLLEY FOR APPROX 1 HOUR CARDIAC ARREST AT APPROX 18:00	i have asked for copies of notes to be sent form scruitney,discussed with S O Reilly 21/10/14, feels it needs screened for SAI. screening arranged for 24/10/14 at 10:30 am		INREV	

Medication incidents

ID	Incident date	Directorate	Division	Site	Loc (Exact)	Description	Drug administered	Correct drug	Action taken	Sub Category	Detail.	Consequence	DHSSPS impact	DHSSPS potential	DHSSPS likelihood	DHSSPS risk rating
Personal Informati	14/09/2014	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	Orthopaedic Ward	on administering 1st dose of iv antibiotic 1.2g benzypenicillan, alerted that patient was allergic to penicillan.	Benzylpenicillin	Benzylpenicillin	called for help, doctor bleeped, assisted into bed, oxygen applied, clinical obs recorded, anaphylaxis treatment administered promply by doctor	Administration or supply of a medicine from a clinical area	Undocumented/ unclear/ incorrect allergy status or known allergen prescribed	Moderate	minor	catastrophic	possible	extreme
Personal Informati	09/09/2014	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	Trauma Ward	Two patients did not receive 10pm clexane on trauma ward ,both were prescribed .	Enoxaparin	Enoxaparin	Staff nurse on night duty spoken too ,medical staff inform and stat doses of clexane prescrided and given,	Administration or supply of a medicine from a clinical area	Omitted/delayed medicine or dose	Minor	insignificant	major	unlikely	high
Personal Informati	12/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	1 North Cardiology	On reviewing patient INR it was noted that patient had not had INR check documented since 9/9/14 and despite this, the patient has been receiving clexane without INR check. Same px to be given if INR less than 2. INR 2.6 10/9/14 as per lab system. Same looked up prior to filling out Datix.	Enoxaparin	Enoxaparin	Person in charge made aware. MO informed. Nil ordered at present. INR 1.8 12/9/14 Repeat bloods ordered for 13/9/14 Documented in patient notes.	Medication error during the prescription process	Contra-indication to the use of the medication	Insignificant	minor	major	possible	high

Personal Informati	19/09/2014	Acute Services	Cancer and Clinical Services / Anaesthetics, Theatres & ICS	Craigavon Area Hospital	Oncology Clinic, Mandeville Unit	Patient on the the 19/09/2014, rang the Mandeville Triage Helpline, to state that he had Chemotherapy drugs remaining and was unsure what to do with remaining medication. On assessment of Patient by the triage Nurse, it was ascertained that he should have completed his fourteen days of chemotherapy drugs on the evening of the 18/09/2014, he had taken his chemo drugs on the morning of the 19/09/2014,. The triage Nurse told him to take no more drugs until discussed with the Nurse -in -charge.On discussion and checking the patients prescription, it was noted that he should have completed his medication,after fourteen days. It was observed that his total dose prescribed for the First cycle of Capox (chemotherapy) was under prescribed as per the patients Body service area. Additional info: Regimen is 2000mg/m2 total daily dose in two divided doses. BSA was 2m2, dose prescribed was 1650mg. Usual to reduce first cycle by 20% which would be 3200mg total daily dose.	Capecitabine	Capecitabine	The Patient was told to take no further chemotherapy drugs and His Medical team would be informed to reveiw his medication at his next visit. Pharmacy was informed of the Precribed dosge given to Patient. The Oncology Registra BCH was also informed of the Prescription dosaging.	Medication error during the prescription process	Dose or strength was wrong or unclear	Minor	minor	major	possible	high
Personal Informati	24/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	2 Medical	Apixaban prescribed 10mg morning. Should be 5mg twice daily. One dose of 10mg administered.	apixaban		Kardex amended. Nightime dose withheld for today. G.P surgery contacted by anticoagulant pharmacist to amend ECR to say 5mg twice daily not 5mg two daily.	Medication error during the prescription process	Wrong/ unclear frequency		insignificant	major	unlikely	high

Personal Informati	26/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	1 North Cardiology	patient agitated and unsettled 1-2mg of midazolam prescribed by registrar prn subcut. family requesting sedation. midazolam 2mg administered intravenously	Midazolam	Midazolam	dr informed immediately. clincal observations recorded on cardiac monitor. annexate administerd by sho	Administration or supply of a medicine from a clinical area	Wrong route for administration of medication	Minor	minor	major	possible	high
Personal Informati	30/09/2014	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	CEAW	VTE risk assessment indicated enoxaparin, not prescribed	Enoxaparin		Entry in notes and front of chart to request prescripton.	Medication error during the prescription process	Omitted/delayed medicine or dose		insignificant	major	unlikely	high
Personal Informati	30/09/2014	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	CEAW	VTE risk assessment indicated enoxaparin, enoxaparin not prescribed.	Enoxaparin		Enrty in notes and on front of chart to prescribe.	Medication error during the prescription process	Omitted/delayed medicine or dose		insignificant	major	unlikely	high
Personal Information	02/09/2014	Acute Services	Surgery and Elective Care	Daisy Hill Hospital	Male Surgical/ HDU	incomplete drug hx taken....methotrexate, ezetimibe and bisoprolol not prescribed.	Bisoprolol		Dr informed	Medication error during the prescription process	Omitted/delayed medicine or dose	Minor	insignificant	minor	likely	medium

Personal Informati	02/09/2014	Acute Services	Integrated Maternity and Womens Health	Craigavon Area Hospital	1 West Gynae	pt was prescibed insulin (Humulin M3) 55iu at 08:00hrs. same was not administered. BM checked pre lunch was 14.9 (note BM was 11.0 previous day having been administered insulin) S/B Dr, insulin 24iu prescribed and administered at 12MD. nurse in charge informed and IR1 completed	Insulins	Insulins	S/B Dr, insulin 24iu prescribed and administered at 12MD. nurse in charge informed and IR1 completed.	Administration or supply of a medicine from a clinical area	Omitted/delayed medicine or dose	Insignificant	minor	moderate	possible	medium
Personal Informati	04/09/2014	Acute Services	Cancer and Clinical Services / Anaesthetics, Theatres & ICS	Craigavon Area Hospital	Oncology Clinic, Mandeville Unit	Patient commenced on CapOx regimen. Oxaliplatin dose had been calculated incorrectly as the dosing for irinotecan had been used instead. This meant that a higher dose of 260mg oxaliplatin was prescribed instead of 190mg. This was noticed at the clinical check stage in pharmacy.	Oxaliplatin	Oxaliplatin	Doctor was contacted and informed. Prescription was amended. Correct dose of oxaliplatin made.	Medication error during the prescription process	Dose or strength was wrong or unclear	Moderate	insignificant	moderate	possible	medium
Personal Informati	10/09/2014	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	General Male Medical, Level 5	patient adjusted drip machine and increased infusion rate. 12hr infusion completed in 6hrs	Potassium Chloride And Sodium Chloride		Dr informed and 2nd bag of fluids not erected	Administration or supply of a medicine from a clinical area	Incorrect/unauthorised self administration		insignificant	moderate	possible	medium
Personal Informati	13/09/2014	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	Male Surgical/ HDU	Patient admitted after out of hospital arrest, has now recovered. Still no chart made up 48 hours after admission, loose leaves of paper only. As a direct result of this wrong treatment given. Yesterday I left in struction do not give diuretics, today they were given as notes an unacceptable mess of loose sheets.	Furosemide	None	Doctor informed, again re management plan	Patient's case notes or records	Missing, inadequate or illegible healthcare record	Minor	minor	moderate	possible	medium

Personal Informati	15/09/2014	Acute Services	Integrated Maternity and Womens Health	Craigavon Area Hospital	CEAW	patient prescribed candesartan 8mg od, takes 12mg od. Also on amlodipine 5mg, omitted from Kardex.	Amlodipine		kardex endorsed and entry in notes to amend kardex	Medication error during the prescription process	Omitted/delayed medicine or dose		insignificant	minor	likely	medium
Personal Informati	17/09/2014	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	Female Medical, Level 5	patient admitted 14/09/14 prescribed warfarin received 3 days of warfarin seen by pharmacist on 17/09/14 and drug reconcillation completed pharmacist discovered that patient had been on warfarin for PE but this had been discontinued in july 14	Warfain		discussed with medical staff and warfarin discontinued	Medication error during the prescription process	Wrong/ unclear drug/medicine	Moderate	insignificant	moderate	likely	medium
Personal Informati	20/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	1 South Medical	Microbiology advised F2 on duty of appropriate changes to medications for treatment of leg ulcers that had been unresponsive to clindamycin. Microbiology advised changing to metronidazole 500mg IV tds. Under the frequency section of the kardex metronidazole was prescribed tds, however only two times of day were selected. Therefore patient only received medication twice daily. The second medication advised by microbiology was daptomycin od with CK levels to be monitored for patient. No CK levels on laboratory system for patient	Metronidazole	Metronidazole	Incident picked up on kardex review on 22/09/14. F2 on ward informed of same, metronidazole frequency clarified and CK levels requested. Entry made in medical notes re above.	Medication error during the prescription process	Wrong/ unclear frequency	Minor	insignificant	moderate	possible	medium

Personal Informati	23/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	ED Clinical Decisions Unit	Patient was due IV antibiotic at 0600 same was not given due to prescription not being clear	Flucloxacillin	Flucloxacillin	Discussed with medical staff at 0915 not to get at this time to get 12md dose	Administration or supply of a medicine from a clinical area	Omitted/delayed medicine or dose	Minor	insignificant	moderate	possible	medium
Personal Informati	24/09/2014	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	Female Medical, Level 5	patient admitted 24/09/14 and discharged later same day prescription came to dispensary had phenindione on discharge should be phenytoin aspirin suppositories instead of oral also patient prescribed oxynorm 27.5mg mane and 25mg bd pre admission patient was on oxynorm 5mg qid for breathing no indication in notes as to increased dose patient received 3 doses	Oxycodone		prescription came to dispensary for clinical checking pharmacist noticed discrepancy in phenidione aspirin and diazepam contacted dr re unusual dose of oxynorm same changed back to pre admission dose	Medication error during the prescription process	Dose or strength was wrong or unclear	Moderate	insignificant	moderate	possible	medium
Personal Informati	25/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Day Clinical Centre	medical patient outlying in 3 south was sent to Discharge lounge with green bag of medications which did not belong to her. patient is on warfarin and did not have district nurse referral completed by staff in 3 south			contacted ward and staff asked that medications besent back. staff say they were not aware of the need for district nurse	Administration or supply of a medicine from a clinical area	Mismatch between patient and medicine	Minor	insignificant	moderate	possible	medium
Personal Informati	26/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	ED Clinical Decisions Unit	Patient had been admitted to CDU to await ambulance. She had been prescribed antibiotic at 0140, same had not been given as patient was on thickened fluids.	Co-Amoxiclav	Co-Amoxiclav	At 0800 stat dose was given. Same will be discussed with staff member	Administration or supply of a medicine from a clinical area	Omitted/delayed medicine or dose		insignificant	moderate	possible	medium

Personal Informati	02/09/2014	Acute Services	Surgery and Elective Care	Daisy Hill Hospital	Male Surgical/ HDU	patient prescribed terazosin 10mg mane but should have been nocte. Dr didnt rewrite, just altered time of dose resulting in patient receiving two doses on a particular day. Patient had sense to refuse doses otherwise this could have been very detrimental.	Terazosin		kardex and discharge letter amended as this was only noticed after discharge a no pharmacy cover	Medication error during the prescription process	Wrong/ unclear frequency	Insignificant	insignificant	minor	possible	low
Personal Informati	03/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	2 North Haematology	Patient may have received 500mg iv flucloxicillen in 10mls of water for injection instead of 10mls of sodium chloride to flush Portacath.	Water For Injections	Sodium Chloride	Portacath flushed with 10mls of sodium chloride and Ward Manager informed.	Administration or supply of a medicine from a clinical area	Wrong/ unclear drug/medicine	Insignificant	insignificant	insignificant	possible	low
Personal Informati	04/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	2 South Medical	I was checking kardex to see if patient needed any medication ordered from pharmacy and discovered that DOXAZOSIN MR 12MG was prescribed on the kardex but nurse had given 3 DOXAZOSIN 4MG (not MR)tablets instead. The doctor had also not signed the kardex for this medication.	Doxazosin	Doxazosin MR	I informed the pharmacist on the ward who recorded it in patients notes and also informed nurse who had administered the medication.	Administration or supply of a medicine from a clinical area	Formulation of medication was wrong	Minor	insignificant	minor	possible	low
Personal Informati	05/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	ED Clinical Decisions Unit	Patient is 2 weeks post op for total hip replacement and had been treated with prophylactic Clexane 40mgs, same had been given by district nurse on 4/9/14. Patient had been weighed 75.8kg and given 120mg during his attendance at ED 2020.	Enoxaparin	Enoxaparin	Above history noted anddatix completed. Clexane not given today. District Nurse will be contacted prior to discharge to inform of dose.	Medication error during the prescription process	Dose or strength was wrong or unclear	Insignificant	insignificant	minor	possible	low

Personal Information	16/09/2014	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	3 South	12MD DOSE OF CLOZAPINE 125MGS GIVEN TO PATIENT AND NOT SIGNED FOR, SAME GIVEN AGAIN AT 1430HRS BY ANOTHER STAFF MEMBER	Clozapine	Clozapine	PHARMACIST INFORMED, 1800HRS DOSE TO BE REDUCED TO 75MGS. OBSERVE BLOOD PRESSURE FY1 AND WARD MANAGER INFORMED	Administration or supply of a medicine from a clinical area	Wrong/ unclear frequency	Minor	minor	minor	possible	low
Personal Information	17/09/2014	Acute Services	Pharmacy	Craigavon Area Hospital	Pharmacy Dispensary	An outpatient prescription had co-codamol 30/500 on the prescription. The 30 was very dark, as where some of the letters in the xylometazoline spray above. I was not happy with the prescription and on contacting the prescriber 8/500 had been prescribed. I removed the co-codamol from the prescription following this discussion.	Co-Codamol		I spoke to the patient informing them that there was an issue with the strength of the co-codamol and that from speaking to the prscriber, 8/500 was intended so as a result no co-codamol was being dispensed and she could buy the 8/500 over the counter if required. I phoned the GP 18/09 to inform them of the incident.				insignificant	minor	possible	low
Personal Informati	18/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	1 North Cardiology	PATIENT COMPLAINED OF DYSPNOEA , WHEN SEEN BY MEDICAL STAFF PATIENT FOUND TO HAVE HAD IV FLUIDS POST PROCEDURE ADMINISTERED AT 167MLS/HR .THIS WAS HOWEVER PRESCRIBED AT 80MLS /HR OVER 6 HRS.VOLUME ALSO PRESCRIBED AT 1000MLS WHICH WAS INCORRECT FOR RATE AND DURATION.			PATIENT RECEIVED IV FUROSEMIDE ,PORTABLE CHEST X RAY CARRIED OUT ,SEEN AND EXAMINED BY MEDICAL STAFF, INTAKE AND OUTPUT MONITORING CLINICAL OBSERVATIONS RECORDED	Administration or supply of a medicine from a clinical area	Dose or strength was wrong or unclear	Minor	minor	minor	possible	low
Personal Informati	19/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	ED Majors	Personal Informatio man, admitted to MAU via ED with chest pain. Was loaded with aspirin by NIAS, but appears to have also been loaded with aspirin in ED. I found the error and spoke with ED cons who advised IR form	Aspirin		ED consultant informed, advised IR form	Medication error during the prescription process	Wrong/ unclear frequency	Minor	insignificant	minor	possible	low

Personal Informati	22/09/2014	Acute Services	Pharmacy	Craigavon Area Hospital	Pharmacy Dispensary	A kardex for a discharge prescription for a patient in Gynae ward was sent down to pharmacy at 13:30. Gynae ward rang pharmacy later that afternoon asking was this patient's discharge medication ready yet; the ward was told it was not and that pharmacy would ring them when it was ready. When a member of the pharmacy team went to track the location of the discharge prescription, it nor the kardex could be found. Looking on the Prescription Tracking System and ECM, the prescription had not been clinically checked and the kardex could not be located. Informed dispensary manager and looked around dispensary to locate the kardex, however it could not be found. Contacted Gynae ward to confirm that the patient's kardex had not been returned to them, and it hadn't. 1 North contacted pharmacy stating that the missing patient's kardex had been sent up to them attached to the outside of a 1 North patient's discharge medication bag. The patient's kardex was returned to pharmacy, and Gynae ward were contacted, explaining that the patient's kardex had been located in another ward and that the patient's discharge medication was being processed now.			Kept Gynae ward informed with regards to missing kardex and apologised for the delay in the patient's discharge medication. Spoke to Gynae ward sister regarding the delay in returning the patient's kardex and discharge medication to the ward. Ward sister confirmed by looking through the patient's notes and kardex that the patient had not missed any doses of medication while inpatient as a result of the missing kardex.	Preparation of medicines / dispensing in pharmacy	Omitted/delayed medicine or dose		insignificant	minor	possible	low

Personal Information	23/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	3 South	Male patient who was discharged from Craigavon Area Hospital arrived at Personal information redacted by USi at 2100 hours. On receiving his discharge medication I discovered that his hospital discharge letter had not been sent with him. This means we could not administer medication as we had no proof of prescription. Medicines not yet administered Mirtazapine 15mg, Forceval Capsule, lansoprazole 30mg,fortisip compact, Tamsulosin 400 micrograms.	Mirtazapine		I contacted the ward after discovering this, via phone. A message was taken by staff on the ward requesting a copy of this letter be emailed to myself as soon as possible so that I can administer his medication. My email address was given. This email was not received before I went off duty. When I came on duty the next morning I checked my email again and had still not received this letter. I then contacted the Intermediate Care Co-ordinator and informed them of this incident. I was informed that they would speak to the ward straight away. At time of completing this report a discharge letter has not yet been received.	Administration or supply of a medicine from a clinical area	Omitted/delayed medicine or dose	Minor	insignificant	minor	possible	low
Personal Informati	23/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	ED Clinical Decisions Unit	Patient had been prescribed medications at 0800 and same not given and patient highlighted to me at 1130 that he had not received them. Other meds were Ramipril10mg, Frusemide 20mg, Amlodipine 10mg, Pioglitazone 30mg, Aspirin 75mg, Irbesartan 150,g, and Buspirune 5mg.	Amitriptyline	Amitriptyline	Apologised and got medications written up as stat doses and same given	Administration or supply of a medicine from a clinical area	Omitted/delayed medicine or dose	Minor	insignificant	minor	possible	low
35958	24/09/2014	Acute Services	Integrated Maternity and Womens Health	Craigavon Area Hospital	1 West Gynae	Medical outlyer requesting further analagesia, night co-ordinator informed.nothing prescribed until 0600 hrs.			IR1 COMPLETED	Medication error during the prescription process	Omitted/delayed medicine or dose	Minor	insignificant	minor	possible	low

Personal Information	25/09/2014	Acute Services	Pharmacy	Community	Home of client	G T3775370307 10/10/1965 CAH01011 Rheum CAH RHEUMATOLOGY ANTI-TNF Maiden Adalimumab 40mg Pen Every 2 weeks 29/08/2014 I have just had a query from one of the specialist nurses a patient who was due to start treatment arrived today to get trained. He turned up at clinic with all information from HC@H which had been put in his fridge. On opening this Personal discovered 6 pens instead of the 2 pens that had been ordered.	Adalimumab		Reported incident to healthcare @ Home company. Checked if specialist nurse wanted the extra medication uplifted? It was requested to be 4 weekly deliveries for the first 12 weeks. In error this was set up as 12 weekly by healthcare @ home and resulted in the order being incorrectly raised for 6 pens instead of 2. HC@H logged an incident to ensure this is investigated and have highlighted this to the New Patient Team Manager to ensure it is addressed quickly. INC-12517 has been logged for your reference. We will ensure the next delivery is postponed until needed.	Preparation of medicines / dispensing in pharmacy	Wrong quantity		insignificant	insignificant	possible	low
Personal Informati	30/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Emergency Department	Staff nurse gave patient's own medication before medications prescibed on kardex .furosemide 20mg, aspirinec 75mg, natecal d3, prednislone 5mg, trospium 20mg,	Lansoprazole	Lansoprazole	Sr in charge informed, dr in charge of department notified and patients kardex wrote up and same signed for.	Administration or supply of a medicine from a clinical area	Unknown	Minor	insignificant	minor	possible	low
Personal Informati	29/09/2014	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	Trauma Ward	on checking control drugs for handover in the AM control drug book stated that there should be one bag of chirocaine with fentanyl but on checking there was only one bag of chirocaine with no fentanyl in it	Levobupivicanie		nurse in charge informed pharmacy informed by nurse in charge	Administration or supply of a medicine from a clinical area	Unknown	Minor	Controlled Drug			

Medication incidents

ID	Incident date	Directorate	Division	Site	Loc (Exact)	Description	Drug administered	Correct drug	Action taken	Sub Category	Detail.	Consequence	DHSSPS impact	DHSSPS potential	DHSSPS likelihood	DHSSPS risk rating
Personal Informati	12/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	1 North Cardiology	On reviewing patient INR it was noted that patient had not had INR check documented since 9/9/14 and despite this, the patient has been receiving clexane without INR check. Same px to be given if INR less than 2. INR 2.6 10/9/14 as per lab system. Same looked up prior to filling out Datix.	Enoxaparin	Enoxaparin	Person in charge made aware. MO informed. Nil ordered at present. INR 1.8 12/9/14 Repeat bloods ordered for 13/9/14 Documented in patient notes.	Medication error during the prescription process	Contra-indication to the use of the medication	Insignificant	minor	major	possible	high
Personal Informati	24/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	2 Medical	Apixaban prescribed 10mg morning. Should be 5mg twice daily. One dose of 10mg administered.	apixaban		Kardex amended. Nightime dose withheld for today. G.P surgery contacted by anticoagulant pharmacist to amend ECR to say 5mg twice daily not 5mg two daily.	Medication error during the prescription process	Wrong/ unclear frequency		insignificant	major	unlikely	high
Personal Informati	26/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	1 North Cardiology	patient agitated and unsettled 1-2mg of midazolam prescribed by registrar prn subcut. family requesting sedation. midazolam 2mg administered intravenously	Midazolam	Midazolam	dr informed immediately. clincal observations recorded on cardiac monitor. annexate administerd by sho	Administration or supply of a medicine from a clinical area	Wrong route for administration of medication	Minor	minor	major	possible	high
Personal Informati	10/09/2014	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	General Male Medical, Level 5	patient adjusted drip machine and increased infusion rate. 12hr infusion completed in 6hrs	Potassium Chloride And Sodium Chloride		Dr informed and 2nd bag of fluids not erected	Administration or supply of a medicine from a clinical area	Incorrect/unauthorised self administration		insignificant	moderate	possible	medium

Personal Informati	13/09/2014	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	Male Surgical/ HDU	Patient admitted after out of hospital arrest, has now recovered. Still no chart made up 48 hours after admission, loose leaves of paper only. As a direct result of this wrong treatment given. Yesterday I left in struction do not give diuretics, today they were given as notes an unacceptable mess of loose sheets.	Furosemide	None	Doctor informed, again re management plan	Patient's case notes or records	Missing, inadequate or illegible healthcare record	Minor	minor	moderate	possible	medium
Personal Informati	17/09/2014	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	Female Medical, Level 5	patient admitted 14/09/14 prescribed warfarin received 3 days of warfarin seen by pharmacist on 17/09/14 and drug reconcillation completed pharmacist discovered that patient had been on warfarin for PE but this had been discontinued in july 14	Warfain		discussed with medical staff and warfarin discontinued	Medication error during the prescription process	Wrong/ unclear drug/medicine	Moderate	insignificant	moderate	likely	medium
Personal Informati	20/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	1 South Medical	Microbiology advised F2 on duty of appropriate changes to medications for treatment of leg ulcers that had been unresponsive to clindamycin. Microbiology advised changing to metronidazole 500mg IV tds. Under the frequency section of the kardex metronidazole was prescribed tds, however only two times of day were selected. Therefore patient only received medication twice daily. The second medication advised by microbiology was daptomycin od with CK levels to be monitored for patient. No CK levels on laboratory system for patient	Metronidazole	Metronidazole	Incident picked up on kardex review on 22/09/14. F2 on ward informed of same, metronidazole frequency clarified and CK levels requested. Entry made in medical notes re above.	Medication error during the prescription process	Wrong/ unclear frequency	Minor	insignificant	moderate	possible	medium

Personal Informati	23/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	ED Clinical Decisions Unit	Patient was due IV antibiotic at 0600 same was not given due to prescription not being clear	Flucloxacillin	Flucloxacillin	Discussed with medical staff at 0915 not to get at this time to get 12md dose	Administration or supply of a medicine from a clinical area	Omitted/delayed medicine or dose	Minor	insignificant	moderate	possible	medium
Personal Informati	24/09/2014	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	Female Medical, Level 5	patient admitted 24/09/14 and discharged later same day prescription came to dispensary had phenindione on discharge should be phenytoin aspirin suppositories instead of oral also patient prescribed oxynorm 27.5mg mane and 25mg bd pre admission patient was on oxynorm 5mg qid for breathing no indication in notes as to increased dose patient received 3 doses	Oxycodone		prescription came to dispensary for clinical checking pharmacist noticed discrepancy in phenidione aspirin and diazepam contacted dr re unusual dose of oxynorm same changed back to pre admission dose	Medication error during the prescription process	Dose or strength was wrong or unclear	Moderate	insignificant	moderate	possible	medium
Personal Informati	25/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Day Clinical Centre	medical patient outlying in 3 south was sent to Discharge lounge with green bag of medications which did not belong to her. patient is on warfarin and did not have district nurse referral completed by staff in 3 south			contacted ward and staff asked that medications besent back. staff say they were not aware of the need for district nurse	Administration or supply of a medicine from a clinical area	Mismatch between patient and medicine	Minor	insignificant	moderate	possible	medium
35979	26/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	ED Clinical Decisions Unit	Patient had been admitted to CDU to await ambulance. She had been prescribed antibiotic at 0140, same had not been given as patient was on thickened fluids.	Co-Amoxiclav	Co-Amoxiclav	At 0800 stat dose was given. Same will be discussed with staff member	Administration or supply of a medicine from a clinical area	Omitted/delayed medicine or dose		insignificant	moderate	possible	medium

Personal Informati	03/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	2 North Haematology	Patient may have received 500mg iv flucloxicillen in 10mls of water for injection instead of 10mls of sodium chloride to flush Portacath.	Water For Injections	Sodium Chloride	Portacath flushed with 10mls of sodium chloride and Ward Manager informed.	Administration or supply of a medicine from a clinical area	Wrong/ unclear drug/medicine	Insignificant	insignificant	insignificant	possible	low
Personal Information	04/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	2 South Medical	I was checking kardex to see if patient needed any medication ordered from pharmacy and discovered that DOXAZOSIN MR 12MG was prescribed on the kardex but nurse had given 3 DOXAZOSIN 4MG (not MR)tablets instead. The doctor had also not signed the kardex for this medication.	Doxazosin	Doxazosin MR	I informed the pharmacist on the ward who recorded it in patients notes and also informed nurse who had administered the medication.	Administration or supply of a medicine from a clinical area	Formulation of medication was wrong	Minor	insignificant	minor	possible	low
Personal Informati	05/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	ED Clinical Decisions Unit	Patient is 2 weeks post op for total hip replacement and had been treated with prophylactic Clexane 40mgs, same had been given by district nurse on 4/9/14. Patient had been weighed 75.8kg and given 120mg during his attendance at ED 2020.	Enoxaparin	Enoxaparin	Above history noted anddatix completed. Clexane not given today. District Nurse will be contacted prior to discharge to inform of dose.	Medication error during the prescription process	Dose or strength was wrong or unclear	Insignificant	insignificant	minor	possible	low
Personal Informati	18/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	1 North Cardiology	PATIENT COMPLAINED OF DYSPNOEA , WHEN SEEN BY MEDICAL STAFF PATIENT FOUND TO HAVE HAD IV FLUIDS POST PROCEDURE ADMINISTERED AT 167MLS/HR .THIS WAS HOWEVER PRESCRIBED AT 80MLS /HR OVER 6 HRS.VOLUME ALSO PRESCRIBED AT 1000MLS WHICH WAS INCORRECT FOR RATE AND DURATION.			PATIENT RECEIVED IV FUROSEMIDE ,PORTABLE CHEST X RAY CARRIED OUT ,SEEN AND EXAMINED BY MEDICAL STAFF, INTAKE AND OUTPUT MONITORING CLINICAL OBSERVATIONS RECORDED	Administration or supply of a medicine from a clinical area	Dose or strength was wrong or unclear	Minor	minor	minor	possible	low

Personal Informati	19/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	ED Majors	Personal Information man, admitted to MAU via ED with chest pain. Was loaded with aspirin by NIAS, but appears to have also been loaded with aspirin in ED. I found the error and spoke with ED cons who advised IR form	Aspirin		ED consultant informed, advised IR form	Medication error during the prescription process	Wrong/ unclear frequency	Minor	insignificant	minor	possible	low
Personal Informati	23/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	3 South	Male patient who was discharged from Craigavon Area Hospital arrived at Personal information redacted by USI at 2100 hours. On receiving his discharge medication I discovered that his hospital discharge letter had not been sent with him. This means we could not administer medication as we had no proof of prescription. Medicines not yet administered Mirtazapine 15mg, Forceval Capsule, lansoprazole 30mg,fortisip compact, Tamsulosin 400 micrograms.	Mirtazapine		I contacted the ward after discovering this, via phone. A message was taken by staff on the ward requesting a copy of this letter be emailed to myself as soon as possible so that I can administer his medication. My email address was given. This email was not received before I went off duty. When I came on duty the next morning I checked my email again and had still not received this letter. I then contacted the Intermediate Care Co-ordinator and informed them of this incident. I was informed that they would speak to the ward straight away. At time of completing this report a discharge letter has not yet been received.	Administration or supply of a medicine from a clinical area	Omitted/delayed medicine or dose	Minor	insignificant	minor	possible	low
Personal Informati	23/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	ED Clinical Decisions Unit	Patient had been prescribed medications at 0800 and same not given and patient highlighted to me at 1130 that he had not received them. Other meds were Ramipril10mg, Frusemide 20mg, Amlodipine 10mg, Pioglitazone 30mg, Aspirin 75mg, Irbesartan 150,g, and Buspirune 5mg.	Amitriptyline	Amitriptyline	Apologised and got medications written up as stat doses and same given	Administration or supply of a medicine from a clinical area	Omitted/delayed medicine or dose	Minor	insignificant	minor	possible	low

Personal Informati	30/09/2014	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Emergency Department	Staff nurse gave patient's own medication before medications prescibed on kardex .furosemide 20mg, aspirinec 75mg, natecal d3, prednislone 5mg, trospium 20mg,	Lansoprazole	Lansoprazole	Sr in charge informed, dr in charge of department notified and patients kardex wrote up and same signed for.	Administration or supply of a medicine from a clinical area	Unknown	Minor	insignificant	minor	possible	low

Medication incidents

ID	Incident date	Directorate	Division	Site	Loc (Exact)	Description	Drug administered	Correct drug	Action taken	Sub Category	Detail.	Consequence	DHSSPS impact	DHSSPS potential	DHSSPS likelihood	DHSSPS risk rating
Personal Informati	14/09/2014	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	Orthopaedic Ward	on administering 1st dose of iv antibiotic 1.2g benzypenicillan, alerted that patient was allergic to penicillan.	Benzylpenicillin	Benzylpenicillin	called for help, doctor bleeped, assisted into bed, oxygen applied, clinical obs recorded, anaphylaxis treatment administered promply by doctor	Administration or supply of a medicine from a clinical area	Undocumented/ unclear/ incorrect allergy status or known allergen prescribed	Moderate	minor	catastrophic	possible	extreme
Personal Information	09/09/2014	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	Trauma Ward	Two patients did not receive 10pm clexane on trauma ward ,both were prescribed .	Enoxaparin	Enoxaparin	Staff nurse on night duty spoken too ,medical staff inform and stat doses of clexane prescrided and given,	Administration or supply of a medicine from a clinical area	Omitted/delayed medicine or dose	Minor	insignificant	major	unlikely	high
Personal Informati	30/09/2014	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	CEAW	VTE risk assessment indicated enoxaparin, not prescribed	Enoxaparin		Entry in notes and front of chart to request prescripton.	Medication error during the prescription process	Omitted/delayed medicine or dose		insignificant	major	unlikely	high
Personal Informati	30/09/2014	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	CEAW	VTE risk assessment indicated enoxaparin, enoxaparin not prescribed.	Enoxaparin		Enrty in notes and on front of chart to prescribe.	Medication error during the prescription process	Omitted/delayed medicine or dose		insignificant	major	unlikely	high

Personal Informati	02/09/2014	Acute Services	Surgery and Elective Care	Daisy Hill Hospital	Male Surgical/ HDU	incomplete drug hx taken....methotrexate, ezetimibe and bisoprolol not prescribed.	Bisoprolol		Dr informed	Medication error during the prescription process	Omitted/delayed medicine or dose	Minor	insignificant	minor	likely	medium
Personal Informati	02/09/2014	Acute Services	Surgery and Elective Care	Daisy Hill Hospital	Male Surgical/ HDU	patient prescribed terazosin 10mg mane but should have been nocte. Dr didnt rewrite, just altered time of dose resulting in patient receiving two doses on a particular day. Patient had sense to refuse doses otherwise this could have been very detrimental.	Terazosin		kardex and discharge letter amended as this was only noticed after discharge a no pharmacy cover	Medication error during the prescription process	Wrong/ unclear frequency	Insignificant	insignificant	minor	possible	low
Personal Informati	16/09/2014	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	3 South	12MD DOSE OF CLOZAPINE 125MGS GIVEN TO PATIENT AND NOT SIGNED FOR, SAME GIVEN AGAIN AT 1430HRS BY ANOTHER STAFF MEMBER	Clozapine	Clozapine	PHARMACIST INFORMED, 1800HRS DOSE TO BE REDUCED TO 75MGS. OBSERVE BLOOD PRESSURE FY1 AND WARD MANAGER INFORMED	Administration or supply of a medicine from a clinical area	Wrong/ unclear frequency	Minor	minor	minor	possible	low
Personal Informati	29/09/2014	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	Trauma Ward	on checking control drugs for handover in the AM control drug book stated that there should be one bag of chirocaine with fentanyl but on checking there was only one bag of chirocaine with no fentanyl in it	Levobupivicanie		nurse in charge informed pharmacy informed by nurse in charge	Administration or supply of a medicine from a clinical area	Unknown	Minor	Controlled Drug			

Medication incidents

ID	Incident date	Directorate	Division	Site	Loc (Exact)	Description	Drug administered	Correct drug	Action taken	Sub Category	Detail.	Consequence	DHSSPS impact	DHSSPS potential	DHSSPS likelihood	DHSSPS risk rating
Personal Informati	02/09/2014	Acute Services	Integrated Maternity and Womens Health	Craigavon Area Hospital	1 West Gynae	pt was prescibed insulin (Humulin M3) 55iu at 08:00hrs. same was not administered. BM checked pre lunch was 14.9 (note BM was 11.0 previous day having been administered insulin) S/B Dr, insulin 24iu prescribed and administered at 12MD. nurse in charge informed and IR1 completed	Insulins	Insulins	S/B Dr, insulin 24iu prescribed and administered at 12MD. nurse in charge informed and IR1 completed.	Administration or supply of a medicine from a clinical area	Omitted/delayed medicine or dose	Insignificant	minor	moderate	possible	medium
Personal Informati	15/09/2014	Acute Services	Integrated Maternity and Womens Health	Craigavon Area Hospital	CEAW	patient prescribed candesartan 8mg od, takes 12mg od. Also on amlodipine 5mg, omitted from Kardex.	Amlodipine		kardex endorsed and entry in notes to amend kardex	Medication error during the prescription process	Omitted/delayed medicine or dose		insignificant	minor	likely	medium
Personal Informati	24/09/2014	Acute Services	Integrated Maternity and Womens Health	Craigavon Area Hospital	1 West Gynae	Medical outlyer requesting further analagesia, night co-ordinator informed.nothing prescribed until 0600 hrs.			IR1 COMPLETED	Medication error during the prescription process	Omitted/delayed medicine or dose	Minor	insignificant	minor	possible	low

Medication incidents

ID	Incident date	Directorate	Division	Site	Loc (Exact)	Description	Drug administered	Correct drug	Action taken	Sub Category	Detail.	Consequence	DHSSPS impact	DHSSPS potential	DHSSPS likelihood	DHSSPS risk rating
Personal Informati	19/09/2014	Acute Services	Cancer and Clinical Services / Anaesthetics, Theatres & ICS	Craigavon Area Hospital	Oncology Clinic, Mandeville Unit	Patient on the the 19/09/2014, rang the Mandeville Triage Helpline, to state that he had Chemotherapy drugs remaining and was unsure what to do with remaining medication. On assessment of Patient by the triage Nurse, it was ascertained that he should have completed his fourteen days of chemotherapy drugs on the evening of the 18/09/2014, he had taken his chemo drugs on the morning of the 19/09/2014,. The triage Nurse told him to take no more drugs until discussed with the Nurse -in -charge.On discussion and checking the patients prescription, it was noted that he should have completed his medication,after fourteen days. It was observed that his total dose prescribed for the First cycle of Capox (chemotherapy) was under prescribed as per the patients Body service area. Additional info: Regimen is 2000mg/m2 total daily dose in two divided doses. BSA was 2m2, dose prescribed was 1650mg. Usual to reduce first cycle by 20% which would be 3200mg total daily dose.	Capecitabine	Capecitabine	The Patient was told to take no further chemotherapy drugs and His Medical team would be informed to reveiw his medication at his next visit. Pharmacy was informed of the Precribed dosge given to Patient. The Oncology Registra BCH was also informed of the Prescription dosaging.	Medication error during the prescription process	Dose or strength was wrong or unclear	Minor	minor	major	possible	high

Personal Informati	04/09/2014	Acute Services	Cancer and Clinical Services / Anaesthetics, Theatres & ICS	Craigavon Area Hospital	Oncology Clinic, Mandeville Unit	Patient commenced on CapOx regimen. Oxaliplatin dose had been calculated incorrectly as the dosing for irinotecan had been used instead. This meant that a higher dose of 260mg oxaliplatin was prescribed instead of 190mg. This was noticed at the clinical check stage in pharmacy.	Oxaliplatin	Oxaliplatin	Doctor was contacted and informed. Prescription was amended. Correct dose of oxaliplatin made.	Medication error during the prescription process	Dose or strength was wrong or unclear	Moderate	insignificant	moderate	possible	medium

Medication incidents

ID	Incident date	Directorate	Division	Site	Loc (Exact)	Description	Drug administered	Correct drug	Action taken	Sub Category	Detail.	Consequence	DHSSPS impact	DHSSPS potential	DHSSPS likelihood	DHSSPS risk rating
Personal Informati	17/09/2014	Acute Services	Pharmacy	Craigavon Area Hospital	Pharmacy Dispensary	An outpatient prescription had co-codamol 30/500 on the prescription. The 30 was very dark, as where some of the letters in the xylometazoline spray above. I was not happy with the prescription and on contacting the prescriber 8/500 had been prescribed. I removed the co-codamol from the prescription following this discussion.	Co-Codamol		I spoke to the patient informing them that there was an issue with the strength of the co-codamol and that from speaking to the prscriber, 8/500 was intended so as a result no co-codamol was being dispensed and she could buy the 8/500 over the counter if required. I phoned the GP 18/09 to inform them of the incident.				insignificant	minor	possible	low

Personal Informati	22/09/2014	Acute Services	Pharmacy	Craigavon Area Hospital	Pharmacy Dispensary	A kardex for a discharge prescription for a patient in Gynae ward was sent down to pharmacy at 13:30. Gynae ward rang pharmacy later that afternoon asking was this patient's discharge medication ready yet; the ward was told it was not and that pharmacy would ring them when it was ready. When a member of the pharmacy team went to track the location of the discharge prescription, it nor the kardex could be found. Looking on the Prescription Tracking System and ECM, the prescription had not been clinically checked and the kardex could not be located. Informed dispensary manager and looked around dispensary to locate the kardex, however it could not be found. Contacted Gynae ward to confirm that the patient's kardex had not been returned to them, and it hadn't. 1 North contacted pharmacy stating that the missing patient's kardex had been sent up to them attached to the outside of a 1 North patient's discharge medication bag. The patient's kardex was returned to pharmacy, and Gynae ward were contacted, explaining that the patient's kardex had been located in another ward and that the patient's discharge medication was being processed now.			Kept Gynae ward informed with regards to missing kardex and apologised for the delay in the patient's discharge medication. Spoke to Gynae ward sister regarding the delay in returning the patient's kardex and discharge medication to the ward. Ward sister confirmed by looking through the patient's notes and kardex that the patient had not missed any doses of medication while inpatient as a result of the missing kardex.	Preparation of medicines / dispensing in pharmacy	Omitted/delayed medicine or dose		insignificant	minor	possible	low

Personal Informati	25/09/2014	Acute Services	Pharmacy	Community	Home of client	G T3775370307 10/10/1965 CAH01011 Rheum CAH RHEUMATOLOGY ANTI-TNF Maiden Adalimumab 40mg Pen Every 2 weeks 29/08/2014 I have just had a query from one of the specialist nurses a patient who was due to start treatment arrived today to get trained. He turned up at clinic with all information from HC@H which had been put in his fridge. On opening this Persona l discovered 6 pens instead of the 2 pens that had been ordered.	Adalimumab		Reported incident to healthcare @ Home company. Checked if specialist nurse wanted the extra medication uplifted? It was requested to be 4 weekly deliveries for the first 12 weeks. In error this was set up as 12 weekly by healthcare @ home and resulted in the order being incorrectly raised for 6 pens instead of 2. HC@H logged an incident to ensure this is investigated and have highlighted this to the New Patient Team Manager to ensure it is addressed quickly. INC-12517 has been logged for your reference. We will ensure the next delivery is postponed until needed.	Preparation of medicines / dispensing in pharmacy	Wrong quantity		insignificant	insignificant	possible	low

Summary of undocumented omitted doses of critical medicines

(03/11/11 to 30/09/14)

Directorate		
Acute	101	MUSC-65, CCS-2*, SEC-27, IMWH -7
OPPC	22	
Mental Health	3	
CYP	10	

Acute

Area	Datix	H&CN/Initials	Date	Critical medicine	Number of doses undocumented	Reason for omission	Factors contributing	Action taken	Learning points
Acute CCS* Mandeville	Personal Information redacted by	Personal Information redacted by the USI	4/11/11	Vinblastine	1 (STAT)	Overlooked	Administration trolley set up by a different member of staff. Chemotherapy chart had been amended. Administration record is for several medicines, not each one.	Additional appointment for patient to have vinblastine administered.	Review of chemotherapy chart design, including administration record required. In interim, when amendments to chemotherapy are required, a new chart should be written.
Acute MUSC Rehab /Stroke	Personal Information redacted by	Personal Information redacted by the USI	15/11/11	Buprenorphine	1 (8am)	Overlooked	Distraction of disruptive patient in bay.	Omission noted that evening but staff wanted to confirm dose had been omitted with day staff. Patch administered the following morning.	Minimise distractions where possible.

Acute MUSC Ramone	Personal Information redacted by	Personal Information redacted by the USI	6/11/11	Rotigotine	2 (8am)	Drug not stocked	Not stocked on ward. Order not sent to Pharmacy on 2 consecutive days (Sat/Sun). Lack of awareness of critical medicines. Ward remote from Pharmacy.	Pharmacist highlighted omission of critical medicine on Monday, order taken to pharmacy and patch applied later that day.	Poster of critical medicines displayed on ward. Individual staff member reminded of critical medicines list and that for critical medicines, order can be taken to pharmacy and wait for dispensing.
Acute MUSC DHH Medical		Personal Information redacted by the USI	4/11/11	Loperamide STAT	1 (STAT)	Dose not administered as patient did not have diarrhoea			Documented clearly in notes
Acute MUSC DHH Medical		Personal Information redacted by the USI		Enoxaparin	1 (10pm)	Dose had been given, not documented	Distraction of disruptive patient in bay.		Staff reminded about documentation
Acute MUSC (2 North Haem)	Personal Information redacted by	Personal Information redacted by the USI	8/11/11	Enoxaparin	1 (8am)	Overlooked	Enoxaparin usually at 10pm	Dose administered from next day when detected	Staff reminded to check prescribed time
Acute MUSC (1 North)	Personal Information redacted by	Personal Information redacted by the USI	17/12/12	Warfarin	1 (4pm)	Overlooked	Patient not an English speaker therefore less interaction during administration of medicines which may have highlighted warfarin due	Detected following day and subsequent dose adjusted to account for omission	Complete review of medicine Kardex to determine medicines due
Acute MUSC (2 North Haem)	Personal Information redacted by	Personal Information redacted by the USI	26-28/12/12	Enoxaparin	3 (8am) patient on BD dosing for NSTEMI	Overlooked	Most patients on OD administration	Consultant detected on ward round (Day 2) and prescribed STAT dose however dose then overlooked again on	Discussed at ward safety meeting importance of checking prescribed time and not assuming enoxaparin

								Day 3	is OD
Acute MUSC (Rehab /Stroke)	Personal Information redacted by	Personal Information redacted by the USI	24-25/12/11	Enoxaparin	2 (10pm) (also 4 other doses where reason recorded)	Uncertainty over whether to administer as patient on warfarin slow induction with instruction to stop when INR > 2, INR not usually measured until day 7	Staff previously involved in incident where enoxaparin had been administered to patient with INR >2	Night staff highlighted to day staff but only checked with prescriber on one occasion. Detected when holiday period over and administration recommenced	Should have been clarified with prescriber when query initially arose
Acute SEC (4 South)			14/1/12	enoxaparin	1 (10pm)	Interim audit data	– H&CN not recorded so further follow-up not possible		
Acute SEC (4 South)			12/1/12	piperacillin/tazobactam	1 (4pm)	Interim audit data	– H&CN not recorded so further follow-up not possible		
Acute SEC (Trauma)			11-12/1/12	enoxaparin	2 (10pm)	Interim audit data	– H&CN not recorded so further follow-up not possible		
Acute SEC (Male surgical)			7/1/12	midazolam	2 (8.50am, 1.30pm)	Not required	Prescribed in case of venepuncture which was not conducted		
Acute SEC (Orthopaedic)			16/1/12	flucloxacillin	1 (10pm)	No IV access	Patient confused and had pulled out venflon and by time new venflon inserted, almost time for next dose		

Acute MUSC (1 North)		Personal Information redacted by the USI	13/1/12	nebivolol	1 (STAT)				
Acute MUSC (1 North)			12/1/12	zopiclone	1 (STAT)	Not required	Prescribed in case patient needed		
Acute MUSC (audited on Stroke/Rehab, omission occurred on Male surgical)		Personal Information redacted by the USI	6/1/12 (2) and 8/1/12 (1)	salbutamol	10am and 2pm (1)2pm	Doses were administered Overlooked	Insufficient recording space as Kardex needed rewriting Patient unwell and nil orally		
Acute MUSC (1 South)	Personal Information redacted by	Personal Information redacted by the USI	17-19/2/12	enoxaparin	(3)8am	Overlooked	Enoxaparin usually prescribed at 10pm (od dosing)	Prescribed time changed to 10pm	Staff reminded to check prescribed time
Acute MUSC (2 South)	Personal Information redacted by	Personal Information redacted by the USI	8/2/12	warfarin	(1)pm	overlooked	No phlebotomy cover so bloods late in being taken with delay in INR available and delay in prescribing so prescribed at time other than usual warfarin time	Further INR check required and length of stay increased by 1 day	Ensure bloods taken promptly if no phlebotomy cover
Acute MUSC (2 North Haem)	Personal Information redacted by	Personal Information redacted by the USI	1/3/12	insulin	(1)5pm	overlooked	Ward busy and SN assigned to other tasks went for break at 16.55, returned at 17.25	Doctor informed, insulin represcribed and administered	Ensuring tasks complete before going on break or handing over to remaining staff
Acute SEC (Ortho)	Personal Information		27 and 29/3/12	enoxaparin	(2) 08.00				

	Personal Information redacted by the USI							
Acute MUSC (A&ECDU)		12/04/12	Stalevo	(3) 18.00, 00.00, 06.00	overlooked	Agency staff, patients own in blister pack and no stock ordered from Pharmacy	Stock obtained and administered when detected	Review of individual staff
Acute SEC (Trauma)		3/4/12	enoxaparin	(1) 08.00	Night staff didn't administer as querying if should be at 10pm and day staff did not follow-up with doctor	Enoxaparin usually at 10pm as routine but does not have to be	STAT dose prescribed and administered	
Acute IMWH (2 West)		10/05/12	Co-amoxiclav	(1) 16.00				
Acute MUSC (2 North Resp)		12/06/12	insulin	(1) 17.00	Overlooked			
Acute IMWH (1 West)		26/06/12	enoxaparin	(1) 08.00				
Acute SEC (Trauma)		20/06/12	warfarin	(1) 18.00				
Acute MUSC (A&E CDU)		6/7/12	insulin	(1) 08.00	overlooked	No other medicines due at 8am, IVs at 6am, orals at 10pm only	STAT dose prescribed and administered at 12noon when detected	Review all sections of Kardex at each medicine round
Acute MUSC (1 South)		22/7/12	fentanyl patch	(2 days late, due changing 22/7/12, changed 24/7/12)	overlooked			Prescriber should indicate when patch should be changed as part of prescription

	Personal Information redacted by the USI							
Acute SEC (Trauma)	[redacted]	28/7/12	enoxaparin	(1) 08.00	overlooked	Prescription changed from od to bd due to previous DVT, prescription was clearly rewritten as BD	STAT dose prescribed and administered at 12.30 when detected	Enoxaparin at any time other that 10pm must be highlighted at handover
Acute SEC (Ortho)	[redacted]	15/8/12	OxyContin	(1) 22.00	overlooked		When detected at 06.00, patient awake and asked if in pain and patient stated she was so OxyNorm 5mg administered	
Acute IMWH (1 West)	[redacted]	02/08/12	enoxaparin	(1)STAT at 18.00	overlooked	Not highlighted on post-op notes	22.00 dose on 03/08/12 changed to am and administered	Highlight times other that 10pm in handover
Acute MUSC (Female medical)	[redacted]	18/08/12	OxyContin	(1) 08.00	overlooked	Night staff usually administer 08.00 medicines but were unable to do so. Not noticed by day staff as looked at wrong date.	Patient received other pain relief at 14.20, 17.00 and 17.45.	Include medicines not administered in handover
Acute MUSC (A&E CDU)	[redacted]	04/09/12	enoxaparin	12 noon (1)	overlooked		Stat dose prescribed and administered at 22.00 when detected	
Acute MUSC (A&E CDU)	[redacted]	18/09/12	clindamycin	16.00 (1)	overlooked		Dose administered at 18.15 when it was confirmed that had not been administered at 16.00	
Acute MUSC (2 North)	[redacted]	18+19/9/12	Sodium valproate	08.00+22.00 (4)	overlooked	Poorly prescribed. 18/9/12 night there had been 2 deaths and a very ill patient who was on 1/2hourly observations had to be transferred to ICU at	SHO informed	

	Personal Information redacted by the USI							
						6am.		
Acute SEC (3 South)		31/10/12	enoxaparin	22.00	Overlooked			
Acute MUSC (A&E CDU)		20/10/12	enoxaparin	08.00	overlooked			
Acute SEC (4 South)		30/10/12	enoxaparin	22.00	overlooked			
Acute MUSC (A&E CDU)		15/10/12	enoxaparin	STAT	Overlooked			
Acute MUSC (2 North)		15/10/12	enoxaparin	08.00	overlooked			
Acute MUSC (2 South Stroke)		22/10/12	warfarin	16.00	overlooked			
Acute SEC (4 North)		5/11/12	Enoxaparin	22.00	Overlooked			
Acute SEC (4 South)		1/11/12	enoxaparin	22.00	Overlooked			
Acute SEC (4 North)		5/11/12	Enoxaparin	22.00	Overlooked			
Acute IMWH (2 West)		20/11/12 1	enoxaparin	08.00	overlooked		Time changed to 22.00 and administered when detected	

Acute SEC (4 North)	Personal Information redacted by the USI	20/01/13	enoxaparin	22.00	Unclear if may have been intentionally withheld as on warfarin however INR 1.3			
Acute MUSC (A&ECDU)		24/01/13	antibiotics	06.00	overlooked			
Acute IMWH (1 West)		2-6/13	phenobarbital	18.00	overlooked	18.00 is not a usual medicine administration time	Administered when noticed	To prescribe at set administration rounds where possible
Acute SEC (4 North		18/02/13	enoxaparin	22.00	overlooked	Patient had two Kardexes, cancelled on one and prescribed on other	Administered following night when next due	Consider introducing 01.00 Kardex check to confirm all doses administered
Acute SEC (3 South)		02/02/13	benzylpenicillin	14.00	overlooked		Noticed when administering dose at 18.00	
Acute MUSC (ED Resus)		05/03/13	Insulin, warfarin	18.00	overlooked			
Acute SEC (Female Surgical)		20/03/13	IV antibiotics	22.00	overlooked	Business of ward, extra beds opened, 2 staff nurses/23 patients		
Acute SEC (Male Surgical)		13/03/13	enoxaparin	22.00	overlooked			
Acute MUSC (ED CDU)		25/03/13	Piperacillin/tazobactam	22.00	overlooked			
Acute		26/4/13+	Oseltamivir	STAT	overlooked		Doctors informed,	

MUSC (1 South)	Personal Information redacted by the USI	1/5/13					extra STAT dose given 2/5/13	
Acute MUSC (ED)		9/05/13	Flucloxacillin and benzylpenicillin	00.00	overlooked	Patient vomiting several times overnight		
Acute IMWH (1 West)		22/5/13	buprenorphine	08.00	overlooked		Dose ordered, STAT dose prescribed and administered at 12.45 on 23/5/13	
Acute SEC (Trauma)		25/06/13	enoxaparin	22.00	overlooked	Patient's Kardex missing when doing medicine round, had left reminder to come back to and forgot	Found Kardex, informed nurse in charge and administered enoxaparin at 05.00	
Acute MUSC (MAU)		30/07/13	warfarin	16.00	overlooked		Detected the following day when transferred to another ward. Doctor informed, INR taken and warfarin prescribed for 31/7/13	
Acute MUSC (MAU)		16/7/13 and 17/7/13	warfarin	16.00	Prescription chart in doctor's office	Warfarin was not referenced on main Kardex and warfarin chart not transferred with patient	Ward where patient was now contacted, HaN co-ordinator contacted, INR checked the following morning	Warfarin must be referenced on main Kardex
Acute SEC (4 South)		14/08/13	dabigatran	20.00	overlooked	Drug was in patient's locker, poor communication between staff	On-call pharmacist contacted at 04.30, enoxaparin prescribed for 6am and to commence dabigatran later that day	
Acute MUSC		20/09/13	Oramorph® (morphine	08.00	Nursing staff did not have	Delay in administration not	Medication administered as soon	Delay should have been escalated and

(MAU)	Personal Information redacted by the USI		sulphate)		time to administer before transfer to another ward at 09.45	highlighted to receiving ward at handover	as possible by receiving ward when delay noted	highlighted at handover
Acute MUSC (1 South)		03/09/13	trihexyphenidyl	22.00	Patient had been NBM, now had NG tube inserted, nurse did not check locker for supply which was there	Locker not checked for supply	Consultant informed, no ill effects. Liquid preparation now available also	Omission should have been escalated and on-call pharmacist contacted
Acute MUSC (HDU/female medical)		07/10/13	rivaroxaban	22.00	Patient admitted for Type II resp failure on rivaroxaban for DVT/PE	Not recognised as a critical medicine, oncall pharmacist not contacted	Supply obtained	Greater awareness of critical medicines. Oncall pharmacist should have been contacted to supply.
Acute MUSC (1 North)		26/12/13	warfarin	16.00	overlooked		Doctor informed, INR sent to lab and warfarin administered at 03.30	
Acute MUSC (1 North)		5-7/12/13	apixiban	22.00	overlooked		Sister to speak with staff	
Acute MUSC (ED)		30/12/13	Sodium valproate	08.00	overlooked		Administered at STAT dose at 14.30	
Acute MUSC (?MAU)		22/01/14	Sevredol	20.00	overlooked		Next dose administered at 24.00	

	Personal Information redacted by the USI							
Acute MUSC (Ramone)		13/1/14	Humulin S Lantus	16.00	overlooked	Patient in discharge ward	Detected when patient transferred to STH, supply obtained from oncall pharmacist as empty pens had been sent	Review arrangements for patients requiring medicines administered while in discharge ward
Acute SEC (4 South)		27/01/14	NovoMix 30	08.00	overlooked	Bank nurse administering medicines	Doctor informed, blood glucose checked and next dose administered as usual	
Acute SEC (4 South)		22-24/2/14 24/2/14	Enoxaparin Dabigatran	08.00 22.00	Overlooked Marked 'D' drug not available when stock on ward	BD dosing usual in ICU, not on ward	Doctor informed, changed to oral dabigatran	Review BD enoxaparin on discharge from ICU and consider OD dosing. If BD required, must be included in handover.
Acute MUSC (Ramone)		27/02/14	oxycodone	08.00	overlooked			
Acute MUSC (MAU)		7/2/14	Fentanyl patch	16.00	Overlooked			
Acute SEC (4 North)		27/2/14	enoxaparin	06.00	overlooked	BD dosing usual in ICU, not on ward	Doctor informed, changed to OD dosing	Review BD enoxaparin on discharge from ICU and consider OD dosing. If BD required, must be included in handover.
Acute MUSC (1 South)		04/02/14	insulin	17.00	Overlooked, chart not at bedside	Separate chart left out for dose to be prescribed	Doctor informed and separate dose prescribed at 03.00	Reminder for staff to keep kardex and supplementary charts tethered

	Personal Information redacted by the USI							
								together.
Acute (ICU)/CYP (3 North)		24/3/14	Amoxicillin IV	14.00	Dose due at 14.00, not administered in ICU, not handed over when patient transferred to 3 North at 14.30 and not administered in 3 North	Dose not administered not highlighted at handover	Doctor informed and subsequent doses adjusted to complete course	Ensure handover of doses not administered and review Kardex on receiving ward.
Acute MUSC CDU ED		27/4/14	enoxaparin	22.00	Overlooked	Medical patient outliying in CDU	Medical team contacted following morning to consider STAT dose	
Acute MUSC Ramone		10/04/14	MST	08.00	overlooked	High dependency on ward	Following morning before omission noted	
Acute MUSC MAU		08/04/14	Insulin	12.00 and 17.00	Overlooked			
Acute MUSC Ramone		08/04/14	Enoxaparin	22.00	overlooked			Introduce end of shift reviews
Acute MUSC Ramone		10/04/14	MST	08.00	overlooked			
Acute MUSC MAU		05/05/14	IV metronidazole	?	?			
Acute MUSC Ramone		1-3/5/14	Co-beneldopa	06.00	overlooked	Not usual oral medicine round	Doctor informed	Handover times outside of usual medicine round
Acute MUSC		01/05/14	enoxaparin	22.00	Overlooked			

1 South	Personal Information redacted by the USI							
Acute MUSC CDU		9-10/5/14	enoxaparin	22.00	Overlooked			
Acute MUSC CDU		9-10/5/14	enoxaparin	22.00	Overlooked			
Acute MUSC MAU		17/06/2014	BuTrans	08.00	Previous patch removed and new patch not applied		Noted when patient transferred to another ward. Additional pain relief administered.	
Acute MUSC 2 North		6-8/6/14	prednisolone	08.00	Patient had two Kardexes, went for a procedure, on return second Kardex was filed, prednisolone and other medicines on other Kardex		First Kardex did have 1 of 2 on it and this was noted on 7/6/14 but no action taken to locate other kardex	
Acute MUSC ED		7/6/14	insulin	Continuous infusion	Patient admitted with DKA, fluids commenced, insulin infusion not commenced as prescribed.			
Acute MUSC		26/07/14	IV medicines	06.00	Overlooked		Doctor informed, STAT doses	

Stroke Ward DHH	Personal Information redacted by the USI						prescribed and administered.	
Acute MUSC 2 South Medical		15/8/14	enoxaparin		Nurse thinks it was given but not signed for			
Acute SEC 4 North		12-15/8/14	enoxaparin	06.00	overlooked			
Acute MUSC 2 North Resp/Med		22/8/14	Sodium valproate	22.00	Overlooked, not noticed until 04.00, next dose due 06.00			
Acute MUSC ED-CDU		19/8/14	enoxaparin	18.00	Overlooked			
Acute MUSC 1 North		2/8/14	hydroxycarbamide		Supply ordered and delivered to ward but not administered and further supply ordered the following day			
Acute MUSC MAU		20/8/14	Fentanyl (Mezolar)		Dose increased earlier that day on ward round, increased not administered detected when patient transferred			

	Personal Information redacted by the USI							
					ward			
Acute IMWH 1 West		2/9/14	Humulin M3 insulin	08.00	Overlooked SC chart not referenced on Kardex			Ensure SC chart is tethered to main Kardex and prescriber to reference insulin chart on the injectable page of the Kardex
Acute SEC Trauma		9/9/14	enoxaparin	22.00	Overlooked			
Acute MUSC ED, CAH		23/9/14	flucloxacillin	06.00	Staff did not realise dose was due	06.00 had a line drawn through and the prescribed time was unclear		

*This type of omission would not have been included in the 2011 audit since chemotherapy is not prescribed on a Kardex and the previous audit was for in-patients only. It is prescribed on a separate chemotherapy chart and is usually administered on an out-patient basis.

Southern Health and Social Care Trust

Quality Care - for you, with you

DIRECTORATE OF ACUTE SERVICES

Interim Director: Mrs Deborah Burns

Tel: Personal Information redacted by the USI

ACUTE DIRECTORATE GOVERNANCE ACTION NOTES

Date: Tuesday 4th November

1.0	**Chair's Business** • Infection Control Access Immix Flow System	**Action**
2.0	**Patient Safety Programme Report** Colum presented his report. Crash calls – unlikely to reach target due to the increased number this year in CAH (47%). The resus officers still do the chart reviews – we need to ask them about their findings. Anne and Raymond to speak to them. The data they provide on appropriateness of resus seems to be improving despite this finding. Pressure ulcers – likely to exceed target by at least 10%. It maybe that our baseline figure was not good enough. This is similar to other Trusts. Lysis rates – other trust figures have been included in the report. agreed to repeat the med reconciliation audit in 3 months' time.	**Raymond, Anne and Colum**
3.0	**Effectiveness & Evaluation** Raymond presented his report. The hyponatraemia action plan is being submitted to the CMO today and will come to the Friday am meeting. The VTE risk assessment audit has shown an increase back to 85%. The next level of auditing the prescribing of prophylaxis is being discussed. The Nil return wards were discussed and will be followed up with Heather and Barry. Debbie happy for this to be reported to the Dept. Hyponatraemia figure is 54%. The review of low sodium's has found 2 patients in ED DHH – however they were not admitted or received fluids – they are to be included in the interests of openness. Barry to speak to the consultants concerned.	**Raymond** **Barry**
4.0	**Patient Support Update** Edele presented her report. The number of enquires remains fairly stable with only a couple still outstanding and the trends are the same. It is expected that enquires re waiting times may start to increase so it was decided that a standard response would be useful.	**Edele & Heather**
5.0	**Complaints Report** David presented his report. Of the 39 complaints, 29 are overdue. However the overall position is much better. Again a standard response for waiting time complaints would also be useful. One	**David Cardwell**

	complaint re the dermatology patient that is back from the ombudsmen and the letter of apology is being written.	
6.0	**Directorate Risk Register** Vivienne presented her report. The pathology reporting backlog is to stay on the Divisional register and Ronan to review to ensure all solutions are included. The corporate 'waiting times' risk to be copied onto the Directorate register as well.	**Vivienne** **Vivienne**
7.0	**Equipment Management & Medical Device** • Internal Audit Schedules is 22nd and 23rd December – Nigel will send a written update including the areas to be audited. Anne to follow up.	**Anne Q**
8.0	**Standards & Guidelines:** Anne has been following up the 73 NICE guidelines that are not implemented fully with the ADs. An email validation re the Acute position may be needed around 20th November. Tracey to email Barry and Simon re the Safe Use of Insulin Group.	**Anne Q**
9.0	**SAIs:** • Summary report – 5 reports will come to the next Friday morning meeting. 5 complex backlog ones are planned for the December meeting. 3 level 1s will also come to the next Friday am meeting. • New SAIs – Personal Inform – the screening decision should be made by the AMD at the screening meeting. • Learning – the October meeting points have been pulled together into one document for the next meeting. • SAI Personal Information redacted by the USI – the question list from the DRO in this case was discussed. A lot of this is available in ICU –Ronan and Anne Q to discuss further	**Anne Q**
10.0	**Incidents** • Summary report – the position is much approved however this has created a large number of SAI screenings and investigations. • Major and above report – Barry to follow up on the ED incident involving the delay with an ambulance patient in DHH. Tracey to speak to Anne Q to ensure her SAI report is updated to ensure that the outcome of screening is reported as soon as it is known.	**Tracey**
11.0	**Medication Incidents** • Summary reports – Tracey presented the two reports.	
12.0	**Mandatory training compliance** To be brought to the next meeting	**ADs**
13.0	**Professional Reports/Updates** • **Nursing –** an update on the normative staffing meeting was given. A detailed piece of work to understand the information produced by finance is needed. • **AHP -** None • **Social Work –** Ruth raised the issue of the vulnerable adult in relation to an admission following a medication incident in a	

	nursing home. It was felt that we didn't need to follow this process inside the hospital for medication incidents.	
14.0	**Any Other Business** None	
15.0	**Date of next meeting** The next Governance meeting will be held on Tuesday 2nd December 2014 at 2.30 pm in the Meeting Room, Admin Floor, CAH	

Boyce, Tracey

From: Boyce, Tracey <[redacted]>
Sent: 01 October 2014 10:46
To: Burns, Deborah
Cc: Stinson, Emma M
Subject: RE: Communication to Acute Directorate Staff re Governance Team Realignments
Attachments: image001.jpg

Hi
Debbie I have changed a bit below in relation to 'line management' and some other bits in blue text– what do you think?

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
Southern HSC Trust

[redacted]

Learn more about mental health medicines and conditions on the Choiceandmedication website http://www.choiceandmedication.org/hscni/

P please consider the environment before printing this e-mail

From: Marshall, Margaret
Sent: 01 October 2014 10:27
To: Boyce, Tracey; Burns, Deborah
Cc: Stinson, Emma M
Subject: Communication to Acute Directorate Staff re Governance Team Realignments

Hi Tracey, Debbie please see below draft email for your consideration and dissemination to staff to inform of governance team realignments:

From 1st October 2014 the following changes in line management arrangement within the Governance Team will be implemented:

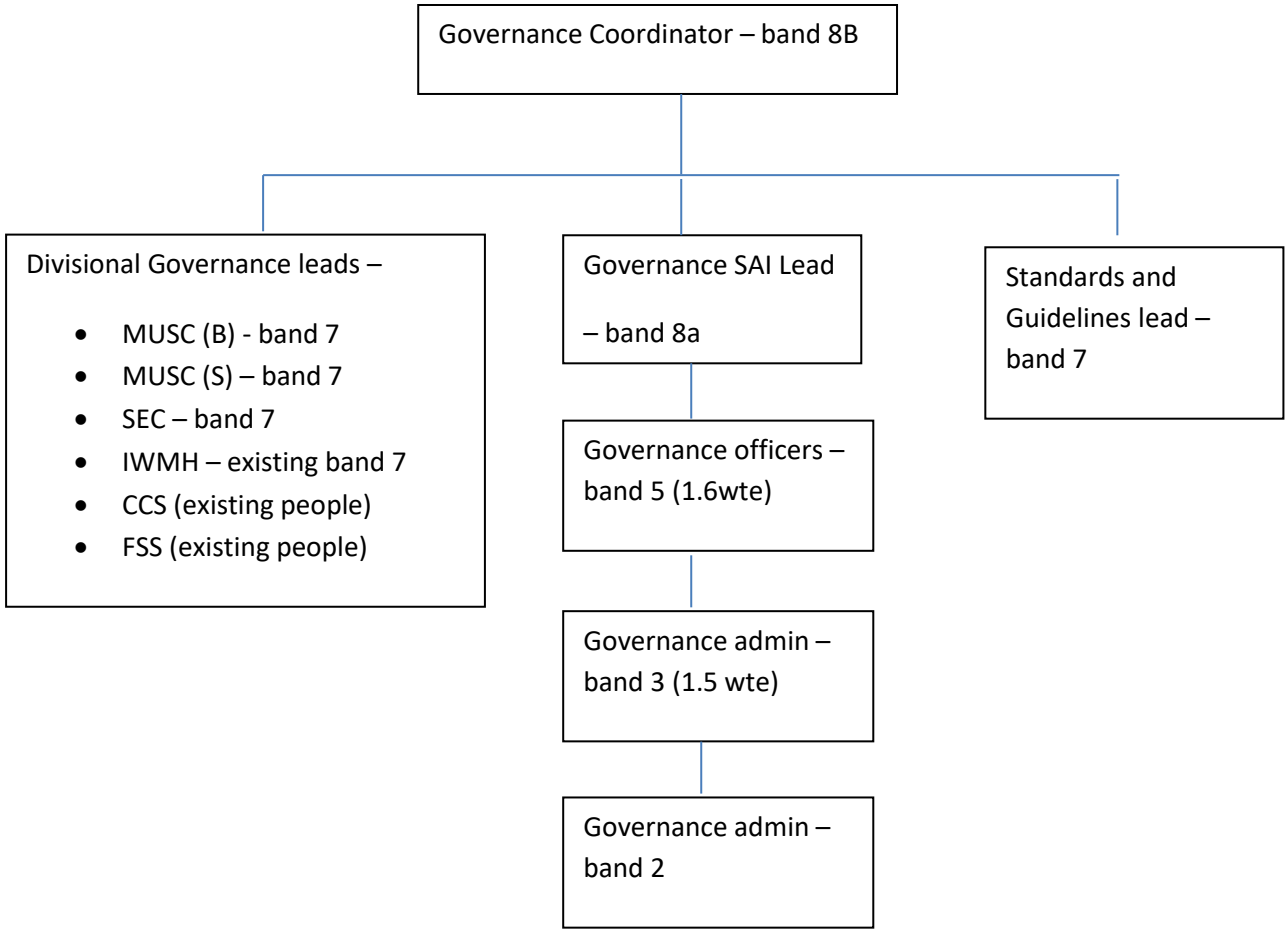
The Acute Directorate Governance Team will be coordinated by Dr Tracey Boyce, with Mrs Connie Connelly and Mr Paul Smyth joining this team as Lead Nurses for Acute governance. The teams will continue to be responsible for supporting their directorate in the management , investigation, learning from complaints and incidents and maintenance of directorate risk registers.

The Patient Safety and Quality Team will be managed by Anne Quinn from the 1st October 2014, Paula Fearon will join this team. The teams key areas of responsibility will be supporting the directorate in implementing standards and guidelines, equipment management, level 2 and 3 SAI investigations and support required for RQIA reviews.

In the coming weeks the teams will be engaging with Assistant Directors , AMD'S and Heads of Services to seek feedback in order to ensure that their teams are effectively supporting the directorate with regards to their areas of responsibility

Margaret Marshall will conclude her secondment as Clinical and Social Care Governance Coordinator in the Acute Directorate from the 1st October 2014.

Acute Governance Structure – for discussion



Roles and responsibilities

Governance Coordinator band 8B

- Corporate liaison
- Level 3 investigations – facilitation and preparation of the report in conjunction with the appointed chair and review team, family meetings, etc
- Level 2 investigations – facilitation and preparation of the report in conjunction with the appointed chair and review team, family meetings, etc
- Lessons learnt implementation
- Allocation of SAIs
- Development of reports for the Directorate and individual Divisions (numbers, trends, Trust Governance reports, etc
- Preparation of Agendas for AD and AMD governance meetings
- Quality assurance of SAI reports
- SAI screening process

Governance SAI lead – band 8A

- Level 2 SAI investigations – facilitation and preparation of the report in conjunction with the appointed chair and review team, family meetings, etc
- Maintenance of 'lessons' learnt database (SAIs, M&Ms, Safety Alerts, etc)
- Management of Governance Officers and Administration team
- Governance training (Datix, SAI process, etc)

Divisional Governance Leads – band 7

- Weekly review of divisions IR1 reports
- Liaison between ward manager and HOS re IR1s and their management
- Preparation of timelines for screening of potential SAIs
- Level 1 SEA investigations in their Division – facilitation, preparation of the report, family meetings, etc
- Attendance at Divisional Governance meetings, etc
- Implementation of lessons learned

Directorate Governance monthly meetings

Acute Clinical Governance (Friday am – includes AMDs)

- Continue as before in relation to draft SAI reports
- Ask other Directorates to send rep to meeting if they want an SAI report considered
- Bring lessons learned implementation problems/ issues?
- Agree what inputs S&G, corporate audit, etc will have to meeting

Acute Governance meeting (Tuesday pm – mainly ADs)

- Put the current 'reports presenters onto a quarterly cycle and ask then to email a monthly report to each Divisional meeting. For example
    - M1 = Complaints trend report and Risk Registers
    - M2 = Patient support trends and S&G report
    - M3 = Patient Safety initiative report and Corporate Audit report
- Devote reminder of meeting to implementation of learning
    - Divisional progress updates against lessons learnt database
    - Discussion of barriers to implementation
    - Setting up short task and finish groups for cross Directorate issues, etc
    - Consideration of audit results to measure implementation success
    - Etc ….
- Do we invite all governance band 7s as well as 8A and 8B, corporate nursing and AHP governance leads.
- What about medic input – done through existing Divisional meetings and Friday Am meeting?

Boyce, Tracey

From: Boyce, Tracey [redacted]
Sent: 04 April 2016 15:16
To: Walker, Helen; Carroll, Ronan; McVey, Anne; Gishkori, Esther; Carroll, Anita; Conway, Barry
Subject: Confidential: Acute Governance Structure alternative proposal April 16
Attachments: Acute Governance Structure proposal April 16.docx

Hi all
Based on the governance discussions we have had over the last couple of weeks and the lead nurse paper I have been thinking about an alternative option for our Governance structure – attached.

It incorporates the lead nurse role into the structure – which is something I know some of you were worried about.

I have left the band 7s role in as an option as I personally don't think the lead nurses would be able to cope with the amount of governance work that needs to be done, on top of their other roles –we have a SAI investigation backlog and we still haven't made a start on the 'implementing lessons learned' piece.

Can we discuss this at team talk tomorrow?

I have also asked David to create a high level SAI report – so that each Division can see where they stand in relation to the number of SAIs they have awaiting investigation – I may have it available tomorrow afternoon.

Please do not share or discuss this with anyone else outside the Acute AD structure – I do not want this option getting to Connie or Paul before I have had a chance to break it to them that their governance role may be affected.

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
Southern HSC Trust

[redacted]

Learn more about mental health medicines and conditions on the Choiceandmedication website http://www.choiceandmedication.org/hscni/

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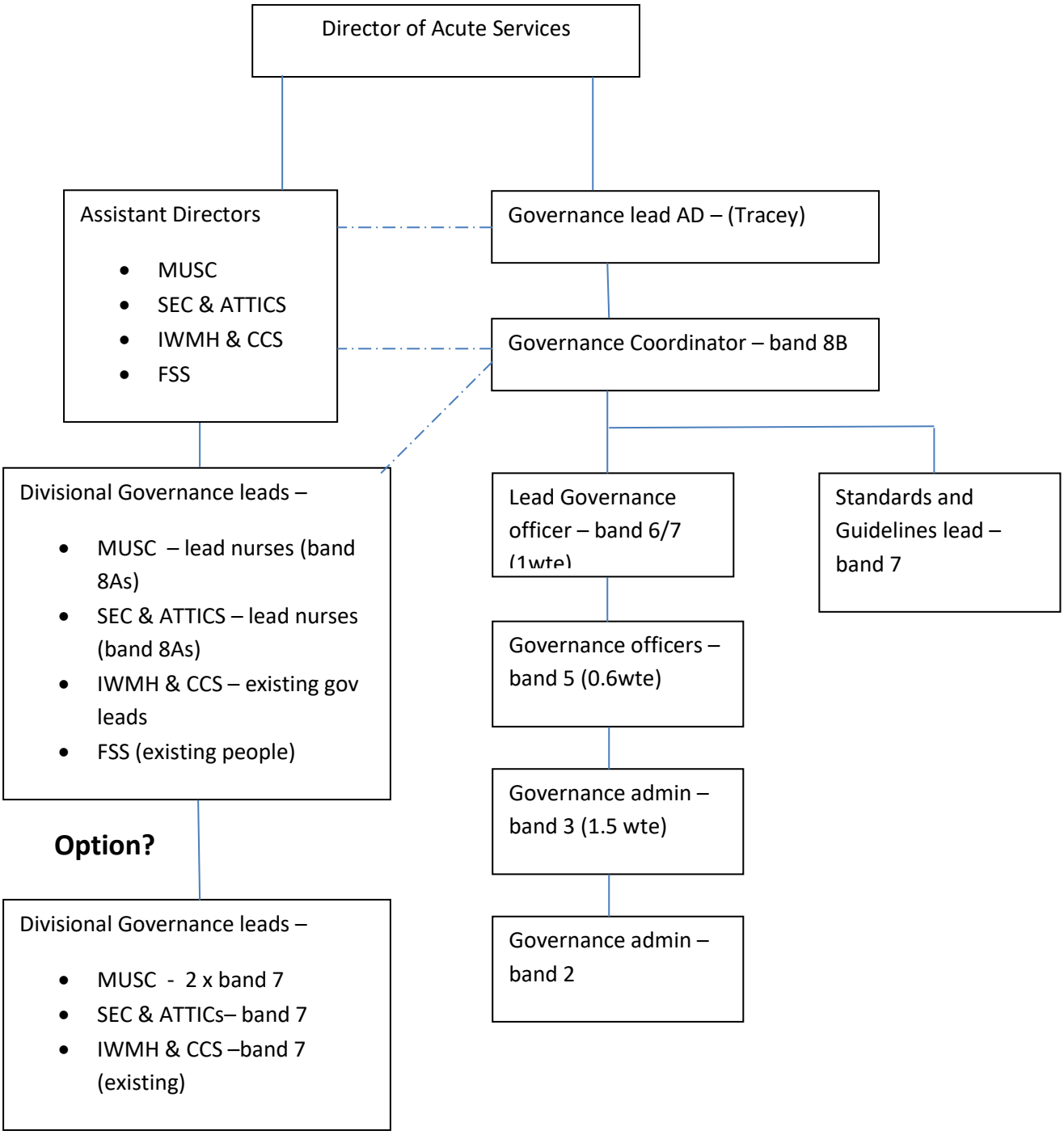
Acute Governance Structure – alternative option for discussion



Roles and responsibilities

Governance Coordinator band 8B

- Corporate liaison for Acute Services in relation to Governance issues
- Level 3 investigations – facilitation and preparation of the report in conjunction with the appointed chair and review team, family meetings, etc
- Level 2 investigations that cross Directorate and/or Division boundaries – facilitation and preparation of the report in conjunction with the appointed chair and review team, family meetings, etc
- Lessons learnt – preparation of the data base of learning for Directorate (SAIs, M&Ms, Safety Alerts, etc)
- Development of reports for the Directorate and individual Divisions (numbers, trends, Trust Governance meeting reports, divisional and ward level dashboards, etc. (complaints, SAIs, IR1s, etc)
- Oversee the maintenance of the Acute Directorate's risk register.
- Preparation of Agendas for AD and AMD governance meetings
- Attend Divisional Governance meetings on a monthly basis
- Quality assurance of SAI reports
- SAI screening process to ensure consistent approach across Divisions
- Management of Governance Officers and Administration team
- Governance training for the Directorate (Datix, SAI process, risk registers, action planning, etc)

Without band 7 option

Divisional Lead Nurses– band 8A

- Weekly review of divisions IR1 reports to identify those that require to be screened as an SAI and to ensure ward manager is taking action for the others.
- Ensure ward managers are recording action taken on Datix appropriately and closing IR1s in a timely manner.
- Liaison between ward manager and HOS re IR1s and their management
- Management of complaint responses in conjunction with HOS to meet regional guidelines
- Preparation of incident timelines for screening of potential SAIs
- Level 1 SEA investigations in their Division – facilitation of the SEA meeting, preparation of the report, arrange and attend family meetings, etc
- Level 2 investigations – facilitation of the investigation meetings and interviews, preparation of the report in conjunction with the appointed chair and review team, arrange and attend family meetings, etc

- Implementation of the lessons learned database via action planning
- Maintenance of 'lessons' learnt database for their Division.

With band 7 option

Divisional Lead Nurses– band 8A

- Level 2 SAI investigations – facilitation and preparation of the report in conjunction with the appointed chair and review team, arrange and attend family meetings, etc
- Maintenance of 'lessons' learnt database (SAIs, M&Ms, Safety Alerts, etc)
- Management of Governance Officers and Administration team
- Implementation of the lessons learned database via action planning

Divisional Governance Leads – band 7

- Weekly review of divisions IR1 reports to identify those that require to be screened as an SAI and to ensure ward manager is taking action for the others.
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- Level 1 SEA investigations in their Division – facilitation, preparation of the report, arrange and attend family meetings, etc
- Attendance at Divisional Governance meetings,
- Attendance at weekly Directorate Governance meetings,
- Maintenance of 'lessons' learnt database for their Division.

Boyce, Tracey

From: Boyce, Tracey
Sent: 07 November 2022 11:34
To: Boyce, Tracey
Subject: FW: Confidential: Acute Governance Structure alternative proposal April 16
Attachments: Acute Governance Structure proposal April 16.docx

Importance: High

Evidence qu43

From: Carroll, Ronan <Personal Information redacted by the USI>
Sent: 29 April 2016 11:50
To: Boyce, Tracey <Personal Information redacted by the USI>; Gishkori, Esther <Personal Information redacted by the USI>; McVey, Anne <Personal Information redacted by the USI>
Cc: Walker, Helen <Personal Information redacted by the USI>; Carroll, Anita <Personal Information redacted by the USI>; Conway, Barry <Personal Information redacted by the USI>; Trouton, Heather <Personal Information redacted by the USI>
Subject: RE: Confidential: Acute Governance Structure alternative proposal April 16
Importance: High

Esther
Emails below where Anne, myself & yourself commented on Tracey's proposal. You will see there are 2 options

1- 8B plus 8a LN's doing divisional governance
2- 8B plus B7x3 supporting LN's/Sr's doing divisional governance

As stated previously I am supportive of option 2.
I would ask that as we going into another mth after the restructuring went live that this is sorted along with LN's.
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by the USI

From: Boyce, Tracey
Sent: 15 April 2016 21:42
To: Gishkori, Esther; Carroll, Ronan; McVey, Anne
Cc: Walker, Helen; Carroll, Anita; Conway, Barry; Trouton, Heather
Subject: RE: Confidential: Acute Governance Structure alternative proposal April 16

Hi Esther
Thanks for your comments

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
Southern HSC Trust

Personal Information redacted by the USI

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From: Gishkori, Esther
Sent: 12 April 2016 03:37
To: Carroll, Ronan; McVey, Anne
Cc: Boyce, Tracey; Walker, Helen; Carroll, Anita; Conway, Barry
Subject: RE: Confidential: Acute Governance Structure alternative proposal April 16

Just to weigh in too!
I see the governance leads being an integral part of both teams. The points made by Ronan and Anne that they need to be a part of the every-day running of the division is valid and I agree with this.
They also need to be an integral part of the team that is their governance colleagues in the other divisions.
For what it's worth, in my experience, one of the reasons any new service doesn't work is because there are no clear roles and responsibilities.
My vision is for these leads to work in a similar way across my whole directorate. For that they will need to fully integrate within governance.
Like anything else, I expect the devil will be in the detail and we need to be sure we set out the old fashioned SMART objectives for them.
We can only do that together. I had promised to speak to Francis about this and while I mentioned it briefly, I have left him alone for the time being as he is quite busy elsewhere. I will speak to him in a week or so.

Best,
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office Personal Information redacted by USI **Mobile** Personal Information redacted by USI
Personal Information redacted by USI

From: Carroll, Ronan
Sent: 10 April 2016 08:14
To: McVey, Anne

Cc: Boyce, Tracey; Walker, Helen; Gishkori, Esther; Carroll, Anita; Conway, Barry
Subject: Re: Confidential: Acute Governance Structure alternative proposal April 16

Governance within acute flows from the director with each AD/AMD having divisional responsibility. In turn this responsibility flows up and down the division. As governance is at the core of clinical care/treatments I am supportive of B7 working/supporting the Srs/LN's/HoS/AD to ensure all aspects of governance are managed in as timely a manner as possible. My view is that for the division this individual needs to part of the division & for the individual I would suggest that by being part of the division they too feel supported & will have ownership of their role & work. But it is not to say that they cannot support another division if operationally this is required.

Ronan Carroll
Assistant Director Acute Services
ATICs/ Surgery & Elective Care
Personal Information redacted by the USI

On 9 Apr 2016, at 22:48, McVey, Anne <Personal Information redacted by the USI> wrote:

> Tracey
>
> I am in favour of band 7 Risk/Governance staff similar to model of risk midwife in IMWH. However I would like this person(s) to be part of MUSC team and integral to the governance arrangements in the Division as AMD and I as AD will ultimately be responsible for the Governance arrangements in MUSC.
>
> Regards Anne
>
> **Anne McVey**
> **Assistant Director of Acute Services**
> **Medicine and Unscheduled Care Division**
> **Tel:** Personal Information redacted by the USI
> **Mobile:** Personal Information redacted by the USI
> **Email:** Personal Information redacted by the USI
>
> <image001.jpg>

From: Boyce, Tracey
Sent: 04 April 2016 15:16
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Subject: Confidential: Acute Governance Structure alternative proposal April 16

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Personal Information redacted by the USI

<image001.jpg>

<image002.jpg>Learn more about mental health medicines and conditions on the Choiceandmedication website http://www.choiceandmedication.org/hscni/

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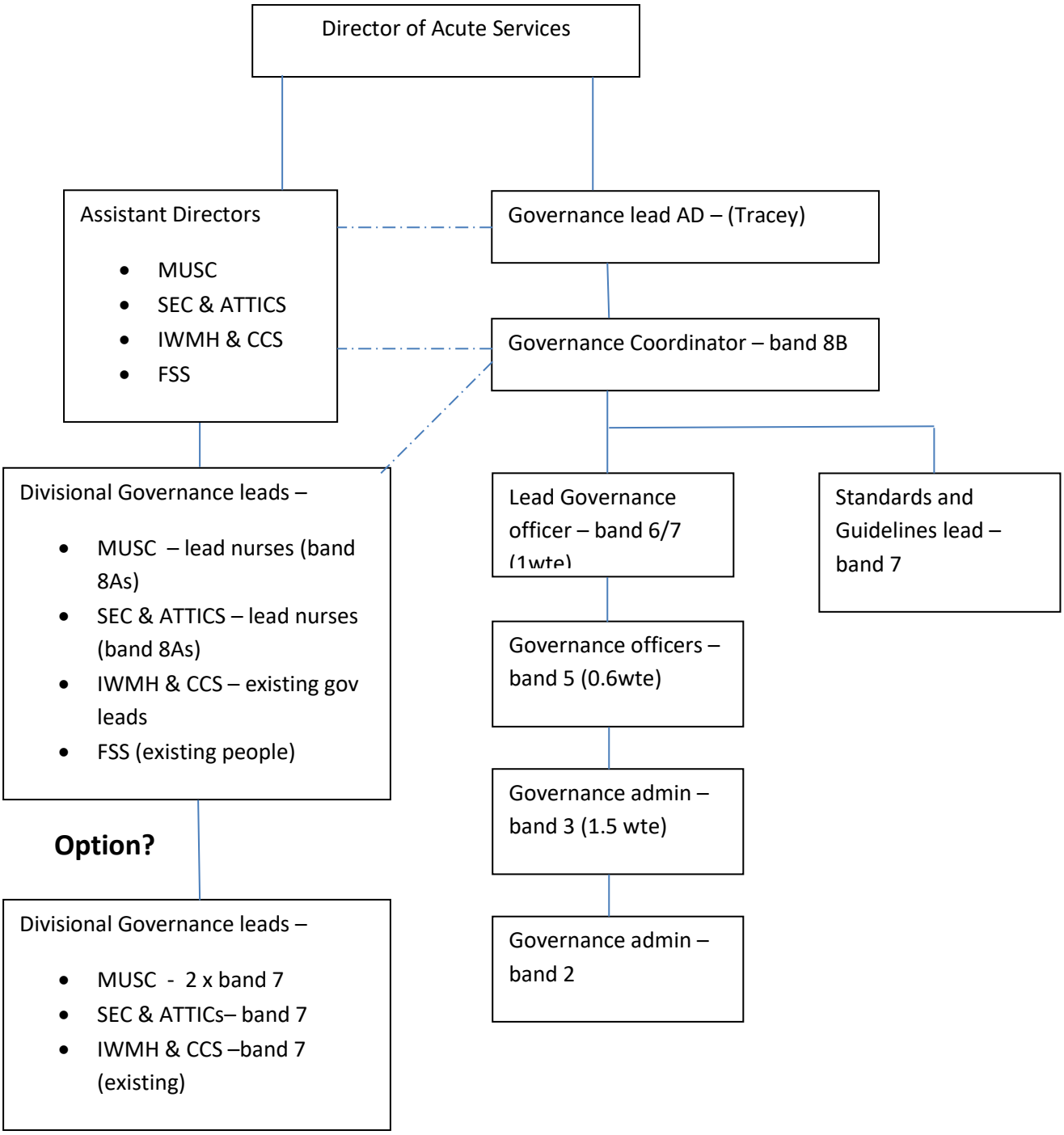
Acute Governance Structure – alternative option for discussion



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Boyce, Tracey

From: Boyce, Tracey <Personal Information redacted by the USI>
Sent: 29 November 2017 10:45
To: Walker, Helen
Subject: Acute Governance Structure proposal Oct 15
Attachments: Acute Governance Structure proposal Oct 15.docx

Hi Helen
Attached is the structure we were discussing and considering in October 2015 as an Acute team –Paul, (the other 8a from the team that Debbie had given me in October 2014) had just moved back to a lead nurse role in MUSC. The 8b post was not in place at that point so all we had in governance was Connie.

As you can see in Oct 15 we were considering keeping Connie at the 8a level, as the SAI lead, with three new 7s in the structure as Divisional Governance leads , incorporating the existing 7 from IWMH. At that point funding was not a constraint in our plan. In December 2015, we followed that structure and moved to reappoint Trudy into the 8B post.

During 2016 it then became clear that funding for the bank of new 7s was going to be an issue – so we continued without them and at the end of that year the structure was slimmed down to remove the 8a role and just leave the 7s – the plan we currently are aiming for.

However there was still no funding to recruit the new 7s we needed – so Connie and Trudy continued to cover all the work themselves, with some help for a short time from Sharon, until the point in 2017 (May I think) when the patient support team (one part time 6 and one 7) was moved into governance. At that point Connie was off Personal Information redacted by the USI

Hope this helps clarify how we got to the current structure.

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
Personal Information redacted by the USI

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Boyce, Tracey

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Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
Personal Information redacted by the USI

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Acute Governance Enhanced Structure – proposal for discussion

31ST May 2018

Additional funding may become available to enhance the Clinical Governance structure within the Acute Directorate in 2018/19. This paper proposes the additional posts/roles that would be added to the existing structure.

The existing structure of the Acute Governance Team is outlined in Appendix A. The existing posts are coloured blue and the proposed new posts are coloured red.

The introduction of additional posts would allow the Acute Governance team to introduce proactive governance activities such as governance dashboards, incident trend analysis, additional governance training and learning events related to trends/patterns identified from Trust incident reports.

Rationale for proposed new posts

3 wte band 6 Governance Nurses

- These posts would be embedded in the MUSC and SEC teams to work with them on their 'day to day' datix and complaint responses (potentially one for SEC, one for ED and one for the rest of MUSC – but need to agree this with the ADs if funded).

2 wte band 5 audit facilitators

- The Audit facilitator posts will be aligned to the Divisions within Acute, supporting the teams in their clinical audit work. At present there is no support for audit within Acute.

1 wte band 5 Equipment/POCT governance officer

- 1 Band 5 governance officer to work with the equipment management/POCT band 7, as from previous discussions with the Directors of Planning and HR, these post will need to take on the cross Directorate work which is not being addressed at the moment, rather than just focussing on the Acute Directorate.

1 band 5 Equipment/POCT governance officer

- 1 additional band 5 governance officer to improve our response to complaints, Ombudsmen enquires and risk register work/training for staff.

0.5 'Governance' PA for 10 consultants

- By creating 10 consultants with 0.5PA for governance we could address the current problems we have with the availability of Consultant medical staff for SAI chairs and other governance working groups. This also fits with the proposal Dr Kahn discussed with the Acute SMT in May. The model would merge aspects of IWMH Medical governance and also MHD's approach to leadership of SAIs. We would provide advanced SAI leadership training for this team of consultants.

Tracey Boyce
Director of Pharmacy/Acute Governance
31st May 2018

Boyce, Tracey

From: Carroll, Anita <Personal Information redacted by the USI>
Sent: 15 August 2018 10:48
To: Devlin, Shane
Cc: Stinson, Emma M; Wright, Elaine; Boyce, Tracey
Subject: FW: Acute Governance structure proposal
Attachments: Appendix A Org chart 31 May 2018.docx; Acute Governance Enhanced Structure proposal 31 May 2018.docx

Shane

Tracey raised this with me regarding the status of this paper.
I am not sure if Esther raised with you , we would need this agreed so that the needed investment could be put in place but I am not sure how far this has gone , or anything else that is needed in terms of process.
Thanks Anita

From: Boyce, Tracey
Sent: 14 August 2018 15:39
To: Carroll, Anita
Cc: Stinson, Emma M
Subject: FW: Acute Governance structure proposal

Hi Anita
As promised

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
Personal Information redacted by the USI

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From: Boyce, Tracey [mailto:Personal Information redacted by the USI]
Sent: 05 June 2018 11:12
To: Gishkori, Esther
Cc: Reid, Trudy; Stinson, Emma M
Subject: FW: Acute Governance structure

Hi Esther
Just realised that you probably needed a paper to go with this for the Acute team discussions and Shane – rather than just a chart.

Please find attached a draft paper for your consideration.

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
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