The total PAs arising from your on-call work is:	1.286
Your availability supplement is:	5% (based on the highest supplement from all your rotas)

On-call rota details

On-call Rota (PA entry)

General information	
What is your on-call activity?	On-call Rota
Where does your on-call rota take place in?	Craigavon Area Hospital
What is your on-call classification?	A
Weekday work	
What is the frequency of your weekday on-call work?	1 in 7.00
	Predictable Unpredictable
How many PAs arise from your weekday on-call work?	**0.286 0.500**
Weekend work (A weekend is classed as Saturday to Sunday for this rota)	
What is the frequency of your weekend on-call work?	1 in 7.00
	Predictable Unpredictable
How many PAs arise from your weekend on-call work?	**0.000 0.500**
Other information	
Which objective does this on-call work relate to?	
Comments	Predictable on call activity = enhanced triage of new outpatient referrals including pre-attendance investigation, GP advice and direct waiting list additions

Sign off

Role: Clinical Director	Role: Clinical Director	Role: Board Member
Name: Mr Haynes, Mark Dean (Con)	Name: Mr Haynes, Mark Dean (Con)	Name: Mr Carroll, Ronan
Signed:	Signed:	Signed:
Date:	Date:	Date:

Timetable

Hot Activities

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Surgeon of the week 09:00 17:00 Week 4 (7 week cycle)	Surgeon of the week 09:00 17:00 Week 4 (7 week cycle)	Surgeon of the week 09:00 17:00 Week 4 (7 week cycle)	Surgeon of the week 09:00 17:00 Week 3 (7 week cycle) Surgeon of the week 09:00 11:00 Week 4 (7 week cycle)	Surgeon of the week 09:00 17:00 Week 3 (7 week cycle)		

Week 1

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Day surgery 08:00 - 13:30 Clinical Lead for element of servce - please specify 13:30 - 16:00	Planned in-patient operating sessions 08:00 - 18:00	Stone treatment clinic 09:00 - 11:00 Patient related admin (reports, results etc) 11:00 - 13:00	Review Outpatients clinic 09:00 - 11:00 Review Outpatients clinic 11:00 - 12:30 Core SPA	Core SPA 09:00 - 12:15 Patient related admin (reports, results etc) 12:15 - 13:30 Core SPA		

Patient related admin (reports, results etc) 16:00 - 18:00		Private Professional Services 14:00 - 17:00	12:30 - 13:30 New patient Clinic 13:30 - 17:30	13:30 - 17:30		

Week 2

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Clinical Lead for element of servce - please specify 12:30 - 15:00 Patient related admin (reports, results etc) 15:00 - 17:00	Planned in-patient operating sessions 08:00 - 18:00	Stone treatment clinic 09:00 - 11:00 Patient related admin (reports, results etc) 11:00 - 13:00 Private Professional Services 14:00 - 17:00	Review Outpatients clinic 09:00 - 11:00 Review Outpatients clinic 11:00 - 12:30 Core SPA 12:30 - 13:30 New patient Clinic 13:30 - 17:30	Core SPA 09:00 - 12:15 Patient related admin (reports, results etc) 12:15 - 13:30 Core SPA 13:30 - 17:30		

Week 3

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Clinical Lead for element of servce - please specify 12:30 - 15:00 Patient related admin (reports, results etc) 15:00 - 17:00	Planned in-patient operating sessions 08:00 - 18:00	Stone treatment clinic 09:00 - 11:00 Patient related admin (reports, results etc) 11:00 - 13:00 Private Professional Services 14:00 - 17:00	Review Outpatients clinic 09:00 - 11:00 Review Outpatients clinic 11:00 - 12:30 Core SPA 12:30 - 13:30 New patient Clinic 13:30 - 17:30	Core SPA 09:00 - 12:15 Patient related admin (reports, results etc) 12:15 - 13:30 Core SPA 13:30 - 17:30		

Week 4

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Clinical Lead for element of servce - please specify 12:30 - 15:00 Patient related admin (reports, results etc) 15:00 - 17:00	Planned in-patient operating sessions 08:00 - 18:00	Stone treatment clinic 09:00 - 11:00 Patient related admin (reports, results etc) 11:00 - 13:00 Private Professional Services 14:00 - 17:00	Review Outpatients clinic 09:00 - 11:00 Review Outpatients clinic 11:00 - 12:30 Core SPA 12:30 - 13:30 New patient Clinic 13:30 - 17:30	Core SPA 09:00 - 12:15 Patient related admin (reports, results etc) 12:15 - 13:30 Private Professional Services 14:00 - 18:00		

Week 5

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Clinical Lead for element of servce - please specify 12:30 - 15:00 Patient related admin (reports, results etc) 15:00 - 17:00	Planned in-patient operating sessions 08:00 - 18:00	Stone treatment clinic 09:00 - 11:00 Patient related admin (reports, results etc) 11:00 - 13:00 Private Professional Services 14:00 - 17:00	Review Outpatients clinic 09:00 - 11:00 Review Outpatients clinic 11:00 - 12:30 Core SPA 12:30 - 13:30 New patient Clinic 13:30 - 17:30	Core SPA 09:00 - 12:15 Patient related admin (reports, results etc) 12:15 - 13:30 Core SPA 13:30 - 17:30		

Activities

A Additional Programmed Activities
H Hot Activity
U Unaffected by hot activity
S Shrunk by hot activity

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
							Total:	Core APA	9.717 0.000	42:08 0:00

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
S	Mon	08:00 - 13:30	wk 1	Day surgery Comments: Includes pre-op ward round / consent 30 minutes travel from Craigavon Area Hospital. 30 minutes travel to Craigavon Area Hospital.	Southern Health and Social Care Tru..	South Tyrone Hospital	DCC	7.98	0.261	1:03
	Mon	08:30 - 12:30		Virtual Clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	24	0.571	2:17
H	Mon	09:00 - 17:00	wk 4 7 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	7.43	0.354	1:25
S	Mon	12:30 - 15:00	wks 2-5	Clinical Lead for element of servce - please specify Comments: Clinical lead for rota's (on-call), includes review of locum CVs as required.	Southern Health and Social Care Tru..	Craigavon Area Hospital	AHR	26.59	0.396	1:35
S	Mon	13:30 - 16:00	wk 1	Clinical Lead for element of servce - please specify Comments: Clinical lead for rota's (on-call), includes review of locum CVs as required.	Southern Health and Social Care Tru..	Craigavon Area Hospital	AHR	7.98	0.119	0:28
S	Mon	15:00 - 17:00	wks 2-5	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	26.59	0.317	1:16
S	Mon	16:00 - 18:00	wk 1	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	7.98	0.095	0:23
S	Tue	08:00 - 18:00	wks 1-5	Planned in-patient operating sessions Comments: Include pre and post operative ward rounds / consent	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	34.57	2.058	8:14
H	Tue	09:00 - 17:00	wk 4 7 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	7.43	0.354	1:25

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
S	Wed	09:00 - 11:00	wks 1-5	Stone treatment clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	34.57	0.412	1:39
H	Wed	09:00 - 17:00	wk 4 7 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	7.43	0.354	1:25
S	Wed	11:00 - 13:00	wks 1-5	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	34.57	0.412	1:39
S	Wed	14:00 - 17:00	wks 1-5	Private Professional Services Comments: Private practice will not take place when Mr Young is required to attend audit	Southern Health and Social Care Tru..	Craigavon Area Hospital	PPS	34.57		2:28
S	Thu	09:00 - 11:00	wks 1-5	Review Outpatients clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	27.14	0.323	1:18
H	Thu	09:00 - 11:00	wk 4 7 wk cycle	Surgeon of the week Comments: Urologist of week handover	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	7.43	0.088	0:21
H	Thu	09:00 - 17:00	wk 3 7 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	7.43	0.354	1:25
S	Thu	11:00 - 12:30	wks 1-5	Review Outpatients clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	34.57	0.309	1:14
S	Thu	12:30 - 13:30	wks 1-5	Core SPA	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	34.57	0.206	0:49
S	Thu	13:30 - 17:30	wks 1-5	New patient Clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	34.57	0.823	3:18
S	Fri	09:00 - 12:15	wks 1-5	Core SPA	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	34.57	0.669	2:41
H	Fri	09:00 - 17:00	wk 3 7 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	7.43	0.354	1:25
S	Fri	12:15 - 13:30	wks 1-5	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	34.57	0.257	1:02
S	Fri	13:30 - 17:30	wks 1-3, 5	Core SPA	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	26.59	0.633	2:32
S	Fri	14:00 - 18:00	wk 4	Private Professional Services	Southern Health and Social Care Tru..	Craigavon Area Hospital	PPS	7.98		0:46

No specified day

"( )" Refers to an activity that replaces or runs concurrently
S Additional Programmed Activities
H Hot Activity

Type	Normal	Premium	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
You have not added any activities.									

Resources

Staff

Equipment

Clinical Space

Other

Additional information

Additional comments

No comments made

SEC BACKLOG REPORT -ALL SPECIALITIES - SEPT 2021															
Consultant	Specialty	Discharges awaiting Dictation	oldest date	Discharges to be typed	oldest date	Clinic letters to be dictated	oldest date	Clinic letters to be typed	oldest date	Results to be dictated	oldest date	Results to be typed	oldest date	DARO	Filing
Mr Glackin (Liz)	UROLOGY	1	Jul-21	23	09/09/2021	1	15/09/2021	31	07/09/2021	36	27/09/2021	64	10/09/2021	Aug-21	
Mr Haynes (Leanne)	UROLOGY							7	21/09/2021	84	20/09/2021	90	26/09/2021	Aug-21	
Mr Khan (Carrie)	UROLOGY	-		21	10/09/2021	-		50	06/09/2021	8	30/09/2021	46	07/09/2021	Sep-21	124 BACK FILING
Mr O'Donoghue (Nicola)	UROLOGY	-		5	19/08/2021	-		97	01/09/2021	132	17/05/2021	14	25/08/2021	Aug-21	X 3 LEVER ARCH
Mr Young (Teresa)	UROLOGY	-		-		-		39	28/09/2021	25	20/09/2021	-		Aug-21	non-ECR (Teresa urology Mr Tyson/Mr Jacob/Mr Solt) About 4 or 5 lever arch files of Mr Young old filing

SEC BACKLOG REPORT -ALL SPECIALITIES - DEC 2021																
Consultant	**Specialty**	**Discharges awaiting Dictation**	**oldest date**	**Discharges to be typed**	**oldest date**	**Clinic letters to be dictated**	**oldest date**	**Clinic letters to be typed**	**oldest date**	**Results to be dictated**	**oldest date**	**Results to be typed**	**oldest date**	**DARO**	**Filing**	**Any other Relevant Information**
Mr Glackin (Liz)	UROLOGY	-		12	08/12/2021			19	15/12/2021	2	05/01/2022	52	15/12/2021	Dec 21	2	
Mr Haynes (Leanne)	UROLOGY	-		13	04/01/2022	-		4	31/12/2021	199	06/12/2021	2	04/01/2022	Dec 21	none	
Mr Khan (Alix)	UROLOGY	-		-		-		80	03/12/2021	30	01/12/2021	39	02/12/2021	Dec 21	3 lever arch files	Typing – MDM 7 09/12/21
Mr O'Donoghue (Nicola)	UROLOGY	-		1	30/12/2021	-		29	21/12/2021	20	13/10/2021	32	24/12/2021	Dec 21	X 4 LEVER ARCH	
Mr Young (Cathy)	UROLOGY	-		29	10/12/2021			50	09/12/2021	-		15	06/12/2021	Nov 21	UIC FILING	

SEC BACKLOG REPORT -ALL SPECIALITIES - MARCH 2022																
Consultant	Specialty	Discharges awaiting Dictation	oldest date	Discharges to be typed	oldest date	Clinic letters to be dictated	oldest date	Clinic letters to be typed	oldest date	Results to be dictated	oldest date	Results to be typed	oldest date	DARO	Filing	Any other Relevant Information
Mr Glackin (Liz)	UROLOGY	1	Jan-22	3	26/03/2022	-		2	29/03/2022	20	21/02/2022	26	24/03/2022	Mar-22	2	
Mr Haynes (Leanne)	UROLOGY	-		8	29/03/2022			3	29/03/2022	288	07/03/2022	-		Mar-22	NONE	
Mr Tyson (Teresa)	UROLOGY	-		-		1	30/03/2022	22	30/03/2022	28	07/03/2022	28	03/04/2022	Mar-22	1 lever arch file non-ECR (Teresa	
Mr Khan (Alix)	UROLOGY	-		-		-		64	14/03/2022	100	Oct-21	24	14/03/2022	not received	3 lever arch files	Typing – MDM 1
Mr O'Donoghue (Nicola)	UROLOGY							46	11/03/2022	146	15/02/2022	24	03/03/2022	Mar-22	X 4 LEVER ARCH	
Mr Young (Cathy)	UROLOGY			30	15/03/2022			43	08/03/2022	-		47	08/04/2022	not received		

Received from SHSCT on 16/05/22. Annotated by the Urology Services Inquiry.

Urology Team Departmental Meeting
Thursday 14th April 2022 at 12:45

Notes of meeting

Present: Wendy Clayton, Fiona Griffin, Jventine Asingei, Anthony Glackin, Jenny McMahon,
Leanne McCourt, Patricia Thompson, Hafs Elhag, Ronan Carroll, Sabahat Hasnain

Apologises: Laura McAuley

Covid update	• Good position regarding covid • CAH – 26 • 1 – ICU
Public Inquiry update	• Nursing staff and trainees should have received letters
Annual leave Leave form urology V1.pdf	• Annual leave discussed as per attachment, Mark and Wendy have discussed form and it will be beneficial • Mr. Young retiring, Wendy will be completing rota • Staff to request leave 6 weeks before on form attached, any out of ordinary staff requested to ring Wendy. Wendy hopes to have holiday requests completed in a more timely manner
Theatre allocation and management of IPDC and operating (AJG)	• **Bladder outlet surgery**- • Discussed at Patient Safety Meeting – hope to do 500 patients • New procedure – RSUME + URDRIF • Day-case surgery at DHH and LVH • 2 half day lists in DHH – day procedure, capacity for LVH • **Catheter care of patients after procedure:-** • **Planned removal – 5-7 days after or 1 month** • **Greenlight removal – 2-3 days** • **½ day list 2-3 days greenlight** • **All day list – 6 days** • Recommended – patients taught to remove catheter at home • **QI Project team** - Wendy, Leanne, Saba, Jason and Tony • Sell positive provide bespoke bladder service in DHH – set up Quality Improvement Project Continence Nurse • Tony can use Friday in Lagan Valley Hospital – resumes AM – TP biopsy
Planned flexible cystoscopy	• Flex cystoscopy overdue and service specification – IS – secretaries raising patients that are behind, some are more urgent – Wendy will contact Consultants
Vasectomy reversal vasectomy reversal.msg	• Reversal vasectomy reversal – triage • Very few carried out due to waiting list • 352 - ? • Routine with CAH • Age of partner considered at time

Elective/Outpatient activity update a. LVH sessions and update on DECC list b. Theatre sessions c. IS contracts; Hermitage and Kingsbridge	• 352 Contract – Wendy in communication with Personal Information redacted by USI [redacted] at 352 • Discussed English Consultants having accessed to NIECR – Maria O'Kane & BSO involved • Referrals discussed and options – sent to nurse in Thorndale re. continence service • Fiona – Amie working FY1 • Down from 6 ↓4 • Wednesday 3 South FYI surgery not urology • FY1 now to call 3 South • Contacted Foundation Rep re. issues • Come down to 4 FYI due to LTS – Amie will discuss – know why they have to 3S Amie to do a weekly rate for FY1 • Tony spoke to Debbie Cullen if issue – leave Amie to allocate • Amie to copy WC into weekly **Theatre scheduler** – • The Urology Consultants requested an Urology speciality scheduler to include all elective work; IPDC, flex cysts, TP biopsies - Wendy to work to estimate WTE/Band and forward to Ronan Carroll to seek funding
Referrals	• On call referrals not being processed • RBC off site emailed for printing • After 5 p.m. left for each Consultant for following day (causing issues tray full at end of day) – Wendy will follow up with email • When in MIS – RBC • SOP – show • Referrals need printed on daily basis
Staffing	• Consultant Urology Recruitment – Medical HR – Joanne McMullen • John/Matthew – Clinical Fellow – Ronan to sign off – Fiona – Susie – replacement • Tony happy to be consulted re. interview please give plenty of notice • GMC awaiting (Wendy thought this was happening)
Urology CNS update	• Catherine off next – ward support • Problem with sickness 3 South trying get one in • Not achievable with lack of FY1s • 3 South – one down – cover for surgical (concern) • Amie – FY1s cover for 3 South • Validating 30 patients
AOB	• Saba confirmed Urology well organised • Education – Con, NS, MG friendly team – medical team enjoyed – Doctor – overall very positive

Urology Annual Leave form – Medical Staff

Southern Health and Social Care Trust

Medical Staff Application for Annual Leave

Note: This form must be completed in full, and submitted to the Rota Organiser, giving at least **6 weeks notice** whenever possible and practicable.

Name:				
Grade:				
Specialty:		Urology		
Hospital:		CAH		
Leave Year:	From:		To:	
Annual Leave Entitlement (days):				
Annual leave carry over (days):				
Annual Leave Taken to Date:				
Number of Days Remaining:				
Period of Leave Requested [inc]	From:		To:	
Total Number of Days Required:				
Applicant Signature				
Submission Date:				
Approval Signature				
Date:				

Submit

Stinson, Emma M

From: ODonoghue, JohnP
Sent: 13 April 2022 12:36
To: Clayton, Wendy
Subject: vasectomy reversal

Wendy,

I'm not at the staff meeting tomorrow [redacted]
Would you be able to bring up what we should do about vasectomy reversals.
There is a referral on triage today and nobody here does them,
J

John P. O'Donoghue
Consultant Urological Surgeon
Craigavon Area Hospital,

[redacted]
[redacted]
68 Lurgan Road, Portadown, BT63 5QQ

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Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: Acting Head of Service for Urology, ENT, OPD & Opth **Staff Number:** Personal Information redacted by the USI

Is Professional Registration up to date? ___N/A___

KEY ISSUES & OUTCOMES	COMMENTS
Have you read and understood your Post Outline? **Post Outlines can be accessed via Trust Intranet (KSF link)** **YES** [X] **NO** [ ] **Have Post Outline levels been achieved:** **YES** [ ] **NO** [ ] **If no, record below what action to be taken:**	**Staff members comments on his/her performance over past year:** • Commenced new interim role from Oct 2021 – Acting HOS • Challenging with learning new services – ENT, Urology, OPD and Ophthalmology • Building relationships with all teams • In the progress of Rebuilding services post coivd surge – OPD and theatres • Working with Lead Consultants and AMD's with job planning in urology and ENT • Participate in regional meetings - Acute IS CAG meetings, Regional Stones DECC • Recruitment of Urology Consultants • Meeting lead nurses to support them on any ward and staffing issues, keeping staff in post up-to-date • Urology & ENT – support Lead Nurses and CNS job plans, setting up clinics, ensure policies in place • Ensure services operationally run smoothly, implementing service improvements • **Line Manager's Feedback on staff members performance over past year:**

Objectives for Next Year:

- Continue to lead and support the ENT, Urology, OPD and Ophthalmology services, meeting regularly and promoting their service
- Ensure job plans are updated for consultants and CNSs
- Set up CNS outpatient clinics
- Stabilise nursing workforce in 3South
- Work with other surgical HOS with the implementation of an ambulatory unit
- Visconn trial in Urology and if successful roll out
- Develop outreach Tracheostomy service throughout the hospital
- Monitoring of elective access targets and KPIs – OPD and IPDC
- Maintain and boost admin staff morale
- Support AD in delivery of action plans, projects and targets

Reviewee Staff Name (Print) Personal Information redacted by the USI Signature _ Personal Information redacted by the USI Date _7/6/2021_____

Reviewer Manager/Supervisor (Print) **Ronan Carroll**____ Signature Personal Information redacted by the USI _____ Date _13/6/21_____

Southern Health and Social Care Trust
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Part B **ANNUAL PERSONAL DEVELOPMENT PLAN** For training requirements specific to your staff group refer to Trust Intranet Training Link

Staff Number: Personal Information redacted by the USI

Training Type	Identified learning need	Date Training Completed	Agreed Action
Corporate Mandatory Training ALL STAFF	Corporate Induction	Complete	
	Departmental Induction/Orientation	Complete	
	Fire Safety	30/12/2021	Valid until 30/12/22
	Record Keeping/Data Protection	13/7/17	Part of IG
	Moving and Handling	18/6/2020	Valid unit 18/6/23
Corporate Mandatory Training ROLE SPECIFIC	Infection Prevention Control	30/12/21	Valid until 30/12/23
	Safeguarding People, Children & Vulnerable Adults		
	Waste Management	N/A	
	Right Patient, Right Blood (Theory/Competency)	N/A	
	Control of Substances Hazardous to Health (COSHH)	N/A	
	Food Safety	N/A	
	Basic ICT	N/A	
	MAPA (level 3 or 4)	N/A	
Essential for Post	Recruitment & Selection Refresher	17/6/19	Valid until 16/6/22
	Information Governance	17/9/19	Valid until 16/6/22
	Display screen equipment programme	18/6/2020	Valid until 18/6/23
	Fraud Awareness	18/6/2020	Valid until 18/6/23
Best practice/ Development (Coaching/Mentoring) (Relevant to current job role)			

Reviewee Staff Name (Print) Personal Information redacted by the USI _____ Signature Personal Information redacted by the USI _____
Date _13/6/3021_____

Reviewer Manager/Supervisor (Print) ___Ronan Carroll___ Signature Personal Information redacted by the USI _____
Date _13/6/2021_____

PLEASE SEND COMPLETED PART B TO: KSF DEPARTMENT, HILL BUILDING, ST LUKES HOSPITAL, LOUGHGALL ROAD, ARMAGH BT61 7NQ

OR EMAIL TO: - [redacted] Personal Information redacted by the USI

Southern Health and Social Care Trust
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Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: Head of ENT, Urology, Ophthalmology & Outpatients – Band 8B **Staff Number:** Personal Information redacted by the USI

Is Professional Registration up to date? _____KEY ISSUES & OUTCOMES	COMMENTS
Have you read and understood your Post Outline? **Post Outlines can be accessed via Trust Intranet (KSF link)** **YES** √ **NO** **Have Post Outline levels been achieved:** **YES** √ **NO** **If no, record below what action to be taken:**	**Staff members comments on his/her performance over past year:** I have been off for 18 weeks Personal Information redacted by the USI (June – October 2018) so it took me a while to come back up to speed in my areas, particularly in respect of the RASC for Cataracts. I continue to work with all my Teams to develop and improve services and continue to be involved regionally for ENT (Head & Neck), Urology,(Professional Issues Group etc. and with Belfast Trust to develop Ophthalmology services to Banbridge and now moving forward working with Region on the RASC for ENT & Urology. I continue to work closely with all my teams in taking forward issues in relation to finance, Governance and performance. I continue to work closely with the three Lead Nurses for my respective areas. Line Manager's Feedback on staff member's performance over past year: as Martina has stated above she has been away from work. However she has taken no time to resume and take up the operational issues within her are of responsibility. Moving forward this year we have agreed a work plan for Martina's areas of responsibility which we agree is all deliverable Ronan Carroll

Objectives for Next Year:

- Stabilise 3 South

ENT

- Develop outreach Tracheostomy service throughout the hospital
- Continue to develop the ECHO project and widen it to other GP practices
- Provide off-site clinics on the bigger Health Centres
- Develop Specialist Clinics for Specialty Doctors, eg VHIT, Rhinology, Tracci training, Allergy
- Develop guidance for GP's and add to CCG
- Introduce E-Triage and help to streamline referrals.
- Develop and implement an 'Emergency/Hot Clinic" in Outpatients so as to remove Ward Attenders from 3 South
- Work with the Region on the Regional Assessment & Surgical Centres for ENT

UROLOGY

- Service Expansion to DHH to include additional Theatres and Nurse-led and Consultant Clinics
- Stone Treatment Increase Stone Treatments from 2 to 6 weekly sessions and the use of acute stone management will reduce demand for IP treatment
- Cancer CNS expansion - Increase x 1 CNS
- Non-cancer CNS expansion - Increase x 1 CNS
- RSAC - Work with the Region on the Regional Surgical & Assessment Centres for Urology

OPHTHALMOLOGY

- Ophthalmology Out patients expansion in Banbridge
- Complete the work for RASC Cataracts to STH

OUTPATIENTS

- Complete the accommodation paper and streamline the accommodation requests for Craigavon Area Hospital
- Move Thorndale Unit over to the management of main outpatients
- Work with lead nurse to ensure skill-mix is correct for all outpatients

Reviewee Staff Name (Print) ___Martina Corrigan_____ Signature _Personal Information redacted by the USI_____28/6/19_____ Date _____

Reviewer Manager/Supervisor (Print) ____Ronan Carroll - Signature _Personal Information redacted by the USI_ Date 27/6/19_____

Part B ANNUAL PERSONAL DEVELOPMENT PLAN

For training requirements specific to your staff group refer to Trust Intranet Training Link

Staff Number: _____ Personal Information redacted by the USI ____

Training type	Identified learning need	Date Training Completed	Agreed Action
Corporate Mandatory Training ALL STAFF	Corporate Induction	Jan 2010	
	Departmental Induction/Orientation	Sept 2009	
	Fire Safety	Aug 2014	Needs refreshed for August 19
	Information Governance Awareness	Aug 2017	
	Equality & Human Rights	Aug 2017	
	Moving and Handling	Aug 2016	
	Infection Prevention Control	Jan 2017	
	Equality, Good Relations and Human Rights – Making A Difference		Still needs completed
Corporate Mandatory Training ROLE SPECIFIC	Safeguarding People, Children & Vulnerable Adults	August 2018	
	Waste Management	NA	
	Right Patient, Right Blood (Theory/Competency)	NA	
	Control of Substances Hazardous to Health (COSHH)	NA	
	Food Safety	NA	
	Basic ICT	Jan 2010	
	MAPA (level 3 or 4)	NA	
	Professional Registration	NA	
Essential for Post			
Best practice/ Development (Coaching/Mentoring) (Relevant to current job role)			

Reviewee Staff Name (Print) ___Martina Corrigan_____ Signature _ Personal Information redacted by the USI Date _28/06/19____

Reviewer Manager/Supervisor (Print) ___Ronan Carroll___ Signature [redacted] Date _27/06/19____

PLEASE SEND COMPLETED PART B TO: KSF DEPARTMENT, HILL BUILDING, ST LUKES HOSPITAL, LOUGHGALL ROAD, ARMAGH BT61 7NQ OR EMAIL TO: -

[redacted]

Southern Health and Social Care Trust
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Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: Head of Service – 8B **Staff Number:** Personal Information redacted by the USI

Is Professional Registration up to date? ____NA__

KEY ISSUES & OUTCOMES	COMMENTS
Have you read and understood your Post Outline? **Post Outlines can be accessed via Trust Intranet (KSF link)** **YES** **Have Post Outline levels been achieved:** **YES** **If no, record below what action to be taken:**	**Staff members comments on his/her performance over past year:** I continue to work with all my Teams to develop and improve services and continue to be involved regionally for ENT (reform), Urology, partial nephrectomy, addressing waiting times, Professional Issues Group etc. and with Belfast Trust to develop Ophthalmology services to Banbridge and Western Trust. I am work closely with all my teams in taking forward issues in relation to finance, Governance and performance. I continue to work closely with the three Lead Nurses for my respective areas. **Line Manager's Feedback on staff members performance over past year:**

Objectives for Next Year:

1. **Review of Outpatients to include roles and responsibilities, start and finish times of clinics and roll out of the Outpatient Rota on all sites.**
2. **Complete the work on the Stone Treatment project which should save on bed-days**
3. **Complete move of ophthalmology services to Banbridge**
4. **Continue with service development for all areas e.g. ENT – Head and Neck, Tracci training, Manipulation of Nasal Bones pathway, Urology, move to Daisy Hill and work towards the paediatric centralisation to Daisy Hill Hospital**

Reviewee Staff Name (Print) : Martina Corrigan Signature Personal Information redacted by the USI Date 25/08/17

Reviewer Manager/Supervisor (Print) _____ Signature _____ Date _____

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Part B

ANNUAL PERSONAL DEVELOPMENT PLAN

For training requirements specific to your staff group refer to Trust Intranet Training Link

Staff Number: _____

Training type	Identified learning need	Date Training Completed	Agreed Action
Corporate Mandatory Training ALL STAFF	Corporate Induction	Jan 2010	
	Departmental Induction/Orientation	Sept 2009	
	Fire Safety	Aug 2014	
	Record Keeping/Data Protection	Aug 2016	
	Moving and Handling	Aug 2016	
	Infection Prevention Control	Aug 2016	
Corporate Mandatory Training ROLE SPECIFIC	Safeguarding People, Children & Vulnerable Adults	Aug 2016 & Aug 2017	
	Waste Management	NA	
	Right Patient, Right Blood (Theory/Competency)	NA	
	Control of Substances Hazardous to Health (COSHH)	NA	
	Food Safety	NA	
	Basic ICT	NA	
	MAPA (level 3 or 4)	NA	
	Professional Registration	NA	
Essential for Post	Records Management	Aug 2016	
Best practice/ Development (Coaching/Mentoring) (Relevant to current job role)			

Reviewee Staff Name (Print) ___Martina Corrigan__ Signature __[redacted] Date _25/08/17_____

Reviewer Manager/Supervisor (Print) _____ Signature _____ Date _____

PLEASE SEND COMPLETED PART B TO: KSF DEPARTMENT, HILL BUILDING, ST LUKES HOSPITAL, LOUGHGALL ROAD, ARMAGH BT61 7NQ

OR EMAIL TO: - [redacted]

ATICS / SEC SUMMARY JUNE 19

	ATICs/SEC AD Ronan Carroll AMD: Damian Scullion Mark Haynes	GS, Endoscopy & Orthodontic HOS Amie Nelson CD: David Gilpin Colin Weir	Urology/ENT HOS Martina Corrigan CD: Ted McNaboe	T&O HOS Brigeen Kelly CD: Ronan McKeown	ATICs HOS Helena Murray CD: Devendra Kumar Chris Clarke Nevile Ruther-Ford Jones
Budget (March 19)	Budget = £56,702,183.73 Actual = £64,741,181.73 Variance = -£8,038,998.00 % Variance =-14.18%	Budget = £14,327,040.99 Actual = £17,205,402.21 Variance = -£2,878,361.22 % Variance = -20.09%	Budget = £8,184,877.00 Actual =£9,550,263.64 Variance= -£1,365,386.64 % Variance = -16.68%	Budget = £6,325,286.00 Actual =£7,857,604.98 Variance= -£1,532,318.98 % Variance =-24.23	Budget = £27,560,482.75 Actual =£29,922,602.30 Variance= -£2,362,119.55 % Variance =-8.57%
Staff • Medical consultants • Nursing	**Overall** Budget = 991.33 Actual = 1088.14 Variance = -96.81 % Variance = -9.77%	**Staff in post:** Budget = 263.62 Actual = 322.03 Variance =-58.41 % Variance =-22.16% CAH Nursing =105.06 wte DHH Nursing = 97.75 wte CAH medical = 42.57 wte DHH medical = 22.61 wte	**Staff in post:** Budget = 165.47 Actual = 159.78 Variance =5.69 % Variance =3.44% 3 South Nursing = 27.29wte OPD Nursing = 59.24 wte ENT Medical = 15.61 wte Urology Medical = 11 wte	**Staff in post:** Budget = 119.64 Actual = 144.59 Variance =-24.95 % Variance =-20.85% Nursing = 120.68 wte Medical = 23.91 wte	**Staff in post:** Budget = 438.66 Actual = 457.26 Variance =-18.60 % Variance = -4.24% B5 and above Nursing = 270.17 wte CAH medical Anaesthetist w = 53.79 wte DHH Medical Anaesthetist = 17.58wte
Vacant positions • nurses		**Nursing vacancy** **CAH:** Sick leave = 1.37wte ML = 5.28 wte SEC/CB / Unpaid =2 wte Vacancy = 9.4 wte **DHH:** Sick leave = 3.4 ML = 10.73 wte SEC/CB / Unpaid = 0.61wte Vacancy = 9.8 **Consultant sickness** Sick leave = 1 wte Off on-call/SOW = 2 wte	**Nursing vacancy** **3 South:** Sick leave = 3.32wte ML = 1.6 wte Unpaid = 0.28 wte **Outpatients:** Sick leave = 1.8 wte ML = 0 wte	**Nursing Vacancy** Sick leave = 4.80 wte ML = 3 wte – 4 further ML in Summer 19 SEC/CB = 1 wte Band = 1 wte	**Nursing Vacancy** **Theatres, Recovery, ICU and Pre-OP** = 43.61wte gap (of which 12.84wte ML) 7.7wte are expected to retire in 19/20 **DSU/Endoscopy** = 13.39 wte gap (of which 2.6wte ML)
Sickness %		**Nursing sick leave** CAH = 5.28 wte (5%) DHH = 3.4 wte (3.4%)	**Nursing sick leave** = 3 South = 3.32 wte (12%) OPD = 1.6wte (3%)	**Nursing sick leave** = 4.80wte (4%)	**Nursing sick leave** **Theatres, Recovery, ICU and Pre-OP** = 12.38 wte **DSU/Endoscopy** = 1.67wte **Total sickness** = 14.05 wte (5.2%)
Performance at end May • Cancer		• **Outpatients** **General surgery longest waits**	• **Outpatients** **Urology longest waits**	• **Outpatients** **Orthopaedics longest waits**	• **Outpatients** **Chronic pain longest waits**

• Opd • In/dc • Reviews		RF = 40 days Urgent = 119wks upgrade, 80wks Routine = 132wks **Breast** RF = 14 days Routine = 33 wks **Mammography screening** On target – 100% • **Inpatient / Daycase** **General surgery longest waits** RF = <31 days Urgent = 161wks Routine= 183wks **Breast** RF = 4-5 weeks Urgent = 32 wks Routine = 96 wks **Endoscopy** RF = 21 days Urgent = 28wks Routine = 129wks Planned = 1 ½ year behind • **Cancer (March 19)** **62 day performance:** Breast = 100% LGI = 28.57% UGI = 66.6% **31 day performance** Breast = 100% LGI = 94.12% UGI = 100%	RF = 55 days Urgent = 178wks Routine = 218wks **ENT** RF = 20 days Urgent = 95wks Routine = 138 wks • **Inpatient / Daycase** **Urology longest waits** RF = >31 days Urgent = 277wks Routine= 264wks **ENT** RF = <31 days Urgent = 86 wks Routine = 131 wks • **Cancer (March 19)** **62 day performance:** Urology= 53.85% ENT = 100% **31 day performance** Urology = 95.45% ENT = 100%	Urgent = 82wks Routine = 128wks **Fractures longest waits** OPD = 3-4wks • **Inpatient / Daycase** **Orthopaedics longest waits** Urgent = 176wks upgrade, 119wks Routine= 169wks	Urgent = 15wks Routine = 44wks • **Daycase** **Chronic pain longest waits** Urgent = 32wks Routine= 174wks • **Bowel screening** SSP appointment = 3wks 1st BCS colon = 12wks (target 2-wks)
Initiatives DECC's Workplan		Work plan – separate attachment • Varicose veins elective daycase centre commenced Jan 19 • DECC workshops for general surgery and endoscopy • Orthodontics – revamping southern Trust service and discussion with HSCB re centralising orthodontics an	Work plan – separate attachment	Work plan – separate attachment	Work plan – separate attachment • Paediatric Theatre operational from June 18 • RASC cataract STH operational from Jan 19 – still to ramp up to 9 sessions (currently 5) • Request for paediatric endoscopy on DHH from HSCB • Obstetric theatre
GOVERNANCE CONCERN	**Divisional Concerns**	• Gen surgery consultant on-		Fracture waits – fractures heal before	• Nursing vacancies and stabilisation of

	• No governance B7 aligned to ATICs/SEC • No procurement office for ATICS/SEC • 'Pension' issue – Consultants cutting back on in house additionality • Consultants are starting to request a reduction in PAs due to 'pension' issue • Overall waiting times for all specialities: OPD, IPDC and planned • Cancer performance • Capital and revenue streams – no funding • Maintenance of services, no rolling replacement programmes • Nursing workforce – recruitment • Agency nursing and medical across all specialities	call / SOW rotas – risk due to current gaps and potential risk to consultants leaving • Above impacting on elective activity in particular red flag, urgent and planned • Maintaining safe and sustainable Junior doctor rotas on 2 acute sites • Impact of breast assessment consultation		they are seen **MSK Hub** – no OT in position and no named ED consultant **Fracture outpatient** accommodation on DHH site – need to secure funding, currently no.1 on capital list	the workforce. Currently 43.61wte gap and 7.7 further retirements in 19/20 for Main theatres only • Providing the appropriate nursing skill in main theatres due to high volume gaps and use of agency • 'FIT' implementation for bowel cancer screening • Ongoing IPTS with no funding stream – Pre-op, Maternity theatres and chronic pain • HDU DHH moving to ATICs

Southern Health and Social Care Trust
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Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: Assistant Director ATICs/SEC 8c **Staff Number:** Personal Information redacted by the USI

Is Professional Registration up to date? yes Revalidation April 2020

KEY ISSUES & OUTCOMES	COMMENTS
Have you read and understood your Post Outline? **Post Outlines can be accessed via Trust Intranet (KSF link)** **YES** [X] **NO** [ ] **Have Post Outline levels been achieved:** **YES** [X] **NO** [ ] **If no, record below what action to be taken:**	**Staff members comments on his/her performance over past year:** This is my 3rd year as the AD for ATIC/SEC and I believe I have a thorough understanding of what our services are expected to deliver. I have worked to create a strong management team which enables the work plan to be best achieved. There are numerous challenges in the delivery and achievement of services but more often than not we can find solutions to overcome these challenges. I believe I have a responsibility to leave a better/stronger team and services. To deliver on this I actively develop those around me, creating a culture of positivity, fairness and remembering patients' vulnerabilities/expectations. Our work plan is the vehicle to keep focus. **Line Manager's Feedback on staff members performance over past year:** In the 12 weeks that I have been in the Director role, Ronan has been extremely supportive. He is very knowledgeable in his ATIC's/SEC AD role and has well developed relationships across his MDT colleagues, which he mobilises to maximise outcomes. He is creative regarding service improvement approaches and always remains focused on the patient, carer and families as our number 1 priorities. He has a very comprehensive set of objectives in place across his brief, building on the previous 2 years. His approach is steadfast and his leadership is appreciated.

Objectives for Next Year:
My objectives are detailed through the Divisional work plan.

Work plan 2019-2020.docx

Reviewee Staff Name (Print) **Ronan Carroll**____ Signature [redacted] Date 3/9/19_____

Reviewer Manager/Supervisor (Print) **MELANIE MCCLEMENTS** Signature ___ [redacted] Date 03/09/2019

Part B ANNUAL PERSONAL DEVELOPMENT PLAN

For training requirements specific to your staff group refer to Trust Intranet Training Link

Staff Number: Personal Information redacted by the USI

Training	Identified learning need	Date Training	
Corporate Mandatory Training ALL STAFF	Corporate Induction		
	Departmental Induction/Orientation		
	Fire Safety		Will be completed by Nov 19
	Information Governance Awareness	31/8/19	
	Equality & Human Rights		
	Moving and Handling	13/7/17 due 13/7/20	
	Infection Prevention Control	13/7/17 due 13/7/20	
	Equality, Good Relations and Human Rights – Making A Difference	31/8/19	
Corporate Mandatory Training ROLE SPECIFIC	Safeguarding People, Children & Vulnerable Adults		
	Waste Management		
	Right Patient, Right Blood (Theory/Competency)		
	Control of Substances Hazardous to Health (COSHH)		
	Food Safety		
	Basic ICT		
	MAPA (level 3 or 4)		
	Professional Registration		
Essential for Post			
Best practice/ Development (Coaching/Mentoring) (Relevant to current job role)			

Reviewee Staff Name (Print) ___Ronan Carroll___ Signature [redacted] Date __3/9/19

Reviewer Manager/Supervisor (Print) MELANIE MCCLEMENTS Signatu [redacted] ate 03/09/2019

PLEASE SEND COMPLETED PART B TO: KSF DEPARTMENT, HILL BUILDING, ST LUKES HOSPITAL, LOUGHGALL ROAD, ARMAGH BT61 7NQ OR EMAIL TO: -
[redacted]

ATICS/SEC Work plan 2019/2020

T&O	GS	ENT	Urology	ATICs
<u>T&O Staff</u> **Medical**: Complete a review of all consultant job plans with Clinical Director. Advertise Middle Grade, Trust Grade & SHO level aiming to stabilise the workforce and reduce agency spend where possible. **Specialist Practioner Role:** follow up on AFC matching of role, advertise & recruit. Agree the working week with the Clinical Director. **Department Staffing** - Update of staffing to be undertaken with Sisters, Lead nurse & Admin assistant. Complete requisitions as required. **<u>Fracture Clinic</u>**	**Maintaining a safe and effective emergency service on both sides (CAH & DHH)** • Vascular consultants are likely to come off the SOW rota, therefore we have to decide how we will fill these gaps • Need to be cognisant of the fact that general surgery as a speciality no longer exist • Need to enhance patient flows and relationships between the two sides **Further enhancing the ambulatory care models on CAH and DHH sites** • In CAH liaising with the triage nurses to sooner identify potentially suitable patients • Improving the utilization of the	**Stabilise 3 South** • Develop outreach Tracheostomy service throughout the hospital • Continue to develop the ECHO project and widen it to other GP practices • Provide off-site clinics on the bigger Health Centres • Develop Specialist Clinics for Specialty Doctors, eg VHIT, Rhinology, Tracci training, Allergy • Develop guidance for GP's and add to CCG • Introduce E-Triage and help to streamline referrals. • Develop and implement an 'Emergency/Hot Clinic" in Outpatients so as to remove Ward	**Stabilise 3 South** **Service Expansion to DHH** • to include additional Theatres and Nurse-led and Consultant Clinics **Stone Treatment** • Increase Stone Treatments from 2 to 6 weekly sessions • Use of acute stone management will reduce demand for IP treatment **Cancer CNS expansion** • Increase x 1 CNS **Non-cancer CNS expansion** • Increase x 1 CNS **RSAC** • Work with the Region on the Regional Surgical & Assessment Centres for	**Workforce stabilisation in Nursing and anaesthetics** • Recruitment drives during the day and weekends – DHH 8/6/19 • Theatre Education practitioner band 7 to support and attain and sustain high standard of practice • Role progression for staff in post – to be scoped • Emergency theatre co-ordinator – streamline service to be scoped **Quality, Safety and Governance** • Equipment training leads • Procurement leads • DATIX champions • Band 6 audit lead • Surgical Assistants

DHH- Secure appropriate accommodation on the Daisy ill site for Fracture clinic relocation From Surgical Assessment Unit. Currently number 1 on Capital Scheme list - areas visited deemed unsuitable due to numbers attending if back to full clinics. **CAH site** - Undertake a Quality improvement project with the assistance of the QI team to ensure patient waiting times are reduced at the Fracture Clinics **CAH site -** Secure appropriate accommodation for the MSK HUB including high quality radiological screens for review of X-rays & onward pathway. **MSK HUB** - • Review staff funding for HUB and check if	urgent bookable lists through the booking of gallstones pancreatitis patients • Redesigning the DHH SAU – Surgical Assessment unit- to better meet the needs of the ambulatory population **Endoscopy** • Trailing straight to CTC in order to create capacity for the trusts planned patients • Appointing a new clinical lead for Endoscopy **Breast services** • Working through the breast service reconfiguration plan **Orthodontics** • New consultant starting in May so we will use this	Attenders from 3 South • Work with the Region on the Regional Surgical & Assessment Centres for ENT	Urology **Ophthalmology** • Ophthalmology Out patients expansion in Banbridge • Complete the work for RASC Cataracts to STH	**Accommodation** • Review of office accommodations and storage. Meeting being arranged to progress **Support Services** • Scope do we have enough support services **Endoscopy** • Nursing Endoscopist - Review of banding and job plans **Decontamination** • Move all decontamination to the management of CSSD **HDU DHH** • Clear vision and way forward required

all staff are in post • Complete a Communication strategy with Clinical Director from T&O and ED to ensure a collective message to be relayed to all sites. • Complete the administration work behind the collection of data from the HUB • Agree the days & times for the HUB in conjunction with all disciplines to ensure full attendance **<u>Trauma</u>** • Continue to focus on the 48 hr HSCB target for # NOF & 168 hr for any other #. • Monitor the use of the trauma bed compliment	opportunity to identify service improvements			**Maternity theatres** • Funding and recruitment required before the transfer of maternity theatres to ATICS – IPT is being revised **Bowel screening – lowering of age and new test** • Require funding for more staff and endoscopy bowel screening sessions **Paediatric theatres – only 2 paed trained nurses** • Training programmes – EEG commissioned places **Pre-op is an unfunded service** • Review the pre-op paper however the Trust needs to identify funding as a priority. Ronan to discuss best way forward with

including the additional 8 allocated to orthopaedics **Orthopaedic** • Continue with daycase uni-knee pathway • Work towards initiating daycase total hip pathway • Monitor elective orthopaedic performance taking into reduction due to trauma demand, ensuring trajectories are in line with assumptions.				Esther re funding source • Also require accommodation **Chronic pain – capacity gap** • Review the chronic pain paper however the Trust needs to identify funding as a priority. • Also require accommodation British Association of Day Surgery – being scoped Anaesthetic Accreditations Surgical /first Assistance – research ongoing

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Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: Assistant Director ATICs/SEC 8c **Staff Number:** Personal Information redacted by the USI

Is Professional Registration up to date? yes Revalidation April 2023

KEY ISSUES & OUTCOMES	COMMENTS
Have you read and understood your Post Outline? **Post Outlines can be accessed via Trust Intranet (KSF link)** **YES** [X] **NO** [ ] **Have Post Outline levels been achieved:** **YES** [X] **NO** [ ] **If no, record below what action to be taken:**	**Staff members comments on his/her performance over past year:** **Whilst the work plan attached was for 19/20, the pandemic prevented any progression, so remains valid.** The main drive for this year (21/22) is to bring stability to ATIC/SEC. 1. To progress the recommencement of all elective activity - workforce permitting. In-pts/DC/Endoscopy/Screening Programmes. 2. To re-establish a tangible surgical service with all surgical specialties having a home. 3. Deliver on the ST's emergency surgical service reconfiguration 4. Deliver on 'No more silo's' with the creation of robust, sustainable Assessment and ambulatory services 5. Deliver on having an improved Theatres nursing workforce 6. Deliver on having an improved governance structure to meet the needs pts 7. To ensure all wards and departments are RQIA ready I believe I have a responsibility to leave a better/stronger team and services. To deliver on this I actively develop those around me, creating a culture of positivity, fairness and remembering patients' vulnerabilities/expectations. Our work plan is the vehicle to keep focus. **Line Manager's Feedback on staff members performance over past year:** 2020/21 was a challenging year as we managed the Covid-19 pandemic demands whilst attempting to continue with business as normal where possible. Ronan balanced both these demands by implementing ICU surge

	plans and resourcing those from across services, which necessitated standing down a range of services. In parallel, he continued with a range of services of an emergency and urgent nature, both unscheduled and elective, for prioritised surgical and cancer patients. Ronan played an active role over the past year in the Senior Management team in Acute, working as a valued team player with myself and AD's implementing our ever-changing response plans and leading his Divisional multidisciplinary services. There were some frustrations as Ronan's service plans for the year had to go in ice to allow the pandemic plans to be implemented but these are back on track for delivery in 21/22. Ronan has also been a Member of the SNMGF, representing the Nursing workforce and leading change as a result. He also is committed to on call weekdays and weekends and we have recently agreed a temporary work life balance request. I value Ronan's experience, corporate memory and straight forward value based approach to the service. He is willing to address the relentless service demands and work with his teams to deliver them. He challenges appropriately to ensure fairness and that our energy is focused on the right things and as he often says that we will leave the service better than we found it.

Objectives for Next Year:
My objectives are detailed through the Divisional work plan. Whilst this work plan was for 19/20, the pandemic prevented any progression, so remains valid

Reviewee Staff Name (Print) **Ronan Carroll**____ Signature [redacted] Date 13/6/21_____

Reviewer Manager/Supervisor (Print) **MELANIE MCCLEMENTS** Signature [redacted] Date 14/6/21

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Part B ANNUAL PERSONAL DEVELOPMENT PLAN

For training requirements specific to your staff group refer to Trust Intranet Training Link

Staff Number: ____ : [redacted] _____

Training type	Identified learning need	Date Training Completed	Agreed Action
Corporate Mandatory Training ALL STAFF	Corporate Induction		In post August 2007
	Departmental Induction/Orientation		In post August 2007
	Fire Safety	? nov 19	
	Information Governance Awareness	31/8/19	30/08/2022
	Equality & Human Rights		
	Moving and Handling	? 13/7/20	
	Infection Prevention Control	? 13/7/20	
	Equality, Good Relations and Human Rights – Making A Difference	13/7/20	30/08/2022
Corporate Mandatory Training ROLE SPECIFIC	Safeguarding People, Children & Vulnerable Adults		
	Waste Management		
	Right Patient, Right Blood (Theory/Competency)		
	Control of Substances Hazardous to Health (COSHH)		
	Food Safety		
	Basic ICT		
	MAPA (level 3 or 4)		
	Professional Registration		1/4/2023
Essential for Post	Recruitment & selection	yes	09/07/2022
Best practice/ Development (Coaching/Mentoring) (Relevant to current job)			

Reviewee Staff Name (Print) _____ Signature _ [redacted] __ Date __14/6/21_____

Reviewer Manager/Supervisor (Print)_____ Signature [redacted] _____Date _____14/6/21

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21st June 2018

- [ ] Urodynamics - additionality commencing in Sept
- [ ] ENT/Head & Neck -Centralised - T&F meeting mid sept - Martina/David
- [ ] [redacted]
- [ ] Kate McGinn - appointed as CNS H&N -
- [ ] Consideration for another CNS for ENT or Urology .
- [ ] Peter Leyden - Secondment 1st Nov x 1yr

- [ ] Urology specialty Dr x 3 funded - Gemma Hand + Saba
- [ ] Consultant post - specialty advisor
- [ ] Macmillan urology CNS being funded
- [ ] WT re- designating post codes
- [ ] Urology paeds list went very well
- [ ] Away day planning 24th September Seagoe
- [ ] ENT regional leaflets

Ophthalmology
Works not complete31st August & 17th sept for all clinics moving from DHH & CAH

ENT clinics moving to DHH.

Outpatients chairs

Jane Scot's post

Photos of Blood results being taken - speak with Helen

28th Feb 2019

Operational

- [ ] 3S -Paper gone to EDoN re 3S
- [ ] EDW - Plan to flow re calibre of pts
- [ ] OPD - ok

Performance

Paul Hughes - Martina to prioress with Amie
Urodynamic - AOB.
Urology RF - WLI approved for Mark
ENT underperformance OPD -3% - INDC - 10%

Finance

- [ ] Nurse rostering templates

Recruitment

- [ ] Matthew Tyson commenced
- [ ] ENT CNS & Urology - commenced
- [ ] CT1 reg - down by 1 senior trainee x 6mths

Service improvement

- [ ] Jo -OPD plan
- [ ] Ophthalmology - **Audit day having a consequence of SBA**
- [x] Banbridge eyes
- [ ] PIG initiatives
- [ ] Urology/gynae service improvement
- [ ] ENT regional H&N - single surgical site 2/3yrs
- [ ] RQIA going ok

Preparation for Workshop

9th March 2021

Old

- [ ] E Triage and factored in JP's
- [ ] Urology service improvement
- [ ] ENT ? E traige ?
- [ ] Outcome of the 28th Feb meeting
- [ ] 7th Urology consultant ?
- [ ] Appointed CNS x 2
- [ ] Matthews Tyson June return
- [ ] Team South - no pts from WT
- [ ] Fess going in STH
- [ ] Intravesical Chemotherapy - Thorndale Wed

New

Staffing

- [ ] Staff Grade Urology Interviews - Thursday
- [ ] Laura McAuley [redacted]

Performance

- [ ] OPD - ENT RF 3wks, 109 Urgent 52 routine
  - INDC RF 3wks
- [ ] OPD - Urology RF 35wks, routine 260 & routine 266
  INDC - 2-3wks

- [ ] Single use flexible cystoscopy - Piloting £15 saving
  3S remains capped at 30 - AP being updated.

- [ ] Complaints x 4

Ophthalmology
Returning to STH for OPD & DC
Required waiting times & volumes to reclaim BPPC top floor

Southern Health and Social Care Trust

Urology Team Group
Minutes

Tuesday 15 December 2020, 08:30

Via Zoom

	Item	Actions
1	**In Attendance:** Shane Devlin Melanie McClements John O'Donoghue Michael Young Kate O'Neill Jenny McMahon Leanne McCourt Jason Young Patricia Thompson Martina Corrigan **Apologies:** Tony Glackin Maria O'Kane Ronan Carroll Mark Haynes Shawgi Omer Nasir Khan	
	Actions arising from Previous Meeting	
2	Martina updated on actions arising from previous meeting: • Locums/Trust funded Junior Doctors – this has been processed and CV's for a number of doctors are with Michael for approval. An advert has also gone out for a Trust Urology Doctor and it is hoped that there will be some applicants for this as well. • Thorndale Unit being handed back to Urology. Martina confirmed that this had happened and that the Team were planning to meet early January to get clinics up and running again • Wider Team meeting – this meeting has been scheduled for Wednesday 16 December and invite has been sent to all of the team – Melanie also reaffirmed that all Team Meetings had been stood down during the past year and that most of the specialties were like Urology and only now getting a chance to refocus. And that she would be advising the wider group of this and that the message will be that it is 'business as usual' as this will be a long process but that to assure staff that our door is	

	always open if they need any support. Melanie also reiterated that information and communication through regular meetings would be key and would continue.	
	Update from Serious Adverse Incident Group	
3	Shane updated that the Interim report for the 9 SAI's was complete and had been shared with the HSCB and that the final reports were on track for completion at end of January 2021.	
	Any Other Business	
4	Kate raised about the Support Group that had been set up on Social Media, and the issue that members of staff were commenting on it. Shane advised that this was something outside the Trust's control Jenny asked if the CNS could get more information about the Professional and Legal Process. Melanie advised that she had raised the legal aspect with HR and they had advised that we needed to wait until everything was put in place QC appointed and Terms of Reference etc. were agreed before we would know the legal processes. Melanie advised that regarding the professional process she would contact the Executive Nurse Team and ask them to consider this. Shane asked the Team did they feel the meetings were beneficial and the CNS advised that they felt that they were good and should continue on a fortnightly basis even if it was only to touch base. It was agreed that the meeting would happen on Tuesday after the Urology Assurance Group Meeting	**Melanie to speak to Director Of Nursing** **Meetings to continue Fortnightly**
5	**Via Zoom Tuesday 12 January 2021 at 08:30**	**Martina to send out new link**

Southern Health and Social Care Trust

Urology Team Group
Minutes

Tuesday 8 December 2020, 08:30

Via Zoom

	Item	Actions
1	**In Attendance** Shane Devlin Maria O'Kane Melanie McClements Ronan Carroll Mark Haynes Michael Young Shawgi Omer Kate O'Neill Jenny McMahon Leanne McCourt Jason Young Patricia Thompson Martina Corrigan **Apologies:** Tony Glackin John O'Donoghue	
	Update from Urology Assurance Group	
2	Melanie and Maria updated from the meeting with the DOH from previous Friday 4 December: • The Department are in the process of appointing a QC to lead the Inquiry and that this most likely will not be until March 2021 • There is currently an IPT being drawn up to be submitted to the DOH and will include support for the internal operational and governance teams. Along with support for additional clinics that may occur as a result of the inquiry	
	Update from Clinical Weekly meeting	
3	Maria advised that there would be two memo's coming out to the Team for action: • Identification of Variation of Diagnoses / Prescribed Treatments Maria explained that the memo and template that will be forwarded for the Team to complete will be if they come across any patients that were previously Aidan's and that there are concerns over, this should be completed and forwarded to Martina. • Declaration of Interest form for CURE which all the Team will be required to complete and return.	

	Maria updated that the Trust have been working with Royal College of Surgeons and BAUS on what support can be given in the form of Subject Matter Expertise. And that the RCS would be undertaking a Clinical Invited Review of a sample of records. Maria advised that DOH had asked that any SAI's identified are suspended but it was agreed by the Trust that we could not do nothing for any patients identified through this process and that the Trust, HSCB and DOH were looking at ways to continue this process internally until the Inquiry commenced. Mark then raised the issue that Urology was a Consultant delivered service as they had only 1.8 WTE Registrars, 1.5 SPR and no SHO's . (which is at the detriment of the training for the Registrars as they are having to do Jun Doc work. It was agreed that locums/Trust funded Junior Doctors should be requested and employed as soon as possible	**Martina to progress through the Locum Team**
	Any Other Business	
4	Jenny asked what was expected from the CNS in the Inquiry and would they be looking at previous and current practices. Melanie assured the group that this was not about waiting times nor backlogs in Urology and the reason for the Inquiry was that this was a focus on an individual's practice and not on the wider Urology Team's practice. She also advised that it was recognised regionally that this was already a stretched service, which was why we had been asked to identify resources required to meet any additional work, for example the review of patients identified as having clinical concerns etc. Melanie also told the group that the Trust also doesn't know what the expectations of the Inquiry were for any of us and that we would have to wait to see what requests came from the Inquiry Team. She assured everyone that we are all in this together and that we would continue to work as a team and if needed we would be also get emotional support to deal with this. The Department of Health are also mindful of this for the members of the Team and that it was important that we are open and honest and that we all take time to reflect. We as a Trust have to work with the Inquiry and it was recognised that this will be a long process. Kate requested that minutes from this meeting are taken and that these are shared with this group so that they will have time to reflect on them. Martina agreed to take these notes and Shane suggested that these will be used to start each of the meetings going forward. Kate also asked about Thorndale Unit coming back to Urology and Ronan advised that this would be happening from week commencing 14 December	**Martina to take minutes and share with Group** **Martina to**

	2020 when all rooms (apart from 2 which ENT will be using) would be for Urology use and that this is in addition to the two rooms that are used in STH all day Monday and Tuesdays. Kate also requested that Departmental meetings recommence so that the Team can come together to plan and Michael agreed to think about a time that would suit best. Jason suggested that the 'wider' teams involved in Urology (nurses, health care assistants, departmental support, secretaries etc.), should have an information session to advise them on what is happening over the Inquiry. Melanie agreed to lead on this and Martina to set up meeting.	**was ready** **Michael to work on suitable days/times** **Martina to set up meeting**
Date of Next Meeting		
5	**Via Zoom – 22nd December 2020 at 08:30**	**Previous link sent out by Martina**

Southern Health and Social Care Trust

Urology Team Group
Minutes

Tuesday 16 February 2021, 08:30
Via Zoom

	Item	Actions
1	**In Attendance:** Melanie McClements Ronan Carroll Michael Young Tony Glackin Nasir Khan Kate O'Neill Jenny McMahon Leanne McCourt Jason Young Patricia Thompson Martina Corrigan ***Apologies:*** Shane Devlin Maria O'Kane Mark Haynes John O'Donoghue Shawgi Omer	
	Introduction	
2.	Melanie commenced the meeting by expressing her thanks to all of the Team for their recent work during the Covid Surge, and wanted to pass on the Chief Executive, Medical Director and her appreciation of their work the willingness of the staff to be redeployed to areas outside of their normal working environment and advised that she didn't underestimate how difficult this may have been	
	Actions arising from Previous Meeting	
3.	Melanie updated on actions arising from previous meeting: •	
	Update from Urology Assurance Group (DOH/HSCB)	
4.	Melanie advised the group that there had been little to update the previous weeks the last UAG meeting (5 February 2021) had been stood down, however the Trust continue to provide an update to this group of progress of different strands. DOH has advised the Trust that they are progressing with identifying a Chair for the panel and once identified will progress with appointing panel members and finalising the Terms of Reference, and Melanie advised that as soon as the	

	Trust were aware of who the Chair would be then this name would be shared with the Team	
	Update from Serious Adverse Incident Group	
5.	Melanie updated that due to a breakdown in communications with that the 9 draft and 1 overarching SAI reports were delayed until the middle of March, however the SAI Team were actively trying to get a first draft for end of February. The Chair of the SAI Team was meeting with all the families this week, in order to update them on their findings and advise them of the new proposed timelines. Melanie advised that the Team should continue to raise IR1's for any patients that they had concerns with and that these would still be screened under the new process. Martina updated that this was that if a patient was deemed to have met the threshold for a SAI then they would be included in the Structured Judgement Review Process which would look and share any learning from the incident. Training for this will be taking place 18th and 25th March 2021 and this invitation had been sent to the Chairs of the MDT's. Tony asked if Early Alerts needed to be shared with the Chairs of the M&M groups as until they have learning this is not relevant and means the Chairs of the M&M's are inundated with items to discuss.	**Martina to organise a suitable date with Chair and Team**
	Any Other Business	
6.	Tony raised about the position Mark was in in that he was one of the Urology Clinical Team and also the AMD for this specialty which left him in a difficult position and that we needed to be mindful of the pressure that this would leave him under. Melanie assured that Mark's position is recognised by both the local commissioner and the DoH and that was also why the Trust have employed Urology Subject Matter Expertise via BAUS and the RCS so as they can support the work that Mark is having to do. Michael asked about what support was being made available for the Nursing Staff and Melanie advised that regarding the professional processes for the CNS that she had been in contact the Executive Director of Nursing (Heather Trouton) and Heather and her team are considering support in respect to professional areas and that they would be in touch with the CNS to take forward.	
	Date and time of next meeting	
7	**Via Zoom Tuesday 9 March 2021 at 08:30**	**Martina to send out link**

From the Deputy Chief Medical Officer
Dr Lourda Geoghegan

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Chief Executives, HSC Trusts
Chief Executive, HSCB & PHA
Chief Executive, RQIA
Chief Executive, NISCC
Chief Executive, PCC

Room C5.17
Castle Buildings
Stormont Estate
Belfast BT4 3SQ
Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

Date: 15 December 2020

Dear Colleagues

NOTICE OF RETENTION / NON-DESTRUCTION OF DOCUMENTS

I refer to the Minister's announcement on 24 November 2020 to establish a statutory Public Inquiry into the Urology Services provided by Mr Aidan O'Brien, formerly a Consultant Urologist in the Southern HSC Trust.

Given the seriousness of matters relating to the establishment of this Inquiry it is important that your organisation takes all necessary steps to preserve any documents, records and other material so that all such material is available promptly on request should it be required by the Inquiry.

We would therefore ask you to ensure that all relevant material is retained and not subject to scheduled disposal. Where there is a doubt over relevancy, we would advise you to err on the side of caution. I would be grateful if you would confirm with Anne-Marie Bovill at the contact details below that this has been done.

Email: Personal Information redacted by the USI

Yours sincerely

Personal Information redacted by USI

DR LOURDA GEOGHEGAN
Deputy Chief Medical Officer

Southern Health and Social Care Trust

Urology Team Group
Minutes

Tuesday 12 January 2021, 08:30
Via Zoom

	Item	Actions
1	**In Attendance:** Shane Devlin Melanie McClements Maria O'Kane Ronan Carroll Mark Haynes Michael Young Kate O'Neill Jenny McMahon Leanne McCourt Jason Young Patricia Thompson Martina Corrigan ***Apologies:*** Tony Glackin John O'Donoghue Shawgi Omer Nasir Khan	
	Actions arising from Previous Meeting	
2	Melanie updated on actions arising from previous meeting: • Melanie advised that regarding the professional processes for the CNS that she had been in contact the Executive Director of Nursing (Heather Trouton) and Heather and her team are considering support in respect to professional areas and that they would be in touch with the CNS to take forward.	
	Update from wider team meeting	
3	Martina updated the group that Melanie and her met with the wider group as requested on 23 December 2020. In attendance were consultants, CNS, nursing and support staff, Admin manager and a member of the secretarial staff . Melanie had updated the group as to what had happened since the Minister had made his announcement on 24 November 2020. It was agreed from the meeting that when there any further updates that Martina would invite this group to come back together to be updated. Martina advised that one of the issues raised was that staff felt aggrieved that	**Martina to organise a further meeting when required**

	they had to hear about this on the news/social media, Melanie (and Shane at this meeting), had assured that the Trust had not been aware until 30 minutes before the Minister made his statement that this was going to be a public inquiry so this was something that was outside of the Trust's control.	
	Update from Urology Assurance Group (DOH/HSCB)	
4.	Melanie advised the group that there had been little to update the previous weeks UAG meeting (8 January 2021), this was because there had been a lull over Christmas. There had been no calls to the information line since 23 December and only two further emails received to the Urology Inquiry email address. The Trust updated the DOH on the interim SAI report. The DOH recognised that the Trust were going into a difficult period with Surge 3 and there was an acceptance of the difficulty to continue business as normal, so they agreed to a 3 week pause in the clinical work for this inquiry. DOH has advised the Trust that they are progressing with identifying a Chair for the panel and once identified will progress with appointing panel members and finalising the Terms of Reference. Shane advised the group that Mr Pengelly the Permanent Secretary had offered that when the process had started to progress further that he was willing to meet this group and offer his support and allow this group an opportunity to discuss their thoughts and views. It was agreed that this would be helpful and acknowledged that it would be more relevant once the Chair had been appointed and the TOR had been finalised.	
	Notice of Retention/ Non-Destruction of Documents	
5.	Melanie advised that the Trust has received a letter from Deputy Chief Medical Officer asking that the Trust ensure that all relevant material is retained and not subject to scheduled disposal. The Trust has had to confirm that this has been actioned with the relevant departments. (Copy of letter below). This will be relevant for emails/patient notes/diaries/reports etc…. Letter to Chief Executives - Pubic Inc	**The team need to read letter and ensure all documents are retained as requested**
	Update from Serious Adverse Incident Group	
6.	Maria/Melanie updated that the Interim report for the 9 SAI's was complete and had been shared with the HSCB and that the final reports were on track for completion at end of January 2021. They advised that they had had a meeting with the chair of the SAI panel (Dr Hughes) and that he had advised them of some of the early learning from the investigation. There is learning around the governance process of the oncology multi-disciplinary team and how the patients that are discussed during the MDT meetings are processed through their pathway and how concerns that are raised are listened to and actioned has also been looked at during this investigation.	**Martina to**

	The Chair is going to organise to brief this team on the final report over the next few weeks It was recognised by the team that the MDT is a bigger team now and that it has moved on a lot in the last 4-5 years and in particular the recognition of the CNS role in the team.	**suitable date with Chair and Team**
	Structured Judgement Review (SJR)	
7.	Maria explained that since this is now a public inquiry that the DOH had asked that there is no more SAI's carried out, but that the Trust felt that there needed to be another process to work through any concerns that were being identified as the piece of work continued. The Trust met before the Christmas break with the Royal College of Physicians to discuss the use of SJR methodology to support patient reviews. The Royal College of Physicians were supportive and felt it was an appropriate framework to use to conduct the described patient safety reviews in the absence of a full SAI process. The Trust is agreeing a virtual training programme with the Royal College of Physicians team for a core group of reviewers from internally and externally and there will be around 20 reviewers trained.	
	Any Other Business	
8.	Michael raised about the waiting times and that Urology had a major problem with these now being unmanageable. Melanie assured the group that this was outside of the Urology Team and the Trust's control and that it was recognised that this was a regional problem and that the Team had to remember that the Public Inquiry focus was not about the waiting times but about one consultant's adherence to the systems and processes being followed. Maria asked the Team about the frequency and length of the meetings and it was agreed after discussion that this should be monthly with the agreement that a meeting could be arranged if anything needed to be discussed or shared in between the agreed monthly meetings.	
	Date and time of next meeting	
5	**Via Zoom Tuesday 16 February 2021 at 08:30**	**Martina to send out link**

Acute Services Operating Theatre Users Committee
SOUTHERN TRUST

Noes of the Theatre User Group Meeting Thursday, 1st December 2016 at 4:00pm, Boardroom, CAH VC to Committee Room 2, DHH

Present:

Dr Scullion	Ronan Carroll	Mr Young
Wendy Clayton	Mary McGeough	Pamela Johnston
Laura Murphy	Emma-Jane Kearney	Mr Leyden
Ursula Gildernew	Mr Gudyma	Marti McKenna

Agenda	Discussion	Action
Apologies	Mary Madine, Helena Murray, Dr E Boggs	
Notes of last meeting	Agreed as true record	
Matters Arising	Discussed throughout the meeting	
List overruns	Extended days and audit days over runs continue. Laura advised that 50% of her theatres over run for extended days on Tue, Wed and Thursday. Big cases are going on the end. Ursula advised that gynae continue to over run	Communication to consultants regarding over runs from THUGs – Damian to draft and circulate
Moving of specialities around theatres	Orthopaedic theatres – ENT/Urology procedures can be done in the ortho theatres but not G Surg / Gynae. Ongoing discussions with Mr Haynes, T&O consultants & microbiologist to get a resolution to this issue. Mr Leyden advised that the ENT lists have been negatively affected by being moved to T8 Dr Boggs was not present but advised prior to the meeting that for gynae complex lap cases they would like T2	Mark has spoken to R.McKeown – Dr Scullion to get feedback
Policy on the surgical management of endoscopic tissue resection	Final policy to be circulated	Pamela Johnston – to be signed off at the Jan 17 agenda
Alcohol Based Skin Preparation Solutions and the risk of fire in operating theatres	To be taken off the agenda	Take off the agenda
Team Briefing re-audited – Dr D Scullion	Dr Scullion advised that the team briefing audit was presented at 2 events and well received with good feedback – supportive from external review. Team briefing is happening on more lists, including obstetrics	Take off the agenda
ACSA	The Trust is being accredited on the 1st – 3rd March on all 3 sites. Dr J Campbell is leading the provided. Few recommendations are struggling to address but against Trust's control. There are no Trusts outside England that have been accredited, so hopefully Southern Trust will be first to achieve.	Put onto the April 17 agenda
Terms of Reference-THUGS	Feedback from Mr Leyden, to be added to the Terms of reference	Update and finalise – take off

ATICS - Nurse Staffing position	1 agency nurse started 12/12/16, others are out for recruitment. Ad-hoc posts filled but still a significant number of vacancies and ML's not filled	
Theatre Dress Code/Surgical Scrubs	Mary spoke with ICP Consultant and Lead Nurses re SOP who advised that gowns are not required. When going out of theatre but within the hospital no gown required. No scrubs allowed outside of the hospital Mary advised that there should be one particular colour for theatres, however, regionally not would go for specific colour for theatres.	Mary to raise again regionally for theatres to have a specific colour
Financial Position	Continue to be underspent due to vacant posts	
Issues	**Theatre/Endoscopy DHH** Provision of scrubs is an issue in DHH. Mary advised that scrubs are being ordered with revenue money	
	Theatres 1-8 & Recovery CAH Emergency theatre with a roll over of ventilated patients, the urology slot is lost at times. It was felt that G Surg were making a decision on a urology patient to be cancelled. G Surg to make contact with urology to jointly agree There is a meeting on the 19th Dec re the utilisation of the emergency lists and junior doctors.	
	DSU, CAH No issue	
	Theatre/DPU, STH No issue	
G&S Requests	**Single use flexible ureteroscopes – urology** 2 scopes to try out, companies are keen to try before purchase. Scopes are £600 each for single use x 4 and £650 each x 4, can make a business case and would be handy to take to STH and are disposable. Mary advised that need to pay for what you trial. Would need an image intensifier in STH – so trial would need to in CAH **Lap fan retractor - urology** £1000 single use x 5; attach to flex arm. Trial after purchase of flex arm. DHH have requested to trial also and evaluation by both sites. **Nerve Monitor (Mr Leyden – attachments)** All details have been forwarded. All carotids, ears and thyroids have a nerve monitor as routine. Would need for every. £13,000 – this would be capital **Trocars Ethicon (M.Madine/Gudyma)** Reps have met with Ethicon who have offered to replace all ports. In relation to money, same money per item with further possibility to reduce the price in relation to volume. Looks like	Agreed trial Agreed trial To be put onto the capital list Keep on the agenda – need feedback from Urology / Gynae

	not losing any money and Surgeons are happy on both sites. Need to ensure the Urology / Gynae are happy also. **Sieves used for all TURs in Urology `** Pamela brought a sample to THUGs, reusable sieve is £3.03, single use sieve is £2 each. However, Mary advised that ATICs is not charged from CSSD. Mr Young advised that he has already tried and would recommend and with ease of use for the scrub nurse **Hemo-loc** Take off Dermabond to Liquidban (Helena) Agreed **Laparoscopic disposable dissector /divider for Gynae Procedures** £10 saving, curve is easier access and better handling. Dr McCracken would like to purchase – disposable. Mr Gudyma advised that they use disposable and would highly recommend.	Trial agreed Take off the agenda Take off the agenda To review and discussed at next months meeting
Urology trial of bipolar system / Urolift update	**Bipolar update** Assessment form has been forwarded to Mary McGeough. **Urolift** Trial has been completed and urology are happy with product. Has been forwarded to Urology HOS to draft business case.	Take off the agenda Take off the agenda
AOB	**Cut off items for agenda** All new items to be with Wendy by previous Wednesday week prior, anything after will not be discussed.	
Date of Next Meeting	Thursday 5th January 2017 4:00pm, Boardroom, CAH with VC to Committee Rm 2, DHH Cut off is Wed 28/12/16 for agenda items Apologies: Mary McGeough, Marti McKenna, Mr Gudyma	

Acute Services Operating Theatre Users Committee
SOUTHERN TRUST

Notes Theatre User Group Meeting Thursday, 2nd March 2017 at 4:00pm, Boardroom, CAH VC to Committee Room 2, DHH

Present:

Mr Young (Chair)	Wendy Clayton	Ronan Carroll
Helena Murray	Pamela Johnston	Dr Gudyma
Emma Jane Kearney	Dr E Boggs	Roisin Murray

Agenda	Discussion	Action
Apologies	Dr D Scullion, Dr Tariq, Mary McGeough	
Matters Arising	THUGs rep – lack of speciality representation was issued. Damian to write to HOS re: departmental representation at every THUGs.	Damian Scullion
Medical suspensions & Pre-op (Ronan)	Wendy to circulate pre-op paper re medical suspensions for comments and discussion at next meetings THUGs meeting	Wendy Clayton
Flex Cyst Consent Stickers (email from Marti)	Sticker to go onto consent form re flex cyst patients. Question is a sticky acceptable to be put onto a consent form. Currently use sticky for OGDs and gynae	Agreed to progress, order and trial with Mr Young & Mr Glackin
List overruns	Pamela advised over runs still occur. Has an impact on delays in recovery. Emma-Jane struggles with over runs on the extended days Ronan suggested targeting consultants who continually over run	Wendy to run report over last 3 months identifying over runs To forward information before next meeting
Moving of specialities around theatres	Damian to follow up with Dr Haynes	
ATICS - Nurse Staffing position	Continue with high level of nursing vacancies. High level of agency/bank staff block booked for a period of 6-months at a time.	
Financial Position	ATICs is in the black at the end of financial year due to vacancies. Recurrent money remains with the Trust	
Issues	**Theatre/Endoscopy DHH** No issues **Theatres 1-8 & Recovery CAH** Dress code policy. More flexibility from Infection control. No gowns and hats off. **DSU, CAH** Continued over runs in DSU in the morning list which is impacting the pm sessions. AM session is supposed to finish at 12:30 **Theatre/DPU, STH** No one present	Wendy to attach dress code policy with notes of minutes

G&S Requests	Ascope (respiratory) Similar to scope for difficult intubation, it's for high risk TB cases. Max of 10 per year. Less than £200 per scope. 2 boxes for Trial, screen is free **Nasal high flow (Dr T Bennett)** Defer no one present to discuss **Nerve Monitor (Mr Leyden – attachments)** Take off agenda opportunity lost for this year, it's capital monies. ENT priority for 17/18 **Trocars Ethicon** Trialling in urology and gynae. Majority of clinicians will be happy with Ethicon. DHH using Ethicon Proposal has been on the agenda for a number of months, has been forwarded to consultants in the past. **Laparoscopic disposable dissector /divider for Gynae Procedures** Take off – going with Maryland **RUMI uterine manipulator (gynae)** Product is RUMI uterine manipulator / handle system. With uterine manipulator tips and sacrocolpopexy tips. Dr Boggs will liaise with Pamela about which disposable products need ordered. A trial of 20 cases of TLH and 5 sacrocolpopexy would be sufficient.	Ursula to advise Dr Polley trial is agreed and determine if DHH will use Feedback from gynae and decision to be made next month Trial for 6 months
AOB	Trials Trials to come back to the group for feedback and decision Security access to maternity All staff will need ID re-programmed to allow access to maternity Extended days Mr Young stated that extended days were to be trial only and he felt they are not as efficient as core hours. They are a challenge to manage. If there is an alternative / better way to still achieve then to look at this e.g maximizing all of DHH theatres Mr Young queried the use of trauma recovery which is currently not in use. Thermablade Thermablade won tender, therefore, Novisure will be no more in use. However, a degree of retraining is required and Ursula advised	Wendy to collate Dr Boggs to contact rep to see if training can be brought forward

	training not available until June. DSU have 5 Novisure left, ordered but given Thermablade but training not until June. Only capacity to do 11 cases if training is not before June 17	
Date of Next Meeting	Thursday 6th April 2017 4:00pm, Boardroom, CAH with VC to Committee Rm 2, DHH	

Southern Health and Social Care Trust

Quality Care - for you, with you

THUGS BUSINESS MINUTES

Notes of meeting held Thursday 6th December @ 4 pm
Meeting Room 1, Admin Floor, CAH (VC Available)

Attendees: , Mr Gudyma, Pamela Johnston Julie O'Hagan, Ann Sherry, Mr Young, Alison Moen – DHH , Jodie Richardson - DHH & Mr Gudyma, Ronan Carroll, Mr McCracken Helena McMurray, Damian Scullion, Mr McKay , Mr Young, Jane Scott,

Apologies		
1.0 Matters Arising	• Discussion at meeting on the 04/10/2018 Allocation of Theatre 2 for laparoscopic colorectal surgery – discussions regarding removing canopy. Helena queried canopy OPKL , would it collapse ,can it be cut ? Checking if viable. Need to find out if ceiling strong enough . Could suspend because of canopy obstructing. Cost involved. Mr McKay advised Practical solution use theatre 3. Theatre 2 GI Theatre 5 x days a week- move specialties. To be discussed further at meeting.	Helena
2.0 Pre-Op Issues	• Damian escalated face to face appts demand and reported there is no need to increase additionality.	
3.0 ATICS	• **Staffing** – Helena advised CAH staffing position . Extra Bank staff fworking , 30 % reduction helps. Going to get worse, significant concerns of core ability to cover core sessions. Cardiology & trauma theatre closed for time. 9.84 wte maternity leave theatres 5-9. Young population of staff relying on Agency staff. ODPs do anaesthetics do only can't scrub or circulate, scrub practitioners do all aspects. There are 3 x x-members of staff in theatre, only do specific duties – dilutes . Staffing done in Oct especially in Pamela's area – 7 x WTE retirements scheduled for next year. • **Financial Position** – Ronan advised month 6 – 3.4 million Goods & Services, £2.988 million Pay roll. 1.223 million over spend - £75K payroll, £476 Goods & Services - project £2 million overspend. • **Theatre Issues** • **A) Theatre Endoscopy – Image Intensifier** - Marti advised Claire Donnelly was absent from meeting today, not ready for discussion. Day Surgery has no issues . • **B) Request to Use Specific Theatres** – Mr Gudyma theatre 3 – Imager in DHH is not working, no scope guide. It was broken before and not working again. It is much easier to do procedure with it. Marti to look into this, it might be getting broken in transfer. • **C) Cardex Issues** – Mr McKay suggested chasing nurses, needs incorporated in the WHO Checklist i.e Cardex Complete. He advised this was the best way to achieve this. Before pt leaves theatre Cardex needs completed – Consultants go to Junior staff , there is nothing to encourage this . Helena advised	***ACTION*** Marti

	Cardex was at version control in Trimprint - she advised she will get wording, proofed & passed by version controls.	
G&S Requests	• **Erbe Jet System** - Helena advised this was for Kevin McElvanna. Marti spoke to Rep ,whole entire set to be bought. Erbe part of module, you can buy just one box. Need costings.	**Action : Marti & Pamela to provide costings**
	• **Polytraps** – Trial running across sites. Marti thought doing well, and advised some of the endoscopists don't like them .	**Action : Pamela to provide feed back after 1 mth trial**
	• **Pico Dressing** – Pamela advised Pathway recommended for pts with BMI over 35. She advised flow chart strongly supported prices of dressing. £120 has supportive evidence and outcomes, increase stock levels in theatres, wouldn't need to order every week .NICE Guidelines states we should be following pathway. VAC Dressing much more expensive. Agreed to monitor it for a month trial on both sites. Helena advised to get stock in DHH & CAH and monitor it. Pamela to send info to DHH. Team brief at start of theatre session .	
	• **Urology Scope Warmer** – Mr Young advised Mr Glackin & Mr Haynes use. It's cheaper, saving of £6. Seems fair enough – Passed – YES.	
	• **Pico Needle** – Mr Young advised that he still transverses back to old needle - £40 a needle. Agree period of both trials. Helena advised sometimes trials keep going after agreed trial period. Jodie will advise when STOPS. PALS will stop the order, has to go through e-procurement.	
	• **Screens** - Mr Gudyma advised mobile screen was fantastic - suggested system trial. Mr McKay to check e-mail from Olympus £4k system to get around screens on a pole makes it easier, screen very big. £4k may be very expensive ,also need to replace all our laparscopic equipment 50% over use.	**Action :** Mr McKay to provide update
	• **Anaesthetics Machine** - Damian advised savings on Gas – Maki £40k, Suse £36k. Purchased 4 x machines connected to ICU. Plan 3-4 years change all machines £90k allocation . Good News is , it's on top of capital list.	
	• **Nerve Stimulator** - Pamela advised, can't get one that suits the needs. Technology target controlled delivery system. Down to low a flow as possible, going to 100 mls. Will make savings by updating	

	technology. Buying 2 x is more cost effective - PASSED • **Harmonic & Bio-Polar** –What choice? Geoff advised why not have both - 2 x modalities keep a lot of Consultants much more happy. Need generators**,** 6 x theatres. Ligasure – bigger shape. Geoff requested to buy 3 of each. He advised DHH use Ligasure. Trail has happened on CAH Site . Pamela advised Surgeons also been trialling this on CAH site. Geoff advised on CAH site better to have 2 x modalities doesn't cost any more money. Alison suggested it to be trialled in DHH . Can't speak for DHH, don't do laparscopic. Ligasure, Thunderbeat & Harmonic. Harmonic change to Thunderbeat – Surgeons like Ligasure. It was agreed to trial for another month. • **Cardiac Services** – Pamela advised don't hold needle anymore, severe problems Olympus within a forum. DHH , STH & CAH have needle holders and each spec will have slightly different requirements. Mr Gudyma advised gynae team borrowing urology . It was agreed to trial Olympus. • **Cataract STH Centre** – Marti advised group there was 1 x session on Friday 14h Dec. Phased implementation 70 pts per week. Ophthalmic Surgeons don't want to do 70 a week, may make 60 pts per week. • **Theatres** - Pamela advised group that theatre staff are under a lot of pressure. There is a varied skill mix, need good tolerance and support from medical colleagues through these difficult times **,** request good theatre ethic, working together policy. There is £90k procured for bronchoscopies. • Helena discussed the ordering process and advise a proceurement of £90k for bronschosocpies and other equipment etc . Helena advised need a nomination to sit on skin staplers, used by Surgeons. Mr Gudyma agreed to meet with Jim Crozier .	
AOB	Governance Issue – Nephrectomy pts , Friday night. Ann Sherry advised Consultant Urologist must review pts before being discharged to ward, patient staying overnight. Anaesthetist not aware of this nor Dr Brown. Needs to be communicated amongst teams , nursing staff and Consultants.	
Date of Next Meeting	• Thursday 3rd January 2019 , Meeting Room ,Admin Floor @ 4 pm	

Theatre User Group
Thursday, 4th April at 4:00pm
Meeting Rm, CAH / Committee Rm 1, DHH via VC / STH via phone

Present:

Damian Scullion (Chair)	Mr J Bunn	Pamela Johnston
Ursula Gildernew	Julie O'Hagan	Emma-Jane Kearney
Helena Murray	Mr M Young	Wendy Clayton
Mr D McKay	Alison Moan	Marti McKenna
Peter Merjavy	Mr T Farnon	Claire Donnelly
Jody Rogerson		

Agenda	Discussions	Outcome/Action
Apologies	Mr J Gudyma, Ann Sherry – sending rep instead Sr Irene Grossman	
The way forward for THUGS meetings **Proposal:**	**Bi-Monthly** Agreed THUGs will have monthly meetings, however, will miss meetings during peak holiday periods Jan, July and August meetings **Requests / Reps attending** For any G&S requests a Senior Rep is required i.e Consultant, HOS, Sr Reg or nursing. If no Rep the G&S request will not be discussed. Proforma must be completed. **Agenda** Fixed agenda to be circulated 7 days before THUGS meeting date **Any other business (AOB)** AOB can only be added up to 48 hrs for urgent items (not G&S). **Capping G&S at certain price** Anything under £3k per annum and a cost saving does not have to go to THUGS for discussion. Proforma still has to be completed and noted for audit trawl	All agreed All agreed Agreed Agreed Agreed
3. ATICS BUSINESS	**Staffing** Ongoing staffing challenges. There are more retirements in 19/20. Theatre sisters are scoping when the retirements will be. Ongoing recruitment drives continue, HOS, Lead Nurse (LN) and Sisters are fully involved in the drives.	

	Financial position £1.2m overspent in G&S. Ongoing G&S meetings with HOS, LN and Srs. **Theatres / site specific issues** T5-8 – Power drills (12 years old) now not under service contract and looking at £340k to replace, it is on the capital list	
4. Theatre Utilisation	**Theatre Utilisation** Internal audit has completed a theatre utilisation audit, a meeting is being arranged with internal audit re findings. After the meeting the report will be shared with the THUGs group Wendy circulated the high level theatre utilisation report. All information is on sharepoint, but any specific information is required to be requested via Wendy. Theatre utilisation to remain as a rolling item on the agenda	
5. Capital list	**Capital List** ATICS have a 'live' capital list; held by Emma-Jane. Equipment can be added following discussion with the Theatre Sisters, the Sisters check if the equipment is on a framework / contract and then it will go onto the capital list with live quotes DMcK requested what is the process when essential equipment has been in on the capital list for a number of years but has not been prioritised for purchasing and is putting patients at risk.	Helena to check out process and feedback to Mr McKay
6. Adult tonsillectomy in STH Day Surgery Unit	Mr Farnon raised the possibility of doing surgery on adult tonsillectomies on the STH day surgery site. Equipment will be required to enable tonsillectomies to be completed in STH, which will have cost implications Ramesh is working on a SOP / proposal re post bleeding on STH site and all risks assessed. Further discussion is require to agree a pathway There is a working group for RASC specialities. Martina will be the ENT rep.	Discussion with ENT and anaesthetist to draft a SOP post bleeding tonsillectomy on STH site. Dr Scullion and Mr McNaboe are meeting w/c 8 April Helena to discuss with Martina with costings

7. Bile duct exploration	There is an increased need for bile duct exploration partly due to lack of ERCP, failed ERCP's and increase in population, therefore, there is a need for more Choledochoscope on all sites. This equipment is on the capital list	 FW: bile duct exploration
8. G&S Requests	**Standards and Benefits of an electronic reporting tool for acute pain** **Peter Merjavy** presented the requirement for an electronic reporting tool for acute pain – audits, outcomes, follow ups. Software is used in England and partial use in the Ulster hospital. To discuss with Siobhan Hanna, AD for Informatics. Dr Merjavy seek a quote for a single package.	Peter Merjavy to meet with Helena Murray to progress (met Fri 5 April 19). Helena to progress with IT and look into business case / streamling fund
	Mr Young - Urology requests a trial of the Olympus ShockPulse-SE Lithotripsy system KEYK10027367- for PCNL	Machine is lent case by case basis. On the capital list – Trial agreed
	Mr Young - Urology Cook disposable 2-part trocar needle – PCNL	Agreed
	Mr Young - Urology Urology surgeons would like to trial Erbe VIO 3 electrosurgical system for TURBTs	Trial for 3-months and it is on the capital list
	Mr Glackin - Urology S curved urethral dilator set – Mr Glackin	Agreed – cost savings of £5k
	Mr Bunn - Orthopaedics Chondogide AMIC for use with cartilage and bone defects within joints – will be used 12-15 times per year (approx extra revenue cost of £20k per annum). Has been trialed with positive feedback. This will be instead of knee replacements	Business case to be completed by JB and HOS
	Mr McKay – General Surgery Allocation of Theatre 2 for laparoscopic colorectal surgery - to be further discussed	
	Mr McKay – General Surgery Trial complete for Airseal insufflators – to be added to capital list. Cost savings. Urgently need the equipment and it is a safety matter. Need new kit.	New quote to be forwarded and to be escalated as a high priority
	Peter Merjavy Trial of Philips Lumify hand held Ultrasound T2, 3, 4 and 6. Cost savings	Agreed for trial and update with results

	Mr Farnon - ENT Duramatrix - £300 per case, reduce theatre time and success of the case **ENT** Surgical Powder to replace Perclot. £25 cheaper **Urology** To trial Veriset patch haemostat (5x10 cm) HPO510E. Annual savings **Marti** KD Surgical - Rotatable Loop Net Retrieval Device (endoscopy consumable) – there is a Rep who would like to trial and it is not on a framework. Request if the rep can give a free trial.	Agreed Agreed Agreed To wait for another week to see if it goes onto a framework Add back on to May agenda
9. Service Developments	None	
10.AOB	**Sterile Cockpit** A 'sterile cockpit' is looking at ways how to communicate better in theatres, being in a quieter environment. It is at phase 1 and phase 3 or WHO checklist Mr McKay, Dr Scullion and Dr Merjavy offered to test out 'sterile cockpit' **Theatre cap challenge** Successful theatre cap challenge in England and suggested testing out in SHSCT theatres. Dr Scullion suggested volunteers in the first instance.	Mr McKay to test Sisters to scope volunteers
11.Date of Next Meeting –	**Thursday 2nd May 2019.** Meeting Room , Admin Floor, CAH / Committee Rm 1, DHH	

Proposal for ADEPT Management Project in Southern Health and Social Care Trust

Aim

To establish and develop a satellite Urology Service in the first instance in Daisy Hill Hospital this is to include Outpatients, daycases and some suitable inpatients.

Background

There is a General Surgeon with a Urology Interest in Daisy Hill Hospital who is retiring. This will mean that there will no longer be any urology service available locally for the Newry and Mourne Population.

The Project

Start with a baseline to find out the views of the Consultant Team and then work at establishing and setting up the service in Daisy Hill. Then auditing at how this is all achieved, using Manpower, Equipment, Facilities available etc..

Below are some of the outcomes that it is anticipated will come from this project:

- Clinical engagement not only from Urology but from General Surgery.
- Developing pathways for suitable elective patients so their operation can be carried out in Daisy Hill Hospital
- Developing pathways, guidance and information on Urological Procedures for emergency patients and therefore preventing inappropriate admissions or reducing length of stay because there will be guidance on what should be done for various conditions.
- Release Main Theatre time in Craigavon Hospital so that team can concentrate on more major cases that need to be done in Craigavon Hospital, therefore ultimately reducing the waiting times for Urology Surgery.

The skills gained from this project will be transferable and will mean that there can be a satellite service can be enhanced in South West Acute Hospital (currently the Urology Team travel to do outpatients and are keen to commence daycases there as well, so if there was time then this process could be rolled out to this facility.

The learning and outcomes could be shared with other Trusts in Northern Ireland.

The successful candidate would be monitored and mentored by Mr Haynes and Mr Glackin (Consultant Urologists) and Mrs Corrigan, Service Manager for Urology.

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: Personal 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 Personal Information redacted by the USI Personal Information redacted by the USI or

	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]
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.**

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Reference: HSC (SQSD) 5/19

Date of Issue: 27th February 2019

EARLY ALERT SYSTEM

For Action:
Chief Executives of HSC Trusts
Chief Executive, HSCB and PHA for cascade to:

- *General Medical Practices*
- *Community Pharmacy Practices*
- *General Dental Practitioners*
- *Ophthalmic Practitioners*

Chief Executive NIAS
Chief Executive RQIA
Chief Executive NIBTS
Chief Executive NIMDTA
Chief Executive NIPEC
Chief Executive BSO

For Information:
Distribution as listed at the end of this Circular.

Related documents

HSC (SQSD) 10/10: Establishment of an Early Alert System

HSC (SQSD) 07/14: Proper use of the Early Alert System

Superseded documents:

HSC (SQSD) 64/16: Early Alert System

Implementation: Immediate

DoH Safety and Quality Circulars can be accessed on:
https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

Issue

This Circular provides updated guidance on the operation of the Early Alert System which is designed to ensure that the Department of Health (DoH) is made aware in a timely fashion of significant events which may require the attention of the Minister, Chief Professional Officers or policy leads.

Action

Chief Executive, HSCB and PHA should:

- Disseminate this circular to all relevant HSCB/PHA staff for consideration through the normal HSCB/PHA processes for assuring implementation of safety and quality circulars.
- Disseminate this circular to Community Pharmacies, General Medical, General Dental and Ophthalmic Practitioners.

Chief Executives of HSC Trusts, NIAS, NIBTS, NIPEC and BSO should:

- Disseminate this circular to all relevant staff.

Chief Executive, RQIA should:

- Disseminate this circular to all relevant independent sector providers.

Chief Executive, NIMDTA should:

- Disseminate this circular to doctors and dentists in training in all relevant specialities.

Background

In June 2010, the process of reporting Early Alerts was introduced. The purpose of this circular is to re-issue revised guidance for the procedure to be followed if an Early Alert is appropriate.

This revised circular will also serve as a reminder to the HSC organisations to ensure that the Department (and thus the Minister) receive prompt and timely details of events (these may include potential serious adverse incidents), which may require urgent attention or possible action by the Department.

You are asked to ensure that this circular is communicated to relevant staff within your organisation.

Purpose of the Early Alert System

The Early Alert System provides a channel which enables Chief Executives and their senior staff (Director level or higher) in HSC organisations to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads, and/or require urgent action by the Department.

Criteria for using the Early Alert System

The established communications protocol between the Department and HSC organisations emphasises the principle of 'no surprises', and an integrated approach to communications. Accordingly, HSC organisations should notify the Department promptly (within 48 hours of the event in question) of any event which has occurred within the services provided or commissioned by their organisation, or relating to Family Practitioner Services, and which meets one or more of the following criteria:

1. *Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;*

2. *The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;*

3. *The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;*

4. *The event may attract media interest;*

5. *The Police Service of Northern Ireland (PSNI) is involved in the investigation of a death or serious harm that has occurred in the HSC service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does not include any deaths routinely referred to the Coroner, unless:*

    i. *there has been an event which has caused harm to a patient or client and which has given rise to the Coroner's investigation; or*
    ii. *evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received; or*
    iii. *the Coroner's inquest is likely to attract media interest.*

6. *The following should always be notified:*

    i. *the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;*
    ii. *the death of, or significant harm to, a Looked After Child or a child on the Child Protection Register;*
    iii. *allegations that a child accommodated in a children's home has committed a serious offence; and*
    iv. *any serious complaint about a children's home or persons working there.*

7. *There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.*

Family Practitioner Services should notify the HSC Board about events within the services they provide that meet one or more of these criteria. The HSC Board will then notify the Department.

Operational Arrangements

It is the responsibility of the reporting HSC organisation to ensure that a senior person from the organisation (at Director level or higher) communicates with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, Assistant Secretary or professional equivalents) regarding the event, and also an equivalent senior executive in the HSC Board, and the Public Health Agency, as appropriate, and any other relevant bodies.

To assist HSC organisations in making contact with Departmental staff, **Annex A** attached provides the contact details of a range of senior Departmental staff together with an indication of their respective areas of responsibility. **The senior officers are not listed in order of contact. Should a senior officer with responsibility for an area associated with an event not be available, please proceed to contact any senior officer on the list.**

It is the responsibility of the reporting Family Practitioner Service practice to ensure that a senior person from the practice **speaks in person** to the Director of Integrated Care (or deputy) in the HSC Board regarding the event.

The next steps will be agreed during the call and appropriate follow-up action taken by the relevant parties. In **all** cases, however, the reporting organisation must arrange for the content of the initial contact to be recorded on the pro forma attached at **Annex B**, and forwarded, within **24 hours** of notification of the event, to the Department at [redacted] and the HSC Board at [redacted]

It is the responsibility of the reporting HSC organisation to comply with any other possible requirements to report or investigate the event they are reporting in line with any other relevant applicable guidance or protocols (e.g. Police Service for Northern Ireland (PSNI), Health and Safety Executive (HSE), Professional Regulatory Bodies, the Coroner etc.) **including compliance with GDPR requirements for information contained in the Early Alert pro forma and the mandatory requirement to notify the Information Commissioner's Office (ICO) about any reportable personal data breaches. The information contained in the pro forma should relate only to the key issue and it should not contain any personal data.**

There will be occasions when reporting organisations feel it is appropriate to provide updates on an Early Alert which has already been reported. Given that a passage of time may have elapsed and Ministerial changes, this is good practice. It may be appropriate, therefore, for a senior person from the organisation (at Director level or higher) to communicate with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the update. This is not mandatory but reporting organisations will wish to exercise judgement as to whether there has been a substantive change in the position which would warrant a call.

Enquiries:

Any enquiries about the content of this circular should be addressed to:

Mr Brian Godfrey
Safety Strategy Unit
Department of Health
Castle Buildings
Stormont
BELFAST
BT4 3SQ
Tel: Personal Information redacted by the USI
qualityandsafety@health-ni.gov.uk

Yours sincerely

Personal Information redacted by USI

Dr Paddy Woods

Distributed for information to:

Director of Public Health/Medical Director, PHA
Director of Nursing, PHA
Director of Performance Management & Service Improvement, HSCB
Director of Integrated Care, HSCB
Head of Pharmacy and Medicines Management, HSCB
Heads of Pharmacy and Medicines Management, HSC Trusts
Safety and Quality Alerts Team, HSC Board
Governance Leads, HSC Trusts
Professor Donna Fitzimmons, Head of Nursing & Midwifery, QUB
Professor Pascal McKeown, Head of Medical School, QUB
Professor Donald Burden, Head of School of Dentistry, QUB
Professor Carmel Hughes, Head of School of Pharmacy QUB
Dr Neil Kennedy, Acting Director of Centre for Medical Education, QUB
Professor Sonja McIlfatrick, Head of School of Nursing, UU
Professor Paul McCarron, Head of Pharmacy School, UU
Staff Tutor of Nursing, Open University
Director, Safety Forum
Lead, NI Medicines Governance Team
NI Medicines Information Service
NI Centre for Pharmacy Learning and Development
Clinical Education Centre
NI Royal College of Nursing

ANNEX A
EARLY ALERT SYSTEM: DEPARTMENTAL OFFICER CONTACT LIST
FEBRUARY 2019

HEALTHCARE POLICY GROUP

Deputy Secretary
Jackie Johnston [redacted]

Primary Care/ Out of Hours Services
Mark Lee [redacted]

Secondary Care
Kiera Lloyd [redacted]

Workforce Policy/Human Resources
Andrew Dawson [redacted]

RESOURCES AND PERFORMANCE MANAGEMENT GROUP

Deputy Secretary
Deborah McNeilly [redacted]

Capital Development
Brigitte Worth [redacted]

Information Breaches/ Data Protection
La'Verne Montgomery [redacted]

Finance Director
Neelia Lloyd [redacted]

SOCIAL SERVICES POLICY GROUP

Chief Social Services Officer
Sean Holland [redacted]

Child Protection/ Looked After Children (LAC's)
Eilis McDaniel [redacted]

Mental Health/ Learning Disability/ Elderly & Community Care
Jerome Dawson [redacted]

Social Services
Jackie McIlroy [redacted]

CHIEF MEDICAL OFFICER GROUP

Chief Medical Officer
Dr Michael McBride [redacted]

Deputy Chief Medical Officers
Dr Paddy Woods [redacted]

Population Health
Liz Redmond [redacted]

Chief Dental Officer
Simon Reid [redacted]

Acting Chief Pharmaceutical Officer
Cathy Harrison [redacted]

Senior Medical Officers
Dr Carol Beattie [redacted]
Dr Naresh Chada [redacted]
Dr Gillian Armstrong [redacted] Healthcare-Associated Infections (HCAIs) (both confirmed and unconfirmed)

CHIEF NURSING OFFICER

Chief Nursing Officer
Charlotte McArdle [redacted]

Deputy Chief Nursing Officer
Rodney Morton [redacted]

☒ **Initial call made to** _____ **(DoH) on** _____ **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name _____ Organisation _____

Position _____ Telephone _____

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.***

……

……

……

……

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: _____

Contact details:

Email address (work or home) ……

Mobile (work or home) …… Telephone (work or home) ……

Forward pro-forma to the Department at: [redacted] and the HSC Board at: [redacted]

FOR COMPLETION BY DoH:

Early Alert Communication received by: …… Office: ……

Forwarded for consideration and appropriate action to: …… Date: ……

Detail of follow-up action (if applicable) ……

Carroll, Ronan

From: Wamsley, Chris
Sent: 06 May 2022 12:56
To: Carroll, Ronan
Subject: RE: USI Witness Statement Template - 57
Attachments: 20220505 SAI's by Specialty - listed by Datix Number and Final Report date (year).xlsx

Hi Ronan

Updated corrected SAI list.

Many thanks
Chris

From: Carroll, Ronan [Personal Information redacted by the USI]
Sent: 06 May 2022 12:50
To: Wamsley, Chris [Personal Information redacted by the USI]
Subject: RE: USI Witness Statement Template - 57

Thks chris

Ronan Carrroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob - [Personal Information redacted by the USI]

From: Wamsley, Chris [Personal Information redacted by the USI]
Sent: 05 May 2022 15:27
To: Carroll, Ronan [Personal Information redacted by the USI]
Subject: USI Witness Statement Template - 57

SAI's by Specialty - listed by Datix Number and Final Report date (year)

Specialty	2015	2016	2017	2018	2019	2020	2021	Ongoing
Anaesthetics/Theatres	Personal Information redacted by USI							[redacted]
Cardiology	[redacted]	[redacted]			[redacted]			
	[redacted]	[redacted]						
	[redacted]							
Dermatology		Personal Information redacted by USI						
Heamatology						[redacted]		
Emergency Department	Personal Information redacted by USI	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
	[redacted]				[redacted]			
	[redacted]				[redacted]			
	[redacted]				[redacted]			
	[redacted]				[redacted]			
	[redacted]							
General Medicine	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]			[redacted]	[redacted]		[redacted]
	[redacted]				[redacted]	[redacted]		[redacted]
	[redacted]				[redacted]			[redacted]
	[redacted]				[redacted]			[redacted]
	[redacted]							[redacted]

Received from SHSCT on 16/05/22. Annotated by the Urology Services Inquiry.

General Surgery	Personal Information redacted by USI	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]			[redacted]	[redacted]			[redacted]
	[redacted]				[redacted]			
	[redacted]				[redacted]			
	[redacted]							
Laboratory Services						[redacted]		[redacted] ([redacted]
						[redacted]		
						[redacted]		
Radiology	Personal Information redacted by USI	[redacted]		[redacted]		[redacted]		[redacted]
								[redacted]
								[redacted]
								[redacted]
Trauma & Orthopaedics	Personal Information redacted by USI							Personal Information redacted by USI
Ophthalomogy			Personal Information redacted by USI					

Obs & Gynae	Personal Information redacted by USI	Personal Information redacted by USI	Personal Information redacted by USI	[redacted]	[redacted]	[redacted]		[redacted]
Urology Surgery	Personal Information redacted by USI	[redacted]		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		[redacted]		[redacted]	[redacted]	[redacted]		[redacted]
		[redacted]		[redacted]	[redacted]	[redacted]		[redacted]
				[redacted]				
					[redacted]	[redacted]		
					[redacted]			
					[redacted]			

Carroll, Ronan

From: Wamsley, Chris
Sent: 04 May 2022 10:18
To: Carroll, Ronan
Subject: Chris would you have a few Datix from staff in 3s between 17 and 18 regarding staffing pressures thks Ronan
Attachments: DatixWebReport (version 2).xlsb

Hi Ronan see attached

Many thanks
Chris

ID	Incident date	Reporter	Division	Site	Loc (Exact)	Severity	Description	Action taken (Investigation)	Handler	Approval status
[redacted]	[redacted]	Personal Information redacted by the USI	MUC	Craigavon Area Hospital	3 South	Minor	two trained staff working on medical (front wing) with no HCA. patients where highly dependent . numerous patients with high MEWS, numerous patients with confusion to which required one to one care and supervision patients personal care was delayed resulting in numerous patients soiled in faeces and urine oberservations delayed as care had to be prioritized repostoiniong delayed as care had to be prioritized the other side on the ward had 4 staff to whom declined to come and assist with patients needs bed manager informed ? "[redacted]" who was unconcerned until a patient was refused admission to front wing due to dependencies of patients then RGN from theatre came to help at approx 1-2am, then help again at 0600 for 45 mins care was substandard and patient safety was compromised	all options had been utilized to cover the vacant shift - shift out to bank and agency but no pick up -co-ordinator and flow aware and options to redeploy staff utilized where possible - due to the pressues not possible at all times - issue discussed with staff	Caroline Caddell	FA
			SEC	Craigavon Area Hospital	3 South	Minor	I was in charge on night duty on 26/12/18 with 3 other agency nurses, one agency HCA and one bank HCA. There were 2 laryngectomy patients, one trache patient and one patient admitted with a dislodged trache. I was the only member of staff trache and laryngectomy trained on the ward, leaving it very unsafe if an emergency was to occur.	IDENTIFIED ON THIS SHIFT SN[Personal Information redacted by the USI] WAS THE ONLY TRAINED STAFF ON SHIFT THAT WAS TRACHE/LARYENGECTOMY TRAINED. ALL 3 OTHER STAFF WERE AGENCY AND NOT COMPETENT IN AIRWAY PATIENTS. THERE WAS A LADY WHO HAD A HISTORY OF LARYENGECTOMY, WHO WAS INDEPENTANT WITH STOMA CARE. A GENTLEMAN WHO HAD A LARYENGECTOMY ON 18/12/18 AND WHO WAS ALSO INDENPENDANT WITH CARE, JUST REQUIRING SUPERVISION, AND A GENTLEMAN WHO HAD A TRACHEOSTOMY IN OCT THAT WAS ALSO REQUIRING SUPERVISION. THE FOURTH GENTLEMAN WAS A PATIENT WHO CAME IN WITH A DISLODGED TRACHE WHO ENT WERE HAPPY TO LEAVE DECANNULATED FOR TRIAL PERIOD AS AIRWAY NOT COMPRIMISED. THEREFORE THE LADY WAS MOVED TO THE BACK SIDE OF THE WARD TO ENSURE THE NURSE WITH TRAINING WAS LOOKING AFTER THE 3 AIRWAY PATIENTS. THE GENTLEMAN WHO WAS DECANNULATED STAYED ON THE FRONT WING AND THE AGENCY NURSE WAS HAPPY TO OBSERVE. BED MANAGER INFORMED TO SEE IF ANY PERMANENT STAFF FROM OTHER WARDS COULD BE SWAPPED WITH THE AGENCY NURSES.	Caroline Caddell	FA
			SEC	Craigavon Area Hospital	3 South	Minor	Only one staff nurse overnight on urology side of ward. Second staff nurse didn't appear and none available in hospital to help.	22/03/17 -gh - await update from ward sister - lead nurse unaware that ward was short staffed on Monday night all appropriate discussions taken place with staff nurse - short notice sick leave	GH	FA
			SEC	Craigavon Area Hospital	3 South	Minor	I came on duty to be told there is a total of 5 neck breathers on the ward. I am the only one on duty competent to care for them. as well as this there was 2 confused patients on the front wing who are mobile, one of which tends to be aggressive overnight, with no 1-1 or extra staff to care for them both and no 1-1 provided for sr 1 down the back wing who has a trache and suffers with dementia. another patient down the back wing bay 2 was confused and getting out of bed, risk of falls. I was very anxious about taking charge of ward and felt my nursing pin was being put at risk due to the workload and not enough staff on duty to cope with the demand of patient needs. as well as this, patient's safety was being put at risk.	THREE PATIENTS ON THE WARD WERE WELL ESTABLISHED TRACHESOSTOMYS, ONE OF WHICH WAS IN TO HAVE SAME REMOVED.TWO OF THE PATIENTS WERE INDEPENDANT WITH SUCTIONING AND STOMA CARE. STAFF NURSE[Personal Information redacted by the USI] AND AGENCY NURSE[Personal Information redacted by the USI] (PREVIOUSLY WORKED ON WARD WITH TRACHE EXPERIENCE) ON THAT SIDE OF WARD WITH INCREASED WORKLOAD. BED MANAGER AWARE no harm came to patients - workload was spread out appropriately overnight - and the following morning approval was given by the AD to increase the numbers and an additional B5 was requested for the remainder of the week.	Caroline Caddell	FA
			SEC	Craigavon Area Hospital	3 South	Minor	Short staffing levels. Two junior staff nurses left with one band 2 HCA. It had been voiced to ward manager that we were not happy to be left on our own but no cover was able to got	16/2/17 cd - details on datix inaccurate. ward short staff at present. shifts out to bank and agency but not filled.lead nurse and HoS informed on 15/2/17 in am. further member of staff phoned in sick. Sr Douglas stayed on to 630pm (Stayed late previous night aswell) and New ward manager Sr Caddell stayed on until night staff came to help down back side of ward therefore meaning ward was adequately staffed down that side. staff to be spoken to. 11/04/17 - complete	Caroline Doyle	FA
			SEC	Craigavon Area Hospital	3 South	Minor	Attended for night duty to discover no staff on the ward were trained to use new glucometers on ward, therefore blood glucose levels could not be checked despite having a number of diabetic patients on the ward. Of particular concern was one patient whose BM rose to 26.2 and required close monitoring.	16-11-17 - gh/cd - staff nurse submitting datix should have had attended her glucometer training - dates were provided by the ward sister - to all staff - some declined to go to the training - cascade trainer at ward level has been working her way through the remaining staff who require training - minimum staff left to train - some staff are awaiting barcodes - same has been raised	Caroline Caddell	FA
			SEC	Craigavon Area Hospital	3 South	Insignificant	staff nurse took sick on ward at 0000 and I was left with 17 patients to nurse with an auxillary	Staff member took ill while on night duty at 2am. Bed manager informed of situation and unable to provide extra assistance from another ward due to shortage of nurses throughout the site. Management cannot predict for staff becoming sick in the middle of their night shift however when this does occur night management team can usually provide assistance. Due to excess numbers of patients requiring beds in the ED last night this was not possible. Staff on the ward coped well throughout the night. 17/08/18- gh- staff had been sent via bed manager - a Band 2 and band 5 from elective - staff to be updated - night report attached to datix	Caroline Caddell	FA

Personal Information redacted by the USI	SEC	Craigavon Area Hospital	3 South	Minor	I was sent to the ward as an agency nurse after being told I had to move from where I was booked. I had no information about the ward. I arrived and was given report on 4 patients. After report I went onto the ward and was told I had to look after 10 patients despite not being given any handover. All day staff had went home and there was only 1 other nurse with me who was busy with her patients. I quickly discovered that one patient had a gastronomy tube and a trache insitu which I was not informed of. Another patient had a stoma that I didn't know about. There was a lady who had surgery earlier that day to remove part of her left kidney. I did not even know she was my patient or what was wrong with her. She called me over and said she felt "damp" I looked under her sheet to find a surgical drain coming from her abdomen and 150ml of blood in the bag. The site was also oozing blood through the dressing onto the bed. I quickly called the other nurse, applied pressure to the site and we cleaned and redressed the area stopping the bleeding. I was extremely concerned that a patient following surgery earlier in the day could be left with a nurse who had not been given report and had no information at all about the patient.	spoke with staff reporting the incident Need to discuss with nurse in charge on duty overnight re handover. ward discussion re handover of patients to agency/bank or staff from other areas coming onto the ward. escalate and discuss at sisters level on ward 17/04/2018 CC Spoke with S/N in charge of night duty who accepts that S/n who came from the elective ward did not arrive in time to have been given the full report from the day staff handing over. Patient flow called ward at 8pm requesting a Band 5 move to elective as staff on that night duty did not have the ENT experience to care for the patients. Report had started when staff were being moved and therefore S?N who arrived did not receive all the details on her allocated patients. On reflection S/N in charge accepts that the nurse coming from elective should have been given full report and will in future ensure this is carried out. S/n in charge highlighted that patient with nephrectomy had been handed over to both nurses however the nurse handing over from day duty did not verbally hand over the presence of a surgical drain.	Sr Ciara McElvanna	FA
	SEC	Craigavon Area Hospital	3 South	Insignificant	The ward was short two staff nurses, for the number of patients on the ward. The coordinator was contacted and informed that no nurse on shift would be taking responsibility or the keys until there was staff made available	su/jm 29/5/18 review incident 2 nursing shifts not covered at late notice (1 nurse phoned at7 ickness, 2nd nurse did not arrive at staff handover) coordinator aware initial plan was to divide ward into 3 areas for 3 nursing staff with support of 2 hca and additional hca for 121. however a staff nurse did not report for duty and the plan was the clinical sister remain on duty until a staff nurse was sent from the coordinator. This left 3 staff nurses with 2 hca and 1 hca for 121. the nic expressed concern regarding staff not with familiar with ward. clinical sister remained with nic and offered support, no incidences occurred during shift. nic for shift is an experienced on night duty no admissions overnight patient kept in recovery to reduce workload	Sr Susanna Uprichard	FA
	CSCG	Craigavon Area Hospital	3 South	Minor	staff nurse unwell on night duty and when home. Bed manager inform and at this time due to the patients on this ward at the time, nursing support was needed. Staff nurse in charge was informed that she needed to take care of all extra patients on the ward. The nurse in charge knowing the risk this action could have on patient safety, refused.	Spoke to the NIC of night duty and this is not a clear indication of the events that occurred between the NIC and the bed manager. It was highlighted to the NIC that professionalism and patient safety is of paramount importance. It is not professional to refuse to care for patient or hang up the telephone. The bed manager was trying to get help from other areas and does not have the luxury of having extra staffing onsite.	Caroline Caddell	FA
	SEC	Craigavon Area Hospital	3 South	Minor	Dementia patient requiring 1:1 supervision, no staff cover for 1:1 supervision overnight, patient became very aggressive @ 07.10am, hitting out at post op day 4 larygectomy patient in same bay, grabbed him by throat and tried to remove patients largy tube. Both patients became agitated and aggressive towards each other. security porters contacted and came onto ward @ 07.20 and stayed until situation was calmed down.	I-I supervision had been requested - patient B very distressed by incident but reassurance give by staff members - no further issues - patient A - social work team and wider MD team involved in placement of this patient	Caroline Caddell	FA
	MUC	Craigavon Area Hospital	3 South	Minor	Patient aggressive and hitting out at staff members and also a risk to other patients and is continuing to wander around ward aggressive. needs 1:1 supervision	Special requested with the nurse bank and all shifts have not been covered. Staff aware to contact security if situation escalates.	Caroline Caddell	FA
	SEC	Craigavon Area Hospital	3 South	Minor	From 16.45hrs two junior staff nurses left on ward (qualified 4.5 months). Raised issue with the two ward managers that were in charge in the am, no further staff were got for the ward. Was not happy with this and ward managers aware of same.	16/2/17 cd - details on datix inaccurate. ward short staff at present. shifts out to bank and agency but not filled.lead nurse and HoS informed on 15/2/17 in am. further member of staff phoned in sick. Sr Douglas stayed on to 630pm (Stayed late previous night aswell) and New ward manager Sr Caddell stayed on until night staff came to help down back side of ward therefore meaning ward was adequately staffed down that side. staff to be spoken to. 23/02/17 - gh- complete	Caroline Doyle	FA
	SEC	Craigavon Area Hospital	3 South	Minor	came on shift, larygectomy patient requiring 1:1 nursing supervision due to high risk of occluding, 3 patients confused on one side of the ward. Nurse in charge contacted patient flow regarding the need for extra staff/help for the above, patient flow who had been on all day said this was not escalated to himself r.e the need for 1:1 or supervision of the confused, even though he had been up on the ward several times throughout the day, also said it was not escalated at the 2 hourly bed meetings. staff on duty feeling stressed and feel it was unsafe practice and pin at risk due to the complex needs of patients and having to provide 1:1 nursing care to largectomy patient.	16/11/17 -gh- / Cd - Laryngectomy patient has been monitored throughout the day shift by an HCA who then alerts a Band 5 staff nurse if any intervention is required - this process has been working well with ward staff and patient . A band 5 special has been requested for all shifts both da and night duty and these have been approved to go out to agency but unfortunately these are not always filled - ward staff are fully aware of the situation and plan for this patient - no harm to patient overnight - patient is included on the safety brief each day with a plan of care discussed at all times	GH	FA
	SEC	Craigavon Area Hospital	3 South	Minor	Staffing issues on night duty, front side of the ward had 2 staff nurse both agency, back side of ward was myself and another agency nurse. one of the agency nurses on the front side stated she was feeling sick and went home, which left one agency nurse to manage a side on her own, the back side has 2 trache patients and was unsafe to leave with one staff member therefore the agency nurse had to take the front side herself, with myself helping as much as I could while also having 9 patients.	continuous review of nursing numbers and skill-mix escalated to LN, HOS. AD and Director	Caroline Caddell	FA

Personal Information redacted by the USI	SEC	Craigavon Area Hospital	3 South	Minor	On ward today only two permanent members of nursing staff myself and my colleague both only 5 months qualified, rest of nursing staff were agency. I myself had to be incharge after only being qualified 5 months.	continuous review of skill-mix and numbers of staff available on shifts and this has been escalated to LN, HOS, AD and Director as being an issue	Caroline Caddell	FA
	SEC	Craigavon Area Hospital	3 South	Minor	Ward short staffed 5 staff nurses and 3 aux to manage 36 patients (2 of whom were 1-1 due to aggressive behavior and previous security incidents) multiple staff provided although reluctant to manage patient care or do handover at end of shift. Multiple staff took up alot of time giving handovers. Continuity of care didn't happen ward was unsafe and care was substandard	ensure that skill mix and staffing are adequate in the ward and it has been escalated to LN, HOS, AD and director	Caroline Caddell	FA
	SEC	Craigavon Area Hospital	3 South	Insignificant	Staffing levels unsafe two nurses on shift from 07.30am to look after 19 patients, this is usually covered by four staff until 17:00 and two/three staff after this time . I am a newly qualified staff nurse and felt it was extremely difficult to provide a level of nursing care that was safe, effective and compassionate. I am at the stage in my career that I am developing skills of time management as well as being new to the ward environment. A ward that is under staffed by half the nurses as usually deemed necessary becomes a challenging and overwhelming environment to do so.	to ensure that staffing levels on all shifts are at a safe level and that there is a proper skill-mix	Martina Corrigan	FA
	SEC	Craigavon Area Hospital	3 South	Insignificant	Ward short staffed and extra patient on ward due to bed pressures in A+E dept. 3 s/n short am shift 2 s/n short pm shift care not given in a timley manner Staff stressed and burnt out staff unable to have proper breaks due to demands of ward staff not leaving on time from shift	to ensure that staffing levels on all shifts are at a safe level and that there is a proper skill-mix	Martina Corrigan	FA
	SEC	Craigavon Area Hospital	3 South	Moderate	Short staffing, two junior nurses to 19 patients (one of the nurses only 2 weeks qualified and cannot do IVs yet)	review of nursing staff and skillmix and escalated to LN, HOS, AD and Director	Caroline Caddell	FA
	SEC	Craigavon Area Hospital	3 South	Minor	Only one Staff on duty trained RPRB and competent.	all registered nurses are aware they are responsible for their own RPRB training however sessions are being offered on the ward to complete competencies either in the live situation or else using a simulation kit. There are no more assessor training days until March/April and due to the business of the ward it is not always possible to complete competencies.	Sr Lynn Harrison	FA
	SEC	Craigavon Area Hospital	3 South	Insignificant	Ward staffing levels unsafe. 2 nurses to look after 19 patients. one nurse recently qualified. unsafe patient: staff ratio and 1:1 supervision required for one patient. Tracheostomy patient on ward and palliative end of life patient who needed support. Staff working without breaks and high levels of stress	Review of staffing levels and skill mix. emphasis to ensure that shifts are all covered adequately with trained staff.	Martina Corrigan	FA
	SEC	Craigavon Area Hospital	3 South	Minor	2 staff nurses on duty at night. one staff nurse went home sick at 2230. one staff nurse left on ward. staff nurse from theatre came to help at 0300 but had no ward experience in 20 years.	Staff member went off duty sick. This cannot be prevented or predicted. Bed manager sought help from another area and the only area who could offer assistance was theatres as all other areas under immense pressures. Staff nurse who came to ward worked to the scope of her practice as ward work is not her background and she was aware of her limitations.	Caroline Caddell	FA
	SEC	Craigavon Area Hospital	3 South	Minor	I RECEIVED A PHONE CALL FROM 3SOUTH AT 23:27, ONE OF THE STAFF NURSE'S TOLD ME THAT SHE IS UNWELL (VOMITING) AND WANT TO GO HOME. I HAVE ADVISED HER TO ATTEND A & E, STAFF REFUSED THE SAME. I HAVE ADVISED HER TO HANDOVER TO THE NURSE INCHARGE OR THE NURSE WORKING WITH HER AND I WILL SEE IF I CAN ARRANGE ANOTHER STAFF TO COVER. I HAVE CONTACTED THEATRES AT THAT TIME TO SEE IF THEY CAN HELP OUT- NO ANSWER ON THE PHONE. TO CONFIRM I HAVE ALSO CONTACTED RECOVERY TO MAKE SURE IF THERE WAS ANY CASE GOING ON IN THEATRES- THERE WAS LAPROTOMY GOING ON THAT STAGE. AT 23:45 NURSE IN CHARGE OF 3SOUTH RANG ME AND SAID SHE WILL NOT LOOK AFTER THE PATIENT BELONGED TO THE STAFF NURSE WHO WENT OFF SICK AND THAT IT IS NOT HER RESPONSIBILITY TO TAKE OVER REST OF THE PATIENTS'. I HAVE TOLD HER THAT AT THE VERY MINUTE I HAVE NO STAFF AVAILABLE TO COVER HER WARD AND THAT I WILL SEE IF I CAN GET A STAFF FOR HER, ALSO TOLD THAT THEATRES HAVE CASES GOING ON AND ICU IS FULL AND THAT ELECTIVE HAS ONLY 2 NURSES' AND HCA WAS ALREADY TAKEN TO COVER 1:1 IN AMU. I HAVE ASKED IF SHE CAN DIVIDE THE PATIENTS' IN TO 3 (FOR 3 STAFF NURSES)UNTIL I GET SOMETHING SORTED, BUT THE NIC REFUSED THE SAME AND TOLD ME THAT " THE POLICY DOESN'T COVER ME TO LOOK AFTER 17 PATIENTS' AND I'M NOT A SCOTTISH NURSING GUILD STAFF AND I DON'T GET PAID FOR IT""I DON'T CARE ABOUT REST OF THE PATIENTS' OTHER THAN MY 9 PATIENTS' THEY WILL NOT BE LOOKED AFTER UNTIL 06:00AM""I WAS ALREADY WITH MY GPS ON SICK LEAVE AND ONLY BACK, YOU ARE BEDMANGER IT'S YOUR RESPONSIBILITY", I HAVE TOLD THE NIC THAT AT THE MINUTE AND TIME I CAN'T GET YOU COVERED AS I'M IN ED SORTING OUT PATIENTS' BUT FROM THE TIME THE OTHER NURSE TOLD ME THAT SHE WAS GOING OFF SICK, I WAS TRYING	I spoke with NIC this am before she left duty having read this. NIC strongly denies having said "she doesn't care about other patients" and having mentioned Scottish Nurses Guild. I have spoken to her regarding her role as the nurse in charge and that on occasions like this the staff need to work as a team and divide all patients into three which has had to happen before when the 4th nurse cannot be allocated. We discussed the role of the night manager and the staffing constraints for the site as a whole and that extra staff are not a luxury that she has when a staff member unfortunately has had to go off unexpectedly. We also discussed how unprofessional it was to have hung up the phone. NIC did state they she felt unsupported with this night manager as she knew that had she have divided the ward into three they would not have received any further assistance. This did not excuse unprofessional behaviour on this occasion. We discussed NIC staying on night duty and her role of nurse in charge and have agreed for NIC to come back onto days due to her health constraints which she mentioned to the night manager. Spoke with HCA who was present on the ward whilst NIC was speaking to the bed manager. HCA did not hear any mention of SNG or other patients being mentioned. HCA did admit that she was not present for the whole of the conversation as she was dealing with another patient.	Caroline Caddell	FA

Personal Information redacted by the USI	SEC	Craigavon Area Hospital	3 South	Minor	Ward short staffed am shift (trained s/n x2) (na x1 and special x1 n/a) pm (special 1-1 n/a) night duty (trained s/n x1) dependency levels high on ward 2 patients with elevated news (7-14) 2 1-1 patients 1 laryngectomy patient (stable) 3 specialities requiring ongoing ward rounds	STAFF LEVELS LOW AS SHIFTS NOT FILLED AND DUE TO SICKNESS. PATIENT FLOW AWARE AND BAND 3 SENT FROM 4SOUTH ON NIGHT DUTY TO HELP AS BAND 5 SHIFT CANCLLED LAST MINUTE.	Sr Ciara McElvanna	FA
	SEC	Craigavon Area Hospital	3 South	Minor	came on duty, 3 staff nurses for 34 patients, 4 HCAs, 1 HCA specialing. Agency home sick at 23:30, left 2 nurses on ward. Nurse sent from ortho arriving on ward approax 00:30/01:00. Medicines were delayed due to lack of nursing staff. Staff felt ward unsafe working conditions.	four band 5s booked in for the shift, Sn on Agency cancelled shift and unable to refill same. During shift other Sn Agency had to go off as unwell at 2330hrs. Help sent from ortho and theatres by bed manager.	Sr Gayle Magill	FA
	SEC	Craigavon Area Hospital	3 South	Minor	came on duty as nurse in charge, working down back wing with 3 members of staff. 18 patients of which 6 are confused and 3 of them are needing supervision as they can get up out of bed and are at risk of falling, 1 has already had a fall on this admission. 2 laryngectomy patients. 1 trache patient, SR 2 requiring 2hrly turns and obs check, SR4 is palliative with family staying. 1 bed move to do and 2 admsissions overnight. 1 unwitnessed fall.	Request made for 1:1 special for confused patients in Bay 1. Unable to access extra staff for patient for night duty. Same escalated to site manager. No patient came to any harm during the duty. 1 X patient relative came to settle her husband which helped the situation. Both patients reportedly settled and slept overnight until 6am.	Caroline Caddell	FA
	SEC	Craigavon Area Hospital	3 South	Minor	The ward was not staffed to cope with the demands and needs of the patients on the ward. I had 9 patients from 07:30-20:00hrs. Many of which were confused, full nursing care and 2 whom required 1:1 supervision which was not provided. The ward was unsafe and patients were not getting the proper care, attention and treatment that is appropriate. These concerns were highlighted to the sister in charge and apparently discussed at the bed meetings. No health care assistants down the front side of ward from 16:45hrs. Unable to take dinner break due to demand of the ward. unsafe area to work for any nurse of any experience.	17/04/2018 On review of the staffing for 12th February all staff shifts were filled the week prior and on that morning 3 x Band 5 cancelled their shifts (2 x long day and 1 x evening shift) Management cannot predict this to occur. Staff from the site were not in a position to help from other areas owing to staffing issues around the site. Ward on risk register for staffing vacancies. Senior management aware of ongoing staffing issues and vacancies remain unfilled with the HR department.	Caroline Caddell	FA
	SEC	Craigavon Area Hospital	3 South	Insignificant	Staff nurse short from 0300 leaving 1 RN to 17 patients. 1 confused patient who should have 1:1 supervision who has been physically aggressive earlier in day	Staff nurse from Scottish Nurses Guild came to work on ward however had to leave due to sickness. Night manager aware however unable to source staff at this time as staff not available due to shortages over the site.	Caroline Caddell	FA
	SEC	Craigavon Area Hospital	3 South	Minor	Only one S/N on Duty that was RPRB trained and competent. CCHAN was asked on two occasions to check blood products. Second Blood unit was ordered for the Patient and CCHAN attended Ward to check blood. CCHAN was asked to see a Patient on the same ward at this time who on examination was having an anaphylactoid reaction. Patient who was having an anaphylactoid reaction with respiratory compromise immediately took priority over the Patient awaiting blood transfusion and subsequently was transferred to HDU. The Nurse was advised to contact the bedmanager to arrange another Staff to check the blood. The Patient received the blood although a unit of blood could have been 'wasted unnecessarily' had the 30 minutes fridge to vein been up.	no action required as the appropriate measures were taken. The patient who was for HDU was prioritized and the patient receiving the blood transfusion got their blood within the recommended time so no incident actually occurred	Sr Lynn Harrison	FA
	SEC	Craigavon Area Hospital	3 South	Minor	two newly qualified members of staff still on preceptorship left on night duty with one bank nurse, one agency nurse and two HCA's. During this night duty there are four neck breathing patients and numerous confused and aggressive patients. This is an unsafe skill mix putting patient care at risk and our registrations at risk.	Due to staff sickness 2 shifts out to bank and agency. 1 covered by bank staff nurse from hospital and another by uncontracted agency. Sister in charge of ward that day was not aware there was not a nurse in charge until staff arrived that evening. Bed manager was contacted but staff from another area could not be moved. Ward had 2 x neck breathers not 4 who were both independent with their respective laryngectomy and tracheostomy (capped). This however does not negate the possibility of an adverse incident with these patient's. On review of incident and new members of Band 6 staff change to include the nurse in charge to be indicated on the allocation book at time of writing to ensure this is highlighted from an early stage should the nurse in charge call in sick again. No harm came to any patient.	Caroline Caddell	FA
	SEC	Craigavon Area Hospital	3 South	Minor	Staffing levels on ward are not safe. Tonight myself and my colleague only each 5 months qualified are left in charge of ward with 36 patients. There are two bank nurses and two HCAS along side us. I myself have been left in charge only gaining my pin at end of September. There are 4 neck breathers as well as very confused and aggressive patients.	Due to staff sickness 2 shifts out to bank and agency. 1 covered by bank staff nurse from hospital and another by uncontracted agency. Sister in charge of ward that day was not aware there was not a nurse in charge until staff arrived that evening. Bed manager was contacted but staff from another area could not be moved. Ward had 2 x neck breathers not 4 who were both independent with their respective laryngectomy and tracheostomy (capped). This however does not negate the possibility of an adverse incident with these patient's. On review of incident and new members of Band 6 staff change to include the nurse in charge to be indicated on the allocation book at time of writing to ensure this is highlighted from an early stage should the nurse in charge call in sick again.	Caroline Caddell	FA

Personal Information redacted by the USI	SEC	Craigavon Area Hospital	3 South	Minor	Short staff - 3 nurses (two permanent trust nurses and one agency nurse) for all of 3 south - 35 patients.	24/07/17 -gh- all appropriate action had been taken to cover the unfilled shifts - some of which occurred at short notice - sr caddell has spoken to the staff on duty and reassured them	GH	FA
	SEC	Craigavon Area Hospital	3 South	Minor	3 staff nurses to 34 patients - under staffed. 2 blood transfusions ongoing (only two nurses have blood training. 2 admissions overnight. 6 day zero post-op patients on 4 hourly observations. 2 patients on hospital @ night performa. 2 confused patients with dementia.	all appropriate action had been taken to cover the shifty - all duties were put to all staff as extra etc .. all agencies had been approved - bed manaer /site manager also aware - incident discussed with all staff involved	GH	FA
	SEC	Craigavon Area Hospital	3 South	Minor	3 nurses for 35 patients - under staffed 2 blood transfusions ongoing (only two nurses have blood training) 2 admissions overnight 6 day zero post-op patients on 4 hourly observations. 2 patients on hospital @ night performa. 2 confused patients with dementia.	all appropriate action shad been taken to cover shifts - all staff aware they could work extra etc.. all shifts to all agencies via bank - bed manager and site manager aware - staff involved all spoken to by ward sister	GH	FA
	SEC	Craigavon Area Hospital	3 South	Minor	3 nurses on for 35 patients - under staffed. 2 blood transfusions ongoing (only two nurses have blood training). 2 admissions overnight. 6 day zero post-ops on 4 hourly observations. 2 patients on hospital @ night performa. 2 confused patients with dementia.	all appropriate action taken at time of incident to cover outstanding shifts - all ataff were given the opportunity to work extra - all shifts were out to agency via nurse bank - bed manager - site manager - hos ad In all aware - staff involved spoken to by ward sister.	GH	FA
	SEC	Craigavon Area Hospital	3 South	Minor	Staffing issue: Poor skill mix on nightshift. Nurse only qualified in Oct in charge of ward of One other permanent staff nurse qualified 3 months and 2 agency staff on the ward. Unsafe practice and skill mix. Palliative 37 year old patient on ward as well as patient in theatre getting insertion of CVC line, which permanent staff on duty have received no training on.	08/06/17 - Personal Information - ward sister aware of night duty mix - due to unforeseen absence - same unavoidable - staff spoken to	GH	FA

Received from SHSCT on 16/05/22. Annotated by the Urology Services Inquiry.

Patient Safety Report for Acute Governance Meeting April 2019

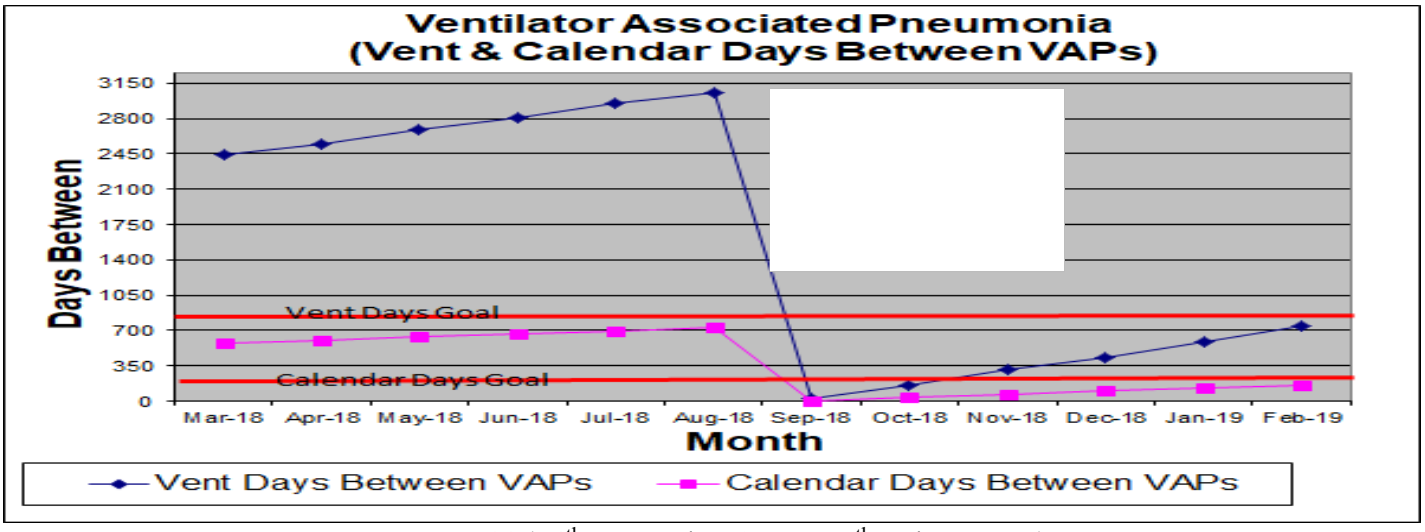
Surgical Site Infection (SSI) Ortho:

- Next update when Q4 2018 SSI Rates are released by the PHA

Surgical Site Infection (SSI) C/Section:

- The next quarterly Audits are taking place in March 19, with results reported in May 19

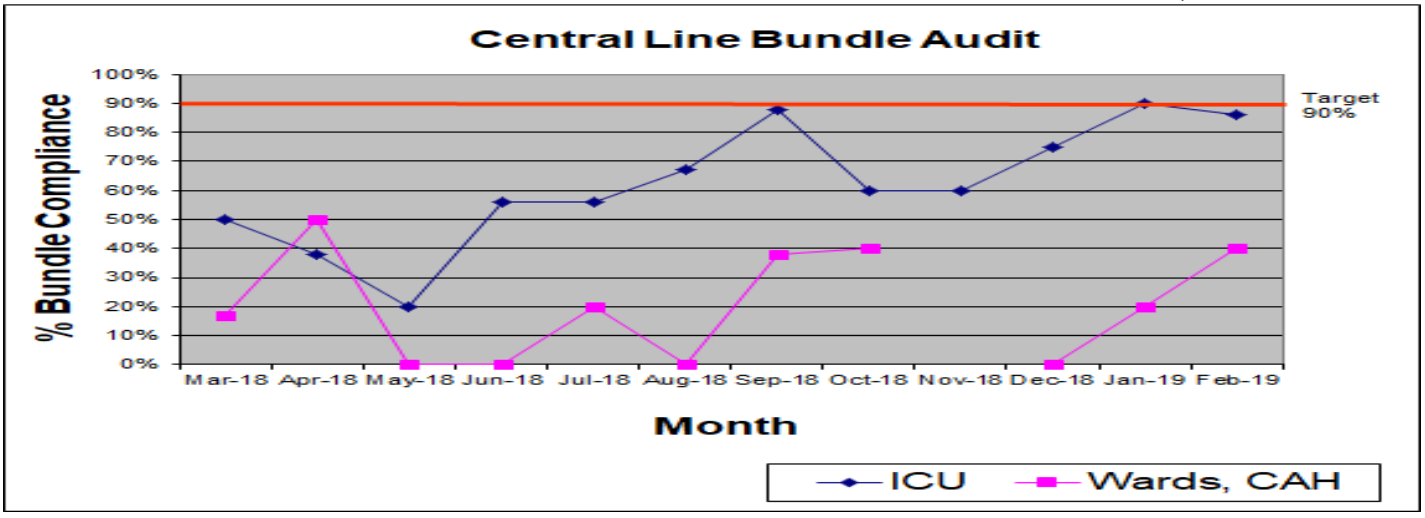
Ventilator Associated Pneumonia (VAP):



- Vent Days Between VAP's **744** (24th September 18 → 28th February 19)
- Calendar Days Between VAP's **158** (24th September 18 → 28th February 19)

Central Line:

- The Run Chart below shows the results of the Central Line Audits for ICU & Wards, CAH for Feb 19



Non-Compliant element ICU:

- In 1 of 7 cases audited the method of Hand Hygiene was not recorded on the Central Line Insertion Record

Non-Compliant elements Wards, CAH:

- In 2 of 10 cases audited the method of Hand Hygiene was inappropriate & in 1 case it was not recorded

- In 1 of 10 cases audited it was recorded that a small drape was used & in 1 case it was not recorded which drape was used
- In 1 of 10 cases audited the method of Skin Preparation was not recorded
- In 2 of 10 cases audited the jugular was used with no contrindication documented
- In 4 of 10 cases audited the Daily Review of the Line was not carried out. In 3 of the 4 cases it was missed on 1 day

- Results shared with Lead Clinician & Lead Nurse for this QI work to address areas of non-compliance

NEWS:

- During 2017/18 the figures released to the PHA were those from the Independent Audit undertaken by the Lead Nurses. However during 2018/19 the figures released will be a combination of the Independent Audit & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q3 18/19	Q2 18/19	Q1 18/19	Q4 17/18
ACUTE	81% (430/532)	80% (419/522)	81% (288/355)	Not Available
TRUST	84% (589/704)	81% (555/681)	81% (411/508)	76% (84/111)

- Next update in May 19 when Q4 18/19 data is available

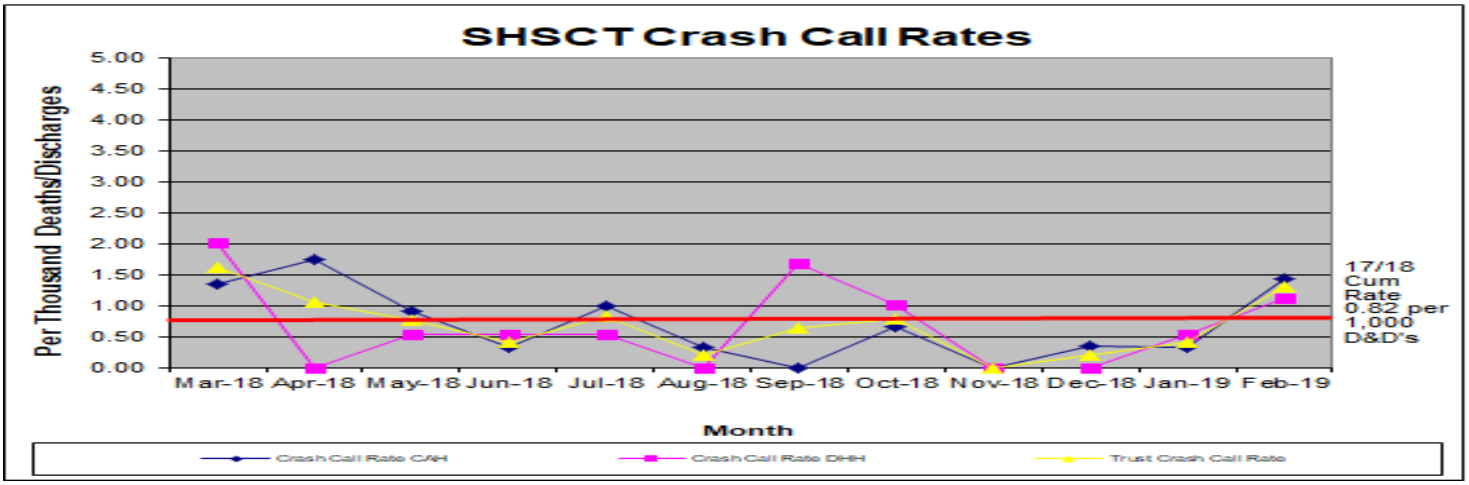
MUST (Malnutrition Universal Screening Tool):

- During 2017/18 the figures released to the PHA were those from the Independent Audit undertaken by the Lead Nurses. However during 2018/19 the figures released will be a combination of the Independent Audit & the audit undertaken by the Ward Managers/Band 6's. Details of compliance is below:

Quarter	Q3 18/19	Q2 18/19	Q1 18/19	Q4 17/18
ACUTE	86% (460/532)	88% (461/522)	87% (308/355)	Not Available
TRUST	89% (626/704)	91% (617/681)	90% (457/508)	86% (96/111)

- Next update in May 19 when Q4 18/19 data is available

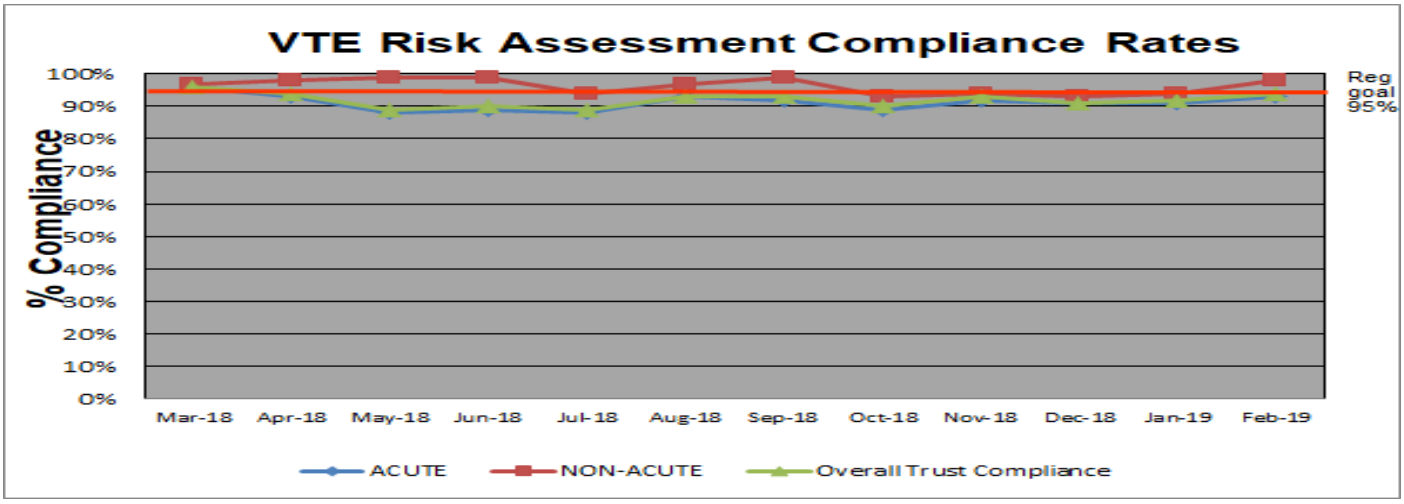
Crash Calls:



- CAH Rate **1.44** per 1,000 deaths/discharges (**4** Crash Calls) up from **0.32** (**1** Crash Call) in Jan 19
- DHH Rate **1.12** per 1,000 deaths/discharges (**2** Crash Calls) up from **0.54** (**1** Crash Call) in Jan 19
- Trust Rate **1.31** per 1,000 deaths/discharges (**6** Crash Calls) up from **0.40** (**2** Crash Calls) in Jan 19
- Trust cumulative Crash Call rate for 18/19 stands at **0.59 (32)** per 1,000 deaths/discharges, down from **0.82 (49)** in 17/18

VTE:

- The Run Chart below shows compliance against the Commissioning Plan target of **95%** compliance. The Trust Compliance includes the Non-Acute Wards & therefore their compliance has been included also for comparison. Trust Overall Compliance in Feb 19 was **93%** (395/420), up from **92%** in Jan 19.



Feb 19 (Week Commencing 04/02/19 → Week Commencing 25/02/19)							
Division	**Site**	**Ward**	**Number of Weekly Audits not done**	**Charts with Fully Completed VTE Risk Assessment**	**Number of Charts Audited**	**Monthly Percentage Compliance**	**Quarter 3 18/19 Percentage Compliance**
S&EC	CAH	3 South	0	18	19	95% ↑	76% ↓
		4 North CESW	0	18	19	95% ↑	97% ↑
		4 South	0	17	18	94% ↓	92% ↓
		Elective Adm.	0	15	20	75% ↓	52% ↑
		Orthopaedic	0	19	20	95% ↓	98% ↓
		Trauma	0	16	16	100% ↔	97% ↓
	DHH	F/male Surg.	0	18	19	95% ↑	93% ↑
		MSW/HDU	0	17	20	85% ↓	96% ↑
M&UC	CAH	1 South	1	13	14	93% ↑	88% ↓
		1 North	0	19	19	100% ↑	87% ↓
		2 North Resp.	0	20	20	100% ↑	93% ↓
		Haematology	0	17	18	94% ↓	95% ↓
		2 South	0	18	20	90% ↑	93% ↓
		2 North Med.	0	18	18	100% ↔	98% ↑
		AMU	0	20	20	100% ↔	93% ↓
	DHH	F/male Med.	0	15	20	75% ↓	79% ↔
		CCC/MMW	4	N/A	N/A	N/A	100% ↔
		Stroke/Rehab	0	17	18	94% ↑	99% ↑
IMWH	CAH	Gynae	0	18	18	100% ↑	94% ↑
TOTAL			**5 ↑ (3)**	**313**	**336**	**93.2% ↑**	**90.6% ↑**

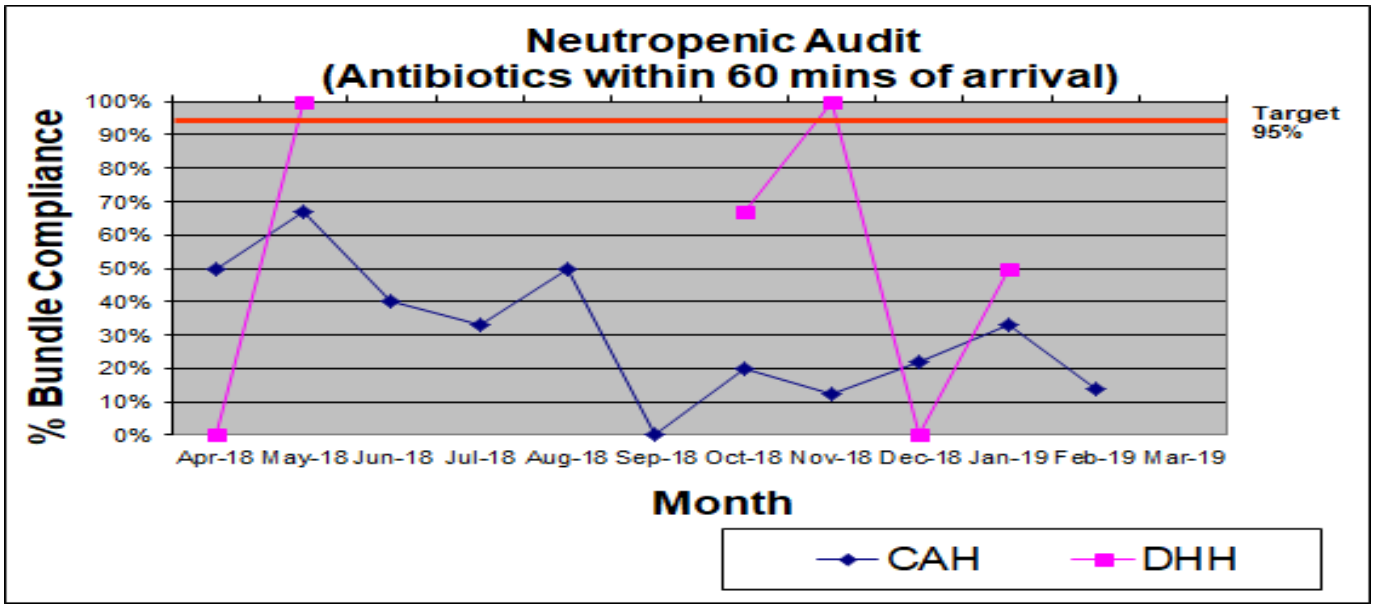
Key: Red – Under 85% compliance, Amber – Compliance between 85% & 94%, Green – Above 95% (Reg. target)

- In summary Overall Compliance with fully completed Risk Assessment on the Acute Wards was **93.2%** (313/336 charts audited) up from **91.3%** (324/355 charts audited) in Jan 19.
- Total number of weekly audits not completed in Feb 19 was **5** up from **3** in Jan 19

Emergency Care QI Work: - Neutropenic Sepsis & Sepsis6:

Neutropenic Sepsis:

An Audit of the monitoring of suspected Neutropenic Sepsis in ED's is carried each month, with results forwarded to the Health & Social Care Board. The below Run Chart shows the percentage of these patients who received antibiotics within 60 minutes of arrival at the ED's of CAH & DHH



- DHH - No pts to audit June → Sept 18. The Audit for Feb 19 will be undertaken on the 1st Apr 19
- CAH – Only 1 of 7 patients audited in Feb 19 received antibiotics within 60 minutes of arrival. The times of those outside the target timeframe ranged from 29 minutes to 122 minutes.

Sepsis6:

Bundle Element	CAH 17/18	CAH Feb 19 (10 pts.)	DHH 17/18	DHH Jan 19 (10 pts.)
Evidence in ED notes that high flow O2 was initiated in ED	17/18 79%	80%	17/18 74%	80%
Evidence in ED Notes that IV Fluids administered with 1 hour of arrival	17/18 57%	80% (in 2 other cases IV Fluids given but outside 1 hour)	17/18 80%	40% (in 6 other cases IV Fluids given but outside 1 hour)
Evidence that serum lactate measurement obtained	17/18 97%	100%	17/18 90%	100%
Evidence of Blood Cultures obtained before patient leaves ED	17/18 81%	90%	17/18 90%	90%
Antibiotics administered within 1 hour of arrival	17/18 56%	70% (in 3 other cases IV antibiotics given but outside 1 hour)	17/18 74%	50% (in 5 other cases IV antibiotics given but outside 1 hour)
Urinary Output measured before patient leaves ED	17/18 65%	60%	17/18 77%	80%
Overall Bundle Compliance	17/18 27%	30%	17/18 36%	30%

- The DHH Audit for Feb 19 will be undertaken on the 1st Apr 19
- Results shared with Lead Clinician & Lead Nurse for this QI work to address areas of non-compliance

SKIN Care (Pressure Ulcer):

- During 2017/18 the figures released to the PHA were those from the Independent Audit undertaken by the Lead Nurses. However during 2018/19 the figures released will be a combination of the Independent Audit & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q3 18/19	Q2 18/19	Q1 18/19	Q4 17/18
ACUTE	70% (201/288)	71% (172/242)	56% (60/107)	Not Available
TRUST	78% (338/435)	79% (293/372)	63% (122/195)	69% (60/87)

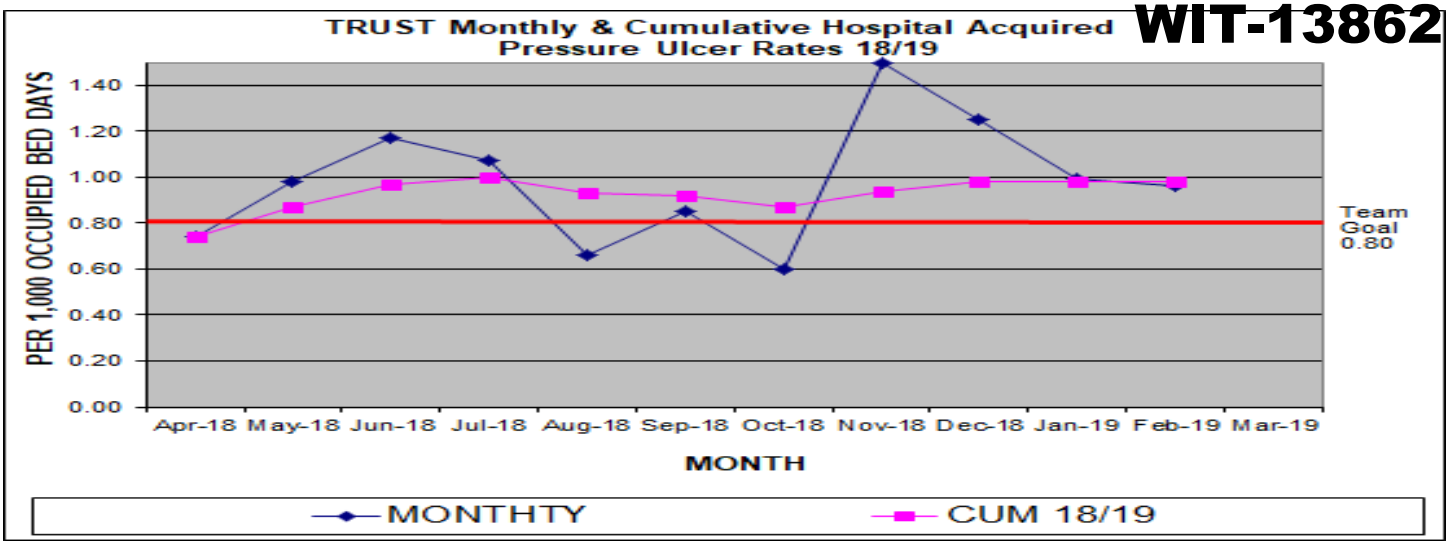
- Next update in May 19 when Q4 18/19 data is available

Ward Acquired Pressure Ulcers & Rate per 1,000 Occupied Bed Days 2018/19:

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL	Rate 18/19	Rate & No 17/18
CAH															
Ward 4 South	2	0	1	0	0	2	0	1	0	0	0		6	0.51	0.54 (7) ↓
Ward 4 North	0	2	3	0	0	0	1	0	2	0	0		8	0.79	0.64 (7) ↑
Ward 3 South	0	2	0	0	0	0	0	2	1	0	1		6	0.53	0.81 (10) ↓
Trauma Ward	0	1	4	4	1	3	1	2	3	1	6		26	3.18	2.53 (23) ↑
Orthopaedic Ward	0	0	0	0	0	0	0	0	0	0	0		0	0	0.85 (4) ↓
Gynae Ward	0	1	0	0	0	0	1	0	0	0	0		2	0.63	0 (0) ↑
ICU	2	0	1	2	3	1	0	5	2	4	1		21	9.66	4.49 (11) ↑
Ward 2 South Medicine	2	1	1	3	2	1	0	1	2	0	2		15	2.69	2.78 (17) ↓
Ward 2 South Stroke	2	2	2	0	0	0	1	1	1	2	0		11	1.99	1.61 (10) ↑
Ward 2 North Resp.	0	0	0	0	0	0	1	0	1	0	0		2	0.34	0.47 (3) ↓
Ward 2 North Medicine	0	0	0	1	0	1	0	1	0	2	0		5	0.91	2.14 (13) ↓
Ward 5 Haematology	2	1	0	1	0	1	0	1	0	1	1		8	1.95	0.68 (3) ↑
Ward 1 South	0	0	1	2	2	3	2	2	2	2	0		16	1.35	1.32 (17) ↑
Ward 1 North	1	0	1	2	0	0	0	2	0	3	0		9	0.86	0.44 (5) ↑
AMU	0	0	0	1	1	1	1	1	0	1	1		7	0.67	0.27 (3) ↑
Rec/Renal/2 West/WinterW	0	0	0	2	0	0	0	1	1	2	2		8	N/A	N/A
DHH															
Male Surgical	0	0	1	0	0	0	0	0	0	0	0		1	0.18	0.17 (1) ↑
Female Surg/Gynae	0	1	1	1	1	2	0	0	0	0	0		6	0.74	0.11 (1) ↑
HDU	0	2	1	0	0	0	0	0	1	0	0		4	1.35	0.31 (1) ↑
Stroke/Rehab	1	1	0	0	0	0	0	0	0	0	0		2	0.21	0 (0) ↑
Male Med/CCU	0	0	0	0	0	0	0	0	0	0	0		0	0	0.17 (2) ↓
Female Medical	0	1	1	0	1	0	2	3	1	0	0		9	0.83	0.42 (5) ↑
Lurgan															
Ward 1	0	0	0	0	0	0	0	0	0	1	0		1	0.20	0 (0) ↑
Ward 2	1	2	2	1	0	0	1	0	2	0	1		10	1.80	1.43 (9) ↑
Ward 3	0	1	1	0	0	0	0	0	1	0	1		4	0.75	1.50 (9) ↓
STH															
Ward 1 STH	0	0	0	0	0	0	0	2	2	0	0		4	0.70	1.15 (7) ↓
Ward 2 STH	0	0	0	0	1	0	0	1	0	0	0		2	0.35	0.50 (3) ↓
MHLD															
Gillis	0	0	0	0	0	0	0	1	1	0	0		2	0.33	0.14 (1) ↑
Willows	0	0	0	0	0	0	0	0	0	0	1		1	0.16	0.15 (1) ↑
TOTAL	13	18	21	20	12	15	11	27	23	19	17		196		
RATE	0.74	0.98	1.17	1.07	0.66	0.85	0.60	1.50	1.25	0.99	0.96			0.98	0.80 (173)↑

- The Trust's Monthly Hospital Acquired Pressure Ulcer Rate for Jan 19, based on **29** Wards was **0.96** (**17**/17,315) per 1,000 Occupied Bed Days down from **0.99 (19)** per 1,000 Bed Days in Jan 19.

- The Trust's 2018/19 Hospital Acquired Pressure Ulcer Rate, based on **29** Wards stands at **0.98 (196)** per 1,000 Bed Days, compared to **0.80 (173)** in 2017/18.

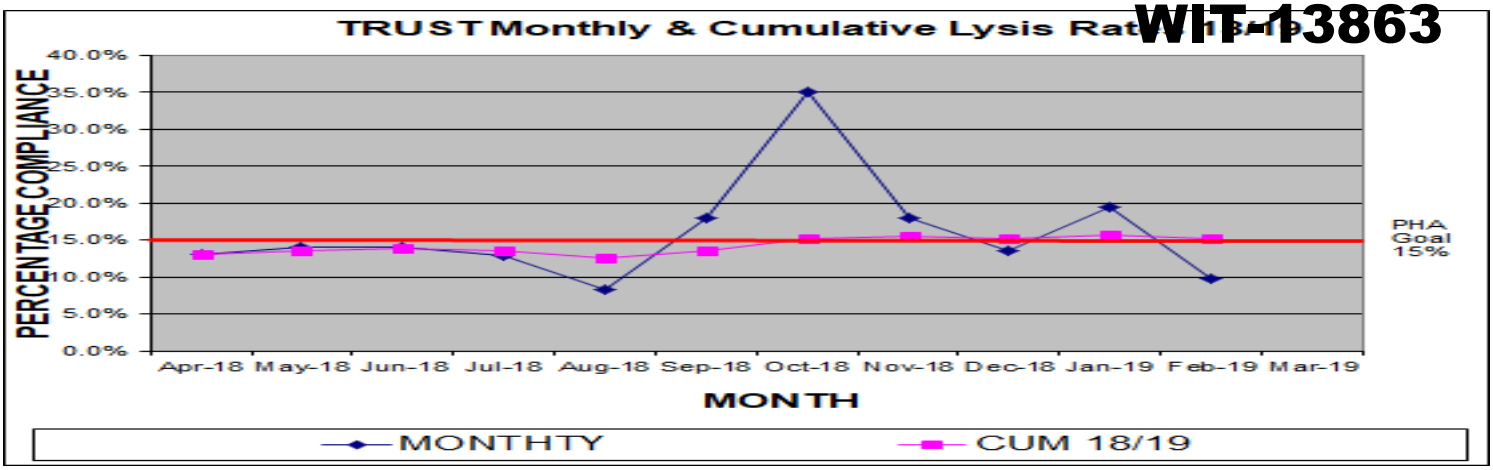


- There were **5** Grade 3/4/DTI's Ward Acquired Pressure Ulcers reported in Feb 19, (3 South, Trauma x3, CAH & Willows, Bluestone Unit). RCA's will be undertaken in these cases in due course. In 18/19 to date RCA's have been carried out on **23** cases with **6** deemed to have been avoidable. This represents **3%** of all Ward Acquired Pressure Ulcers reported in 18/19
- From April 2018, Device Related Pressure Ulcers have to be included in the Trust's data, as per the PHA

Stroke Collaborative:

- Regional agreement to collect data on the following, however only Lysis Data will be reported to the PHA/DHSSPS on a quarterly basis:

	CAH		DHH		TRUST		
Measure		**Feb 19**		**Feb 19**		**Feb 19**	**Commentary Feb 19**
Patients who are potentially eligible for thrombolysis are assessed by Acute Stroke Team within 30 minutes of arrival	16/17 97% 17/18 98%	**100% (47/47)**	16/17 99% 17/18 99%	**100% (13/13)**	16/17 98% 17/18 99%	**100% (60/60)**	-
Patients who are potentially eligible for thrombolysis receive CT scan within 45 minutes	16/17 91% 17/18 96%	**100% (18/18)**	16/17 95% 17/18 95%	**100% (7/7)**	16/17 94% 17/18 96%	**100% (25/25)**	-
Patients deemed suitable for thrombolysis receive first bolus within 60 minutes	16/17 74% 17/18 59%	**67% (2/3)**	16/17 67% 17/18 88%	**100% (1/1)**	16/17 71% 17/18 68%	**75% (3/4)**	CAH: Patient presented out-of-hours. Outside target timeframe by 12 mins. Reason for delay due to delay in INR processing
Patients transferred to Hyper Acute Stroke Unit (or appropriate environment) within 90 mins	16/17 100% 17/18 91%	**100% (3/3)**	16/17 100% 17/18 100%	**100% (1/1)**	16/17 100% 17/18 94%	**100% (4/4)**	-
	CAH		**DHH**		**TRUST**		**AIM 17/18 (Based on Commissioning Plan) To ensure that the proportion of thrombolysis administration is at least 15%**
Outcome Measure	**2017/18**	**Feb 19**	**2017/18**	**Feb 19**	**2017/18**	**Feb 19**	
Monthly Thrombolysis Rate		**11.1% (3/27)**		**7.1% (1/14)**		**9.8% (4/41)**	
Thrombolysis Rate (Yearly)	10.8% (34/314)	**15.8% (43/273)**	10.1% (16/159)	**13.7% (17/124)**	10.6% (50/473)	**15.1% (60/397)**	



- The above is "Real Time" data, which is subject to change. The Directorate of Performance & Reform is responsible for reporting to the RHSCB. From the above table only the lysis rates are reported. Furthermore their report is 3 months in arrears to allow Clinical Coding to reach an acceptable level.

Critical Medicines Omitted:

- During 2017/18 the figures released to the PHA were those from the Independent Audit undertaken by the Lead Nurses. However during 2018/19 the figures released will be a combination of the Independent Audit & the audit undertaken by the Ward Managers/Band 6's. Details of compliance is below:

Quarter	Q3 18/19	Q2 18/19	Q1 18/19	Q4 17/18
ACUTE	3 (532)	9 (522)	2 (355)	Not Available
TRUST	5 (704)	9 (681)	2 (508)	0 (111)

- Next update in May 19 when Q4 18/19 data is available

Maternity Quality Improvement Collaborative:

- Awaiting update from Wendy Clarke & Patricia Kingsnorth

WHO Surgical Safety Checklist:

- Awaiting the results of the follow-up Audit from Emma Jane Kearney & Marti McKenna

Patient Falls:

- During 2017/18 the figures released to the PHA were those from the Independent Audit undertaken by the Lead Nurses. However during 2018/19 the figures released will be a combination of the Independent Audit & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q3 18/19	Q2 18/19	Q1 18/19	Q4 17/18
Acute Bundle A Compliance	76% (402/532)	71% (370/522)	60% (213/355)	Not Available
Trust Bundle A Compliance	80% (563/704)	75% (514/681)	68% (344/508)	81% (90/111)

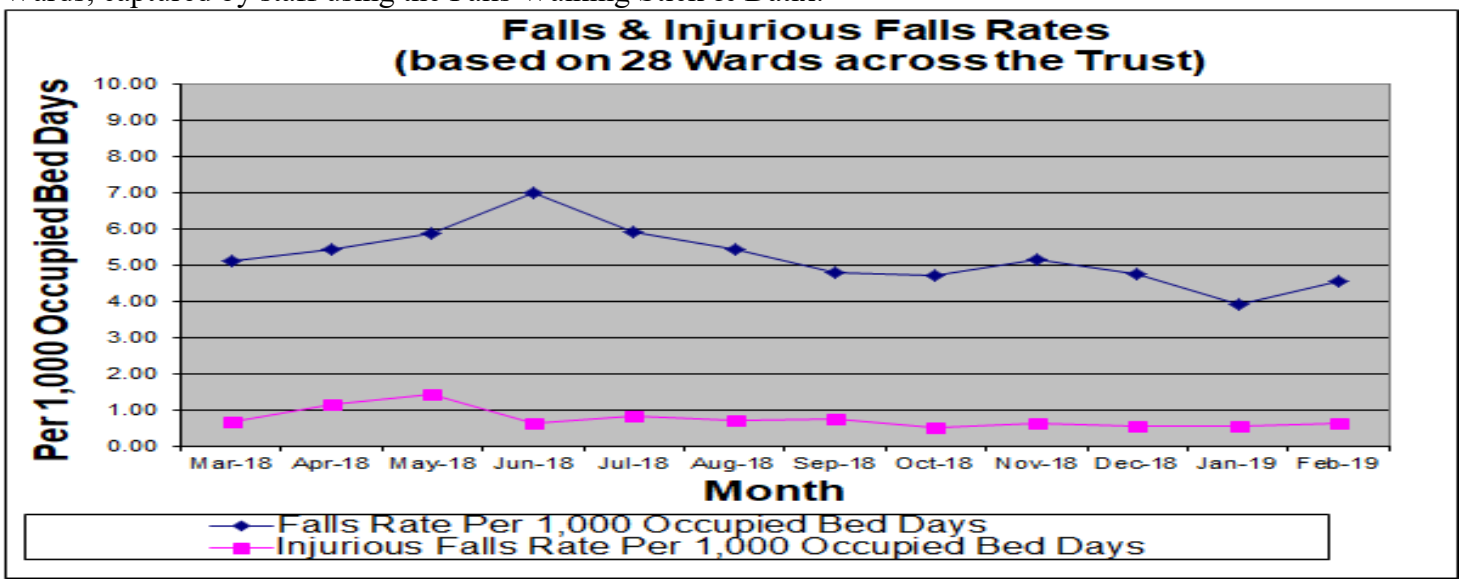
Quarter	Q3 18/19	Q2 18/19	Q1 18/19	Q4 17/18
Acute Bundle B Compliance	69% (295/426)	48% (186/388)	51% (122/240)	Not Available
Trust Bundle B Compliance	74% (438/591)	58% (306/532)	62% (238/385)	56% (54/96)

- Next update in May 19 when Q4 18/19 data is available

The table below gives details of individual Ward's Falls Numbers & Fall Rate 18/19

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL	Rate 18/19	Rate 17/18
CAH															
Ward 4 South	5	2	3	1	0	2	3	2	4	5	5		32	2.72	3.18 (41) ↓
Ward 4 North	4	5	5	5	4	1	4	5	3	4	2		42	4.14	2.37 (26) ↑
Ward 3 South	5	7	0	4	6	2	3	5	1	1	5		39	3.43	4.21 (52) ↓
Trauma Ward	7	2	2	4	5	3	3	6	6	3	2		43	5.27	4.95 (45) ↑
Orthopaedic Ward	1	1	3	3	3	0	3	2	0	1	3		20	4.77	3.84 (18) ↑
Gynae Ward	0	1	0	0	4	0	0	0	1	1	1		8	2.53	3.21 (11) ↓
Ward 2 South Medicine	7	4	4	1	1	5	2	7	3	4	6		44	7.88	8.51 (52) ↓
Ward 2 South Stroke	5	8	2	3	0	2	3	3	5	4	2		37	6.70	8.88 (55) ↓
Ward 2 North Resp.	4	5	6	0	1	2	2	0	1	1	2		24	4.06	3.46 (22) ↑
Ward 2 North Medicine	2	5	3	1	5	6	2	1	6	5	0		36	6.52	10.20 (62) ↓
Haematology Ward	0	3	1	3	1	1	1	0	2	1	0		13	3.17	5.63 (25) ↓
Ward 1 South	5	4	6	8	3	7	10	4	6	7	3		63	5.32	6.97 (90) ↓
Ward 1 North	3	4	5	6	3	2	3	3	3	2	1		35	3.35	4.41 (50) ↓
AMU	8	13	5	7	17	6	5	4	15	4	2		86	8.25	7.36 (83) ↑
3 North Winter Ward	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1	3		4	2.55	N/A
DHH															
Male Surgical	2	3	7	2	0	1	0	0	3	1	3		22	3.99	3.67 (22) ↑
Female Surg/Gynae	2	4	2	4	5	1	2	2	3	3	1		29	3.57	2.92 (26) ↑
HDU	2	0	0	1	2	0	0	0	0	1	1		7	2.27	3.13 (10) ↓
Stroke/Rehab	3	4	11	7	6	2	4	7	2	2	5		53	5.49	4.93 (52) ↑
Male Med/CCU	9	2	6	2	7	4	4	3	6	2	5		50	4.65	3.99 (46) ↑
Female Medical	5	6	11	2	4	3	8	4	3	0	7		53	4.91	5.16 (62) ↓
Lurgan															
Ward 1	1	2	6	4	4	3	1	3	1	1	1		27	5.28	2.15 (12) ↑
Ward 2	2	2	3	4	2	1	2	2	1	3	2		24	4.31	4.14 (26) ↑
Ward 3	2	2	1	1	1	2	0	3	0	1	1		14	2.62	3.00 (18) ↓
STH															
Ward 1 STH	1	1	1	0	0	1	3	1	1	0	1		10	1.75	1.15 (7) ↑
Ward 2 STH	0	3	0	0	2	4	1	1	1	2	1		15	2.65	2.17 (13) ↑
MHLD															
Gillis	7	10	19	19	5	13	9	11	7	3	2		105	17.33	18.59 (129) ↓
Willows	2	3	12	17	7	10	8	18	0	11	11		99	16.00	11.00 (75) ↑
TOTAL	94	106	124	109	98	84	86	97	84	74	78		1034		
RATE	5.43	5.86	7.01	5.93	5.46	4.79	4.73	5.16	4.74	3.91	4.55			5.23	5.28 (1130) ↓

The Run Chart below shows Patient Falls & Injurious Falls Rates per 1,000 Occupied Bed Days based on 28 Wards, captured by staff using the Falls Walking Stick & Datix.

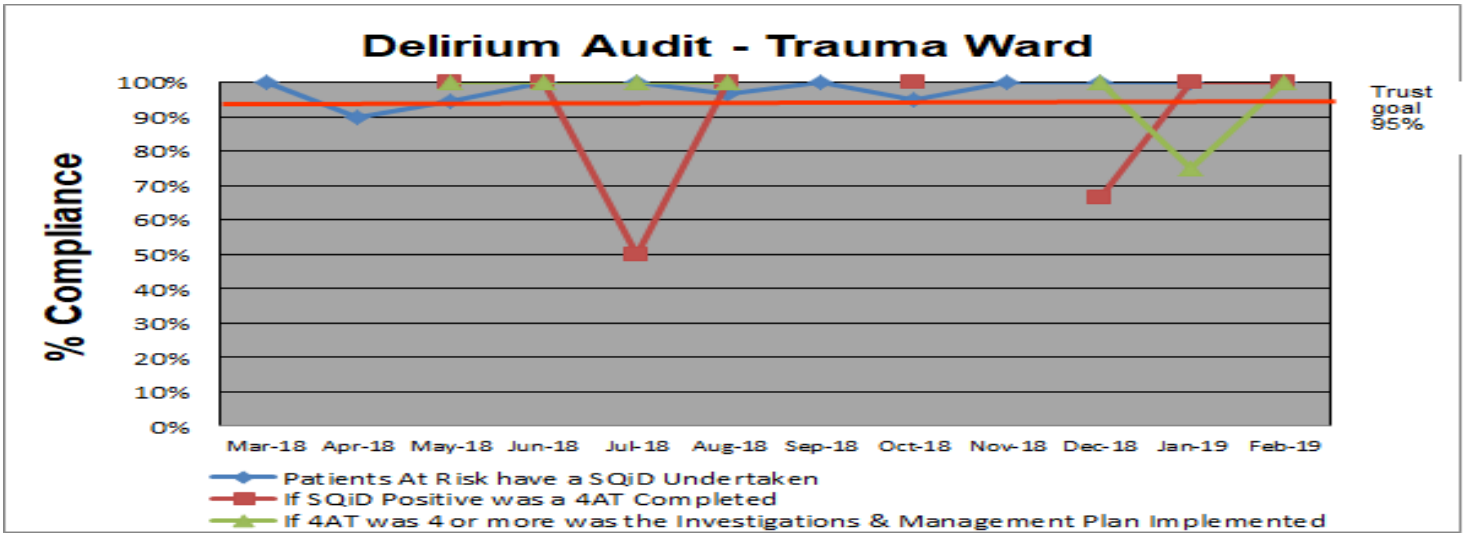


- Falls Rate **4.55** (**78**/17,128 Occupied Bed Days) up from **3.91** (**74**/18,944) in Jan 19
- Injurious Falls Rate **0.64** (**11**/7,128 Occupied Bed Days) up from **0.53** (**10**/18,944) in Jan 19
- Cumulative Falls Rate 18/19 stands at **5.23**, compared to **5.28** in 2017/18.

Regional Delirium Audit:

- Three measures are in place to demonstrate progress in the use of the Delirium Tool:
  - **Number of at risk patients who have a SQiD (single question in delirium) carried out**
  - **Number of patients with a 4AT completed (tool to assess for delirium)**
  - **Number of patients with an investigations & management plan completed**

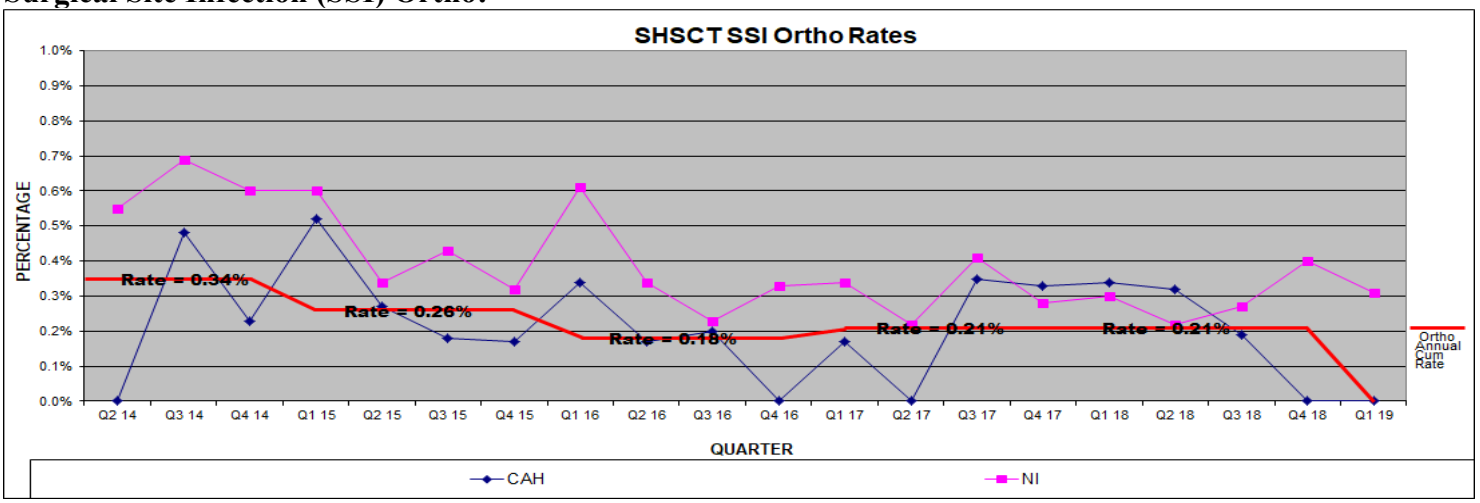
The Run Chart below shows the progress with each of the above elements on the Trauma Ward, CAH



- Non-Compliant elements:
  - N/A
- Audits received from Ward 2 South, CAH for Feb & Mar 19

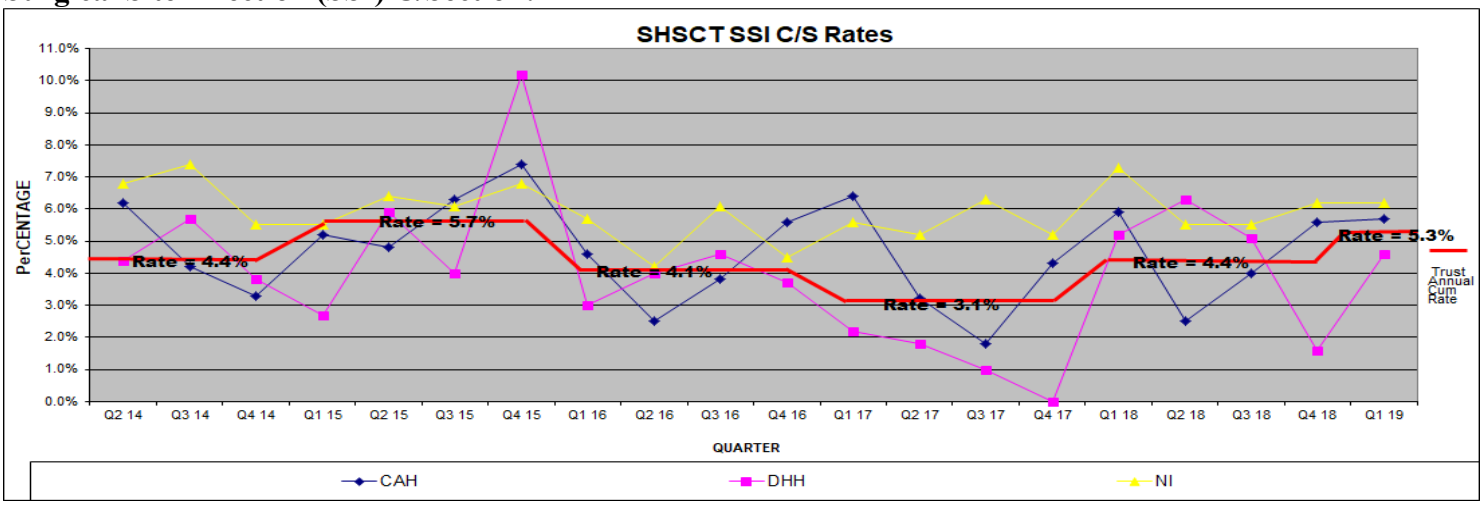
Patient Safety Report for Acute Governance Meeting Sept 2019

Surgical Site Infection (SSI) Ortho:



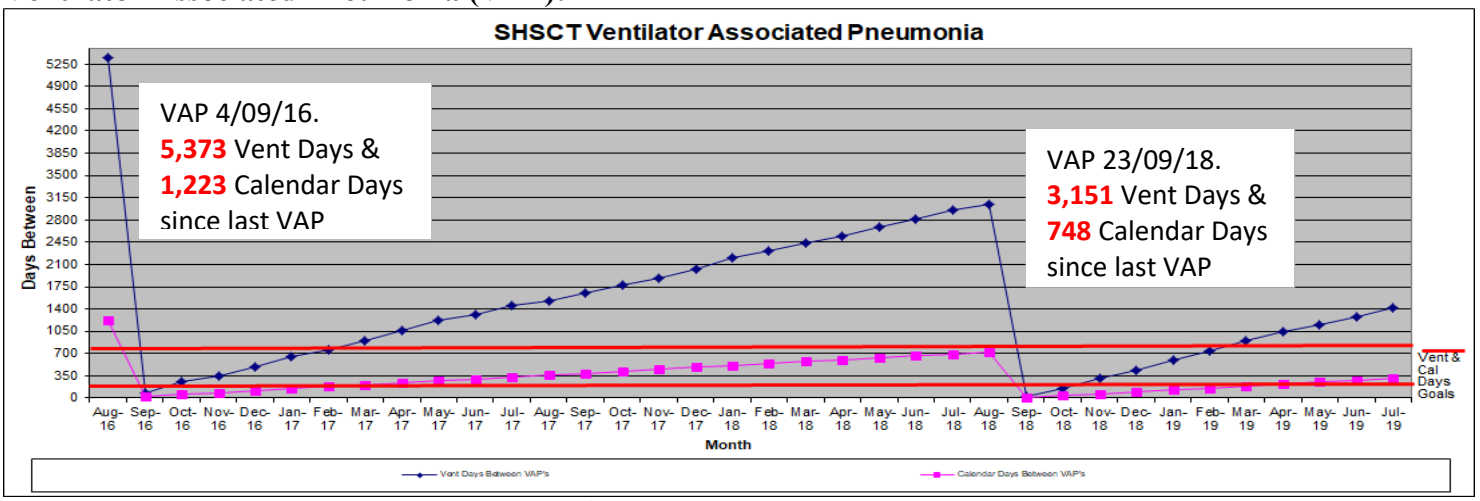
- Q1 2019 SSI Rates have been released by the PHA. CAH Rate was **0%** (0/574 procedures). NI Rate was **0.31%** (9/2,913 procedures). CAH Rate (last 8 quarters i.e. Q2 2017 → Q1 2019) was **0.19%** (9/4,705). NI Rate (last 8 quarters i.e. Q2 2017 → Q1 2019) was **0.30%** (74/24,765).

Surgical Site Infection (SSI) C/Section:



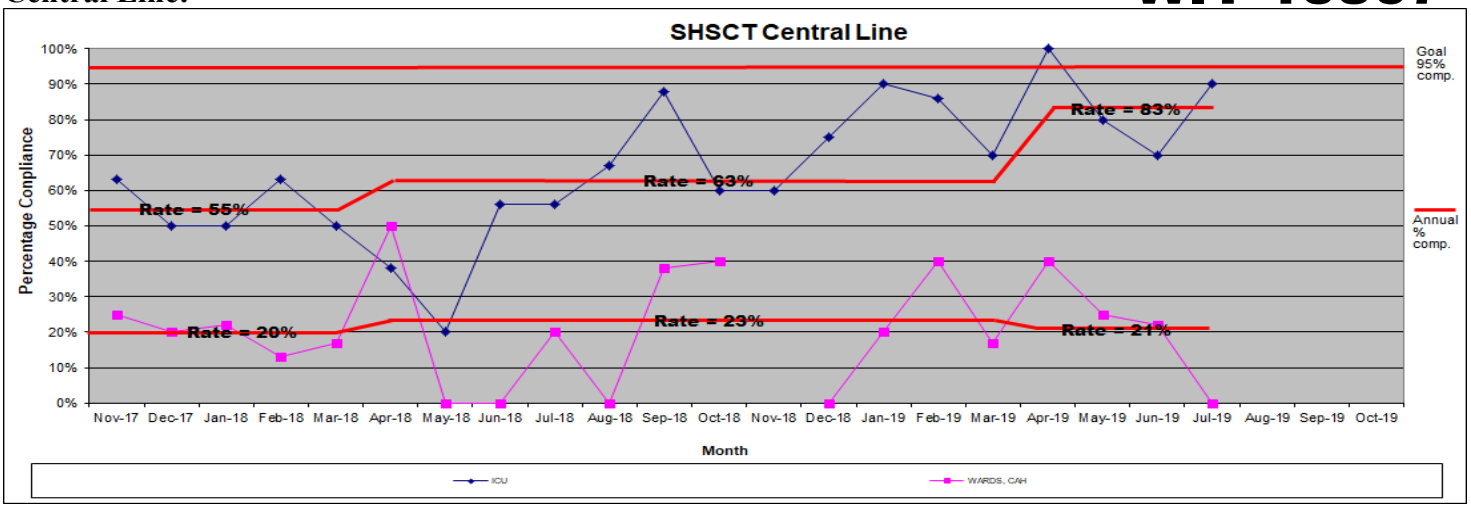
- Next update when Q2 2019 SSI Rates are released by the PHA
- The quarterly SSI C/Section Audits will be undertaken in Sept 19, with results reported on in Nov 19

Ventilator Associated Pneumonia (VAP):



- Vent Days Between VAP's **1422** (24th September 18 → 31st July 19)
- Calendar Days Between VAP's **311** (24th September 18 → 31th July 19)

Central Line:



Non-Compliant elements ICU:

- In 1 of 10 cases audited the Central Line Insertion Record was not completed therefore there was no evidence of the method of Hand Hygiene, Skin Prep or type of Drape used
- In 1 of 10 cases audited the jugular was used with no contrindication documented

Non-Compliant elements Wards, CAH:

- In 1 of 6 cases audited the Central Line Insertion Record was not completed therefore there was no evidence of the method of Hand Hygiene, Skin Prep or type of Drape used
- In 1 of 6 cases audited the method of Hand Hygiene was inappropriate
- In 2 of 6 cases audited the jugular was used with no contrindication documented
- In 3 of 6 cases audited the Daily Review of the Line was not carried out every day the line was in situ (1 day missed in all 3 cases)

- A Central Line infection was reported on 8th July 19 on Ward 4 South. Chris Clarke will undertake an RCA in this case in due course, which will be shared with colleagues for learning
- Results shared with Lead Clinician & Lead Nurse for this QI work to address areas of non-compliance

NEWS:

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q1 19/20	Q4 18/19	Q3 18/19	Q2 18/19
ACUTE	82% (360/439)	80% (430/532)	81% (430/532)	80% (419/522)
TRUST	85% (501/588)	83% (517/620)	84% (589/704)	81% (555/681)

- Next update in Nov 19 when Q2 19/20 data is available

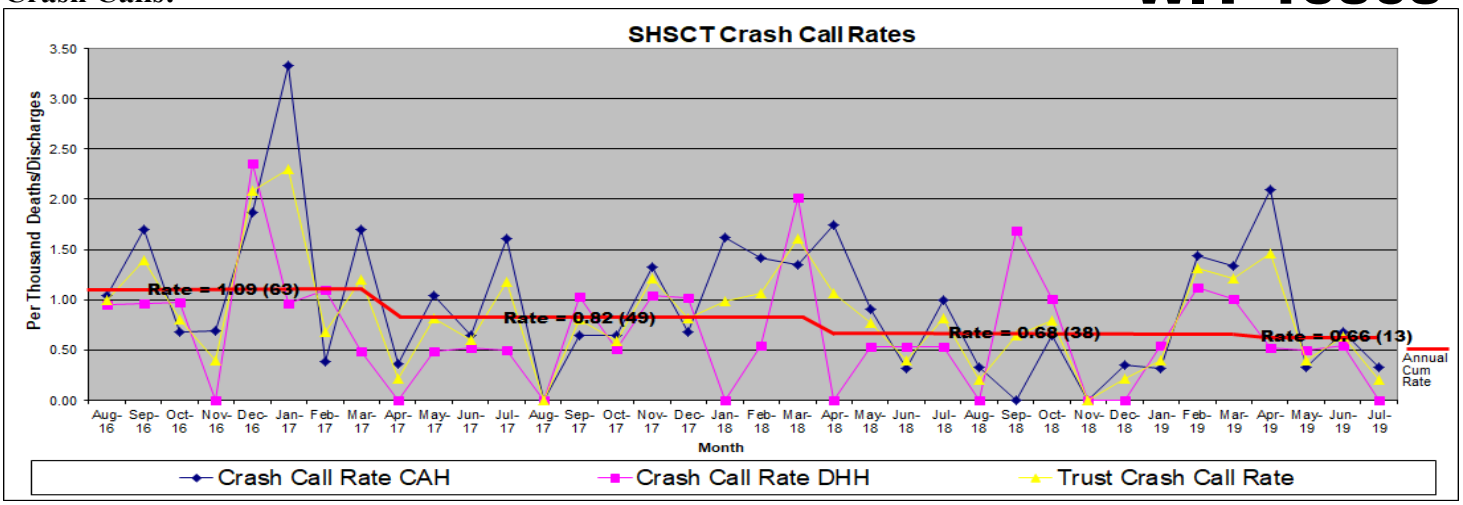
MUST (Malnutrition Universal Screening Tool):

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q1 19/20	Q4 18/19	Q3 18/19	Q2 18/19
ACUTE	88% (386/439)	91% (425/469)	86% (460/532)	88% (461/522)
TRUST	90% (531/588)	93% (575/620)	89% (626/704)	91% (617/681)

- Next update in Nov 19 when Q2 19/20 data is available

Crash Calls:



- CAH Rate **0.33** per 1,000 deaths/discharges (**1** Crash Call) down from **0.68** (**2** Crash Calls) in June 19
- DHH Rate **0** per 1,000 deaths/discharges (**0** Crash Calls) down from **0.54** (**1** Crash Call) in June 19
- Trust Rate **0.20** per 1,000 deaths/discharges (**1** Crash Call) down from **0.63** (**3** Crash Calls) in June 19
- Trust cumulative Crash Call rate for 19/20 stands at **0.66 (13)** per 1,000 deaths/discharges, down from **0.68 (38)** in 18/19

VTE:

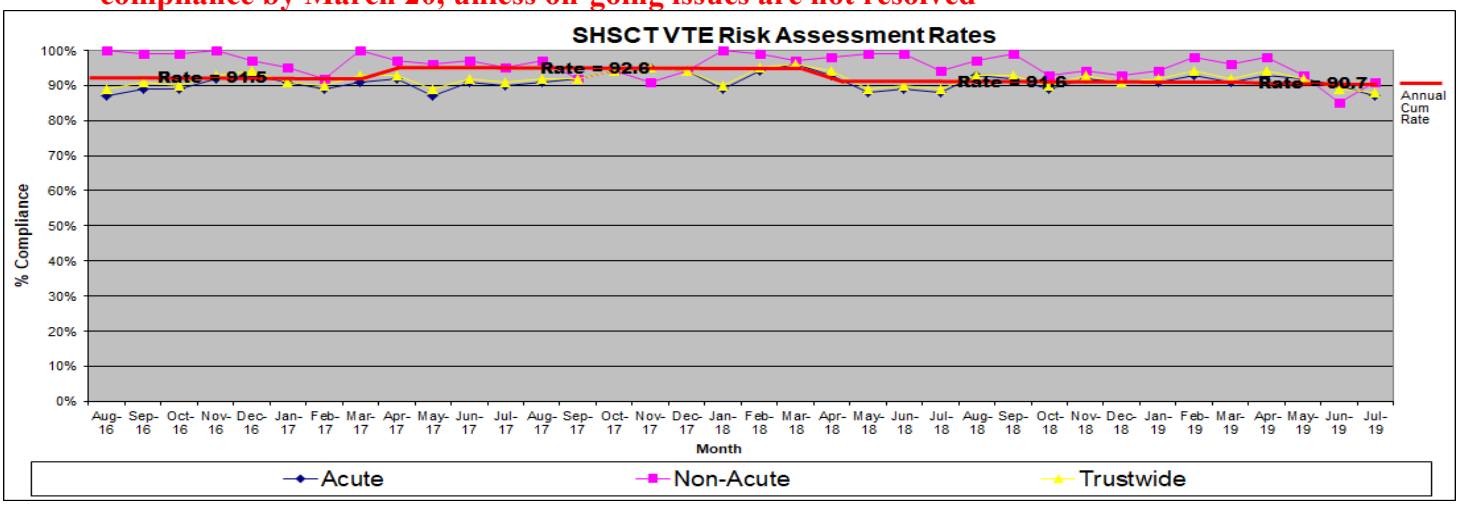
July 19 (Week Commencing 01/07/19 → Week Commencing 29/07/19)

Division	Site	Ward	Number of Weekly Audits not done	Charts with Fully Completed VTE Risk Assessment	Number of Charts Audited	Monthly Percentage Compliance	Quarter 1 19/20 Percentage Compliance
S&EC	CAH	3 South	0	21	24	87% ↓	89% ↑
		4 North CESW	0	23	25	92% ↓	92% ↑
		4 South	0	23	25	92% ↓	92% ↓
		Elective Adm.	1	1	20	5% ↓	62% ↑
		Orthopaedic	0	23	23	100% ↔	100% ↑
		Trauma	0	23	23	100% ↔	98% ↓
	DHH	F/male Surg.	0	24	25	96% ↑	92% ↓
		MSW/HDU	0	24	24	100% ↑	96% ↑
M&UC	CAH	1 South	1	20	20	100% ↑	89% ↓
		1 North	0	20	25	80% ↓	88% ↓
		2 North Resp.	0	21	23	91% ↑	94% ↑
		Haematology	0	15	15	100% ↔	93% ↓
		2 South	1	16	18	89% ↓	96% ↑
		2 North Med.	0	20	25	80% ↓	90% ↓
		AMU	0	23	25	92% ↑	90% ↓
	DHH	F/male Med.	0	16	20	80% ↓	75% ↓
		CCC/MMW	0	23	24	96% ↓	100% ↑
		Stroke/Rehab	0	20	25	80% ↓	97% ↑
IMWH	CAH	Gynae	0	22	23	96% ↓	97% ↑
TOTAL			**3 ↑ (2)**	**378**	**432**	**87.5% ↓**	**91.5% ↓**

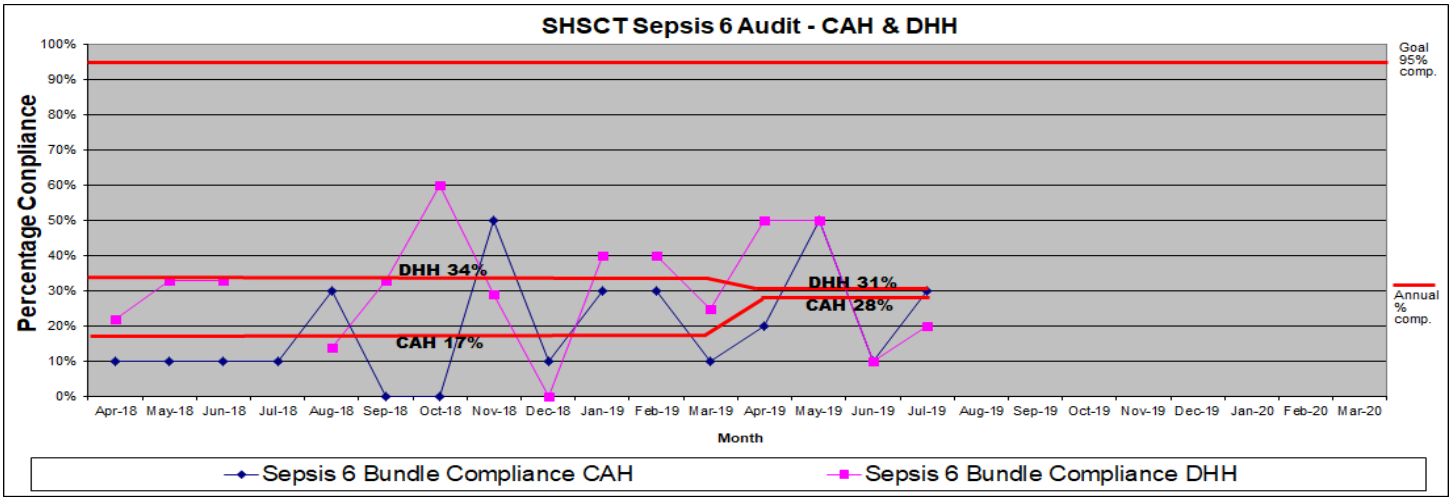
Key: Red – Under 85% compliance, Amber – Compliance between 85% & 94%, Green – Above 95% (Reg. target)

- In summary Overall Compliance with fully completed Risk Assessment on the Acute Wards was **87.5%** (378/432 charts audited) down from **89.5%** (307/343 charts audited) in June 19.
- Total number of weekly audits not completed in July 19 was **3** up from **2** in June 19

- The Run Chart below shows compliance against the Commissioning Plan target of 95% compliance. The Trust Compliance includes the Non-Acute Wards & therefore their compliance has been included also for comparison. Trust Overall Compliance in July 19 was **88%** (464/527), down from **89%** in June 19.
- **Compliance in the EAW will result in the Trust failing to achieve the Regional Goal of 95% compliance by March 20, unless on-going issues are not resolved**



Emergency Care QI Work: Sepsis 6 CAH & DHH:



- Summary of July 19 Audit CAH - All 10 patients did receive IV Fluids & IV Antibiotics prior to leaving ED. However in 4 cases for each they were not administered within an hour of arrival The other element where compliance remains a challenge is the recording of Urinary Output
- Summary of July 19 Audit DHH – Again administering IV Fluids & IV Antibiotics within the hour is the main challenge

- Results shared with Lead Clinician & Lead Nurse for this QI work to address areas of non-compliance

Critical Medicines Omitted:

The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q1 19/20	Q4 18/19	Q3 18/19	Q2 18/19
ACUTE	2 (439)	5 (469)	3 (532)	9 (522)
TRUST	3 (588)	6 (620)	5 (704)	9 (681)

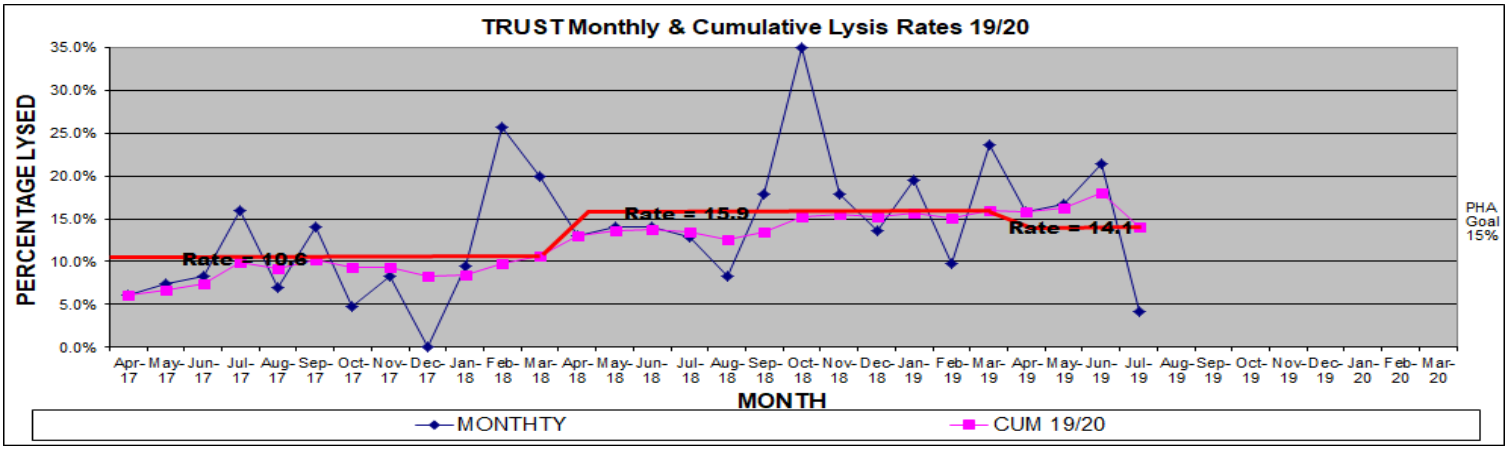
- Next update in Nov 19 when Q2 19/20 data is available

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		July 19		July 19		July 19	Commentary July 19
Patients who are potentially eligible for thrombolysis are assessed by Acute Stroke Team within 30 minutes of arrival	17/18 98% 18/19 99%	100% (53/53)	17/18 99% 18/19 99%	100% (29/29)	17/18 99% 18/19 99%	100% (82/82)	-
Patients who are potentially eligible for thrombolysis receive CT scan within 45 minutes	17/18 96% 18/19 99%	100% (11/11)	17/18 95% 18/19 98%	100% (18/18)	17/18 96% 18/19 99%	100% (29/29)	-
Patients deemed suitable for thrombolysis receive first bolus within 60 minutes	17/18 59% 18/19 90%	100% (2/2)	17/18 88% 18/19 75%	N/A (0/0)	17/18 68% 18/19 86%	100% (2/2)	-
Patients transferred to Hyper Acute Stroke Unit (or appropriate environment) within 90 mins	17/18 91% 18/19 4%	100% (2/2)	17/18 100% 18/19 89%	N/A (0/0)	17/18 94% 18/19 93%	100% (2/2)	-

	CAH		DHH		TRUST		AIM 19/20 (Based on Commissioning Plan) To ensure that the proportion of thrombolysis administration is at least (% to be confirmed)
Outcome Measure	2018/19	July 19	2018/19	July 19	2018/19	July 19	
Monthly Thrombolysis Rate		5.9% (2/34)		0% (0/14)		4.2% (2/48)	
Thrombolysis Rate (Yearly)	16.3% (49/301)	16.9% (20/118)	14.9% (20/134)	7.7% (4/52)	15.9% (69/435)	14.1% (24/170)	



The above is "Real Time" data, which is subject to change. The Directorate of Performance & Reform is responsible for reporting to the RHSCB. From the above table only the lysis rates are reported. Furthermore their report is 3 months in arrears to allow Clinical Coding to reach an acceptable level.

SKIN Care (Pressure Ulcer):

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

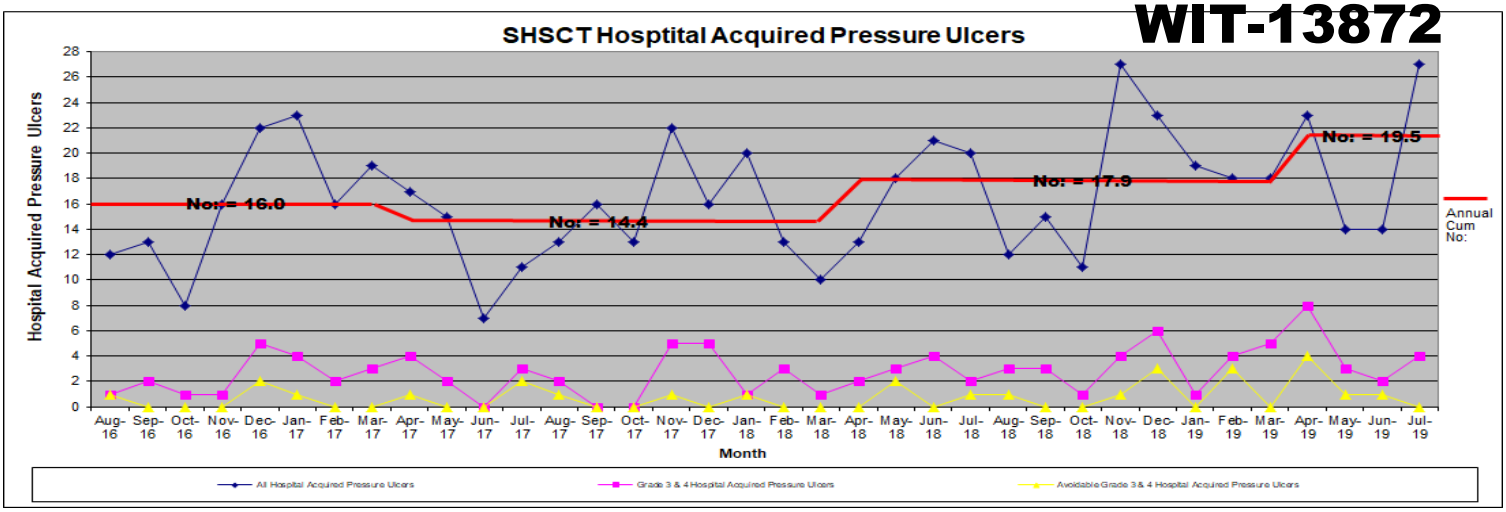
Quarter	Q1 19/20	Q4 18/19	Q3 18/19	Q2 18/19
ACUTE	67% (143/212)	74% (165/222)	70% (201/288)	71% (172/242)
TRUST	78% (271/346)	82% (295/361)	78% (338/435)	79% (293/372)

- Next update in Nov 19 when Q2 19/20 data is available

- There were **27** Hospital Acquired Pressures reported in July 19. Of these **4** were Grade 3/4 Ward Acquired Pressure Ulcers, (1 South, 2 South Medical & 2 North Medical, CAH, & Stroke/Rehab, DHH).
- In 19/20 RCA's have been carried out on **12** cases to date with **6** deemed avoidable. RCA's will be undertaken in the remainder of these cases in due course
- In 18/19 RCA's were carried out on **38** cases with **11** deemed to have been avoidable. This represents **5.1%** of all Ward Acquired Pressure Ulcers reported in 18/19

Ward Acquired Pressure Ulcers & Rate per 1,000 Occupied Bed Days 2019/20:

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL	Rate 19/20	Rate & No 18/19
CAH															
Ward 4 South	1	0	0	2									3	0.69	0.62 (8) ↑
Ward 4 North	1	0	0	0									1	0.26	0.81 (9) ↓
Ward 3 South	2	1	1	0									4	1.07	0.48 (6) ↑
Trauma Ward	3	1	1	1									6	2.03	3.13 (28) ↓
Orthopaedic Ward	0	0	0	0									0	0	0 (0) ↔
Gynae Ward	0	0	0	0									0	0	0.58 (2) ↓
ICU	1	0	0	4									5	6.41	10.10(24) ↓
Ward 2 South Medicine	0	0	3	2									5	2.41	2.62 (16) ↓
Ward 2 South Stroke	0	1	0	3									4	1.95	1.82 (11) ↑
Ward 2 North	0	2	0	5									7	1.69	0.72 (9) ↑
Ward 5 Haematology	1	1	0	0									2	1.33	1.79 (8) ↓
Ward 1 South	2	4	4	3									13	3.00	1.31 (17) ↑
Ward 1 North	1	0	0	0									1	0.26	0.79 (9) ↓
AMU	0	1	1	4									6	1.53	0.70 (8) ↑
Rec/Renal/2 West/WinterW	2	1	2	0									5	N/A	N/A
DHH															
Male Surgical	0	0	0	0									0	0	0.17 (1) ↓
Female Surg/Gynae	0	0	0	1									1	0.32	0.79 (7) ↓
HDU	1	0	0	0									1	0.91	1.23 (4) ↓
Stroke/Rehab	0	0	0	1									1	0.28	0.19 (2) ↑
Male Med/CCU	0	0	0	0									0	0	0 (0) ↔
Female Medical	0	0	0	0									0	0	0.85 (10) ↓
Lurgan															
Ward 1	2	0	0	0									2	1.06	0.18 (1) ↑
Ward 2	1	0	0	0									1	0.50	1.64 (10) ↓
Ward 3	1	0	1	0									2	1.06	0.68 (4) ↑
STH															
Ward 1 STH	3	0	1	0									4	1.97	0.64 (4) ↑
Ward 2 STH	1	1	0	1									3	1.52	0.49 (3) ↑
MHLD															
Gillis	0	1	0	0									1	0.53	0.45 (3) ↑
Willows	0	0	0	0									0	0	0.29 (2) ↓
TOTAL	23	14	14	27									78		
RATE	1.25	0.73	0.77	1.45										1.05	0.98 (215)↑



- The Trust's Monthly Hospital Acquired Pressure Ulcer Rate for July 19, based on **29** Wards was **1.45** (**27**/18,601) per 1,000 Occupied Bed Days up from **0.77** (**14**/18,189) per 1,000 Occupied Bed Days in June 19

- The Trust's 2019/20 Hospital Acquired Pressure Ulcer Rate, based on **29** Wards stands at **1.05 (78)** per 1,000 Bed Days, up from **0.98 (215)** in 2018/19.

WHO Surgical Safety Checklist:

- The Monthly Audits were reinstated in May 19.
- Overall Bundle compliance in July 19 was **93%** (56/60), up from **75%** (45/60) in June 19
- All 6 areas audited achieved the goal of **90%** or better in July 19

Patient Falls:

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q1 19/20	Q4 18/19	Q3 18/19	Q2 18/19
Acute Bundle A Compliance	77% (340/439)	72% (339/469)	76% (402/532)	71% (370/522)
Trust Bundle A Compliance	82% (480/588)	78% (481/620)	80% (563/704)	75% (514/681)

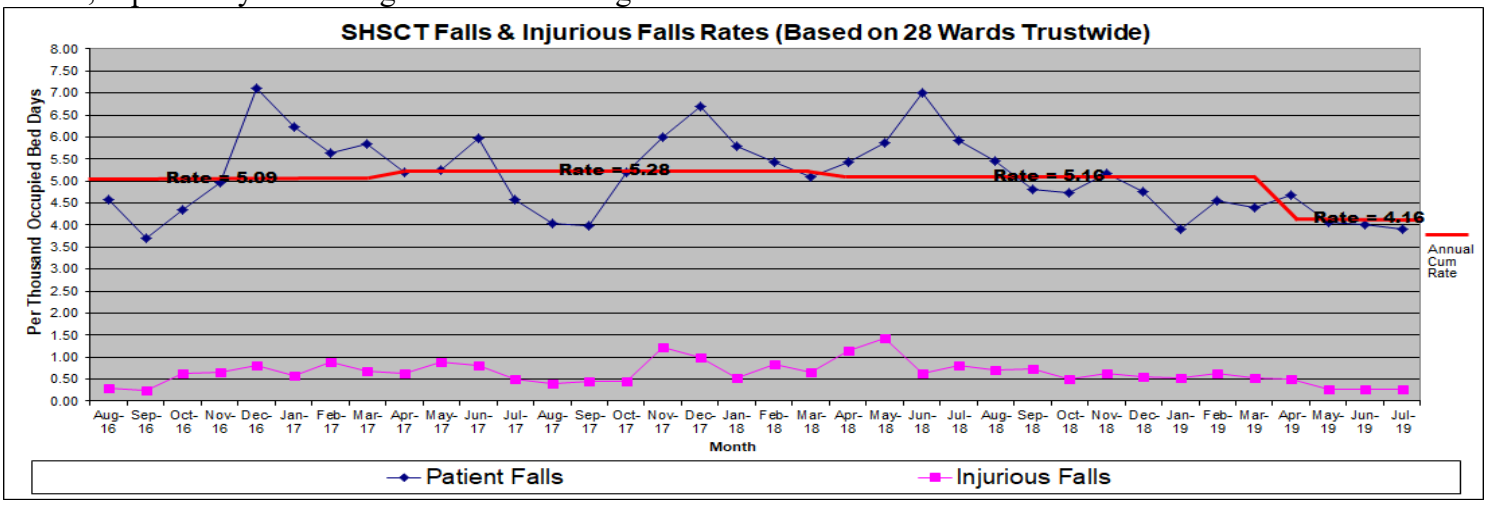
Quarter	Q1 19/20	Q4 18/19	Q3 18/19	Q2 18/19
Acute Bundle B Compliance	63% (205/326)	70% (252/361)	69% (295/426)	48% (186/388)
Trust Bundle B Compliance	71% (338/473)	76% (390/511)	74% (438/591)	58% (306/532)

- Next update in Nov 19 when Q2 19/20 data is available

The table below gives details of individual Ward's Falls Numbers & Falls Rate 19/20

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL	Rate 19/20	Rate 18/19
CAH															
Ward 4 South	5	0	3	0									8	1.83	2.72 (35) ↓
Ward 4 North	1	2	2	1									6	1.56	4.33 (48) ↓
Ward 3 South	1	2	2	3									8	2.14	3.30 (41) ↓
Trauma Ward	3	3	4	3									13	4.39	5.26 (47) ↓
Orthopaedic Ward	1	0	1	3									5	3.67	4.55 (21) ↓
Gynae Ward	0	3	0	1									4	3.49	2.60 (9) ↑
Ward 2 South Medicine	5	4	4	4									17	8.20	8.53 (52) ↓
Ward 2 South Stroke	4	3	4	0									11	5.37	6.29 (38) ↓
Ward 2 North	4	4	4	3									15	3.61	4.96 (62) ↓
Haematology Ward	4	3	0	2									9	6.00	2.90 (13) ↑
Ward 1 South	7	4	7	4									22	5.07	5.18 (67) ↓
Ward 1 North	2	3	3	4									12	3.12	3.59 (41) ↓
AMU	12	7	12	5									36	9.20	7.82 (89) ↑
3 North Winter Ward	5	3	2	2									12	5.38	3.31 (7) ↑
DHH															
Male Surgical	2	3	0	3									8	3.84	4.14 (25) ↓
Female Surg/Gynae	0	1	1	5									7	2.24	3.82 (34) ↓
HDU	3	0	0	0									3	2.47	2.46 (8) ↑
Stroke/Rehab	4	1	1	4									10	2.82	5.22 (55) ↓
Male Med/CCU	4	2	3	9									18	4.49	4.41 (52) ↑
Female Medical	7	6	2	2									17	4.21	5.08 (60) ↓
Lurgan															
Ward 1	1	2	1	1									5	2.65	5.23 (29) ↓
Ward 2	0	2	1	2									5	2.49	4.27 (26) ↓
Ward 3	1	3	2	2									8	4.24	2.57 (15) ↑
STH															
Ward 1 STH	2	1	0	0									3	1.48	1.93 (12) ↓
Ward 2 STH	1	0	2	1									4	2.03	2.44 (15) ↓
MHLD															
Gillis	3	4	3	3									13	6.89	16.32 (108) ↓
Willows	3	11	8	5									27	10.86	15.86 (108) ↓
TOTAL	85	77	72	72									306		
RATE	4.68	4.07	4.00	3.91										4.16	5.16 (1117) ↓

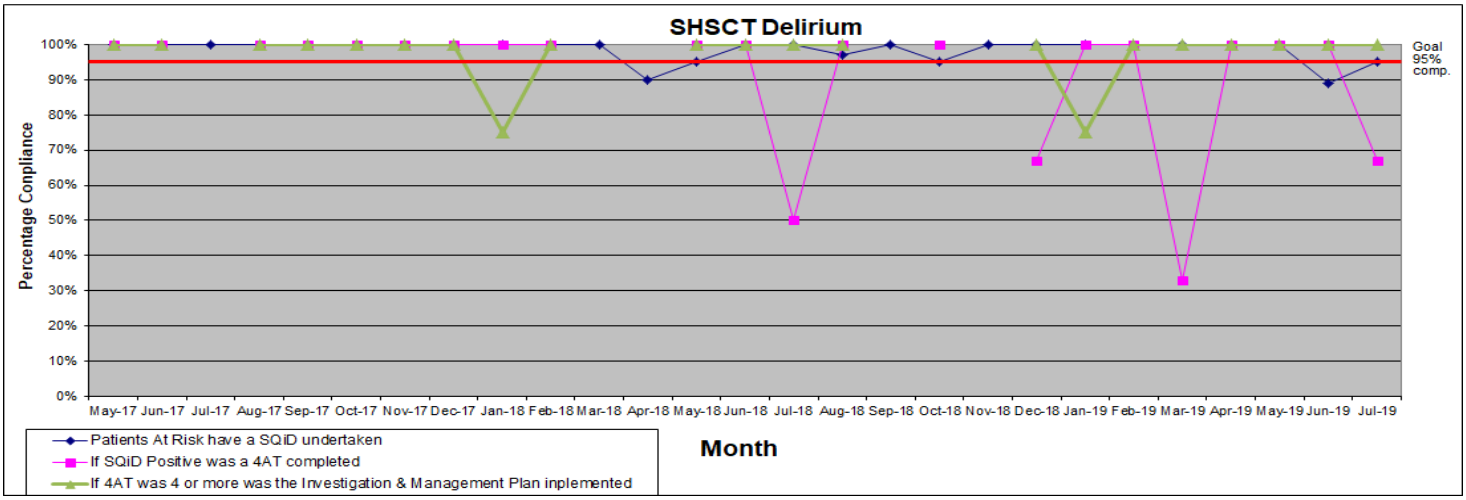
The Run Chart below shows Patient Falls & Injurious Falls Rates per 1,000 Occupied Bed Days based on 28 Wards, captured by staff using the Falls Walking Stick & Datix.



- Falls Rate **3.91** (**72**/18,413 Occupied Bed Days) down from **4.00** (**72**/17,999) in June 19
- Injurious Falls Rate **0.27** (**5**/18,413 Occupied Bed Days) down from **0.28** (**5**/17,999) in June 19
- Cumulative Falls Rate for 19/20 stands at **4.16**, compared to **5.16** in 18/19

- Three measures are in place to demonstrate progress in the use of the Delirium Tool:
  - **Number of at risk patients who have a SQiD (single question in delirium) carried out**
  - **Number of patients with a 4AT completed (tool to assess for delirium)**
  - **Number of patients with an investigations & management plan completed**

The Run Chart below shows the progress with each of the above elements on the Trauma Ward, CAH

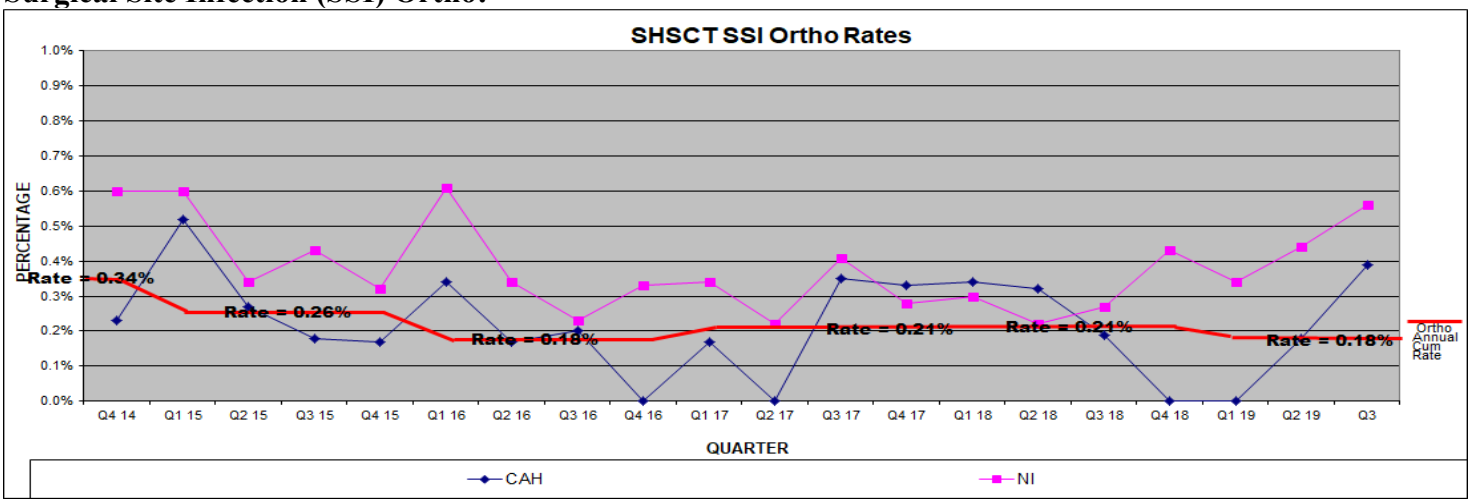


- Non-Compliant elements:
  - 1 of 20 patients audited & who were at risk of developing delirium did not have a SQiD carried out
  - 1 of 3 patients audited, who were SQiD positive, did not have a 4AT competed

- Auditing is now underway on 9 Wards across the Trust. Four of which are in Acute, Trauma, Ward 1 South, Ward 2 South & Ward 4 South, CAH. Other wards e.g. 1 North, CAH & Stroke/Rehab, DHH, Female Medical, DHH will commence auditing in the coming months

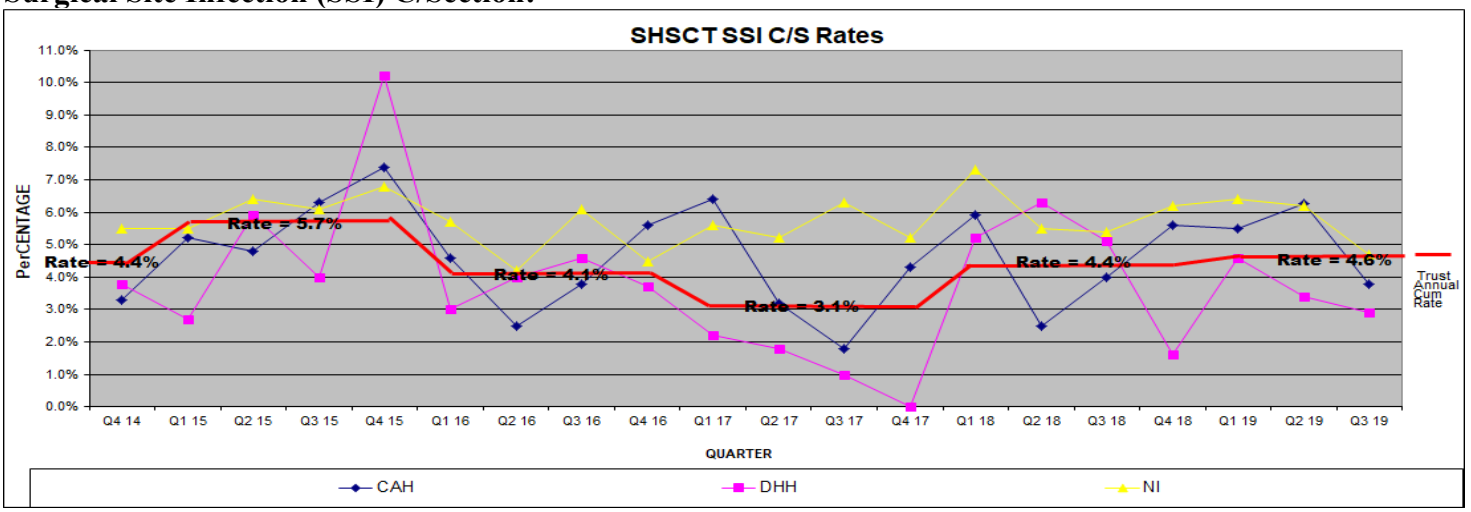
Patient Safety Report for Acute Governance Meeting Mar 2020

Surgical Site Infection (SSI) Ortho:



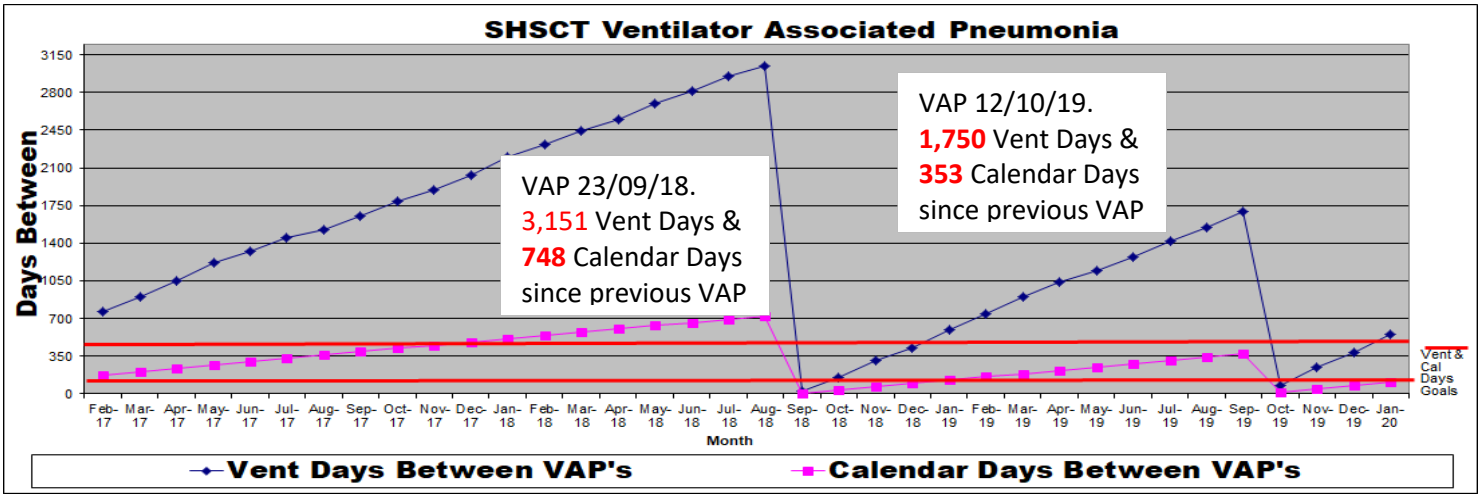
- Next update when Q4 2019 SSI Rates are released by the PHA

Surgical Site Infection (SSI) C/Section:



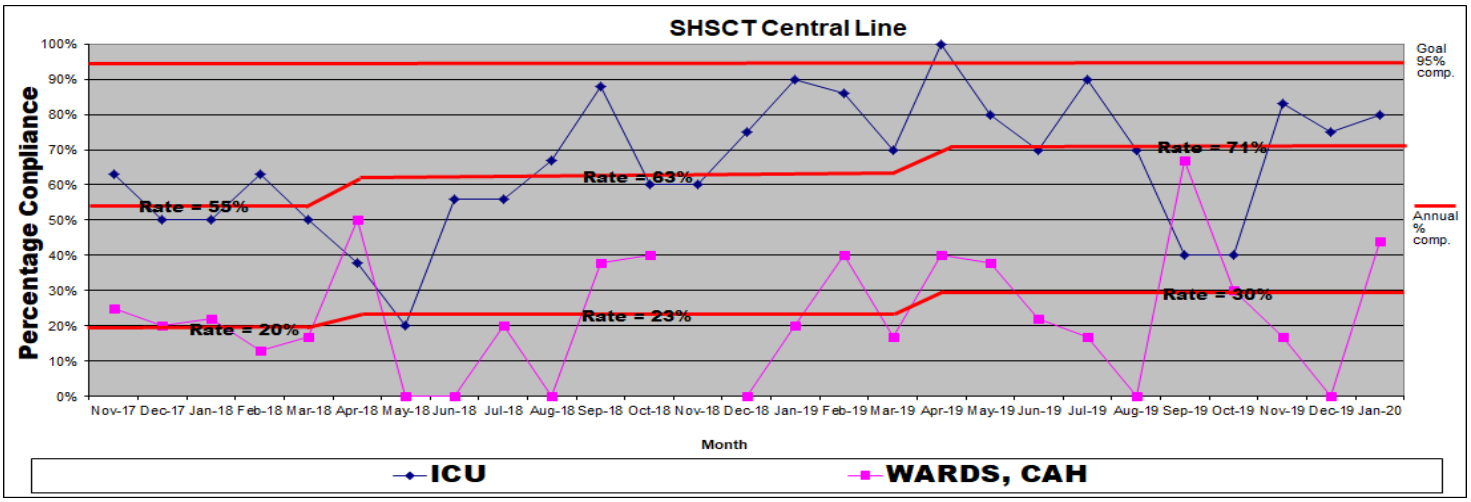
- Next update when Q4 2019 SSI Rates are released by the PHA
- The next quarterly SSI C/Section Audits take place in Mar 20, with results reported May 20

Ventilator Associated Pneumonia (VAP):



- Vent Days Between VAP's **549** (13th October 19 → 31st January 20)
- Calendar Days Between VAP's **80** (13th October 19 → 31st January 20)

Central Line:



Overall Bundle Compliance Jan 20, ICU **80%** (8/10 cases audited) & Wards, CAH **44%** (4/9 cases audited)

Non-Compliant elements ICU:

- In 1 of 10 cases audited the method of Hand Hygiene was inappropriate
- In 1 of 10 cases audited is was documented that a Small Drape was used

Non-Compliant elements Wards, CAH:

- In 1 of 9 cases audited the jugular was used with no contrindication documented
- In 4 of 9 cases audited the Daily Review of the Line was not carried out every daythe line was in situ

- Results shared with Lead Clinician & Lead Nurse for this QI work to address areas of non-compliance

NEWS:

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q3 19/20	Q2 19/20	Q1 19/20	Q4 18/19
ACUTE	84% (521/618)	87% (498/573)	82% (360/439)	80% (430/532)
TRUST	87% (657/741)	89% (657/741)	85% (501/588)	83% (517/620)

- Next update when Q4 19/20 data is available

MUST (Malnutrition Universal Screening Tool):

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

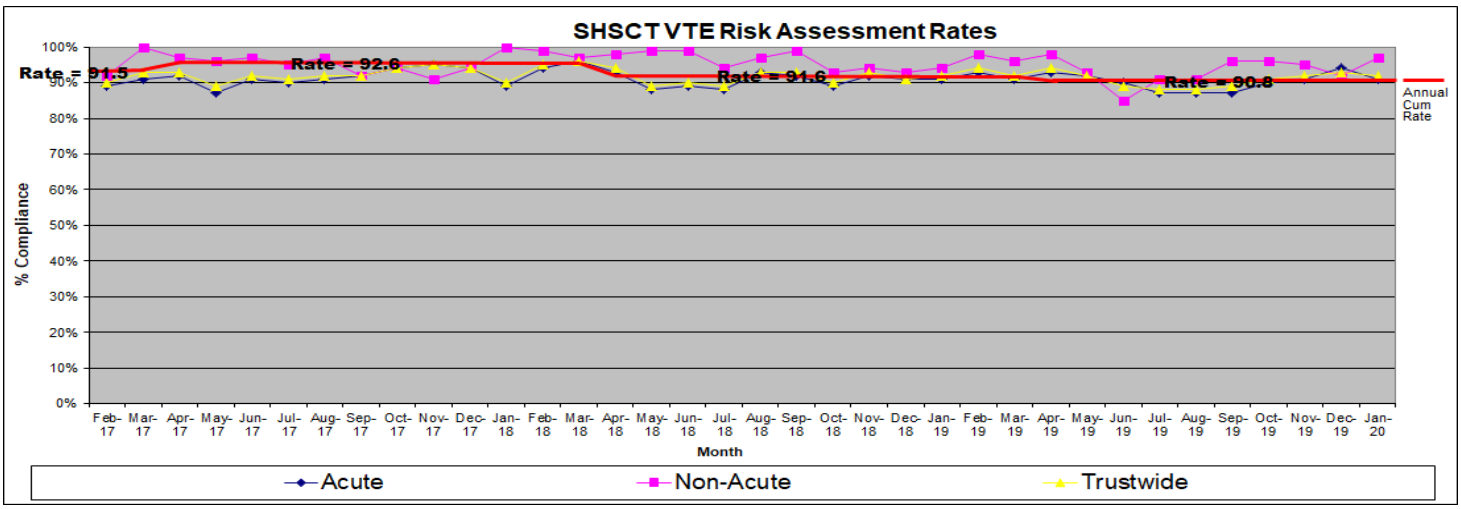
Quarter	Q3 19/20	Q2 19/20	Q1 19/20	Q4 18/19
ACUTE	84% (518/618)	87% (498/573)	88% (386/439)	91% (425/469)
TRUST	86% (662/741)	89% (662/741)	90% (531/588)	93% (575/620)

- Next update when Q4 19/20 data is available

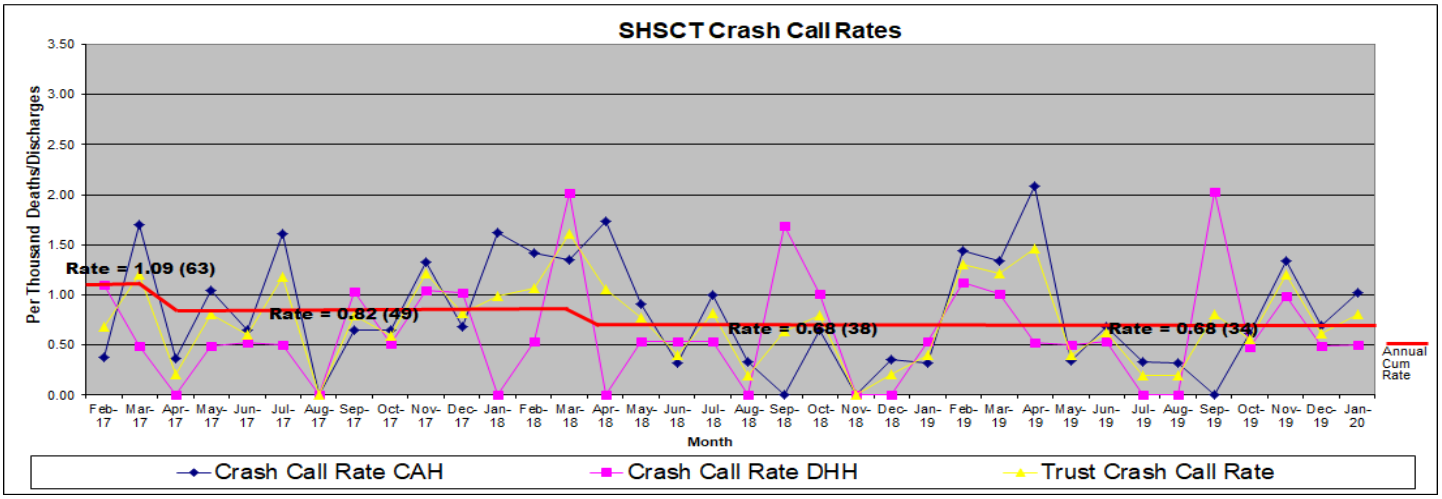
Jan 20 (Week Commencing 06/01/20 → Week Commencing 27/01/20)							
Division	**Site**	**Ward**	**Number of Weekly Audits not done**	**Charts with Fully Completed VTE Risk Assessment**	**Number of Charts Audited**	**Monthly Percentage Compliance**	**Quarter 3 19/20 Percentage Compliance**
S&EC	CAH	3 South	0	12	17	71% ↓	83% ↑
		4 North CESW	0	16	19	84% ↓	94% ↑
		4 South	0	15	19	79% ↓	88% ↓
		Elective Adm.	0	10	18	56% ↓	74% ↑
		Orthopaedic	0	15	15	100% ↔	100% ↔
		Trauma	0	19	19	100% ↔	100% ↑
	DHH	F/male Surg.	0	19	20	95% ↓	98% ↑
		MSW/HDU	0	20	20	100% ↑	97% ↑
M&UC	CAH	1 South	0	22	24	92% ↑	89% ↓
		1 North	0	17	20	85% ↓	86% ↓
		2 North Resp.	0	18	19	95% ↓	95% ↑
		Haematology	0	15	15	100% ↔	100% ↑
		2 South	0	20	20	100% ↑	95% ↓
		2 North Med.	0	20	20	100% ↔	95% ↑
		AMU	0	19	20	95% ↑	86% ↓
	DHH	F/male Med.	0	15	17	88% ↑	87% ↑
		CCC/MMW	0	17	20	85% ↓	80% ↓
		Stroke/Rehab	0	20	20	100% ↑	92% ↑
IMWH	CAH	Gynae	0	19	19	100% ↔	100% ↑
TOTAL			**0 ↓ (11)**	**328**	**361**	**90.9% ↓**	**91.8% ↑**

Key: Red – Under 85% compliance, Amber – Compliance between 85% & 94%, Green – Above 95% (Reg. target)

- In summary Overall Compliance with fully completed Risk Assessment on the Acute Wards was **90.9%** (328/361 charts audited) down from **93.6%** (365/390 charts audited) in Dec 19.
- Total number of weekly audits not completed in Jan 20 was **0** down from **11** in Dec 19
- The Run Chart below shows compliance against the Commissioning Plan target of **95%** compliance. The Trust Compliance includes the Non-Acute Wards & therefore their compliance has been included also for comparison. Trust Overall Compliance in Dec 19 was **92%** (414/450), down from **93%** in Dec 19



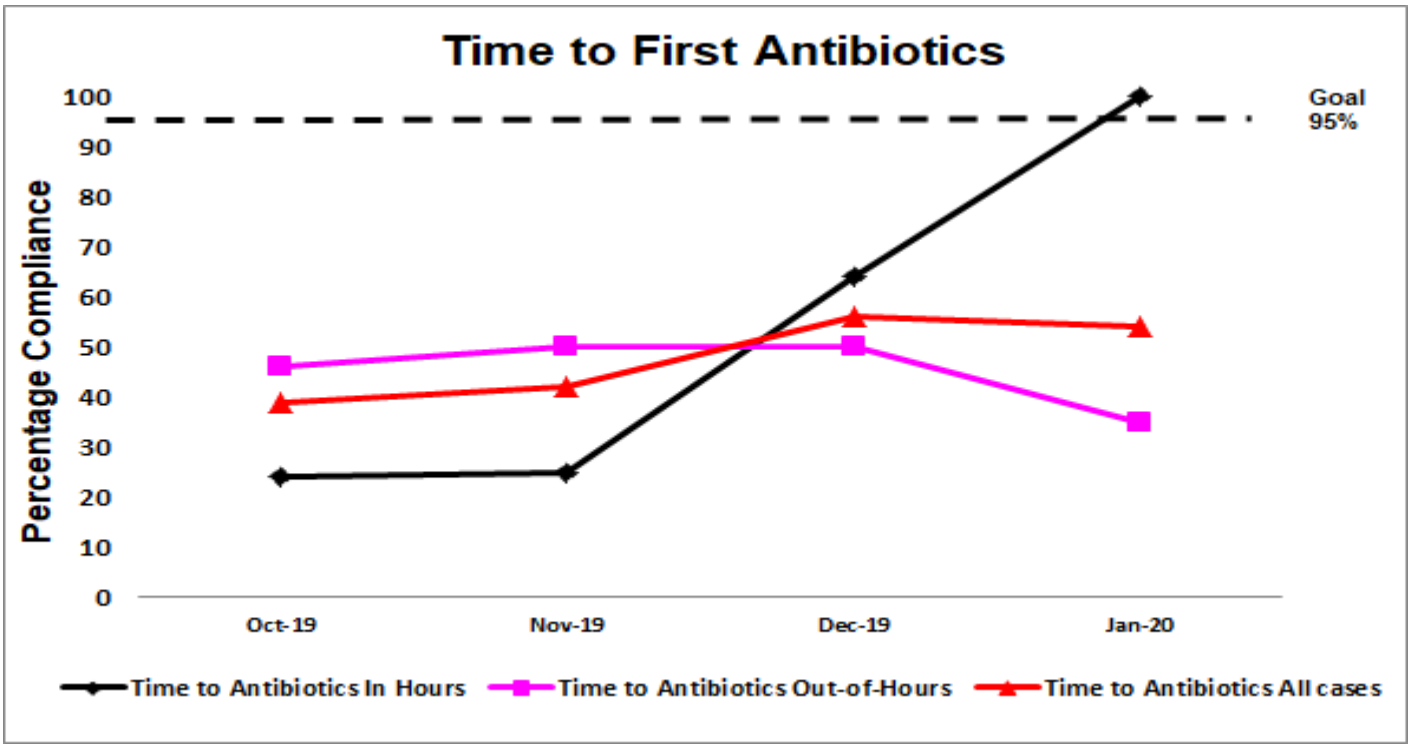
Crash Calls:



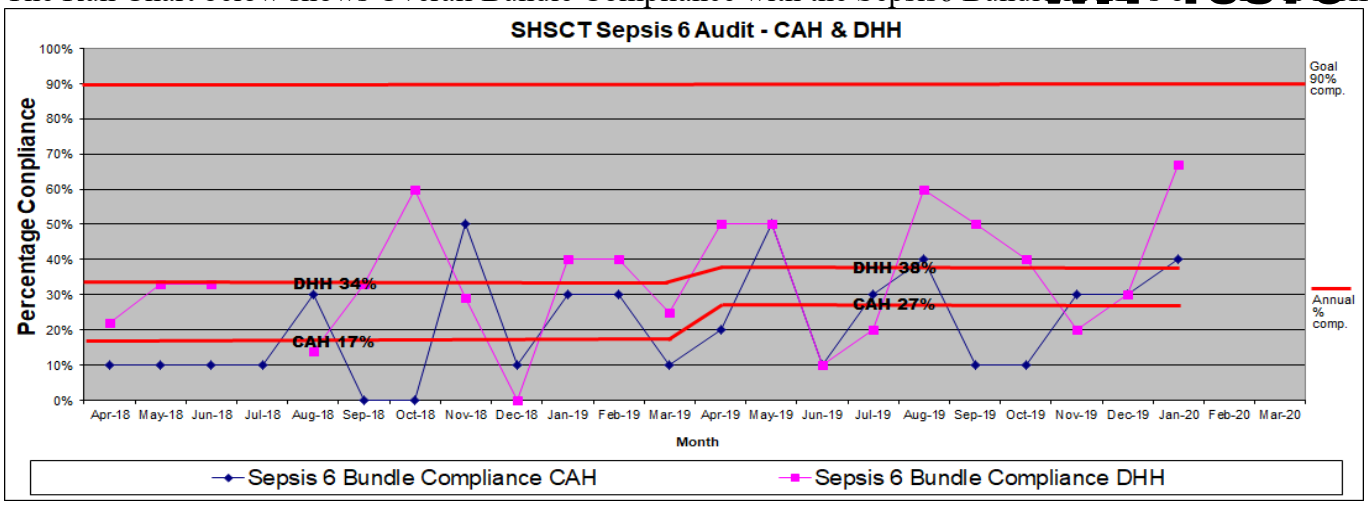
- CAH Rate **1.02** per 1,000 deaths/discharges (**3** Crash Calls) up from **0.69** (**2** Crash Calls) in Dec 19
- DHH Rate **0.50** per 1,000 deaths/discharges (**1** Crash Call) up from **0.49** (**1** Crash Call) in Dec 19
- Trust Rate **0.81** per 1,000 deaths/discharges (**4** Crash Calls) up from **0.61** (**3** Crash Calls) in Dec 19
- Trust cumulative Crash Call Rate for 19/20 stands at **0.68 (34)** per 1,000 deaths/discharges, same as 18/19 **0.68 (38)**

Emergency Care QI Work: Sepsis 6 CAH & DHH:

- The new Regional Sepsis QI initiative has been ongoing from Oct 19. The Regional Agreed aim is to improve the time to 1st antibiotics "In Hours" i.e. Mon → Fri 9:00am → 5:00pm. Work is underway in 3 Pilot Areas ED, CAH, (Oct 19 – Dr. Suzie Budd, Clinical Lead), AMU, CAH (Dec 19 – Dr. Emily Hannah, Clinical Lead) & ED, DHH (14th Jan 20 – Dr. Laura Lavery, Clinical Lead). In the ED's of CAH & DHH it was decided to measure compliance 24/7. The Run Chart below shows progress made in ED, CAH. Data from the other Pilot Areas will be shared in due course



The Run Chart below shows Overall Bundle Compliance with the Sepsis6 Bundle in ED's of CAH & DHH

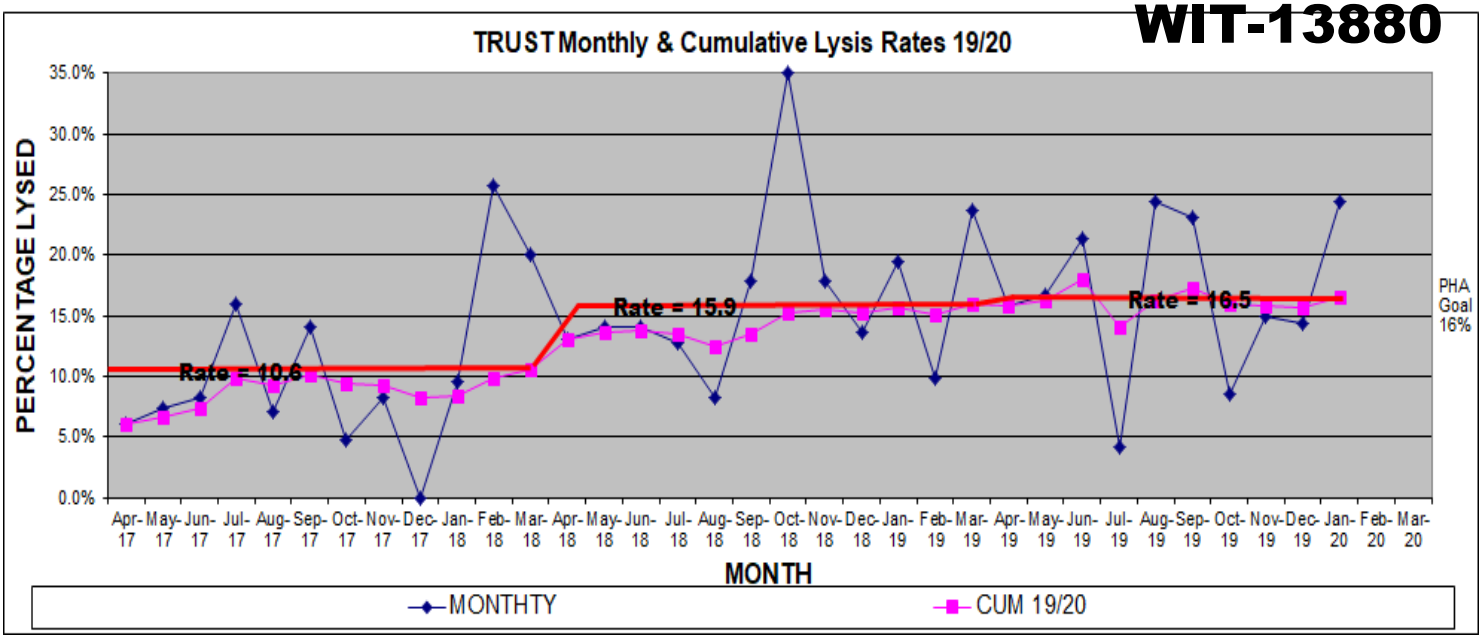


- Summary of Jan 20 Audit CAH – Overall Compliance with the Sepsis 6 Bundle was **40%** up from **30%** in Dec 19. The time dependent elements of the Bundle i.e. IV Fluids & IV Antibiotics administered within 1 hour of arrival remain a challenge.
- Summary of Jan 20 Audit DHH – Overall Compliance with the Sepsis 6 Bundle was **67%** up from **30%** in Dec 19. As with CAH, the Time Dependent elements of the Bundle remain a challenge.

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		**Jan 20**		**Jan 20**		**Jan 20**	**Commentary Jan 20**
Patients who are potentially eligible for thrombolysis are assessed by Acute Stroke Team within 30 minutes of arrival	17/18 98% 18/19 99%	**100% (50/20)**	17/18 99% 18/19 99%	**100% (20/20)**	17/18 99% 18/19 99%	**100% (70/70)**	-
Patients who are potentially eligible for thrombolysis receive CT scan within 45 minutes	17/18 96% 18/19 99%	**100% (29/29)**	17/18 95% 18/19 98%	**100% (14/14)**	17/18 96% 18/19 99%	**100% (43/43)**	-
Patients deemed suitable for thrombolysis receive first bolus within 60 minutes	17/18 59% 18/19 90%	**100% (7/7)**	17/18 88% 18/19 75%	**100% (3/3)**	17/18 68% 18/19 86%	**100% (10/10)**	-
Patients transferred to Hyper Acute Stroke Unit (or appropriate environment) within 90 mins	17/18 91% 18/19 94%	**100% (7/7)**	17/18 100% 18/19 89%	**100% (3/3)**	17/18 94% 18/19 93%	**100% (10/10)**	-
	CAH		**DHH**		**TRUST**		**AIM 19/20 (Based on Commissioning Plan) To ensure that the proportion of thrombolysis administration is at least 16%**
Outcome Measure	**2018/19**	**Jan 20**	**2018/19**	**Jan 20**	**2018/19**	**Jan 20**	
Monthly Thrombolysis Rate		**21.9% (7/32)**		**33.3% (3/9)**		**24.4% (10/41)**	
Thrombolysis Rate (Yearly)	16.3% (49/301)	**17.1% (48/280)**	14.9% (20/134)	**15.3% (22/144)**	15.9% (69/435)	**16.5% (70/424)**	



The above is "Real Time" data, which is subject to change. The Directorate of Performance & Reform is responsible for reporting to the RHSCB. From the above table only the lysis rates are reported. Furthermore their report is 3 months in arrears to allow Clinical Coding to reach an acceptable level.

Critical Medicines Omitted:

The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q3 19/20	Q2 19/20	Q1 19/20	Q4 18/19
ACUTE	17 (618)	5 (573)	2 (439)	5 (469)
TRUST	18 (773)	6 (741)	3 (588)	6 (620)

- Next update in when Q4 19/20 data is available

SKIN Care (Pressure Ulcer):

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

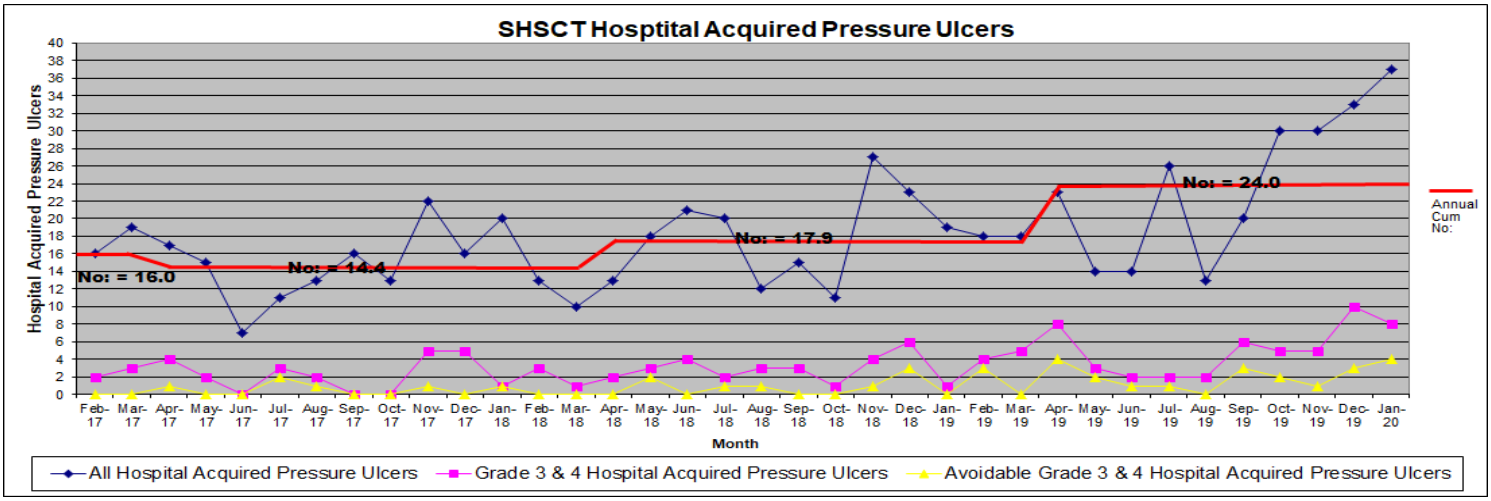
Quarter	Q3 19/20	Q2 19/20	Q1 19/20	Q4 18/19
ACUTE	63% (237/378)	71% (207/293)	67% (143/212)	74% (165/222)
TRUST	70% (346/495)	77% (324/420)	78% (271/346)	82% (295/361)

- Next update in when Q4 19/20 data is available

- There were 37 Hospital Acquired Pressures reported in Jan 19. Of these, 8 were Grade 3/4 Ward Acquired Pressure Ulcers, (Trauma (2), Recovery, 1 South, 2 South Stroke, 3 South & ICU, CAH & Stroke/Rehab, DHH).
- In 19/20 RCA's have been carried out on 32 cases to date with 15 deemed avoidable. RCA's will be undertaken in the remainder of these cases (10) in due course
- In 18/19 RCA's were carried out on 38 cases with 11 deemed to have been avoidable. This represents 5.1% of all Ward Acquired Pressure Ulcers reported in 18/19

Ward Acquired Pressure Ulcers & Rate per 1,000 Occupied Bed Days 2019/20:

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL	Rate 19/20	Rate & No 18/19
CAH															
Ward 4 South	1	0	0	2	2	0	7	4	3	1			20	1.83	0.62 (8) ↑
Ward 4 North	1	0	0	0	0	1	1	2	3	0			8	0.83	0.81 (9) ↑
Ward 3 South	2	1	1	0	2	2	0	0	1	5			14	1.47	0.48 (6) ↑
Trauma Ward	3	1	1	1	0	5	5	6	4	6			32	4.27	3.13 (28) ↑
Orthopaedic Ward	0	0	0	0	0	0	0	0	1	0			1	0.34	0 (0) ↑
Gynae Ward	0	0	0	0	1	0	0	0	0	0			1	0.35	0.58 (2) ↓
ICU	1	0	0	4	1	5	4	3	2	2			22	11.15	10.10(24) ↑
Ward 2 South Medicine	0	0	3	2	0	0	2	1	0	2			10	1.91	2.62 (16) ↓
Ward 2 South Stroke	0	1	0	3	1	0	1	0	1	2			9	1.75	1.82 (11) ↓
Ward 2 North	0	2	0	5	0	1	1	0	3	1			13	1.25	0.72 (9) ↑
Ward 5 Haematology	1	1	0	0	1	0	1	1	0	0			5	1.33	1.79 (8) ↓
Ward 1 South	2	4	4	3	0	0	2	3	2	4			24	2.20	1.31 (17) ↑
Ward 1 North	1	0	0	0	1	1	0	2	1	0			6	0.62	0.79 (9) ↓
AMU	0	1	1	4	0	1	1	1	1	3			13	1.30	0.70 (8) ↑
Rec/Renal/2 West/WinterW	2	1	2	0	1	2	2	2	1	4			17	N/A	N/A
DHH															
Male Surgical	0	0	0	0	0	0	0	0	2	1			3	0.58	0.17 (1) ↑
Female Surg/Gynae	0	0	0	1	1	0	0	1	1	1			5	0.60	0.79 (7) ↓
HDU	1	0	0	0	0	1	0	0	2	1			5	1.97	1.23 (4) ↑
Stroke/Rehab	0	0	0	0	0	0	1	0	0	1			2	0.22	0.19 (2) ↓
Male Med/CCU	0	0	0	0	0	0	0	0	0	0			0	0	0 (0) ↔
Female Medical	0	0	0	0	2	0	1	0	3	0			6	0.58	0.85 (10) ↓
Lurgan															
Ward 1	2	0	0	0	0	0	1	1	1	1			6	1.27	0.18 (1) ↑
Ward 2	1	0	0	0	0	0	0	0	0	1			2	0.39	1.64 (10) ↓
Ward 3	1	0	1	0	0	0	0	0	1	0			3	0.61	0.68 (4) ↓
STH															
Ward 1 STH	3	0	1	0	0	0	0	2	0	0			6	1.15	0.64 (4) ↑
Ward 2 STH	1	1	0	1	0	0	0	1	0	0			4	0.78	0.49 (3) ↑
MHLD															
Gillis	0	1	0	0	0	1	0	0	0	1			3	0.62	0.45 (3) ↑
Willows	0	0	0	0	0	0	0	0	0	0			0	0	0.29 (2) ↓
TOTAL	23	14	14	26	13	20	30	30	33	37			240		
RATE	1.25	0.73	0.77	1.40	0.70	1.08	1.56	1.62	1.77	1.92				1.28	0.98 (215)↑



- The Trust's Monthly Hospital Acquired Pressure Ulcer Rate for Jan 20, based on **29** Wards was **1.92** (**37**/19,302) per 1,000 Occupied Bed Days up from **1.77** (**33**/18,546) per 1,000 Occupied Bed Days in Dec 19
- The Trust's 2019/20 Hospital Acquired Pressure Ulcer Rate, based on **29** Wards stands at **1.28 (240)** per 1,000 Bed Days, up from **0.98 (215)** in 2018/19.

Patient Falls:

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q3 19/20	Q2 19/20	Q1 19/20	Q4 18/19
Acute Bundle A Compliance	**77% (474/618)**	**81% (462/573)**	**77% (340/439)**	**72% (339/469)**
Trust Bundle A Compliance	**79% (613/773)**	**84% (621/741)**	**82% (480/588)**	**78% (481/620)**

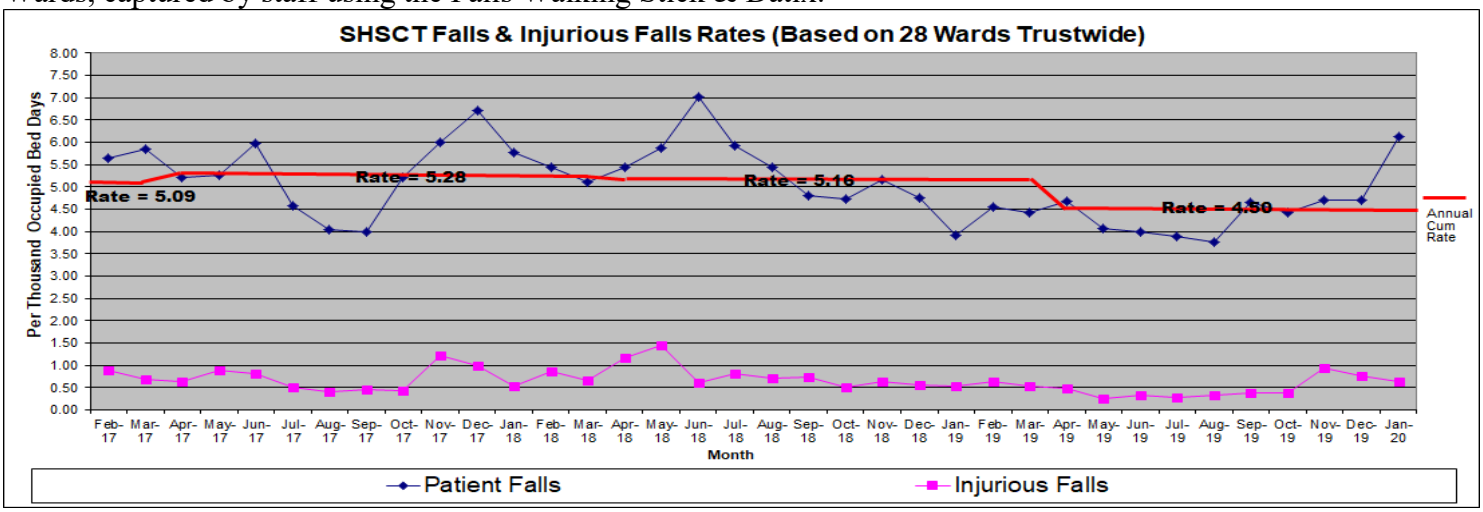
Quarter	Q3 19/20	**Q2 19/20**	**Q1 19/20**	**Q4 18/19**
Acute Bundle B Compliance	**69% (346/503)**	**66% (285/430)**	**63% (205/326)**	**70% (252/361)**
Trust Bundle B Compliance	**74% (482/653)**	**73% (429/587)**	**71% (338/473)**	**76% (390/511)**

- Next update when Q4 19/20 data is available

The table below gives details of individual Ward's Falls Numbers & Falls Rate 19/20:

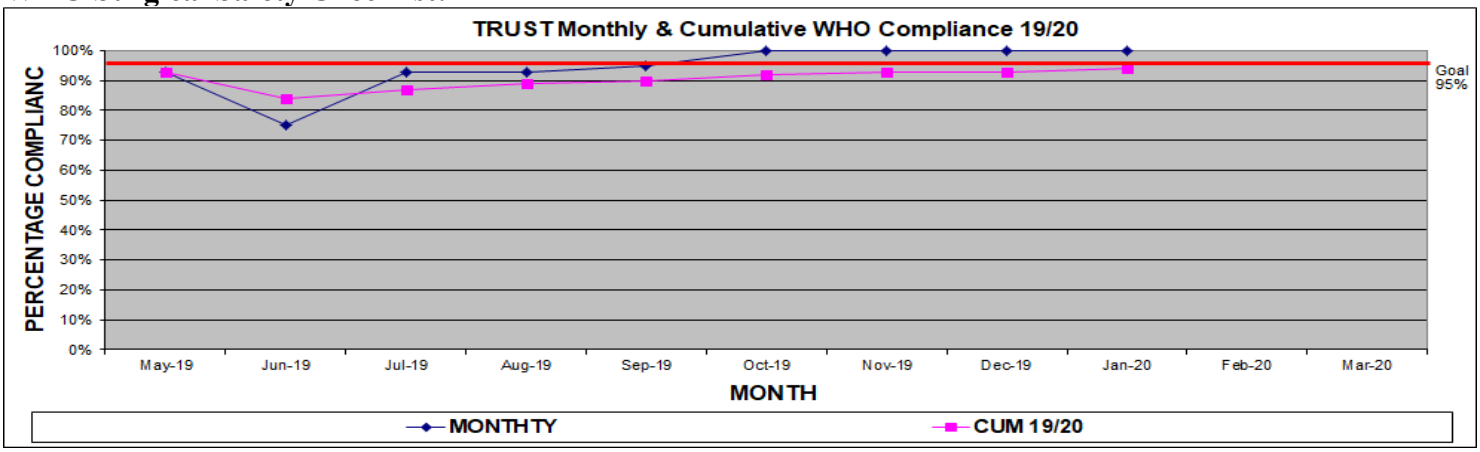
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL	Rate 19/20	Rate 18/19
CAH															
Ward 4 South	5	0	3	0	4	4	9	2	3	3			33	3.02	2.72 (35) ↑
Ward 4 North	1	2	2	1	0	4	2	2	1	5			20	2.08	4.33 (48) ↓
Ward 3 South	1	2	2	3	2	7	3	6	4	4			34	3.57	3.30 (41) ↑
Trauma Ward	3	3	4	3	6	2	4	2	4	8			39	5.21	5.26 (47) ↓
Orthopaedic Ward	1	0	1	3	0	0	1	2	1	1			10	3.44	4.55 (21) ↓
Gynae Ward	0	3	0	1	0	0	1	0	0	1			6	2.08	2.60 (9) ↓
Ward 2 South Medicine	5	4	4	4	10	6	1	6	2	3			45	8.60	8.53 (52) ↑
Ward 2 South Stroke	4	3	4	0	0	2	2	7	4	9			35	6.81	6.29 (38) ↑
Ward 2 North	4	4	4	3	2	1	5	3	3	4			33	3.17	4.96 (62) ↓
Haematology Ward	4	3	0	2	2	2	1	2	0	2			18	4.78	2.90 (13) ↑
Ward 1 South	7	4	7	4	3	0	3	3	2	7			40	3.67	5.18 (67) ↓
Ward 1 North	2	3	3	4	1	6	3	6	2	4			34	3.51	3.59 (41) ↓
AMU	12	7	12	5	5	11	11	9	9	12			93	9.27	7.82 (89) ↑
3 North Winter Ward	5	3	2	2	0	3	1	4	3	0			23	4.07	3.31 (7) ↑
DHH															
Male Surgical	2	3	0	3	1	2	0	2	1	2			16	3.08	4.14 (25) ↓
Female Surg/Gynae	0	1	1	5	2	2	3	0	5	4			23	2.76	3.82 (34) ↓
HDU	3	0	0	0	1	0	0	0	0	1			5	1.97	2.46 (8) ↓
Stroke/Rehab	4	1	1	4	3	8	3	2	8	4			38	4.27	5.22 (55) ↓
Male Med/CCU	4	2	3	9	4	2	5	5	8	10			52	5.19	4.41 (52) ↑
Female Medical	7	6	2	2	6	4	5	2	7	7			48	4.66	5.08 (60) ↓
Lurgan															
Ward 1	1	2	1	1	2	3	2	2	0	1			15	3.18	5.23 (29) ↓
Ward 2	0	2	1	2	4	1	1	0	0	3			14	2.71	4.27 (26) ↓
Ward 3	1	3	2	2	1	0	1	3	1	3			17	3.46	2.57 (15) ↑
STH															
Ward 1 STH	2	1	0	0	0	1	2	2	0	0			8	1.53	1.93 (12) ↓
Ward 2 STH	1	0	2	1	0	1	4	0	1	0			10	1.95	2.44 (15) ↓
MHLD															
Gillis	3	4	3	3	3	11	5	11	13	9			65	13.39	16.32 (108) ↓
Willows	3	11	8	5	8	2	6	3	5	10			61	10.16	15.86 (108) ↓
TOTAL	85	77	72	72	70	85	84	86	87	117			835		
RATE	4.67	4.06	3.99	3.90	3.76	4.65	4.41	4.71	4.71	6.13				4.50	5.16 (1117) ↓

The Run Chart below shows Patient Falls & Injurious Falls Rates per 1,000 Occupied Bed Days, based on 28 Wards, captured by staff using the Falls Walking Stick & Datix.



- Falls Rate **6.13** (**117**/19,097 Occupied Bed Days) up from **4.71** (**87**/18,416) in Dec 19
- Injurious Falls Rate **0.63** (**12**/19,097 Occupied Bed Days) down from **0.76** (**14**/18,461) in Dec 19
- Cumulative Falls Rate for 19/20 stands at **4.50**, compared to **5.16** in 18/19

WHO Surgical Safety Checklist:



- The Monthly Audits were reinstated in May 19
- Overall Bundle compliance in Jan20 was **100%** (60/60), same as Dec 19

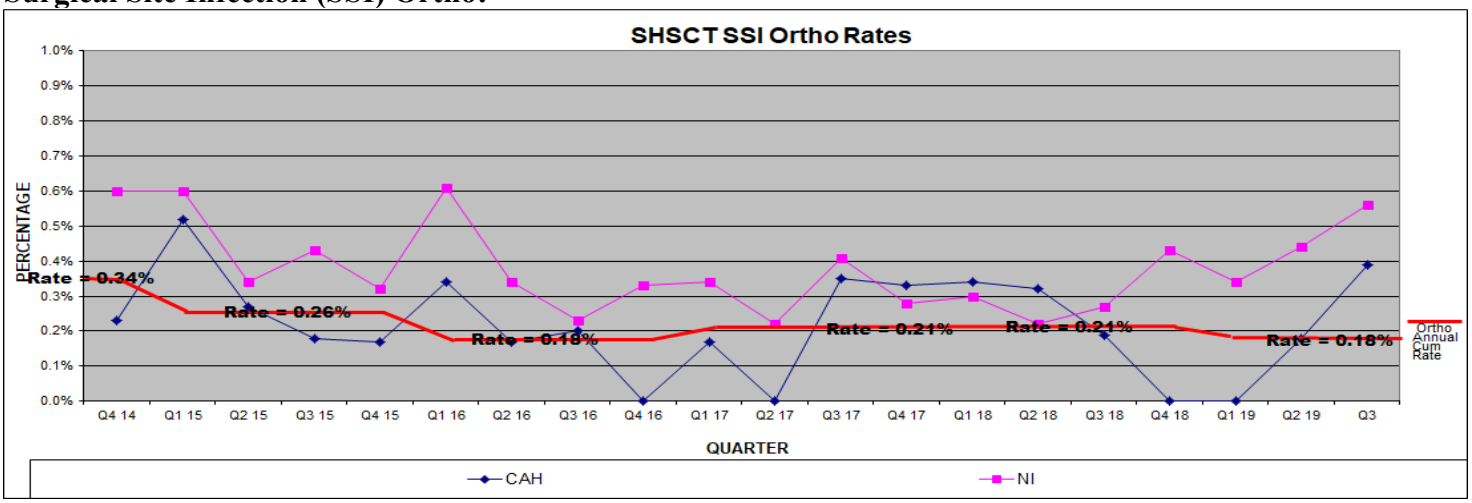
Regional Delirium Audit:

The table below shows compliance against the 3 Measures of the Delirium Bundle, for the Acute Wards, where auditing is underway. All 5 Non-Acute Wards also undertake a monthly audit.

Ward/Measure	At risk patients who have a SQiD carried out (single question in delirium)	Patients with a 4AT completed (tool to assess for delirium)	Patients with an Investigations & Management Plan completed
Trauma (Jan 20)	**90% (18/20)**	**100% (6/6)**	**100% (5/5)**
1 South (Sept 19)	**100% (20/20)**	**100% (6/6)**	**100% (1/1)**
1 North (Oct 19)	**100% (2/2)**	**100% (2/2)**	**100% (1/1)**
2 South Med (Jan 20)	**100% (20/20)**	**65% (13/20)**	**90% (9/10)**
4 North (Jan 20)	**100% (20/20)**	**100% (3/3)**	**N/A (0/0)**
4 South (Jan 20)	**100% (20/20)**	**100% (4/4)**	**50% (1/2)**
Stroke/Rehab (Dec 19)	**58% (11/19)**	**100% (6/6)**	**17% (1/6)**
Female Surgical (Jan 20)	**100% (20/20)**	**100% (6/6)**	**100% (6/6)**

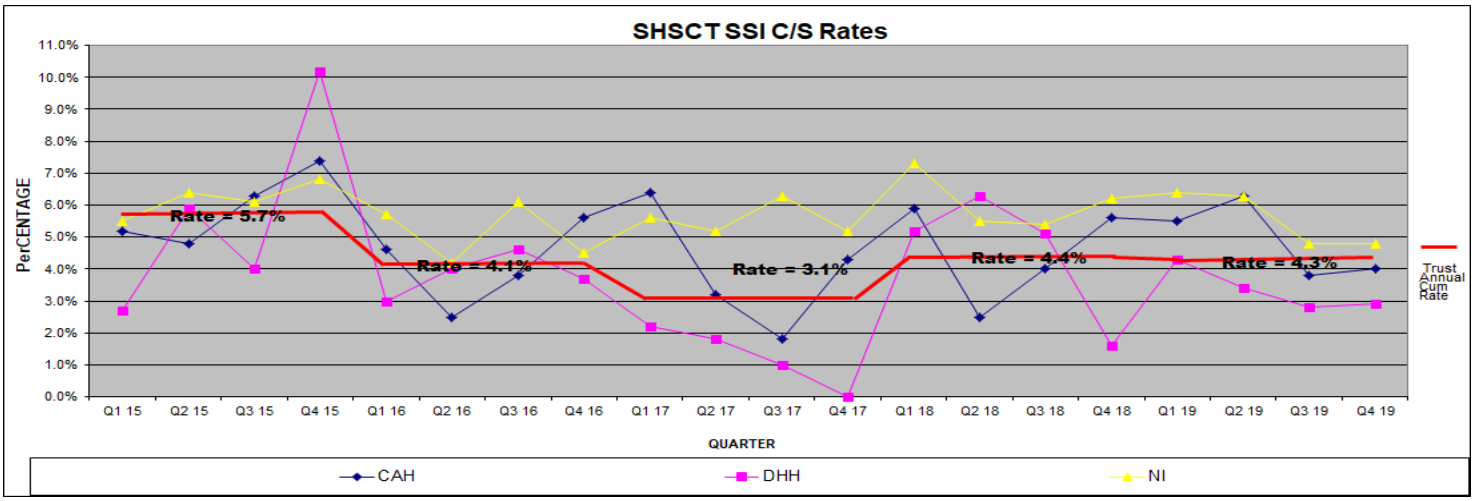
Patient Safety Report for Acute Governance Meeting July 2020

Surgical Site Infection (SSI) Ortho:



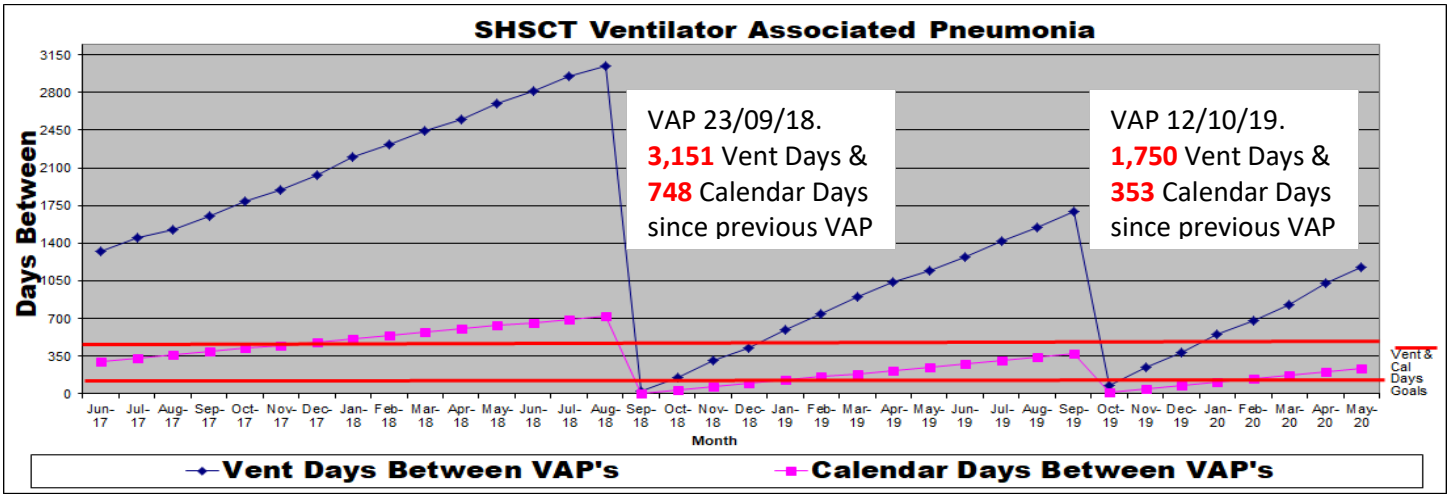
- Delay in release of Q4 data due to Covid-19. Next update when Q4 2019 SSI Rates are released by the PHA

Surgical Site Infection (SSI) C/Section:



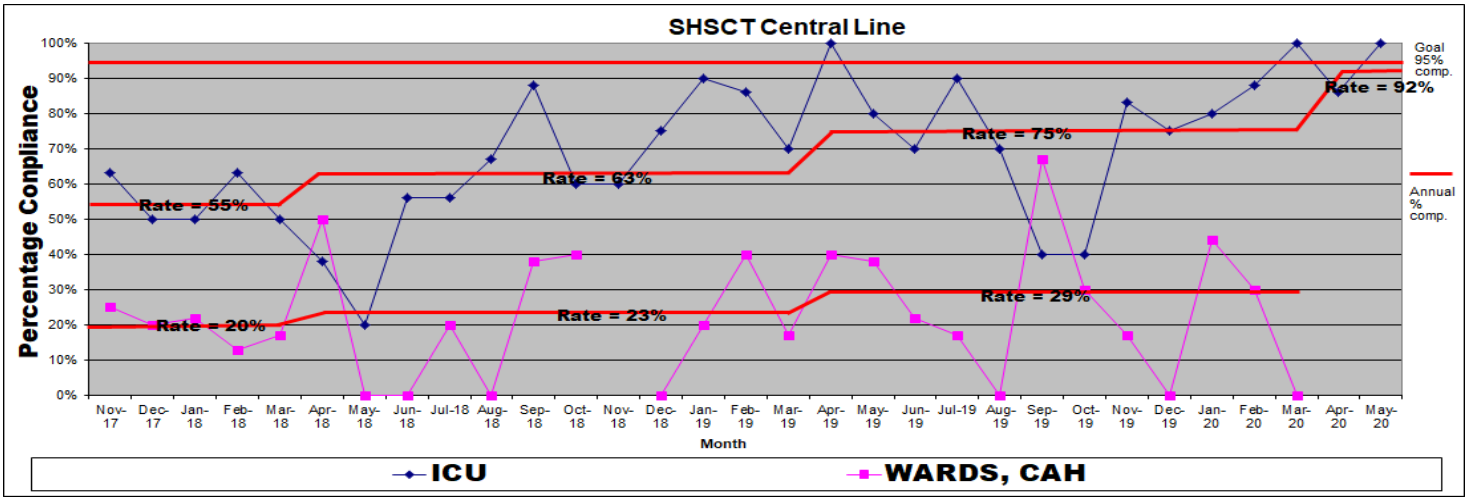
- Next update when Q1 2020 SSI Rates are released by the PHA
- The next quarterly SSI C/Section Audits are taking place in June 20, with results reported Aug 20

Ventilator Associated Pneumonia (VAP):



- Vent Days Between VAP's **1172** (13th October 19 → 31st May 20)
- Calendar Days Between VAP's **232** (13th October 19 → 31st May 20)

Central Line:



Overall Bundle Compliance May 20, ICU **100%** (5/5 cases audited), up from **86%** (6/7 cases audited) in Apr 20

- The Audit on the Wards has been suspended until further notice due to Covid-19
- Results shared with Lead Clinician & Lead Nurse for this QI work to address areas of non-compliance

NEWS:

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q4 19/20	Q3 19/20	Q2 19/20	Q1 19/20
ACUTE	88% (346/392)	84% (521/618)	87% (498/573)	82% (360/439)
TRUST	90% (442/492)	87% (657/741)	89% (657/741)	85% (501/588)

- NB: Q4 data is for Jan & Feb 20 only. March audits not undertaken due to Covid-19
- Q1 20/21 Audit has been suspended by the PHA

MUST (Malnutrition Universal Screening Tool):

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q4 19/20	Q3 19/20	Q2 19/20	Q1 19/20
ACUTE	90% (353/392)	84% (518/618)	87% (498/573)	88% (386/439)
TRUST	92% (451/492)	86% (662/741)	89% (662/741)	90% (531/588)

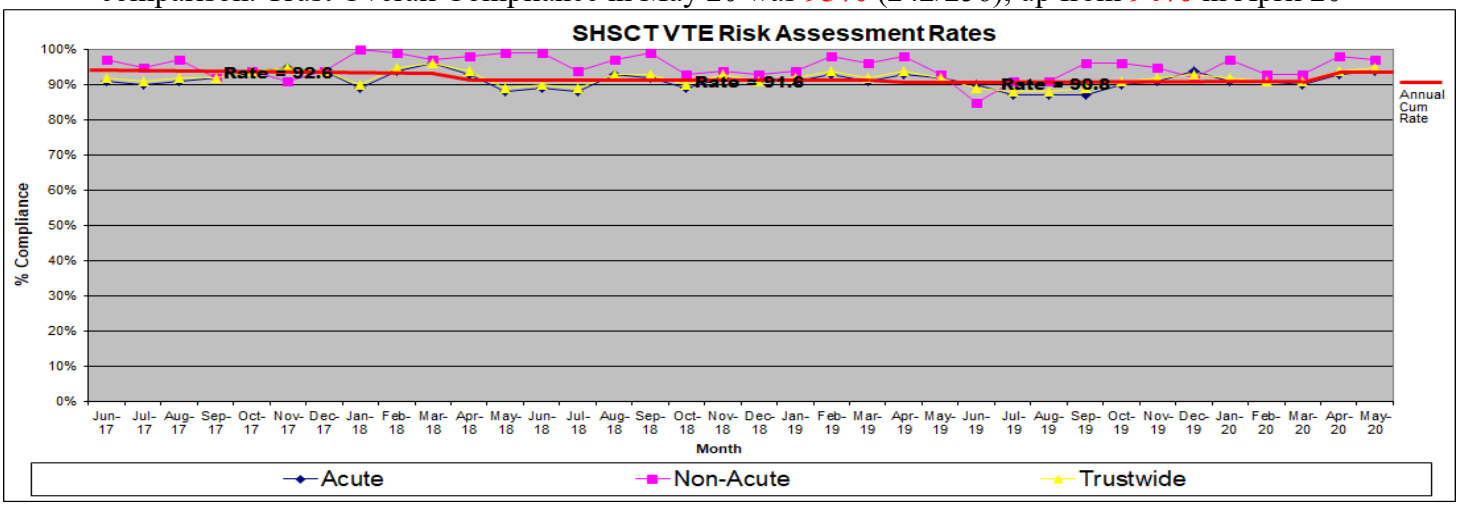
- NB: Q4 data is for Jan & Feb 20 only. March audits not undertaken due to Covid-19
- Q1 20/21 Audit has been suspended by the PHA

May 20 (Week Commencing 04/05/20 → Week Commencing 25/05/20)

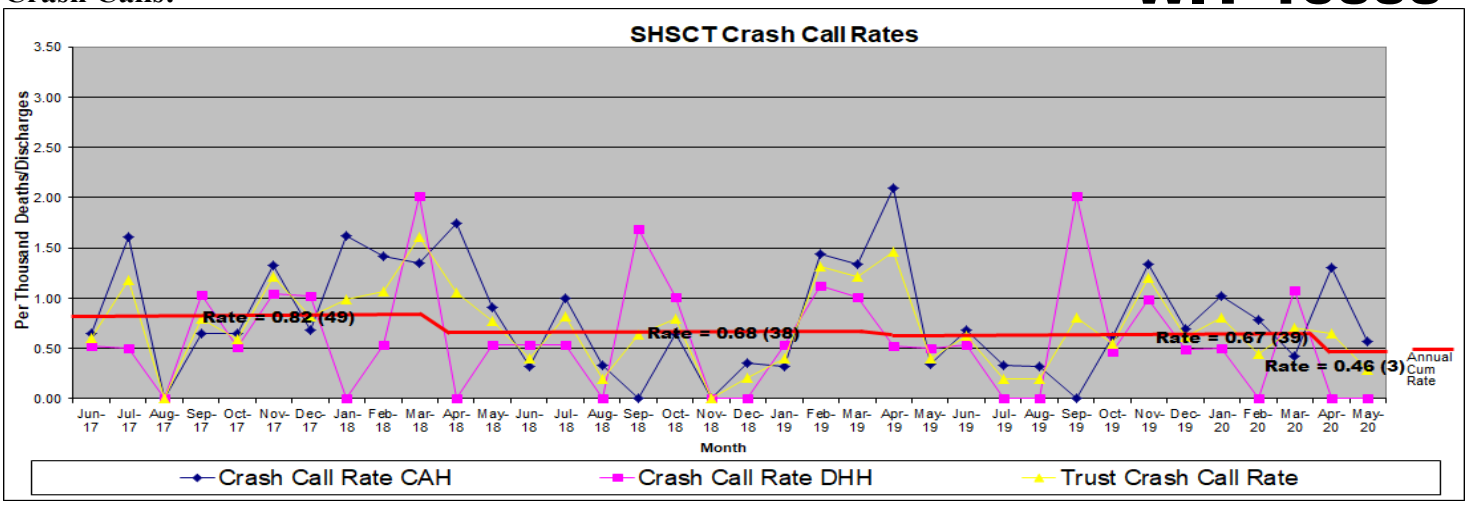
Division	Site	Ward	Number of Weekly Audits not done	Charts with Fully Completed VTE Risk Assessment	Number of Charts Audited	Monthly Percentage Compliance	Quarter 4 19/20 Percentage Compliance
S&EC	CAH	3 South	0	12	20	60% ↔	78% ↓
		4 North CESW	0	24	24	100% ↑	91% ↓
		4 South	N/A	N/A	N/A	N/A	88% ↔
		Elective Adm.	0	5	5	100% ↑	54% ↓
		Orthopaedic	0	13	14	93% ↓	100% ↔
		Trauma	0	15	15	100% ↔	100% ↑
	DHH	F/male Surg.	1	14	14	100% ↑	97% ↓
		MSW/HDU	N/A	N/A	N/A	N/A	97% ↔
M&UC	CAH	1 South	1	5	5	100% ↑	88% ↓
		1 North	N/A	N/A	N/A	N/A	88% ↑
		2 North Resp.	0	10	10	100% ↑	96% ↑
		Haematology	2	3	3	100% ↔	100% ↔
		3 North	N/A	N/A	N/A	N/A	100% ↑
		2 North Med	0	10	10	100% ↔	98% ↑
		AMU	0	15	15	100% ↔	89% ↑
	DHH	F/male Med.	0	19	19	100% ↑	84% ↓
		CCC/MMW	0	18	20	90% ↓	82% ↑
		Stroke/Rehab	0	19	20	95% ↑	97% ↑
IMWH	CAH	Gynae	N/A	N/A	N/A	N/A	98% ↓
TOTAL			4 ↑ (2)	182	194	93.8% ↑	90.6% ↓

Key: Red – Under 85% compliance, Amber – Compliance between 85% & 94%, Green – Above 95% (Reg. target)

- In summary Overall Compliance with fully completed Risk Assessment on the Acute Wards was **93.8%** (182/194 charts audited) up from **92.6%** (138/149 charts audited) in April 20
- Total number of weekly audits not completed in May 20 was **4** up from **2** in April 20
- The Run Chart below shows compliance against the Commissioning Plan target of **95%** compliance. The Trust Compliance includes the Non-Acute Wards & therefore their compliance has been included also for comparison. Trust Overall Compliance in May 20 was **95%** (242/256), up from **94%** in April 20



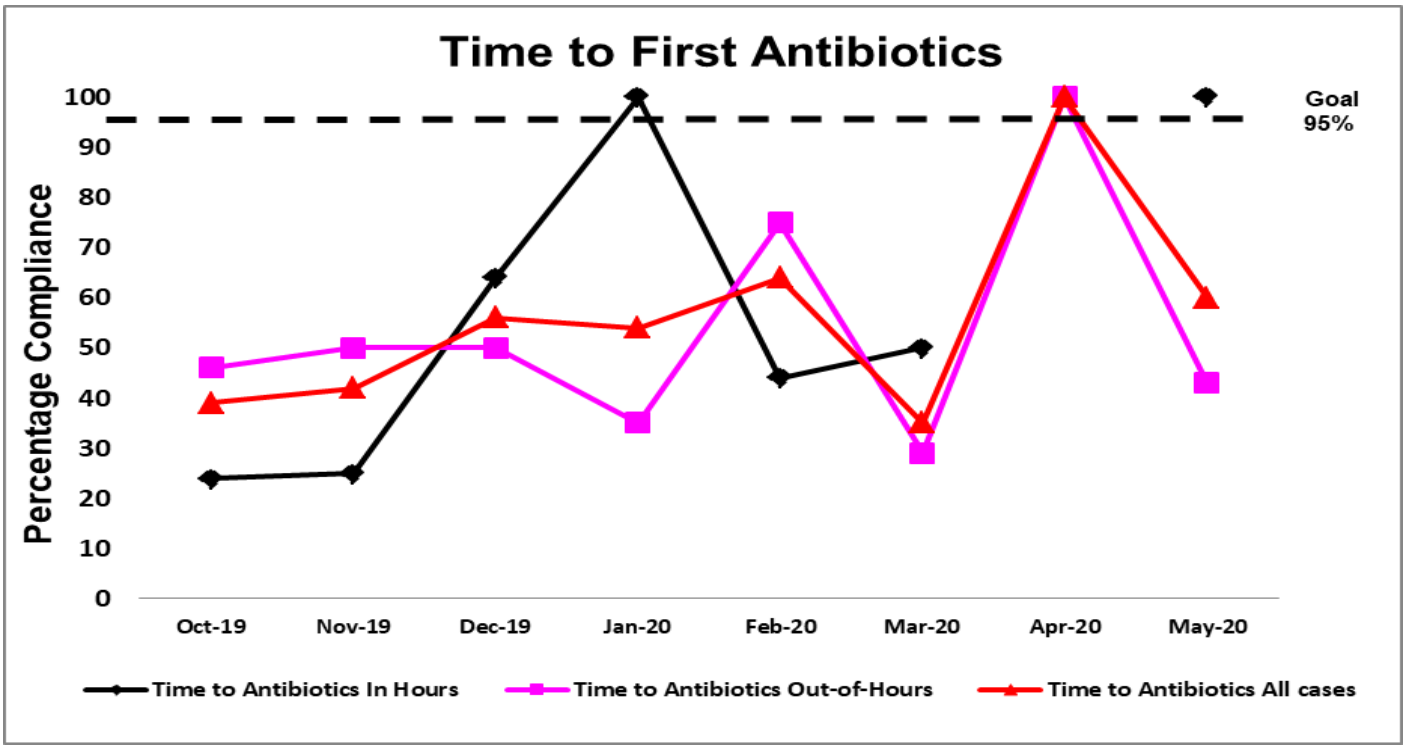
Crash Calls:



- CAH Rate **0.57** per 1,000 deaths/discharges (**1** Crash Call) down from **1.30** (**2** Crash Calls) in Apr 20
- DHH Rate **0** per 1,000 deaths/discharges (**0** Crash Calls) same as Apr 20
- Trust Rate **0.29** per 1,000 deaths/discharges (**1** Crash Call) down from **0.65** (**2** Crash Calls) in Apr 20
- Trust cumulative Crash Call Rate for 20/21 stands at **0.46 (3)** per 1,000 deaths/discharges, down from **0.67 (39)** in 19/20

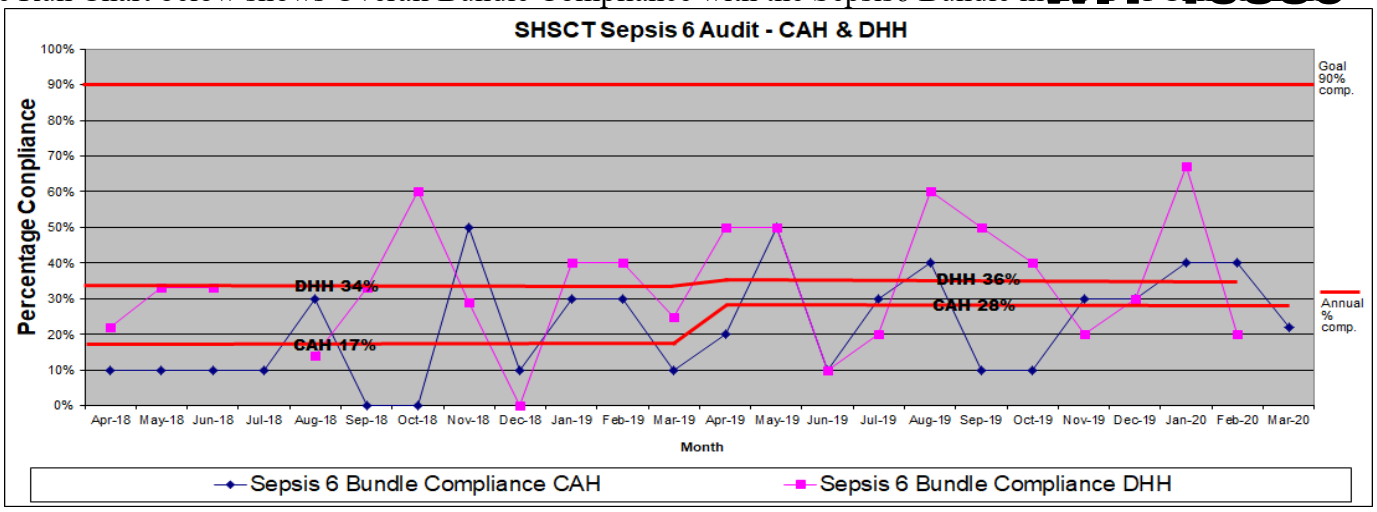
Emergency Care QI Work: Sepsis 6 CAH & DHH:

- The new Regional Sepsis QI initiative has been ongoing from Oct 19. The Regional Agreed aim is to improve the time to 1st antibiotics "In Hours" i.e. Mon → Fri 9:00am → 5:00pm. Work is underway in 3 Pilot Areas ED, CAH, (Oct 19 – Dr. Suzie Budd, Clinical Lead), AMU, CAH (Dec 19 – Dr. Emily Hannah, Clinical Lead) & ED, DHH (14th Jan 20 – Dr. Laura Lavery, Clinical Lead). In the ED's of CAH & DHH it was decided to measure compliance 24/7. The Run Chart below shows progress made in ED, CAH. Data from the other Pilot Areas will be shared in due course



- In hours compliance **100%** (3/3 cases audited). No cases in Apr 20
- Out-of-hours compliance **43%** (3/7 cases audited), down from **100%** (1/1 case audited) in Apr 20
- Overall compliance **60%** (6/10 cases audited), down from **100%** (1/1 case audited in Apr 20)
- Auditing in ED, DHH & AMU have been suspended due to Covid-19

The Run Chart below shows Overall Bundle Compliance with the Sepsis6 Bundle in both CAH & DHH

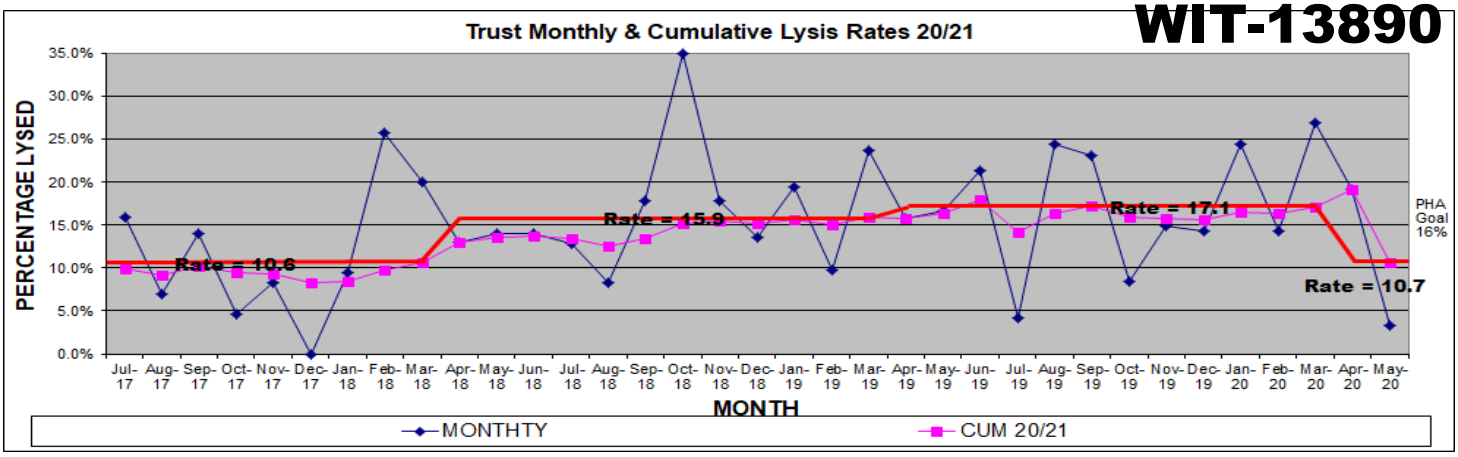


- Auditing has been suspended due to Covid-19

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		**May 20**		**May 20**		**May 20**	**Commentary May 20**
Patients who are potentially eligible for thrombolysis are assessed by Acute Stroke Team within 30 minutes of arrival	18/19 99% 19/20 99%	**100% (40/40)**	18/19 99% 19/20 99%	**N/A**	18/19 99% 19/20 99%	**100% (40/40)**	-
Patients who are potentially eligible for thrombolysis receive CT scan within 45 minutes	18/19 99% 19/20 99%	**100% (15/15)**	18/19 98% 19/20 98%	**N/A**	18/19 99% 19/20 99%	**100% (15/15)**	-
Patients deemed suitable for thrombolysis receive first bolus within 60 minutes	18/19 90% 19/20 78%	**100% (1/1)**	18/19 75% 19/20 75%	**N/A**	18/19 86% 19/20 77%	**100% (1/1)**	-
Patients transferred to Hyper Acute Stroke Unit (or appropriate environment) within 90 mins	18/19 94% 19/20 98%	**100% (1/1)**	18/19 89% 19/20 96%	**N/A**	18/19 93% 19/20 98%	**100% (1/1)**	-
	CAH		**DHH**		**TRUST**		**AIM 20/21 (Based on Commissioning Plan) To ensure that the proportion of thrombolysis administration To be confirmed. Was 16% in 19/20**
Outcome Measure	**2019/20**	**May 20**	**2019/20**	**May 20**	**2019/20**	**May 20**	
Monthly Thrombolysis Rate		**3.3% (1/30)**		**N/A**		**3.3% (1/30)**	
Thrombolysis Rate (Yearly)	17.6% (58/329)	**10.7% (6/56)**	16.1% (28/174)	**N/A**	15.9% (69/435)	**10.7% (6/56)**	



The above is "Real Time" data, which is subject to change. The Directorate of Performance & Reform is responsible for reporting to the RHSCB. From the above table only the lysis rates are reported. Furthermore their report is 3 months in arrears to allow Clinical Coding to reach an acceptable level.

- Audit suspended in DHH due to Covid-19

Critical Medicines Omitted:

The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q4 19/20	Q3 19/20	Q2 19/20	Q1 19/20
ACUTE	1 (392)	17 (618)	5 (573)	2 (439)
TRUST	1 (492)	18 (773)	6 (741)	3 (588)

- NB: Q4 data is for Jan & Feb 20 only. March audits not undertaken due to Covid-19
- Q1 20/21 Audit has been suspended by the PHA

SKIN Care (Pressure Ulcer):

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

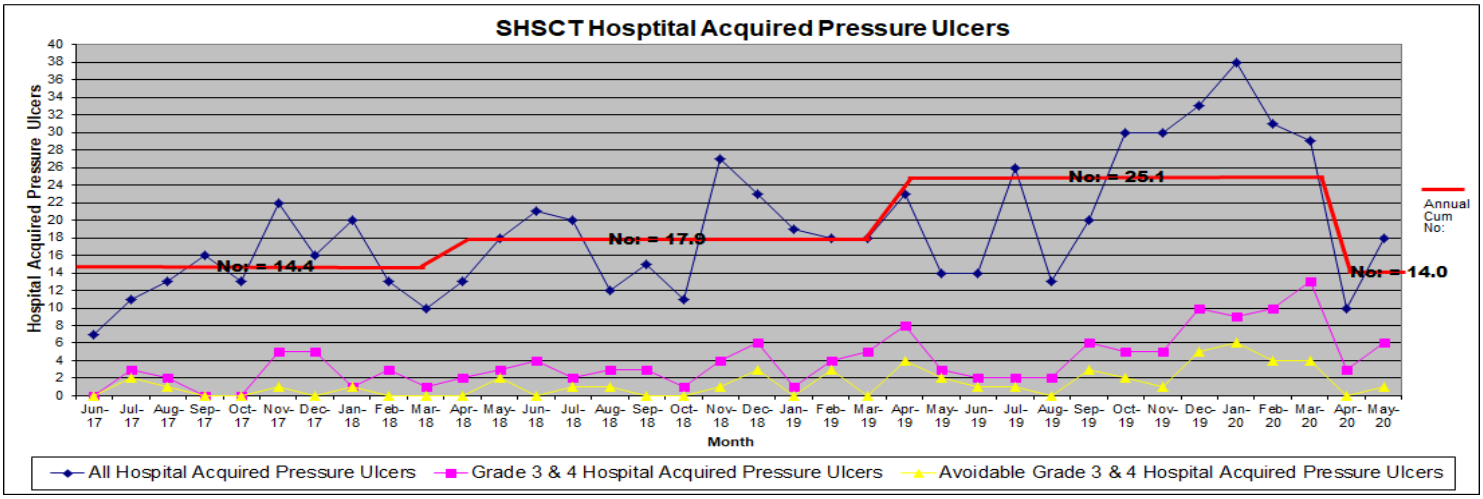
Quarter	Q4 19/20	Q3 19/20	Q2 19/20	Q1 19/20
ACUTE	76% (178/233)	63% (237/378)	71% (207/293)	67% (143/212)
TRUST	81% (264/325)	70% (346/495)	77% (324/420)	78% (271/346)

- NB: Q4 data is for Jan & Feb 20 only. March audits not undertaken due to Covid-19
- Q1 20/21 Audit has been suspended by the PHA

- There were 18 Hospital Acquired Pressures reported in May 20. Of these, 6 were Grade 3/4 or DTI's, (2 South Medical, 3 North Stroke, 4 North & Trauma, CAH & Female Surgical & Female Medical, DHH).
- In 19/20 RCA's have been carried out on 62 cases to date with 33 deemed avoidable. This represents 11% of all Ward Acquired Pressure Ulcers reported in 19/20. The outstanding RCA's (13) will be carried out in due course.
- In 20/21 RCA's have been carried out on 3 cases to date with 1 deemed to have been avoidable. This represents 4% of all Ward Acquired Pressure Ulcers reported in 20/21. The outstanding RCA's (6) will be carried out in due course.

Ward Acquired Pressure Ulcers & Rate per 1,000 Occupied Bed Days 2020-21

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL	Rate 20/21	Rate & No 19/20
CAH															
Ward 4 South	3	0											3	7.01	1.94 (25) ↑
Ward 4 North	0	1											1	0.83	0.89 (10) ↓
Ward 3 South	1	2											3	2.31	1.24 (14) ↑
Trauma Ward	1	2											3	3.39	4.64 (41) ↓
Orthopaedic Ward	0	0											0	0	0.62 (2) ↓
Gynae Ward	N/A	N/A											N/A	N/A	0.30 (1) ↓
ICU	2	2											4	12.46	12.12 (28)↑
Ward 3 North Medicine	1	1											2	2.81	2.75 (17) ↑
Ward 2 South Stroke	0	1											1	1.47	1.49 (9) ↓
Ward 2 North	0	1											1	0.78	1.39 (17) ↓
Ward 5 Haematology	1	0											1	1.81	1.36 (6) ↑
Ward 1 South	0	0											0	0	2.01 (26) ↓
Ward 1 North	0	0											0	0	0.70 (8) ↓
AMU	1	1											2	1.92	1.52 (18) ↑
2 South Medical	0	2											2	1.65	N/A
Other Areas e.g. Recovery	0	1											1	N/A	N/A
DHH															
Male Surgical	0	0											0	0	0.65 (4) ↓
Female Surg/Gynae	0	1											1	1.04	0.51 (5) ↑
HDU	0	0											0	0	1.70 (5) ↓
Stroke/Rehab	0	0											0	0	0.28 (3) ↓
Male Med/CCU	0	0											0	0	0 (0) ↔
Female Medical	0	2											2	1.33	0.74 (9) ↑
Lurgan															
Ward 1	0	0											0	0	0.65 (4) ↓
Ward 2 Stroke	0	0											0	0	1.26 (7) ↓
Ward 3	0	0											0	0	0.85 (5) ↓
STH															
Ward 1 STH	0	0											0	0	1.12 (7) ↓
Ward 2 STH	0	N/A											0	0	0.65 (4) ↓
MHLD															
Gillis	0	1											1	0.97	0.51 (3) ↑
Willows	0	0											0	0	0 (0) ↔
TOTAL	10	18											28		
RATE	1.01	1.33												1.20	1.36 (301)↓



- The Trust's Monthly Hospital Acquired Pressure Ulcer Rate for May 20, based on **26** Wards was **1.33** (**18**/13,509) per 1,000 Occupied Bed Days up from **1.01** (**10**/9,865) per 1,000 Occupied Bed Days in Apr 20
- The Trust's 20/21 Hospital Acquired Pressure Ulcer Rate, based on **27** Wards stands at **1.20 (28)** per 1,000 Bed Days, down from **1.36 (301)** in 2019/20.

Received from SHSCT on 16/05/22. Annotated by the Urology Services Inquiry.

Patient Falls:

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q4 19/20	Q3 19/20	Q2 19/20	Q1 19/20
Acute Bundle A Compliance	79% (310/392)	77% (474/618)	81% (462/573)	77% (340/439)
Trust Bundle A Compliance	82% (402/492)	79% (613/773)	84% (621/741)	82% (480/588)

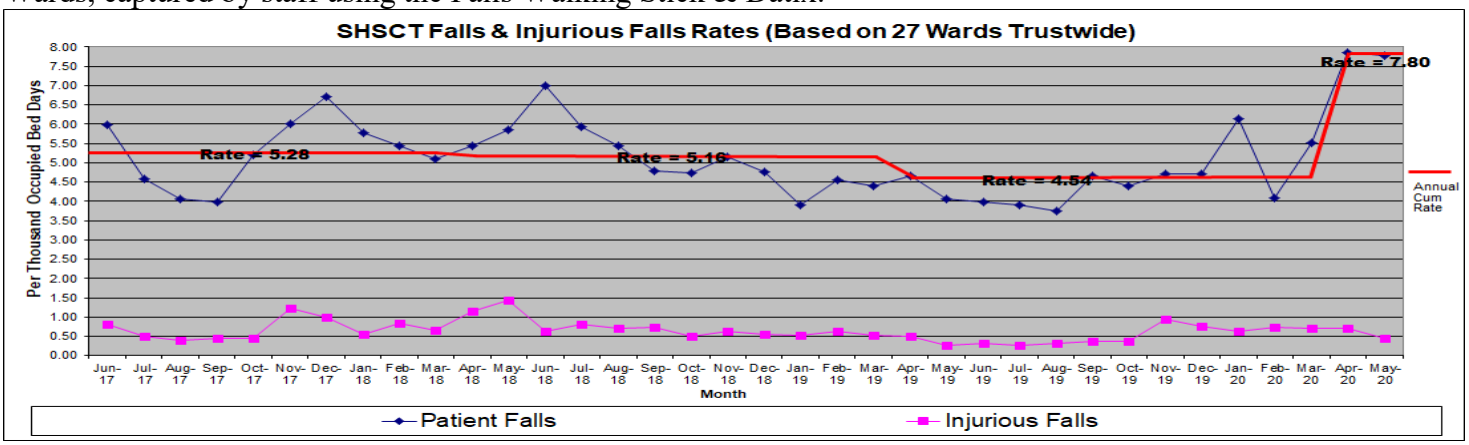
Quarter	Q4 19/20	Q3 19/20	Q2 19/20	Q1 19/20
Acute Bundle B Compliance	77% (249/323)	69% (346/503)	66% (285/430)	63% (205/326)
Trust Bundle B Compliance	81% (341/421)	74% (482/653)	73% (429/587)	71% (338/473)

- NB: Q4 data is for Jan & Feb 20 only. March audits not undertaken due to Covid-19
- Q1 20/21 Audit has been suspended by the PHA

The table below gives details of individual Ward's Falls Numbers & Falls Rate 20/21:

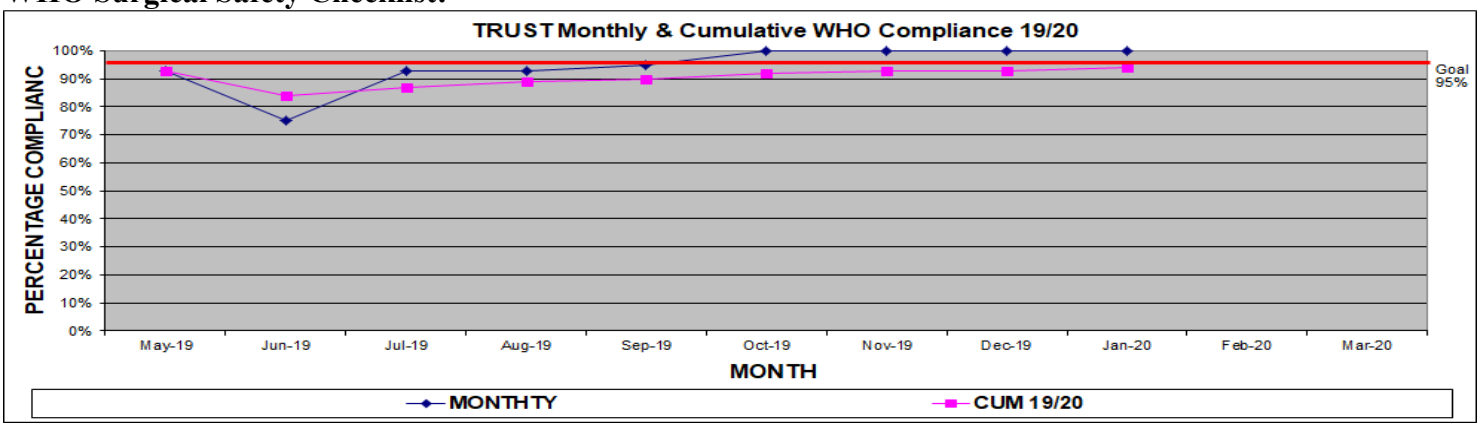
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL	Rate 20/21	Rate 19/20
CAH															
Ward 4 South	2	0											2	4.67	2.88 (37) ↑
Ward 4 North	3	3											6	5.00	2.22 (25) ↑
Ward 3 South	10	5											15	11.56	3.73 (42) ↑
Trauma Ward	4	4											8	9.03	5.77 (51) ↑
Orthopaedic Ward	4	5											9	18.40	3.08 (10) ↑
Gynae Ward	N/A	N/A											N/A	N/A	1.79 (6) ↓
Ward 3 North Medicine	2	5											7	9.82	8.26 (51) ↑
Ward 3 North Stroke	1	3											4	5.88	6.94 (42) ↓
Ward 2 North	4	7											11	8.53	3.36 (41) ↑
Haematology Ward	1	0											1	1.81	4.75 (21) ↓
Ward 1 South	5	9											14	9.35	3.55 (46) ↑
Ward 1 North	1	2											3	2.19	3.59 (41) ↓
AMU	2	5											7	6.74	9.40 (111) ↓
2 South Medicine	0	3											3	2.48	3.91 (26) ↓
DHH															
Male Surgical	3	0											3	8.70	2.76 (17) ↑
Female Surg/Gynae	0	0											0	0	2.67 (26) ↓
HDU	0	0											0	0	2.72 (8) ↓
Stroke/Rehab	4	2											6	4.55	4.73 (50) ↓
Male Med/CCU	4	16											20	15.07	4.76 (56) ↑
Female Medical	2	7											9	5.98	4.34 (53) ↑
Lurgan															
Ward 1	0	6											6	13.16	3.08 (19) ↑
Ward 2 Stroke	3	3											6	8.13	3.61 (20) ↑
Ward 3	3	2											5	11.21	3.57 (21) ↑
STH															
Ward 1 STH	2	0											2	2.89	1.44 (9) ↑
Ward 2 STH	0	N/A											0	0	2.28 (14) ↓
MHLD															
Gillis	12	4											16	15.53	14.24 (83) ↑
Willows	4	13											17	15.48	9.47 (69) ↑
TOTAL	76	104											180		
RATE	7.86	7.77												7.80	4.54 (995) ↑

The Run Chart below shows Patient Falls & Injurious Falls Rates per 1,000 Occupied Bed Days based on 28 Wards, captured by staff using the Falls Walking Stick & Datix.



- Falls Rate **7.77** (**104**/13,378 Occupied Bed Days) down from **7.86** (**76**/9,675) in Apr 20
- Injurious Falls Rate **0.45** (**6**/13,378 Occupied Bed Days) down from **0.72** (**7**/9,675) in Apr 20
- Cumulative Falls Rate for 20/21 stands at **7.80**, compared to **4.54** in 19/20
- There has been a significant rise in patient falls in the first 2 months in 20/21 compared to 19/20. 17 Wards across the Trust have seen a rise in falls/falls rate. Acute wards which has seen a significant rise in falls/falls rate are 1 South, 3 South & Orthopaedic Wards, CAH & Male Medical Ward, DHH, which seen a 4 fold increase in patient falls in May compared to Apr 20

WHO Surgical Safety Checklist:



- The Monthly Audits were reinstated in May 19
- Auditing has been suspended due to Covid-19

Regional Delirium Audit:

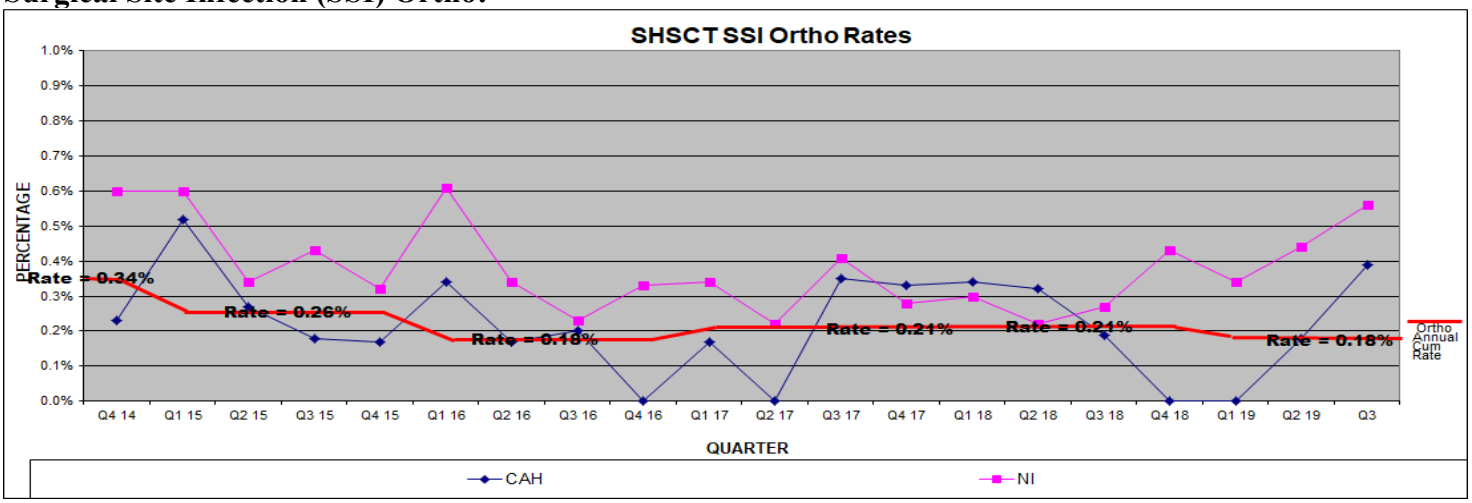
The table below shows compliance against the 3 Measures of the Delirium Bundle, for the Acute Wards, where auditing is underway. All 5 Non-Acute Wards also undertake a monthly audit.

Ward/Measure	At risk patients who have a SQiD carried out (single question in delirium)	Patients with a 4AT completed (tool to assess for delirium)	Patients with an Investigations & Management Plan completed
Trauma (May 20)	**100% (20/20)**	**100% (3/3)**	**100% (2/2)**
1 South (Sept 19)	**100% (20/20)**	**100% (6/6)**	**100% (1/1)**
1 North (Feb 20)	**100% (20/20)**	**100% (5/5)**	**N/A (0/0)**
2 South Med (Feb 20)	**100% (20/20)**	**56% (5/9)**	**100% (5/5)**
4 North (May 20)	**100% (20/20)**	**100% (2/2)**	**100% (1/1)**
4 South (Feb 20)	**100% (20/20)**	**100% (4/4)**	**100% (1/1)**
Stroke/Rehab(May20)	**92% (11/12)**	**100% (11/11)**	**100% (4/4)**
Female Surg. (May20)	**100% (18/18)**	**100% (3/3)**	**100% (3/3)**

- Audits received from 4 North & Trauma, CAH & Stroke/Rehab & Female Surgical, DHH in May 20

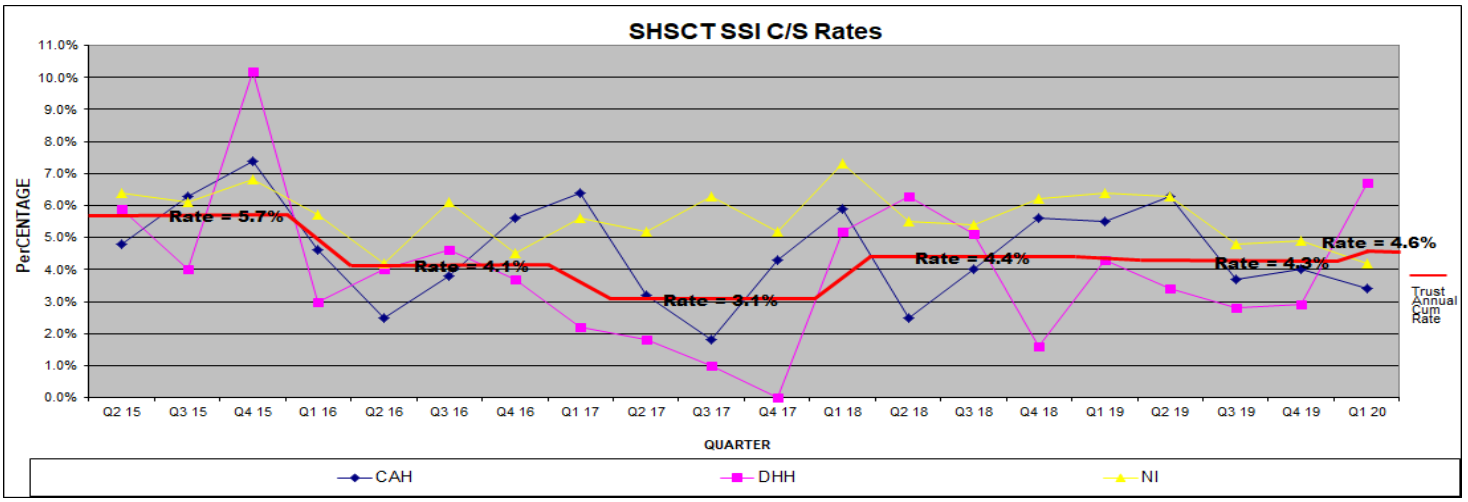
Patient Safety Report for Acute Governance Meeting Oct 2020

Surgical Site Infection (SSI) Ortho:



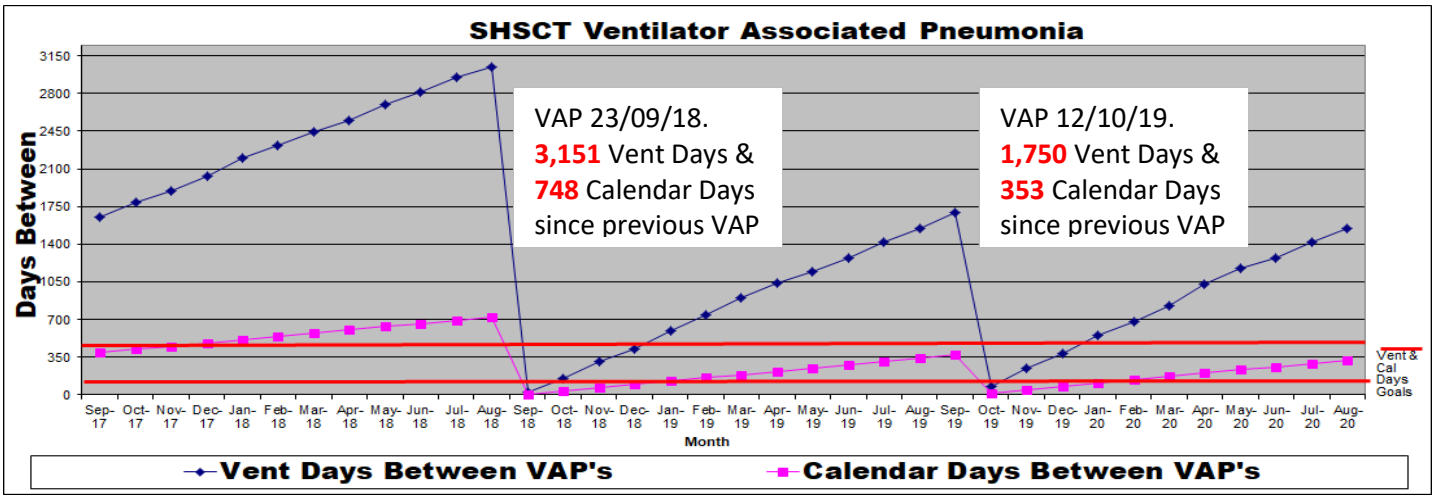
- Delay in release of Q4 data due to Covid-19.
- Next update when Q4 2019 SSI Rates are released by the PHA

Surgical Site Infection (SSI) C/Section:



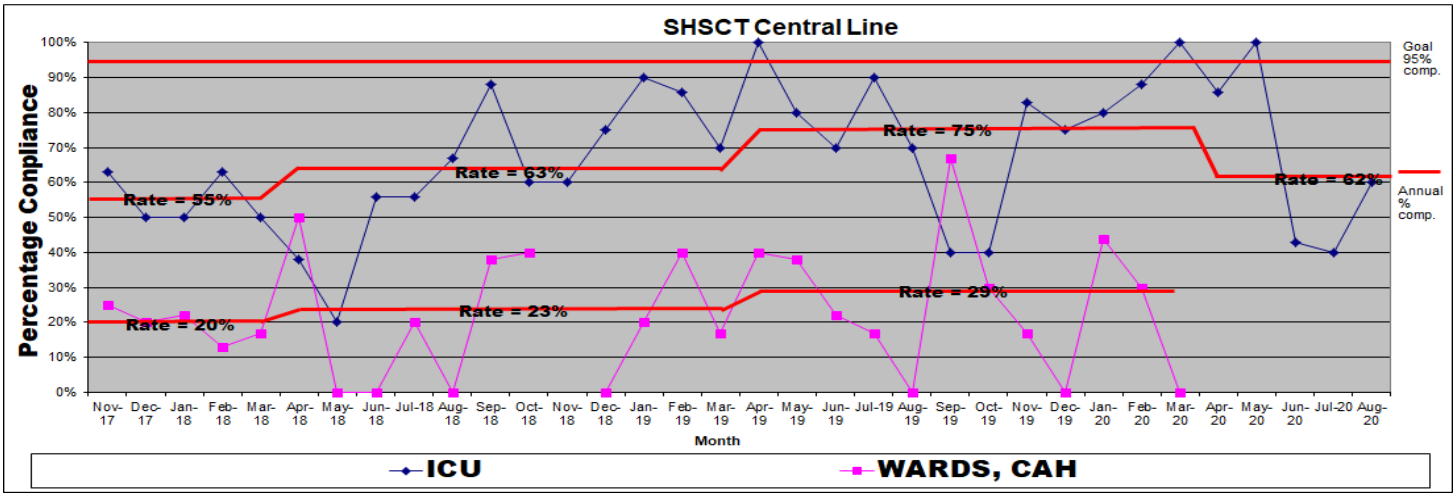
- Next update when Q2 2020 SSI Rates are released by the PHA
- The quarterly SSI C/Section Audits were reinstated in Sept 20. Results reported in due course

Ventilator Associated Pneumonia (VAP):



- Vent Days Between VAP's **1549** (13th October 19 → 31st Aug 20)
- Calendar Days Between VAP's **324** (13th October 19 → 31th Aug 20)

Central Line:



Overall Bundle Compliance July 20, ICU **60%** (6/10 cases audited), up from **40%** (4/10 cases audited) in July 20

- Non-Compliant Cases:
  - In 1 of 10 cases audited the Central Line Insertion Record was not completed therefore there was no evidence of the method of Hand Hygiene, Skin Prep or type of Drape used
  - In 1 of 10 cases audited the jugular was used with no contraindication documented
  - In 2 of 10 cases audited it was recorded that a small drape was used
  - In 1 of 10 cases audited the Daily Review of the Line was not carried out every day the line was in situ (1 days missed)

- The Audit on the Wards has been suspended until further notice due to Covid-19

- Results shared with Lead Clinician & Lead Nurse for this QI work to address areas of non-compliance

NEWS:

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q4 19/20	Q3 19/20	Q2 19/20	Q1 19/20
ACUTE	88% (346/392)	84% (521/618)	87% (498/573)	82% (360/439)
TRUST	90% (442/492)	87% (657/741)	89% (657/741)	85% (501/588)

- NB: Q4 data is for Jan & Feb 20 only. March audits not undertaken due to Covid-19

- Q1 20/21 Audit has been suspended by the PHA

MUST (Malnutrition Universal Screening Tool):

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q4 19/20	Q3 19/20	Q2 19/20	Q1 19/20
ACUTE	90% (353/392)	84% (518/618)	87% (498/573)	88% (386/439)
TRUST	92% (451/492)	86% (662/741)	89% (662/741)	90% (531/588)

- NB: Q4 data is for Jan & Feb 20 only. March audits not undertaken due to Covid-19
- Q1 20/21 Audit has been suspended by the PHA

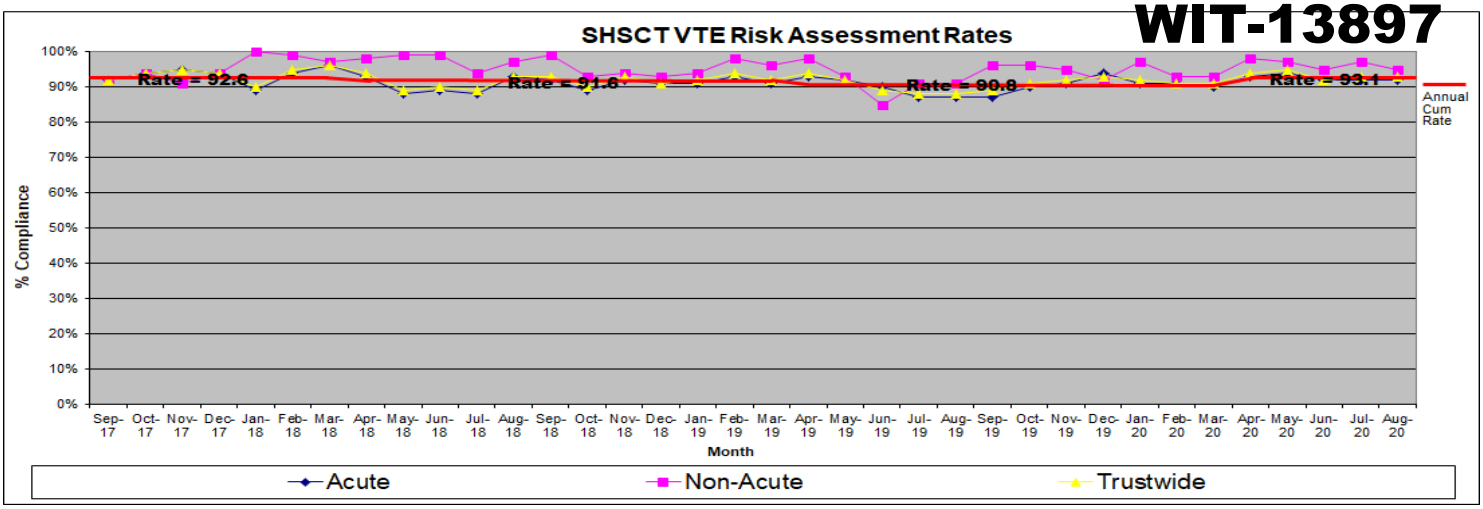
VTE:

Aug 20 (Week Commencing 03/08/20 → Week Commencing 31/08/20)

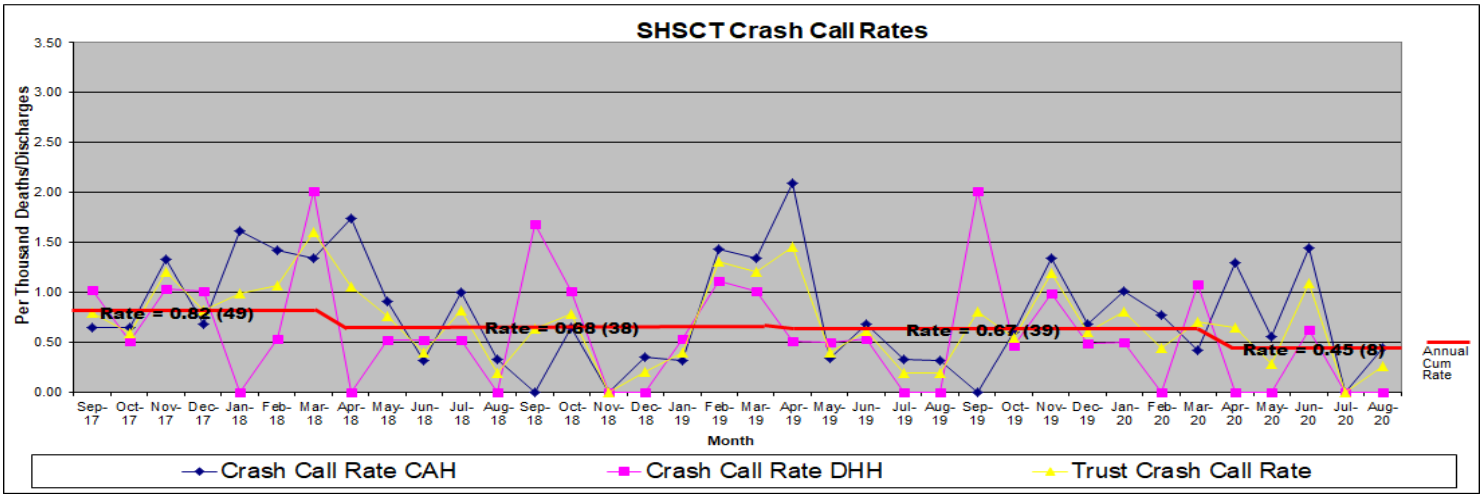
Division	Site	Ward	Number of Weekly Audits not done	Charts with Fully Completed VTE Risk Assessment	Number of Charts Audited	Monthly Percentage Compliance	Quarter 1 2/021 Percentage Compliance
S&EC	CAH	3 South	1	19	20	95% ↑	70% ↓
		4 North CESW	0	22	25	88% ↓	98% ↑
		4 South	0	20	23	87% ↑	82% ↓
		Elective Adm.	0	17	25	68% ↓	84% ↑
		Orthopaedic	0	20	20	100% ↔	97% ↓
		Trauma	0	22	22	100% ↔	100% ↔
	DHH	F/male Surg.	0	25	25	100% ↔	95% ↓
		MSW/HDU	N/A	N/A	N/A	N/A	80% ↓
M&UC	CAH	1 South	1	18	19	95% ↓	100% ↑
		1 North	0	20	24	83% ↓	N/A
		2 North Resp.	0	21	24	88% ↓	94% ↓
		Haematology	2	11	11	100% ↔	97% ↓
		3 North	0	25	25	100% ↔	80% ↓
		2 North Med	0	21	24	88% ↓	97% ↓
		AMU	0	25	25	100% ↔	98% ↑
	DHH	F/male Med.	0	23	25	92% ↓	97% ↑
		CCC/MMW	0	21	25	84% ↓	89% ↑
		Stroke/Rehab	0	25	25	100% ↔	94% ↓
IMWH	CAH	Gynae	0	21	21	100% ↔	N/A
TOTAL			4 ↑ (3)	376	408	92.2% ↓	92.8% ↑

Key: Red – Under 85% compliance, Amber – Compliance between 85% & 94%, Green – Above 95% (Reg. target)

- In summary Overall Compliance with fully completed Risk Assessment on the Acute Wards was **92.2%** (376/408 charts audited) down from **92.4%** (302/327 charts audited) in July 20
- Total number of weekly audits not completed in Aug 20 was **4** up from **3** in July 20
- The Run Chart below shows compliance against the Commissioning Plan target of **95%** compliance. The Trust Compliance includes the Non-Acute Wards & therefore their compliance has been included also for comparison. Trust Overall Compliance in Aug 20 was **93%** (453/489), same as July 20



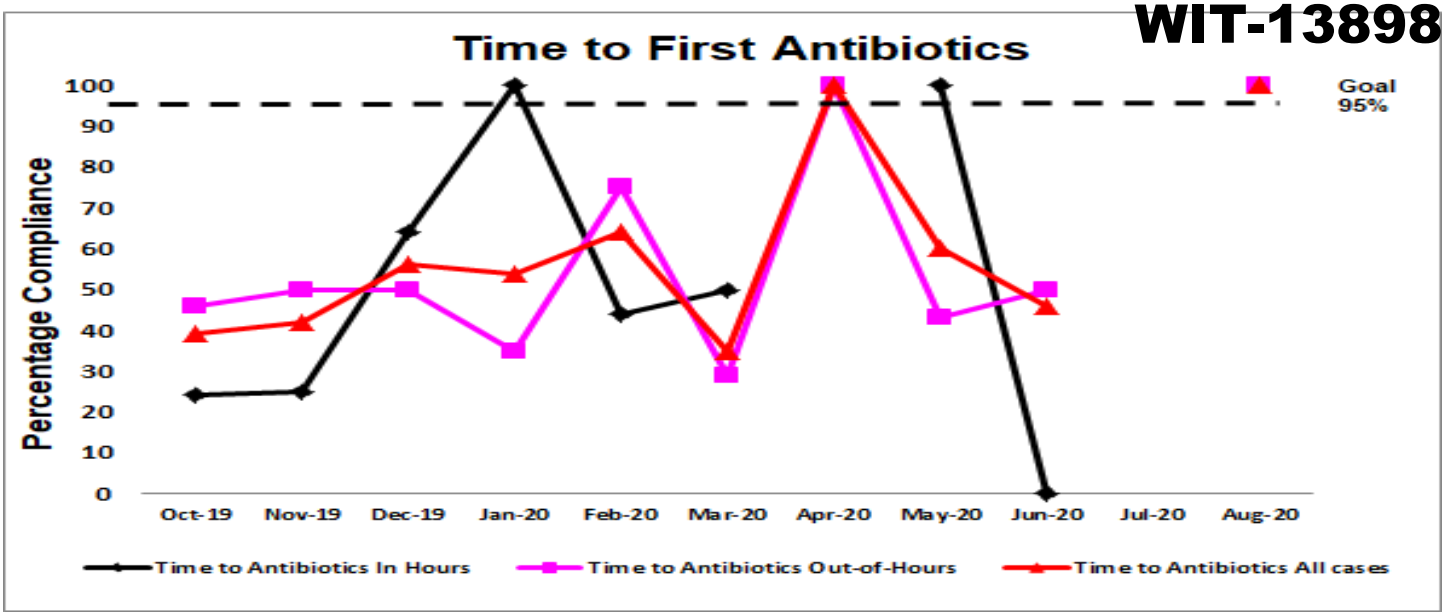
Crash Calls:



- CAH Rate **0.45** per 1,000 deaths/discharges (**1** Crash Call) up from **0** (**30** Crash Calls) in July 20
- DHH Rate **0** per 1,000 deaths/discharges (**0** Crash Calls) same as July 20
- Trust Rate **0.26** per 1,000 deaths/discharges (**1** Crash Call) up from **0** (**0** Crash Calls) in July 20
- Trust cumulative Crash Call Rate for 20/21 stands at **0.45 (8)** per 1,000 deaths/discharges, down from **0.67 (39)** in 19/20

Emergency Care QI Work: Sepsis 6 CAH & DHH:

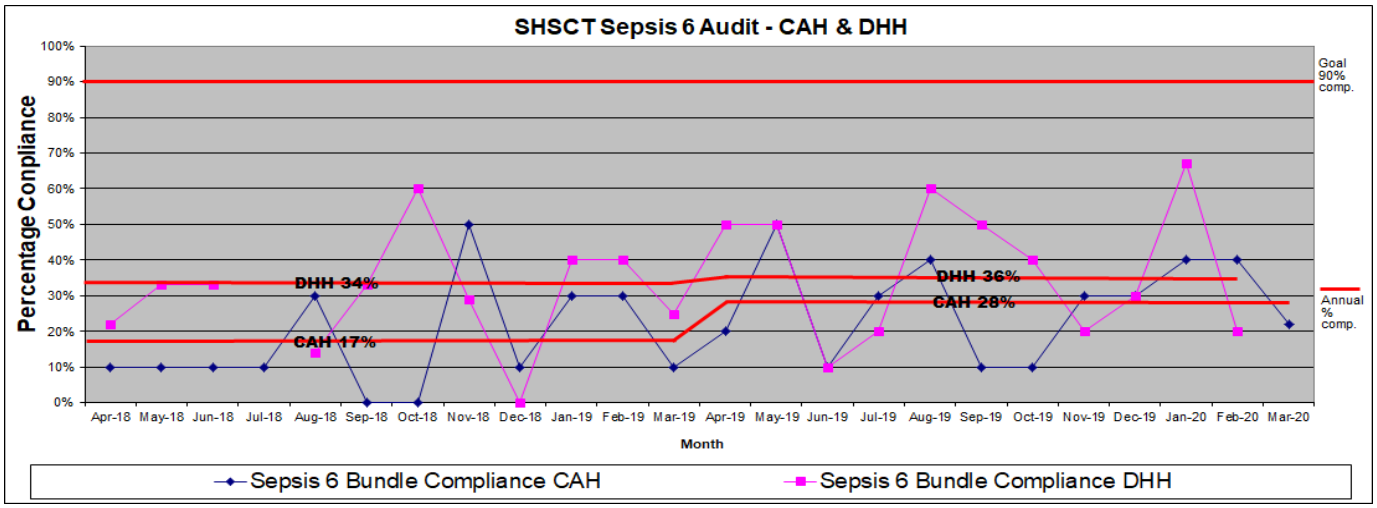
- The new Regional Sepsis QI initiative has been ongoing from Oct 19. The Regional Agreed aim is to improve the time to 1st antibiotics "In Hours" i.e. Mon → Fri 9:00am → 5:00pm. Work is underway in 3 Pilot Areas ED, CAH, (Oct 19 – Dr. Suzie Budd, Clinical Lead), AMU, CAH (Dec 19 – Dr. Emily Hannah, Clinical Lead) & ED, DHH (14th Jan 20 – Dr. Laura Lavery, Clinical Lead). In the ED's of CAH & DHH it was decided to measure compliance 24/7. The Run Chart below shows progress made in ED, CAH. Data from the other Pilot Areas will be shared in due course



- No cases applicable to the criteria July 20. Only 2 cases were applicable in Aug 20. Both were out-of-hours & both were compliant

- Auditing in ED, DHH & AMU have been suspended due to Covid-19

The Run Chart below shows Overall Bundle Compliance with the Sepsis6 Bundle in ED's of CAH & DHH



- Auditing has been suspended due to Covid-19

Critical Medicines Omitted:

The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q4 19/20	Q3 19/20	Q2 19/20	Q1 19/20
ACUTE	1 (392)	17 (618)	5 (573)	2 (439)
TRUST	1 (492)	18 (773)	6 (741)	3 (588)

- NB: Q4 data is for Jan & Feb 20 only. March audits not undertaken due to Covid-19

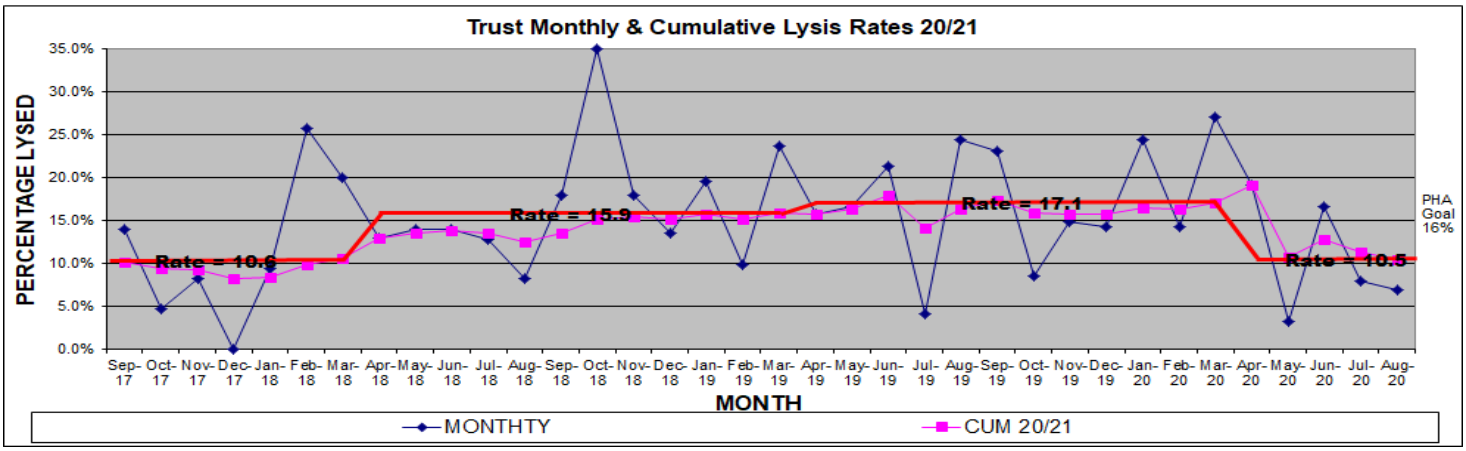
- Q1 20/21 Audit has been suspended by the PHA

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		Aug 20		Aug 20		Aug 20	Commentary Aug 20
Patients who are potentially eligible for thrombolysis are assessed by Acute Stroke Team within 30 minutes of arrival	18/19 99% 19/20 99%	100% (36/36)	18/19 99% 19/20 99%	N/A	18/19 99% 19/20 99%	100% (36/36)	-
Patients who are potentially eligible for thrombolysis receive CT scan within 45 minutes	18/19 99% 19/20 99%	100% (12/12)	18/19 98% 19/20 98%	N/A	18/19 99% 19/20 99%	100% (12/12)	-
Patients deemed suitable for thrombolysis receive first bolus within 60 minutes	18/19 90% 19/20 78%	100% (2/2)	18/19 75% 19/20 75%	N/A	18/19 86% 19/20 77%	100% (2/2)	-
Patients transferred to Hyper Acute Stroke Unit (or appropriate environment) within 90 mins	18/19 94% 19/20 98%	100% (2/2)	18/19 89% 19/20 96%	N/A	18/19 93% 19/20 98%	100% (2/2)	-

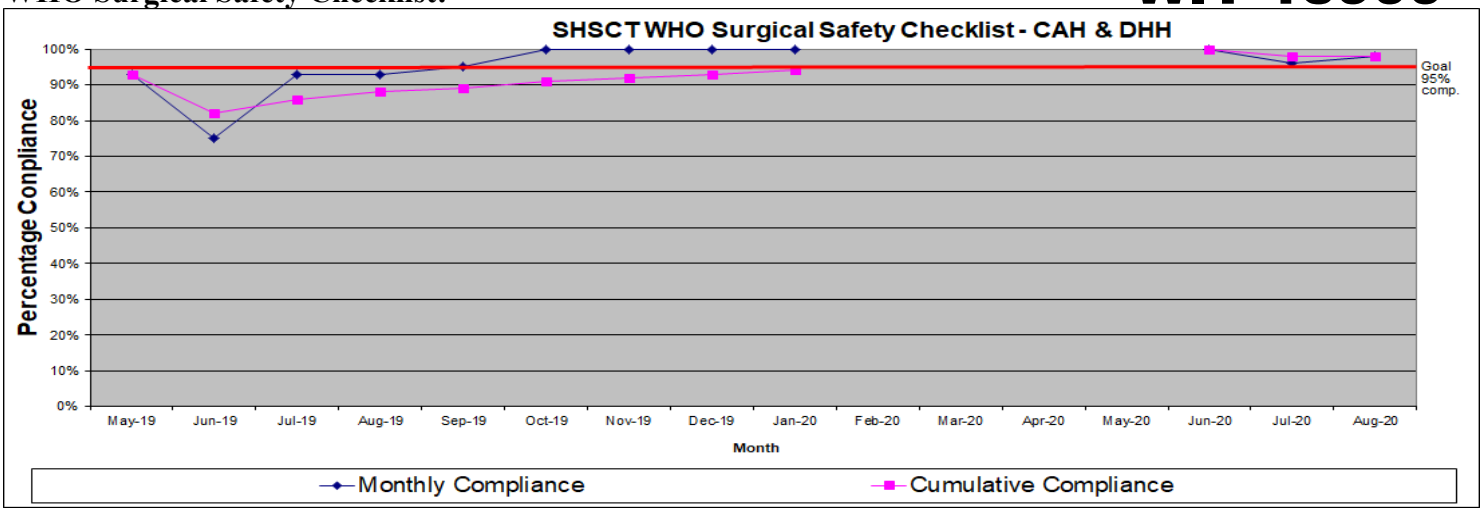
	CAH		DHH		TRUST		AIM 20/21 (Based on Commissioning Plan) To ensure that the proportion of thrombolysis administration To be confirmed. Was 16% in 19/20
Outcome Measure	2019/20	Aug 20	2019/20	Aug 20	2019/20	Aug 20	
Monthly Thrombolysis Rate		6.9% (2/29)		N/A		6.9% (2/29)	
Thrombolysis Rate (Yearly)	17.6% (58/329)	10.5% (16/153)	16.1% (28/174)	N/A	15.9% (69/435)	10.5% (16/153)	



The above is "Real Time" data, which is subject to change. The Directorate of Performance & Reform is responsible for reporting to the RHSCB. From the above table only the lysis rates are reported. Furthermore their report is 3 months in arrears to allow Clinical Coding to reach an acceptable level.

- Audit suspended in DHH due to Covid-19

WHO Surgical Safety Checklist:



- The Monthly Audits were reinstated in May 19 & were suspended Feb → May 20 due to Covid-19
- Compliance in Aug 20 was **98%** (49/50 cases audited) up from **96%** in July 20 (48/50 cases audited)

Regional Delirium Audit:

The table below shows compliance against the 3 Measures of the Delirium Bundle, for the Acute Wards, where auditing is underway. All 5 Non-Acute Wards also undertake a monthly audit.

Ward/Measure	At risk patients who have a SQiD carried out (single question in delirium)	Patients with a 4AT completed (tool to assess for delirium)	Patients with an Investigations & Management Plan completed
Trauma (Aug 20)	95% (20/20)	83% (5/6)	60% (3/5)
1 South (Sept 19)	100% (20/20)	100% (6/6)	100% (1/1)
1 North (Aug 20)	100% (20/20)	100% (3/3)	100% (3/3)
3 North Med (Aug 20)	95% (19/20)	60% (6/10	100% (6/6)
4 North (June 20)	100% (20/20)	100% (6/6)	100% (2/2)
4 South (Aug 20)	100% (20/20)	100% (8/8)	100% (2/2)
Stroke/Rehab (Aug20)	100% (19/19)	100% (4/4)	100% (2/2)
Female Surg. (Aug 20)	100% (16/16)	N/A (0/0)	N/A (0/0)

- Audits received from Wards highlighted in red. Ward 4 North restarted Audit in Sept 20

SKIN Care (Pressure Ulcer):

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

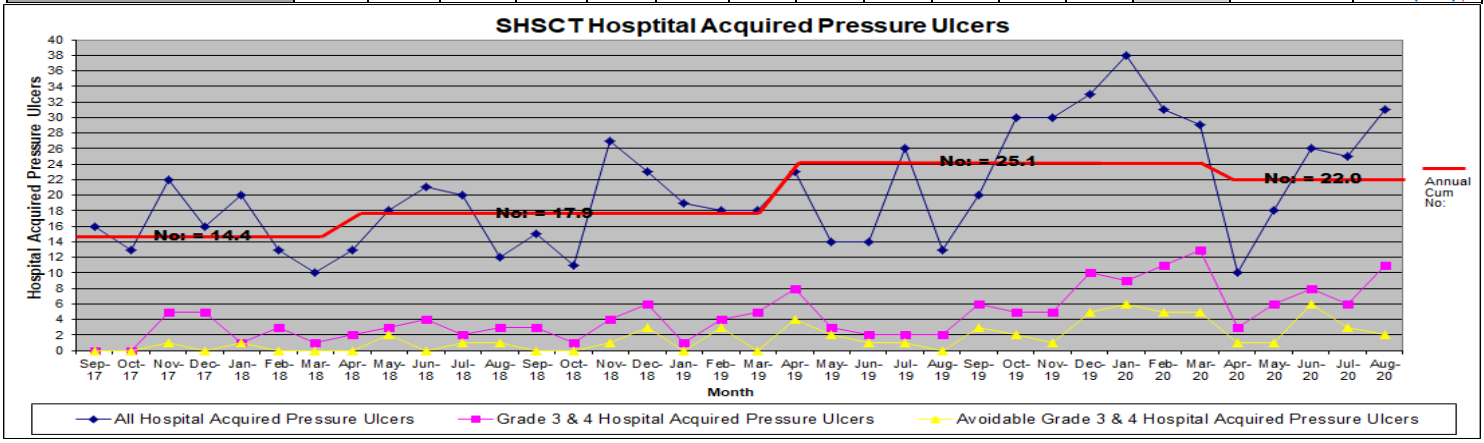
Quarter	Q4 19/20	Q3 19/20	Q2 19/20	Q1 19/20
ACUTE	76% (178/233)	63% (237/378)	71% (207/293)	67% (143/212)
TRUST	81% (264/325)	70% (346/495)	77% (324/420)	78% (271/346)

- NB: Q4 data is for Jan & Feb 20 only. March audits not undertaken due to Covid-19
- Q1 20/21 Audit has been suspended by the PHA

- There were **31** Hospital Acquired Pressure Ulcers reported in Aug 20. Of these, **11** were Grade 3/4 U or DTI's, (AMU X 3, 3 South X 2, 2 South Medical X 2, 1 South, I North, 3 North, CAH & Ward 1 Lgn).
- In 20/21 RCA's have been carried out on **24** cases to date with **13** deemed to have been avoidable. This represents **12%** of all Ward Acquired Pressure Ulcers reported in 20/21. The outstanding RCA's (**10**) will be carried out in due course.

Ward Acquired Pressure Ulcers & Rate per 1,000 Occupied Bed Days 2020/21

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL	Rate 20/21	Rate & No 19/20
CAH															
Ward 4 South	3	0	0	1	0								4	1.59	1.94 (25) ↓
Ward 4 North	0	1	0	0	1								2	0.56	0.89 (10) ↓
Ward 3 South	1	2	4	4	8								19	4.44	1.24 (14) ↑
Trauma Ward	1	2	2	0	0								5	1.72	4.64 (41) ↓
Orthopaedic Ward	0	0	2	2	0								4	3.15	0.62 (2) ↑
Gynae Ward	N/A	N/A	N/A	0	0								0	0	0.30 (1) ↓
ICU	2	2	2	3	0								9	10.87	12.12 (28)↓
Ward 3 North Medicine	1	1	4	3	4								13	6.11	2.75 (17) ↑
Ward 2 South Stroke	0	1	1	0	0								2	0.97	1.49 (9) ↓
Ward 2 North	0	1	2	2	0								5	1.23	1.39 (17) ↓
Ward 5 Haematology	1	0	2	1	1								5	3.17	1.36 (6) ↑
Ward 1 South	0	0	1	3	3								7	1.51	2.01 (26) ↓
Ward 1 North	0	0	1	0	1								2	0.48	0.70 (8) ↓
AMU	1	1	0	1	3								6	1.69	1.52 (18) ↑
2 South Medical	0	2	2	1	3								8	1.92	N/A
CEAW	0	0	0	0	0								0	0	N/A
Other Areas e.g. Recovery	0	1	0	1	0								2	N/A	N/A
DHH															
Male Surgical/DEAW	0	0	0	0	0								0	0	0.65 (4) ↓
Female Surg/Gynae	0	1	1	0	0								2	0.81	0.51 (5) ↑
HDU	0	0	0	1	0								1	1.54	1.70 (5) ↓
Stroke/Rehab	0	0	0	0	1								1	0.26	0.28 (3) ↓
Male Med/CCU	0	0	0	1	0								1	0.24	0 (0) ↑
Female Medical	0	2	0	0	1								3	0.69	0.74 (9) ↓
Lurgan															
Ward 1	0	0	0	0	3								3	2.16	0.65 (4) ↑
Ward 2 Stroke	0	0	1	0	1								2	0.99	1.26 (7) ↓
Ward 3	0	0	0	0	0								0	0	0.85 (5) ↓
STH															
Ward 1 STH	0	0	0	0	1								1	0.49	1.12 (7) ↓
Ward 2 STH	0	N/A	0	0	N/A								0	0	0.65 (4) ↓
MHLD															
Gillis	0	1	1	1	0								3	1.16	0.51 (3) ↑
Willows	0	0	0	0	0								0	0	0 (0) ↔
TOTAL	10	18	26	25	31								110		
RATE	1.01	1.33	1.71	1.53	1.87									1.54	1.36 (301)↑



- The Trust's Monthly Hospital Acquired Pressure Ulcer Rate for Aug 20, based on **28** Wards was **1.87** (**31**/16,585) per 1,000 Occupied Bed Days up from **1.53** (**25**/16,337) per 1,000 Occupied Bed Days in July 20
- The Trust's 20/21 Hospital Acquired Pressure Ulcer Rate, based on **28** Wards stands at **1.54 (79)** per 1,000 Bed Days, up from **1.36 (301)** in 2019/20.

Received from SHSCT on 16/05/22. Annotated by the Urology Services Inquiry.

Patient Falls:

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q4 19/20	Q3 19/20	Q2 19/20	Q1 19/20
Acute Bundle A Compliance	79% (310/392)	77% (474/618)	81% (462/573)	77% (340/439)
Trust Bundle A Compliance	82% (402/492)	79% (613/773)	84% (621/741)	82% (480/588)

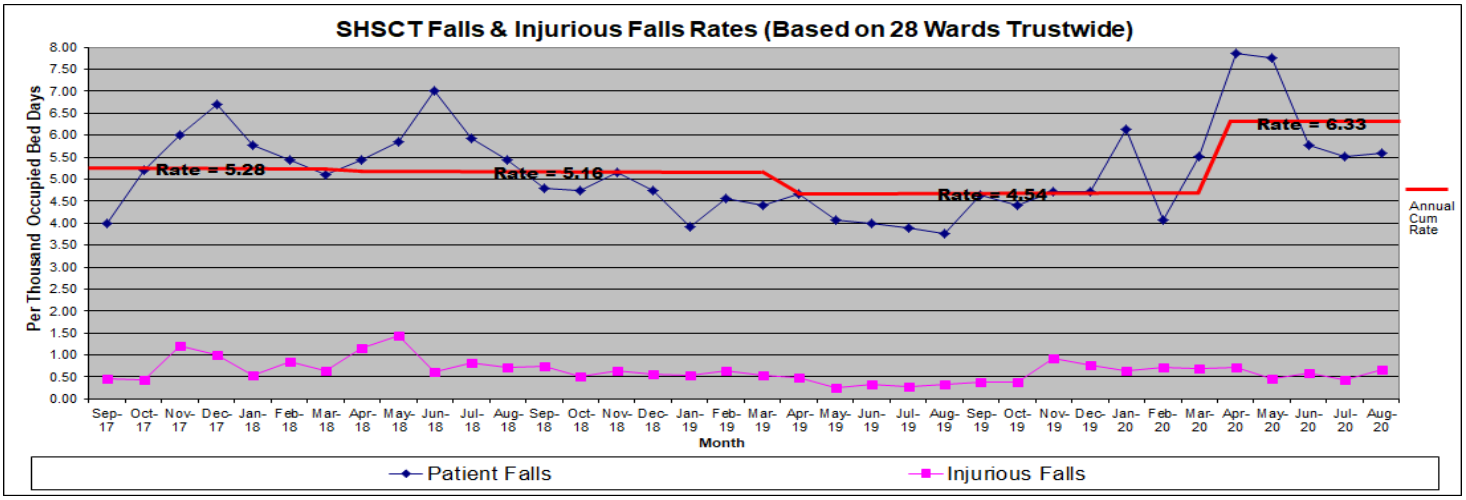
Quarter	Q4 19/20	Q3 19/20	Q2 19/20	Q1 19/20
Acute Bundle B Compliance	77% (249/323)	69% (346/503)	66% (285/430)	63% (205/326)
Trust Bundle B Compliance	81% (341/421)	74% (482/653)	73% (429/587)	71% (338/473)

- NB: Q4 data is for Jan & Feb 20 only. March audits not undertaken due to Covid-19
- Q1 20/21 Audit has been suspended by the PHA

The table below gives details of individual Ward's Falls Numbers & Falls Rate 20/21:

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL	Rate 20/21	Rate 19/20
CAH															
Ward 4 South	2	0	0	3	2								7	2.78	2.88 (37) ↓
Ward 4 North	3	3	3	4	7								20	5.63	2.22 (25) ↑
Ward 3 South	10	5	7	8	3								33	7.71	3.73 (42) ↑
Trauma Ward	4	4	3	4	8								23	7.90	5.77 (51) ↑
Orthopaedic Ward	4	5	1	5	0								15	11.80	3.08 (10) ↑
Gynae Ward	N/A	N/A	N/A	0	0								0	0	1.79 (6) ↓
Ward 3 North Medicine	2	5	4	4	7								22	10.35	8.26 (51) ↑
Ward 3 North Stroke	1	3	5	6	1								16	7.74	6.94 (42) ↑
Ward 2 North	4	7	3	2	3								19	4.68	3.36 (41) ↑
Haematology Ward	1	0	0	1	0								2	1.27	4.75 (21) ↓
Ward 1 South	5	9	4	2	3								23	4.95	3.55 (46) ↑
Ward 1 North	1	2	1	2	6								12	2.87	3.59 (41) ↓
AMU	2	5	9	8	3								27	7.59	9.40 (111) ↓
2 South Medicine	0	3	10	2	3								18	4.31	3.91 (26) ↑
CEAW	N/A	N/A	0	0	0								0	0	N/A
DHH															
Male Surgical	3	0	0	0	0								3	5.96	2.76 (17) ↑
Female Surg/Gynae	0	0	0	2	0								2	0.81	2.67 (26) ↓
HDU	0	0	1	0	0								1	1.54	2.72 (8) ↓
Stroke/Rehab	4	2	6	5	2								19	4.91	4.73 (50) ↑
Male Med/CCU	4	16	11	12	8								51	12.41	4.76 (56) ↑
Female Medical	2	7	6	3	7								25	5.73	4.34 (53) ↑
Lurgan															
Ward 1	0	6	2	3	3								14	10.10	3.08 (19) ↑
Ward 2 Stroke	3	3	2	0	0								8	3.96	3.61 (20) ↑
Ward 3	3	2	1	1	0								7	4.50	3.57 (21) ↑
STH															
Ward 1 STH	2	0	1	1	3								7	3.41	1.44 (9) ↑
Ward 2 STH	0	N/A	0	0	N/A								0	0	2.28 (14) ↓
MHLD															
Gillis	12	4	2	6	7								31	11.99	14.24 (83) ↓
Willows	4	13	5	5	16								43	14.27	9.47 (69) ↑
TOTAL	76	104	87	89	92								448		
RATE	7.82	7.75	5.77	5.52	5.60									6.33	4.54 (995) ↑

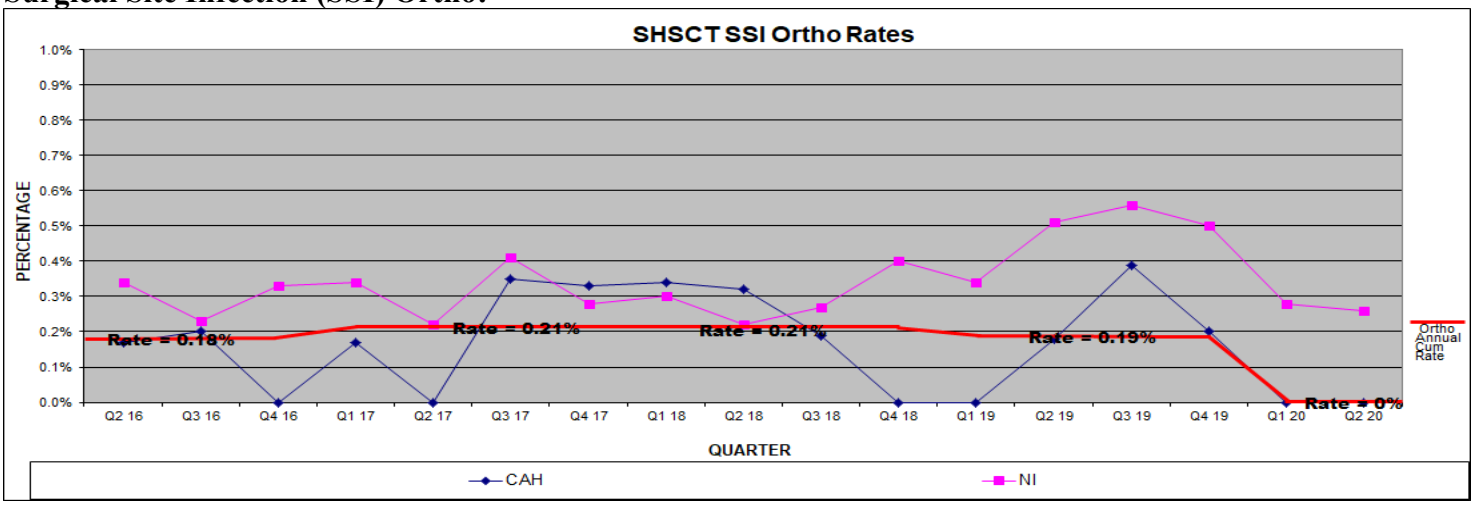
The Run Chart below shows Patient Falls & Injurious Falls Rates per 1,000 Occupied Bed Days, based on 28 Wards, captured by staff using the Falls Walking Stick & Datix.



- Falls Rate **5.60** (**92**/16,414 Occupied Bed Days) up from **5.52** (**89**/16,145) in July 20
- Injurious Falls Rate **0.67** (**11**/16,414 Occupied Bed Days) up from **0.43** (**7**/16,145) in July 20
- Cumulative Falls Rate for 20/21 stands at **6.33**, compared to **4.54** in 19/20

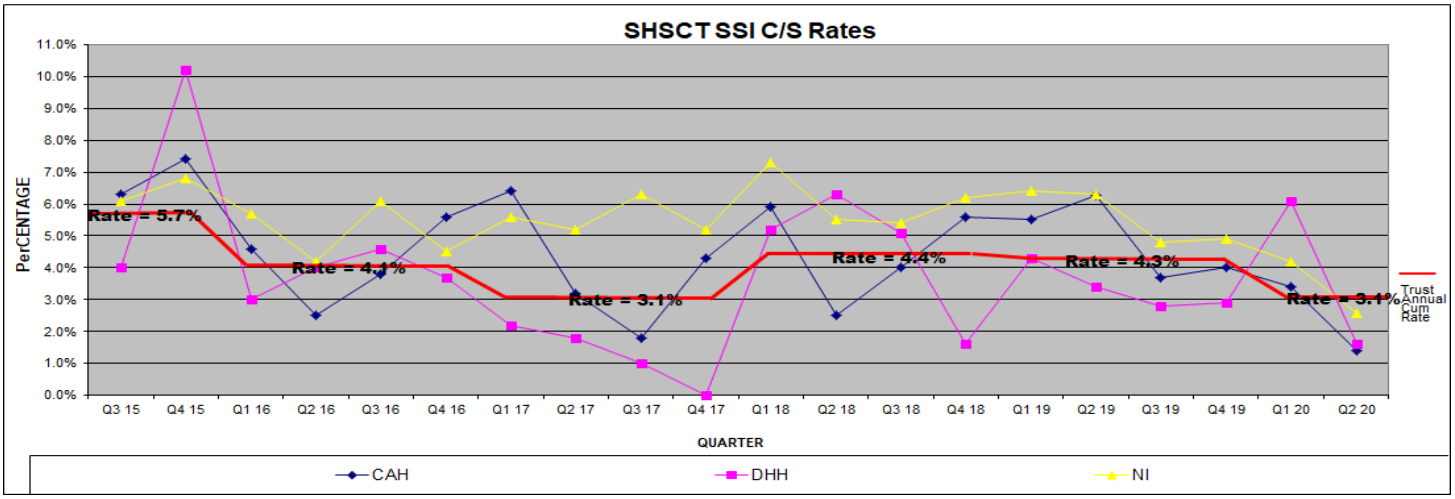
Patient Safety Report for Acute Governance Meeting Jan 2021

Surgical Site Infection (SSI) Ortho:



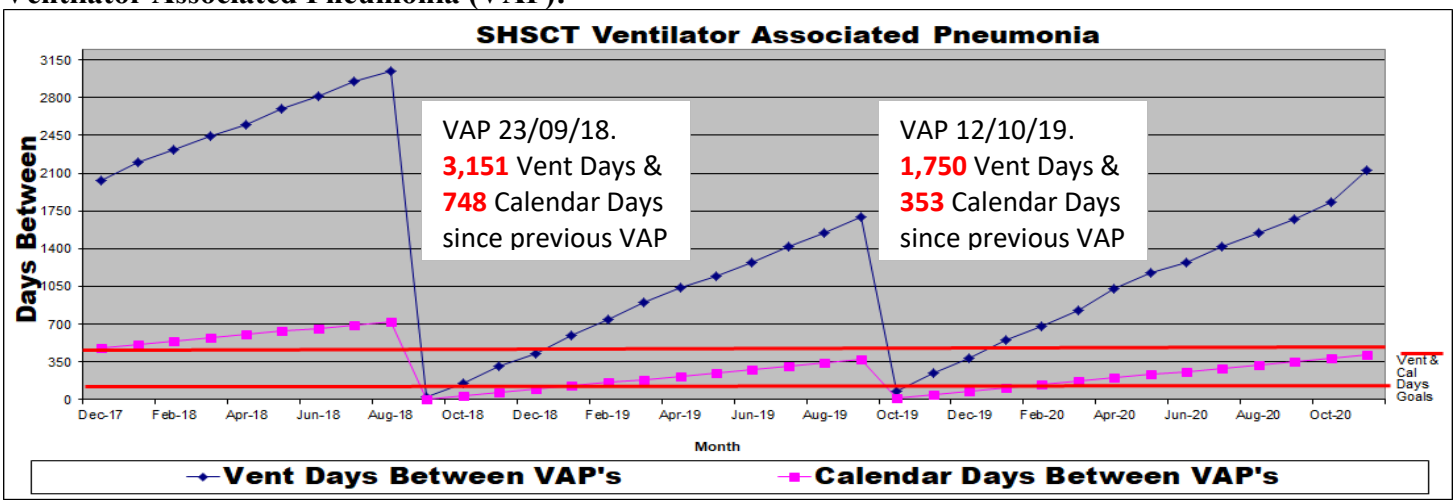
- Next update when Q3 SSI Rates released by PHA

Surgical Site Infection (SSI) C/Section:



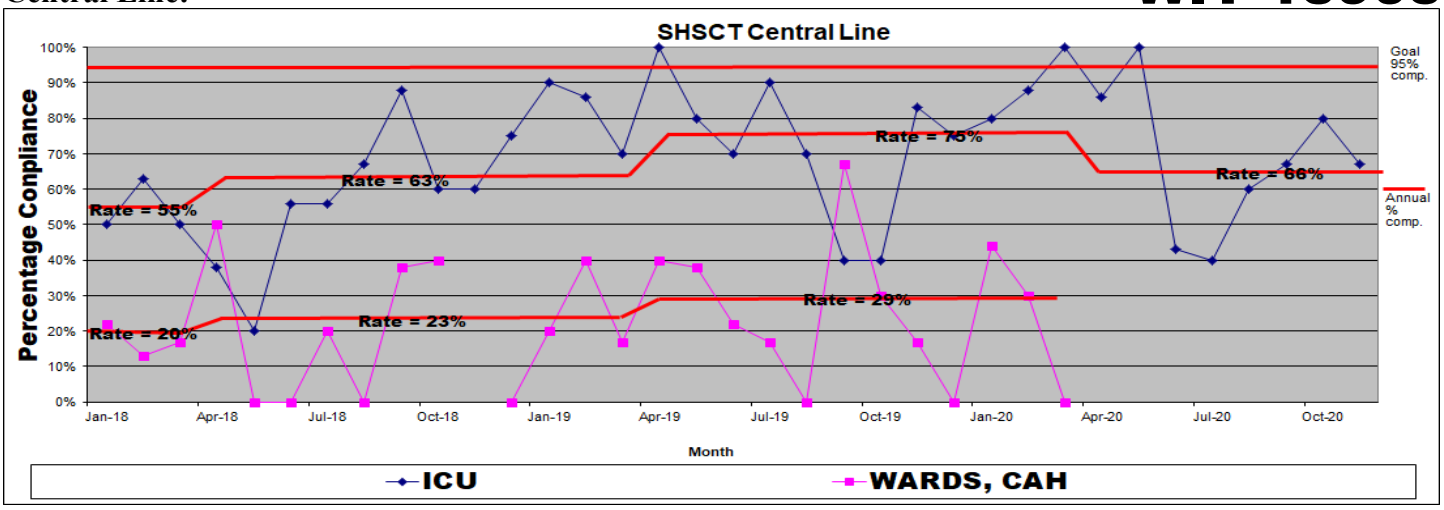
- The quarterly C/S Audits take place in Dec 2020 with results reported in Feb 21

Ventilator Associated Pneumonia (VAP):



- Vent Days Between VAP's **2128** (13th October 19 → 30th Nov 20)
- Calendar Days Between VAP's **415** (13th October 19 → 3tht Nov 20)

Central Line:



Overall Bundle Compliance Nov 20, ICU **67%** (4/6 cases audited), down from **80%** (8/10 cases audited) in Oct 20

- Non-Compliant Cases:
  - In 1 of 6 cases audited Natural Detergent was used as the method of Hand Hygiene
  - In 1 of 6 cases audited the Daily Review of the Line was missed

- There were 2 Central Line Infections in Nov 20. Both patients were in ICU 2 (Temp COVID ICU Recovery Ward)

- The Audit on the Wards has been suspended until further notice due to Covid-19

- Results shared with Lead Clinician & Lead Nurse for this QI work to address areas of non-compliance

NEWS:

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q2 20/21	Q1 20/21	Q4 19/20	Q3 19/20
ACUTE	92% (428/463)	Audit cancelled due to Covid-19	88% (346/392)	84% (521/618)
TRUST	93% (541/584)		90% (442/492)	87% (657/741)

- NB: Q4 19/20 data is for Jan & Feb 20 only. March audits not undertaken due to Covid-19

- Q1 20/21 Audit was cancelled by the PHA due to Covid-19

MUST (Malnutrition Universal Screening Tool):

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q2 20/21	Q1 20/21	Q4 19/20	Q3 19/20
ACUTE	88% (404/458)	Audit cancelled due to Covid-19	90% (353/392)	84% (518/618)
TRUST	90% (521/578)		92% (451/492)	86% (662/741)

- NB: Q4 19/20 data is for Jan & Feb 20 only. March audits not undertaken due to Covid-19

- Q1 20/21 Audit was cancelled by the PHA due to Covid-19

Critical Medicines Omitted:

The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q2 20/21	Q1 20/21	Q4 19/20	Q3 19/20
ACUTE	2 (461)	Audit cancelled due to Covid-19	1 (392)	17 (618)
TRUST	2 (582)		1 (492)	18 (773)

- NB: Q4 19/20 data is for Jan & Feb 20 only. March audits not undertaken due to Covid-19
- Q1 20/21 Audit was cancelled by the PHA due to Covid-19

VTE:

Nov 20 (Week Commencing 02/11/20 → Week Commencing 30/11/20)

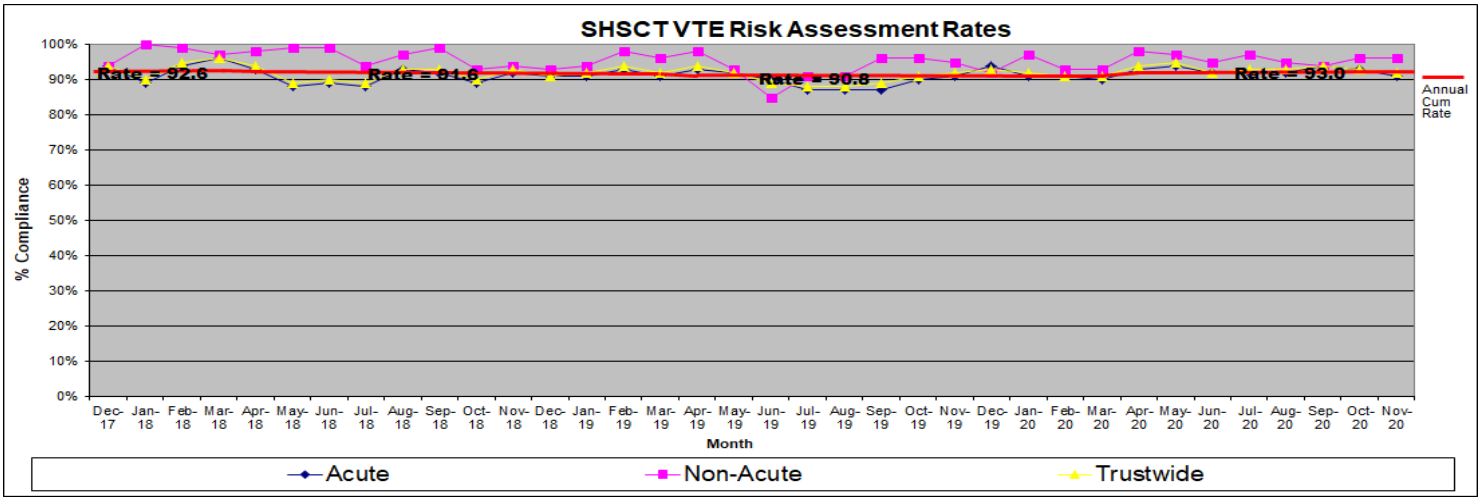
Division	Site	Ward	Number of Weekly Audits not done	Charts with Fully Completed VTE Risk Assessment	Number of Charts Audited	Monthly Percentage Compliance	Quarter 2 20/21 Percentage Compliance
S&EC	CAH	3 South	3	6	10	60% ↓	79% ↑
		4 North CESW	3	5	5	100% ↔	94% ↓
		4 South	0	23	24	96% ↓	84% ↑
		Elective Adm.	0	18	25	72% ↓	70% ↓
		Orthopaedic	5	N/A	N/A	N/A	100% ↑
		Trauma	4	5	5	100% ↔	100% ↔
	DHH	F/male Surg.	0	24	25	96% ↑	100% ↑
		MSW/HDU	N/A	N/A	N/A	N/A	N/A
M&UC	CAH	1 South	0	21	23	91% ↓	96% ↓
		1 North	0	18	24	75% ↓	89% ↑
		2 North Resp.	0	24	25	96% ↑	92% ↓
		Haematology	1	9	9	100% ↔	100% ↑
		3 North	1	18	18	100% ↔	100% ↑
		2 North Med	0	21	24	88% ↑	93% ↓
		AMU	0	25	25	100% ↑	98% ↔
		Frailty Ward	0	5	5	100%	N/A
	DHH	F/male Med.	0	22	24	92% ↓	91% ↓
		CCC/MMW	0	22	23	96% ↓	88% ↓
		Stroke/Rehab	0	25	25	100% ↑	98% ↑
		Respiratory L3	0	24	24	100% ↔	N/A
IMWH	CAH	Gynae	0	14	17	82 % ↓	100% ↑
TOTAL			17 ↑ (0)	329	360	91.4% ↓	92.7% ↓

Key: Red – Under 85% compliance, Amber – Compliance between 85% & 94%, Green – Above 95% (Reg. target)

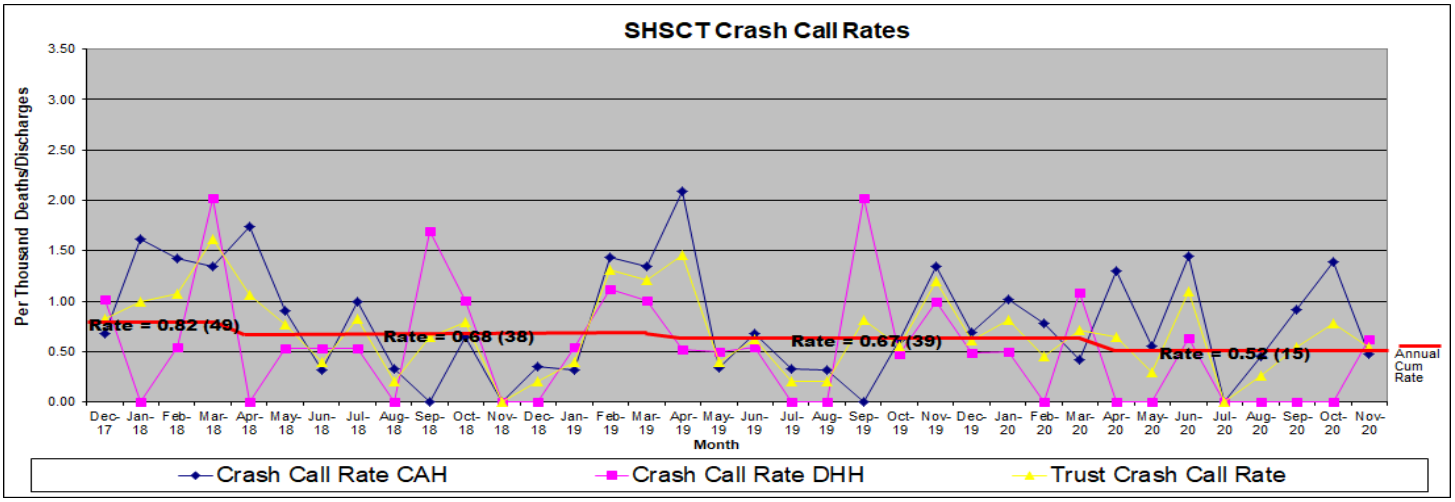
- In summary Overall Compliance with fully completed Risk Assessment on the Acute Wards was **91.4%** (329/360 charts audited) down from **92.6%** (300/324 charts audited) in Oct 20

- Total number of weekly audits not completed in Oct 20 was **17** up from **0** in Oct 20

- The Run Chart below shows compliance against the Commissioning Plan target of 95% compliance. The Trust Compliance includes the Non-Acute Wards & therefore their compliance has been included also for comparison. Trust Overall Compliance in Nov 20 was **92%** (406/440), down from **93%** in Oct 20



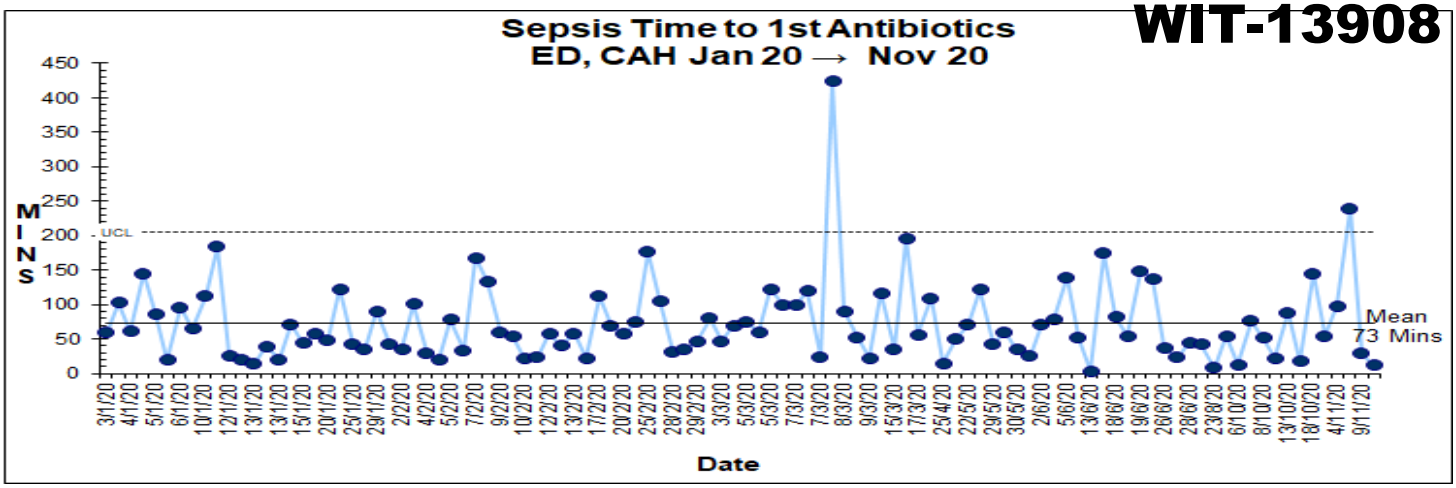
Crash Calls:



- CAH Rate **0.48** per 1,000 deaths/discharges (**1** Crash Call) down from **1.39** (**3** Crash Calls) in Oct 20
- DHH Rate **0.62** per 1,000 deaths/discharges (**1** Crash Call) up from **0** (**0** Crash Calls) in Oct 20
- Trust Rate **0.54** per 1,000 deaths/discharges (**2** Crash Calls) down from **0.73** (**3** Crash Calls) in Oct 20
- Trust cumulative Crash Call Rate for 20/21 stands at **0.52 (15)** per 1,000 deaths/discharges, down from **0.67 (39)** in 19/20

Emergency Care QI Work: Sepsis 6 CAH & DHH:

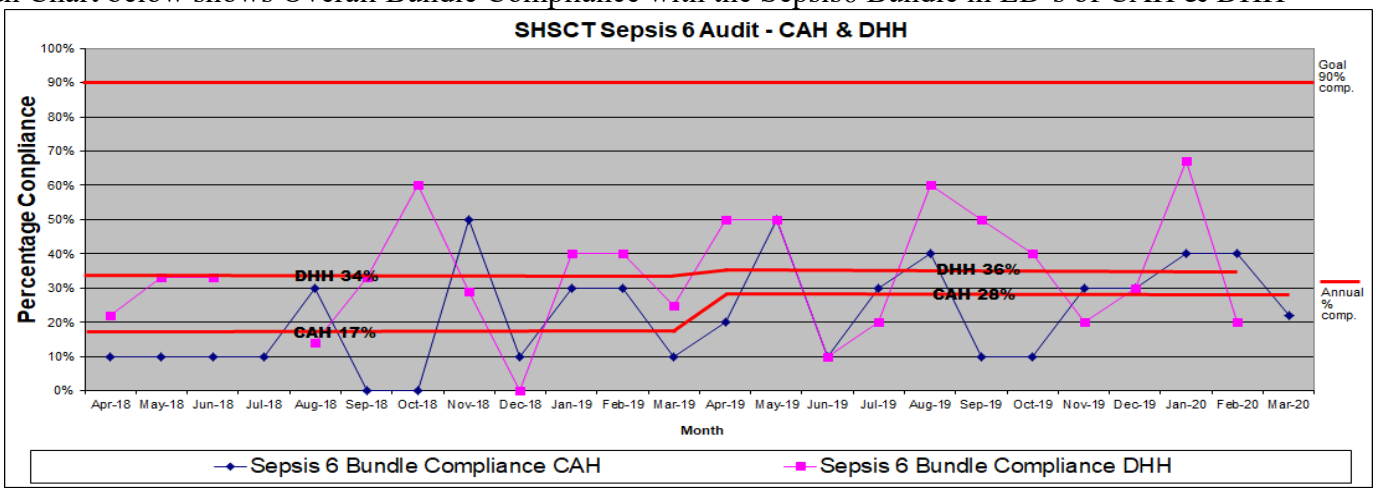
- The new Regional Sepsis QI initiative has been ongoing from Oct 19. The Regional Agreed aim is to improve the time to 1st antibiotics "In Hours" i.e. Mon → Fri 9:00am → 5:00pm. Work is underway in 3 Pilot Areas ED, CAH, (Oct 19 – Dr. Suzie Budd, Clinical Lead), AMU, CAH (Dec 19 – Dr. Emily Hannah, Clinical Lead) & ED, DHH (14th Jan 20 – Dr. Laura Lavery, Clinical Lead). In the ED's of CAH & DHH it was decided to measure compliance 24/7. The Run Chart below shows progress made in ED, CAH. Data from the other Pilot Areas will be shared in due course



- Compliance in-hours was **0%** (0/2 cases audited). Cases outside target timeframe by 38 mins & 180 mins. Compliance out-of-hours was **100%** (2/2 cases audited)

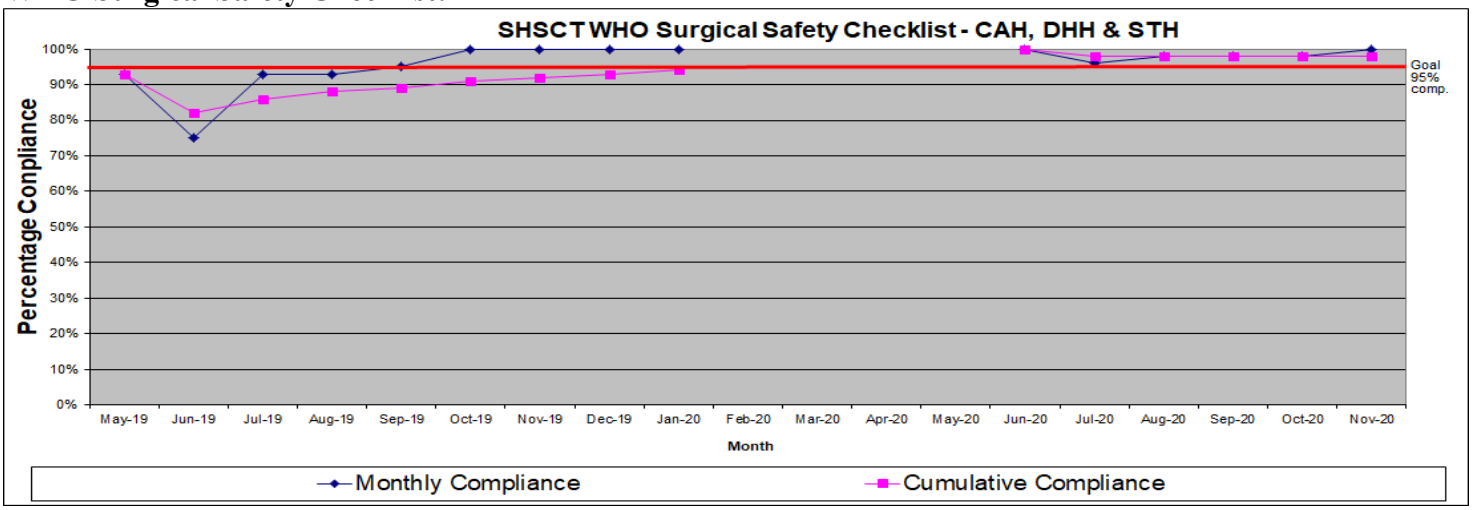
- Auditing in ED, DHH & AMU have been suspended due to Covid-19

The Run Chart below shows Overall Bundle Compliance with the Sepsis6 Bundle in ED's of CAH & DHH



- Auditing has been suspended due to Covid-19

WHO Surgical Safety Checklist:



- The Monthly Audits were reinstated in May 19 & were suspended Feb → May 20 due to Covid-19

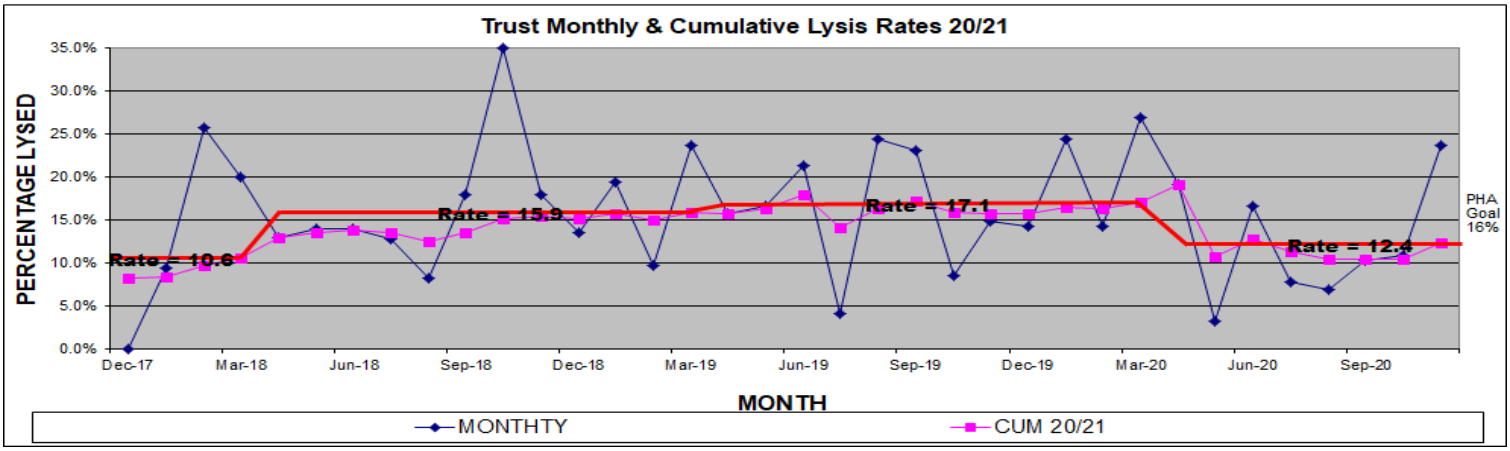
- Nov 20 Compliance **100%** (50/50) up from **98%** (49/50) in Oct 20, Cumulative Compliance 20/21 **98%**

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		Nov 20		Nov 20		Nov 20	Commentary Nov 20
Patients who are potentially eligible for thrombolysis are assessed by Acute Stroke Team within 30 minutes of arrival	18/19 99% 19/20 99%	100% (26/26)	18/19 99% 19/20 99%	100% (19/19)	18/19 99% 19/20 99%	100% (45/45)	-
Patients who are potentially eligible for thrombolysis receive CT scan within 45 minutes	18/19 99% 19/20 99%	100% (12/12)	18/19 98% 19/20 98%	100% (17/17)	18/19 99% 19/20 99%	100% (29/29)	-
Patients deemed suitable for thrombolysis receive first bolus within 60 minutes	18/19 90% 19/20 78%	100% (5/5)	18/19 75% 19/20 75%	75% (3/4)	18/19 86% 19/20 77%	89% (8/)	DHH – Patient presented out-of-hours. Outside timeframe by 4 mins.
Patients transferred to Hyper Acute Stroke Unit (or appropriate environment) within 90 mins	18/19 94% 19/20 98%	100% (5/5)	18/19 89% 19/20 96%	100% (4/4)	18/19 93% 19/20 98%	100% (9/9)	-

	CAH		DHH		TRUST		AIM 20/21 (Based on Commissioning Plan) To ensure that the proportion of thrombolysis administration To be confirmed. Was 16% in 19/20
Outcome Measure	2019/20	Nov 20	2019/20	Nov 20	2019/20	Nov 20	
Monthly Thrombolysis Rate		20.0% (5/25)		30.8% (4/13)		23.7% (9/38)	
Thrombolysis Rate (Yearly)	17.6% (58/329)	11.7% (29/248)	16.1% (28/174)	22.2% (4/18)	15.9% (69/435)	12.4% (33/266)	



The above is "Real Time" data, which is subject to change. The Directorate of Performance & Reform is responsible for reporting to the RHSCB. From the above table only the lysis rates are reported. Furthermore their report is 3 months in arrears to allow Clinical Coding to reach an acceptable level.

- Audit in DHH restarted in Oct 20

SKIN Care (Pressure Ulcer):

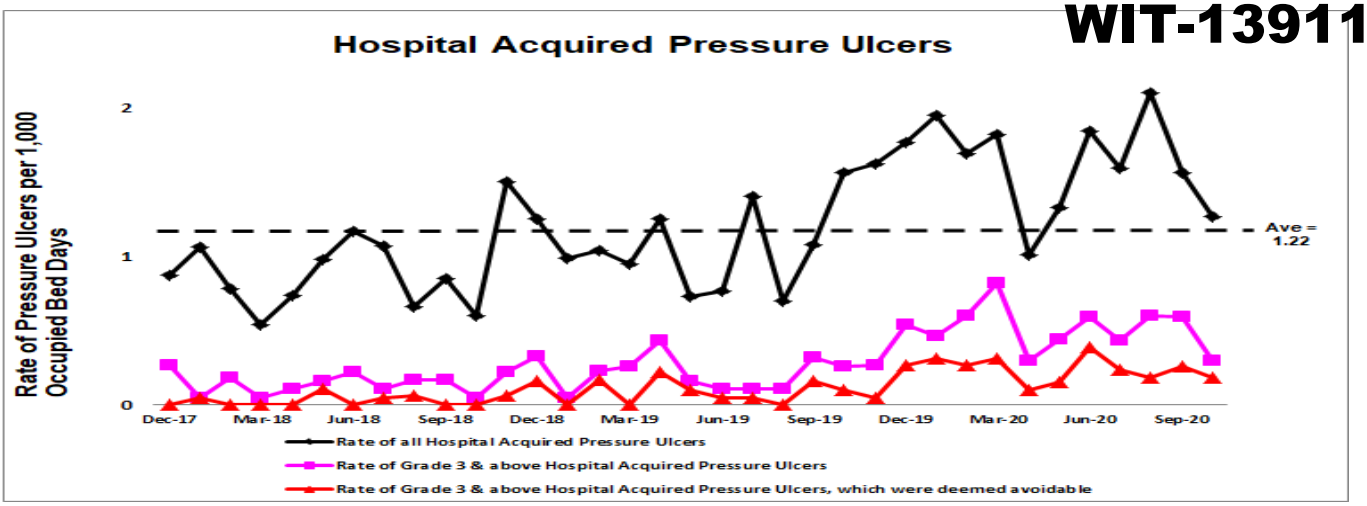
- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q2 20/21	Q1 20/21	Q4 19/20	Q3 19/20
ACUTE	84% (262/311)	Audit cancelled due to Covid-19	76% (178/233)	63% (237/378)
TRUST	85% (331/389)		81% (264/325)	70% (346/495)

- NB: Q4 19/20 data is for Jan & Feb 20 only. March audits not undertaken due to Covid-19
- Q1 20/21 Audit was cancelled by the PHA due to Covid-19
- There were **32** Hospital Acquired Pressure Ulcers reported in Nov 20. Of these, **5** were deep wounds i.e. Grade 3/4 U or DTI's, (2 South Medical (2), ED, Gynae, CAH & Ward 2 Lurgan).
- In 20/21 RCA/Post Incident Reviews have been carried out on **45** cases to date with **22** deemed to have been avoidable. This represents **11%** of all Ward Acquired Pressure Ulcers reported in 20/21. The outstanding RCA's (**9**) will be carried out in due course.

Ward Acquired Pressure Ulcers & Rate per 1,000 Occupied Bed Days 2020/21:

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL	Rate 20/21	Rate & No 19/20
CAH															
Ward 4 South	3	0	0	1	0	0	1	0					5	1.16	1.94 (25) ↓
Ward 4 North	0	1	0	0	1	1	0	1					4	0.72	0.89 (10) ↓
Ward 3 South	1	2	4	4	8	2	5	0					26	4.36	1.24 (14) ↑
Trauma Ward	1	2	2	0	0	1	1	0					7	1.42	4.64 (41) ↓
Orthopaedic Ward	0	0	2	1	0	1	0	3					7	2.73	0.62 (2) ↑
Gynae Ward	N/A	N/A	N/A	0	0	1	0	2					3	1.78	0.30 (1) ↑
ICU	2	2	2	3	0	4	2	4					19	12.86	12.12(28)↑
Ward 3 North Medicine	1	1	4	3	4	2	1	4					20	5.65	2.75 (17) ↑
Ward 3 North Stroke	0	1	1	0	0	0	0	0					2	0.57	1.49 (9) ↓
Ward 2 North	0	1	2	2	0	0	2	0					7	1.09	1.39 (17) ↓
Ward 5 Haematology	1	0	2	1	1	N/A	N/A	0					5	3.12	1.36 (6) ↑
Ward 1 South	0	0	1	3	3	0	2	1					10	1.35	2.01 (26) ↓
Ward 1 North	0	0	1	0	1	2	0	1					5	0.76	0.70 (8) ↑
AMU	1	1	0	1	3	2	1	1					10	1.67	1.52 (18) ↑
2 South Medical	0	2	2	1	3	3	1	5					17	2.45	2.10 (14) ↑
CEAW	0	0	0	0	0	0	0	1					1	0.74	N/A
Emergency Department	0	0	2	1	4	0	0	3					10	N/A	N/A
Ramone 4	N/A	N/A	N/A	N/A	N/A	N/A	1	0					1	N/A	N/A
Other Areas e.g. Recovery	0	1	0	1	0	1	1	2					6	N/A	N/A
DHH															
Male Surgical/DEAW/Resp.	0	0	0	0	0	0	0	0					0	0	0.65 (4) ↓
Female Surg/Gynae	0	1	1	0	0	0	1	0					3	0.75	0.51 (5) ↑
HDU	0	0	0	1	0	1	0	0					2	1.77	1.70 (5) ↑
Stroke/Rehab	0	0	0	0	1	1	0	1					3	0.48	0.28 (3) ↑
Male Med/CCU	0	0	0	1	0	0	1	0					2	0.32	0 (0) ↑
Female Medical	0	2	0	0	1	2	0	0					5	0.68	0.74 (9) ↓
Emergency Department	0	0	0	0	0	0	0	0					0	N/A	N/A
Lurgan															
Ward 1	0	0	0	0	3	0	0	0					3	1.28	0.65 (4) ↑
Ward 2 Stroke	0	0	1	0	1	0	0	1					3	0.97	1.26 (7) ↓
Ward 3	0	0	0	0	0	0	1	1					2	0.75	0.85 (5) ↓
STH															
Ward 1 STH	0	0	0	0	1	0	0	0					1	0.30	1.12 (7) ↓
Ward 2 STH	0	N/A	0	0	N/A	N/A	0	1					1	1.03	0.65 (4) ↑
MHLD															
Gillis	0	1	1	1	0	0	0	0					3	0.74	0.51 (3) ↑
Willows	0	0	0	0	0	0	0	0					0	0	0 (0) ↔
TOTAL	10	18	28	25	35	24	21	32					193		
RATE	1.01	1.33	1.84	1.53	2.10	1.56	1.27	1.98						1.61	1.36(301)↑



- The Trust's Monthly Hospital Acquired Pressure Ulcer Rate for Nov 20, based on **30** Wards was **1.98** (**32**/16,121) per 1,000 Occupied Bed Days up from **1.27** (**21**/16,526) per 1,000 Occupied Bed Days in Oct 20
- The Trust's 20/21 Hospital Acquired Pressure Ulcer Rate, based on **30** Wards stands at **1.61 (193)** per 1,000 Bed Days, up from **1.36 (301)** in 2019/20.

Regional Delirium Audit:

The table below shows compliance against the 3 Measures of the Delirium Bundle, for the Acute Wards, where auditing is underway. All 5 Non-Acute Wards also undertake a monthly audit.

Ward/Measure	At risk patients who have a SQiD carried out (single question in delirium)	Patients with a 4AT completed (tool to assess for delirium)	Patients with an Investigations & Management Plan completed
Trauma (Aug 20)	95% (20/20)	83% (5/6)	60% (3/5)
1 North (Nov 20)	100% (20/20)	100% (4/4)	100% (2/2)
3 North Med (Nov 20)	100% (20/20)	100% (5/5)	100% (4/4)
3 South (Oct 20)	88% (14/16)	100% (5/5)	75% (3/4)
4 North (Oct 20)	90% (18/20)	100% (1/1)	N/A (0/0)
4 South (Sept 20)	100% (14/14)	100% (3/3)	100% (3/3)
Stroke/Rehab (Nov20)	100% (17/17)	100% (8/8)	N/A (0/0)
Female Surg. (Oct 20)	100% (20/20)	100% (3/3)	100% (3/3)

- Ward's in black audits suspended due to Covid-19

Patient Falls:

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q2 20/21	Q1 20/21	Q4 19/20	Q3 19/20
Acute Bundle A Compliance	86% (401/467)	Audit cancelled due to Covid-19	79% (310/392)	77% (474/618)
Trust Bundle A Compliance	87% (512/587)		82% (402/492)	79% (613/773)

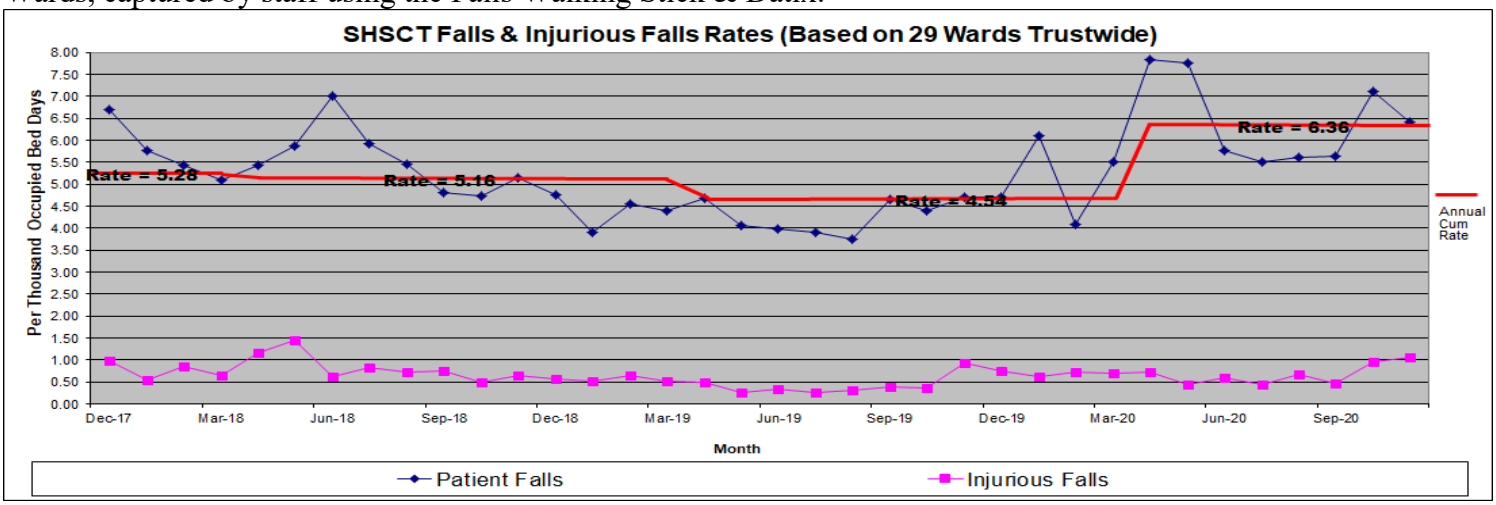
Quarter	Q2 20/21	Q1 20/21	Q4 19/20	Q3 19/20
Acute Bundle B Compliance	83% (340/411)	Audit cancelled due to Covid-19	77% (249/323)	69% (346/503)
Trust Bundle B Compliance	84% (444/526)		81% (341/421)	74% (482/653)

- NB: Q4 19/20 data is for Jan & Feb 20 only. March audits not undertaken due to Covid-19
- Q1 20/21 Audit was cancelled by the PHA due to Covid-19

The table below gives details of individual Ward's Falls Numbers & Fall Rate 20/21

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL	Rate 20/21	Rate 19/20
CAH															
Ward 4 South	2	0	0	3	2	2	2	2					13	3.03	2.88 (37) ↑
Ward 4 North	3	3	3	4	7	5	2	1					28	5.06	2.22 (25) ↑
Ward 3 South	10	5	7	8	3	7	6	6					52	8.73	3.73 (42) ↑
Trauma Ward	4	4	3	4	8	3	0	10					36	7.28	5.77 (51) ↑
Orthopaedic Ward	4	5	1	5	0	0	8	3					26	10.15	3.08 (10) ↑
Gynae Ward	N/A	N/A	N/A	0	0	1	2	2					5	2.97	1.79 (6) ↑
Ward 3 North Medicine	2	5	4	4	7	4	5	3					34	9.61	8.26 (51) ↑
Ward 3 North Stroke	1	3	5	6	1	1	4	4					25	7.12	6.94 (42) ↑
Ward 2 North	4	7	3	2	3	5	1	2					27	4.20	3.36 (41) ↑
Haematology Ward	1	0	0	1	0	N/A	N/A	0					2	1.25	4.75 (21) ↓
Ward 1 South	5	9	4	2	3	4	11	4					42	5.65	3.55 (46) ↑
Ward 1 North	1	2	1	2	6	3	3	5					23	3.48	3.59 (41) ↓
AMU	2	5	9	8	3	6	16	7					56	9.38	9.40 (111) ↓
2 South Medicine	0	3	10	2	3	12	8	6					44	6.35	3.91 (26) ↑
CEAW	N/A	N/A	0	0	0	0	0	0					0	0	N/A
Ramone 4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2					2	N/A	N/A
DHH															
Male Surgical/Resp	3	0	0	0	0	0	0	1					4	3.64	2.76 (17) ↑
Female Surg/Gynae	0	0	0	2	0	2	2	0					6	1.49	2.67 (26) ↓
HDU	0	0	1	0	0	0	0	0					1	0.89	2.72 (8) ↓
Stroke/Rehab	4	2	6	5	2	3	5	7					34	5.43	4.73 (50) ↑
Male Med/CCU	4	16	11	12	8	3	4	2					60	9.63	4.76 (56) ↑
Female Medical	2	7	6	3	7	8	7	7					47	6.43	4.34 (53) ↑
Lurgan															
Ward 1	0	6	2	3	3	2	3	7					26	11.09	3.08 (19) ↑
Ward 2 Stroke	3	3	2	0	0	3	1	1					13	4.22	3.61 (20) ↑
Ward 3	3	2	1	1	0	1	2	1					11	4.12	3.57 (21) ↑
STH															
Ward 1 STH	2	0	1	1	3	1	1	0					9	2.67	1.44 (9) ↑
Ward 2 STH	0	N/A	0	0	N/A	N/A	0	1					1	1.03	2.28 (14) ↓
MHLD															
Gillis	12	4	2	6	7	5	12	8					56	13.86	14.24 (83) ↓
Willows	4	13	5	5	16	3	5	5					56	11.33	9.47 (69) ↑
TOTAL	76	104	87	89	92	84	110	97					739		
RATE	7.84	7.77	5.77	5.52	5.61	5.64	7.12	6.42						6.36	4.54 (995) ↑

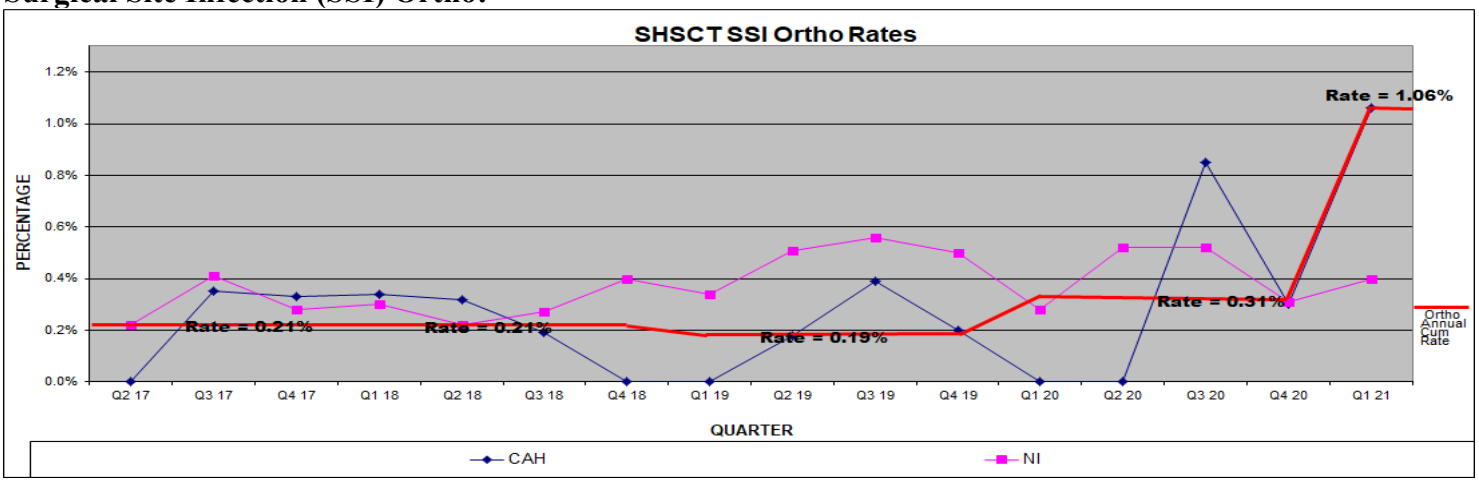
The Run Chart below shows Patient Falls & Injurious Falls Rates per 1,000 Occupied Bed Days based on 28 Wards, captured by staff using the Falls Walking Stick & Datix.



- Falls Rate **6.42** (**97**/15,116 Occupied Bed Days) down from **7.12** (**110**/15,460) in Oct 20
- Injurious Falls Rate **1.06** (**16**/15,116 Occupied Bed Days) up from **0.97** (**15**/15,460) in Oct 20
- Cumulative Falls Rate for 20/21 stands at **6.36**, compared to **4.54** in 19/20

Patient Safety Report for Acute Governance Meeting Aug 2021

Surgical Site Infection (SSI) Ortho:



- Q1 2021 SSI Rates have been released by the PHA. CAH Rate was **1.06%** (3/282 procedures). NI Rate was **0.40%** (6/1,516 procedures). CAH Rate (last 8 quarters i.e. Q2 2019 → Q1 2021) was **0.35%** (11/3,139). NI Rate (last 8 quarters i.e. Q2 2019 → Q1 2021) was **0.46%** (79/17,326).
- The Cumulative Rate for 2021 stands at **1.06%**, up from **0.31%** in 2020
- Due to the elevation of the SSI Rate in Q1 2021the Annual SSI Audit, which was due to be undertaken in Sept 21 will be brought forward to Aug 21. Results will be shared in due course

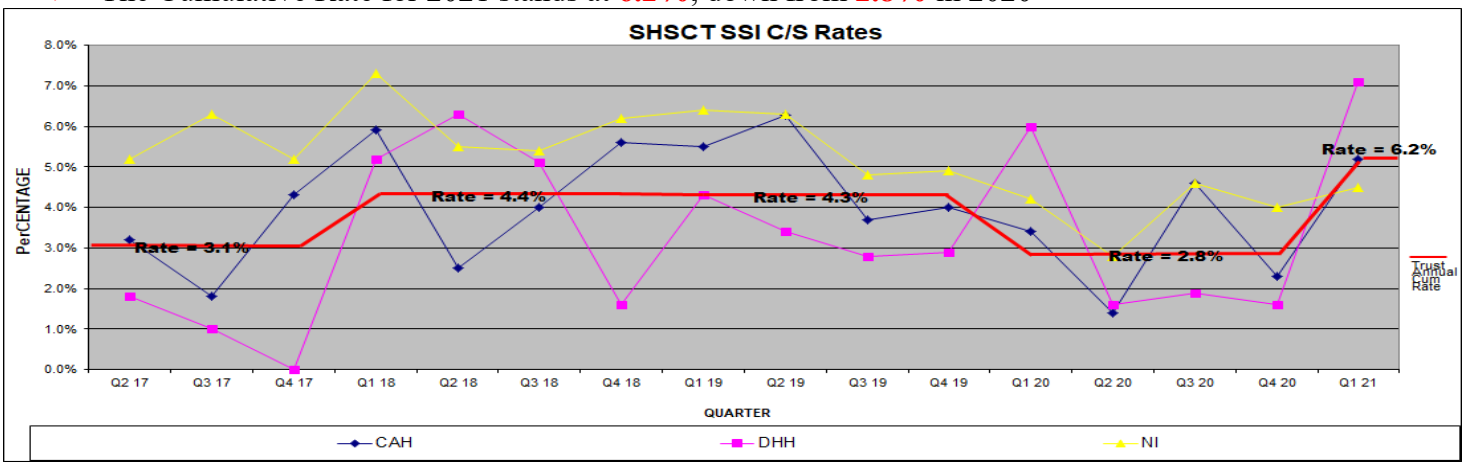
Surgical Site Infection (SSI) C/Section:

- Q1 2021 SSI rates have been released by the PHA. A summary of the data is as follows:

SSI Rates:
CAH **5.15%** (**10**) up from **2.26%** (**4**) in Q420
DHH **7.11%** (**15**) up from **1.64%** (**3**) in Q420
TRUST **6.17%** (**25**) up from **1.94%** (**7**) in Q420
NI Average **4.52%** (**70**) up from **3.97%** (**59**) in Q420

Surveillance Forms Returned to the PHA:
CAH **82.2%** down from **86.8%** in Q420
DHH **91.3%** up from **90.6%** in Q420
TRUST **86.7%** down from **88.7%** in Q420
NI Average **85.7** up from **85.2%** in Q420

- CAH SSI Rate above the NI Average for the 1st time since Q4 20
- DHH SSI Rate above the NI Average for the 1st time since Q1 20
- Trust's SSI Rate above the NI Average for the 1st time since Q1 20
- Of the **8** Units in NI, DHH had the highest SSI Rate in Q1 20 (had lowest SSI Rate in Q4 20), with CAH the **4nd** highest (has 2nd lowest SSI Rate in Q4 20)
- The Cumulative Rate for 2021 stands at **6.2%**, down from **2.8%** in 2020



- The quarterly SSI C/Section Audits took place in June 2021

Overall Bundle Compliance at CAH **60%** (12/20 patients audited), down from **85%** in March 21

Non-compliant elements:

- Appropriate use of Antibiotics – In 6 of 20 cases audit antibiotics were not given prior to the administration of anaesthesia, with no contraindication documented

- Glucose Control (Diabetic patients only) – In 2 of 6 cases audited the mother's Serum Glucose Level was not measured/recorded/monitored Day 1 post C/Section.

- Mary Dawson has raised the issue of antibiotics being administered after spinal with Alison Blair

Overall Bundle Compliance at DHH **80%** (16/20 patients audited) – down from **95%** in Mar 21

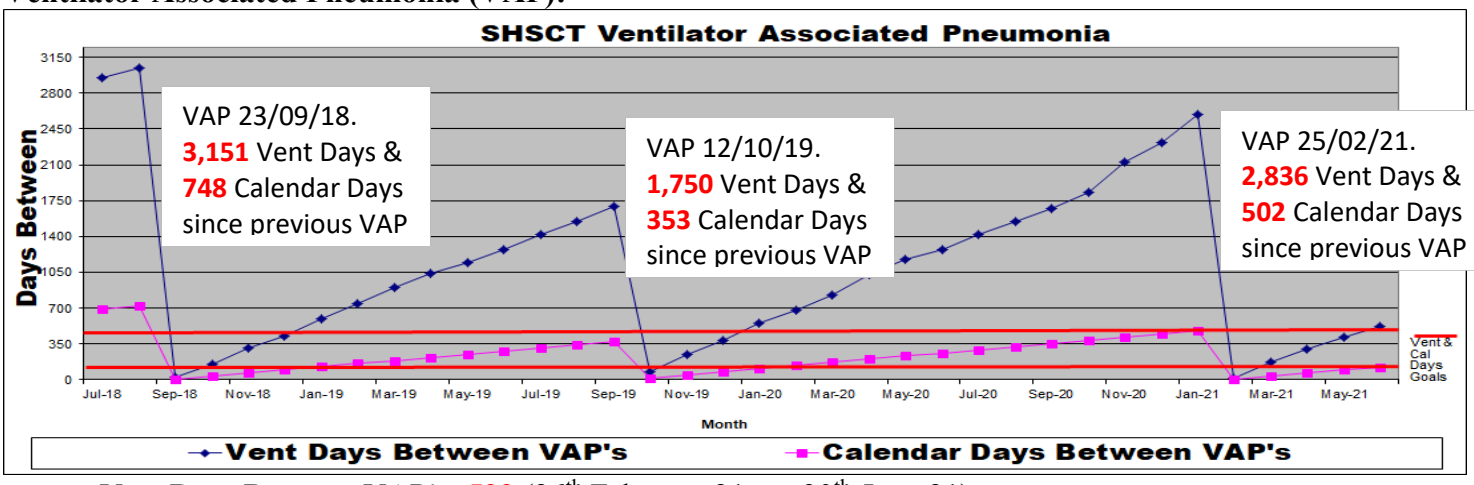
Non-compliant elements:

- Appropriate use of Antibiotics – In 1 of 20 cases audit antibiotics were not given prior to the administration of anaesthesia, with no contraindication documented

- Appropriate Hair Removal - In 3 of 20 cases audited the method of hair removal was inappropriate or not recorded & there was no evidence in the mother's chart that she had received a copy of the Trust's Information leaflet, which addresses same.

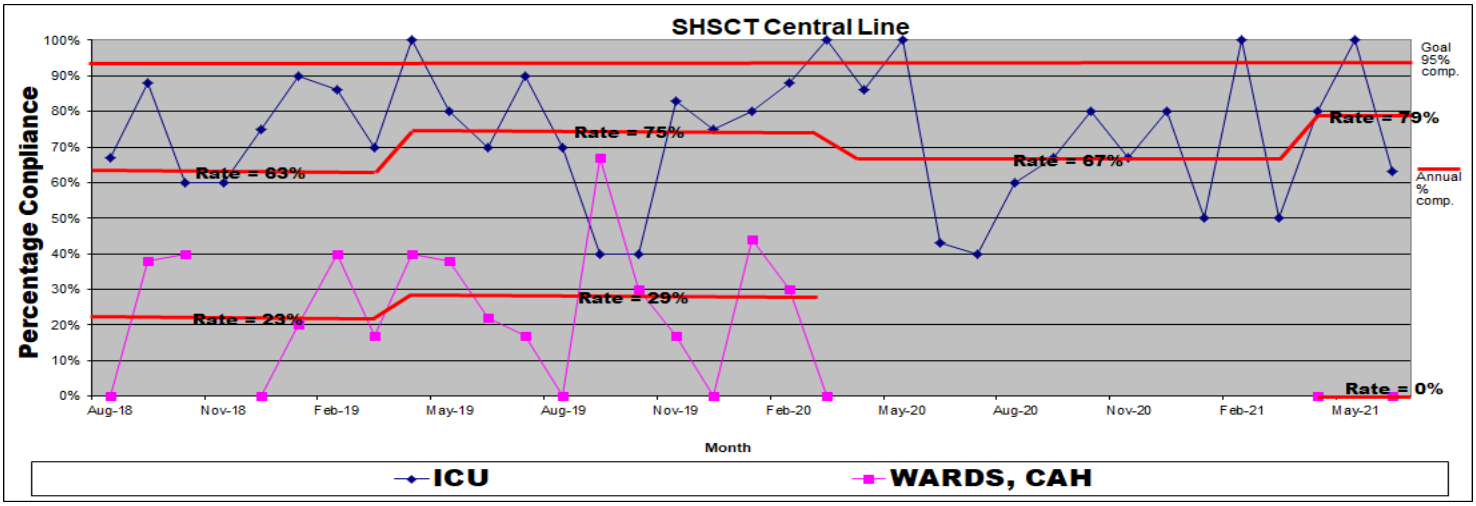
- The next quarterly Audits will take place in Sept 2021

Ventilator Associated Pneumonia (VAP):



- Vent Days Between VAP's **522** (26th February 21 → 30th June 21)
- Calendar Days Between VAP's **125** (26th February 21 → 30th June 21)

Central Line:



Overall Bundle Compliance June 21, ICU **63%** (5/8 cases audited), down from **100%** (6/6 cases audited) in May21
Cumulative Compliance 21/22 stands at **79%**, up from **67%** in 20/21

- Non-Compliant Cases:
  - In 2 of 8 cases audited the method of Hand Hygiene used was inappropriate
  - In 1 of 8 cases audited a Small drape was used

Overall Bundle Compliance June 21, Wards, CAH **0%** (0/9 cases audited)
Cumulative Compliance 21/22 stands at **0%**, down from **29%** in 19/20 (audit not undertaken 20/21 due to Covid)

- Non-Compliant Cases:
  - In 2 of 9 cases audited the Central Line Insertion Form was not completed, therefore there was no record of method of Hand Hygiene, Skin Prep., & size of drape used & no contraindication documented when the subclavian site was not used.
  - In all 9 cases the Jugular was used with no contraindication documented as to why the subclavian site was not used.
  - In 4 of 9 cases audited there were gaps in the monitoring of the Daily Review of the Line (1 case 6 days missed, 1 case 4 days missed, 1 case 3 days missed & 1 case 1 day missed)
- Results shared with Lead Clinician, Lead Nurse & Wards for this QI work to address areas of non-compliance. Dr. Chris Clarke has also agreed to review the evidence in respect of the use of the Subclavian in preference to the Jugular

NEWS:

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q1 21/22	Q4 20/21	Q3 20/21	Q2 20/21
ACUTE	91% (619/682)	95% (365/384)	94% (422/451)	92% (428/463)
TRUST	91% (767/842)	93% (494/531)	93% (554/596)	93% (541/584)

MUST (Malnutrition Universal Screening Tool):

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q1 21/22	Q4 20/21	Q3 20/21	Q2 20/21
ACUTE	91% (558/614)	89% (317/356)	90% (365/406)	88% (404/458)
TRUST	91% (702/770)	91% (453/498)	92% (502/548)	90% (521/578)

Critical Medicines Omitted:

The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

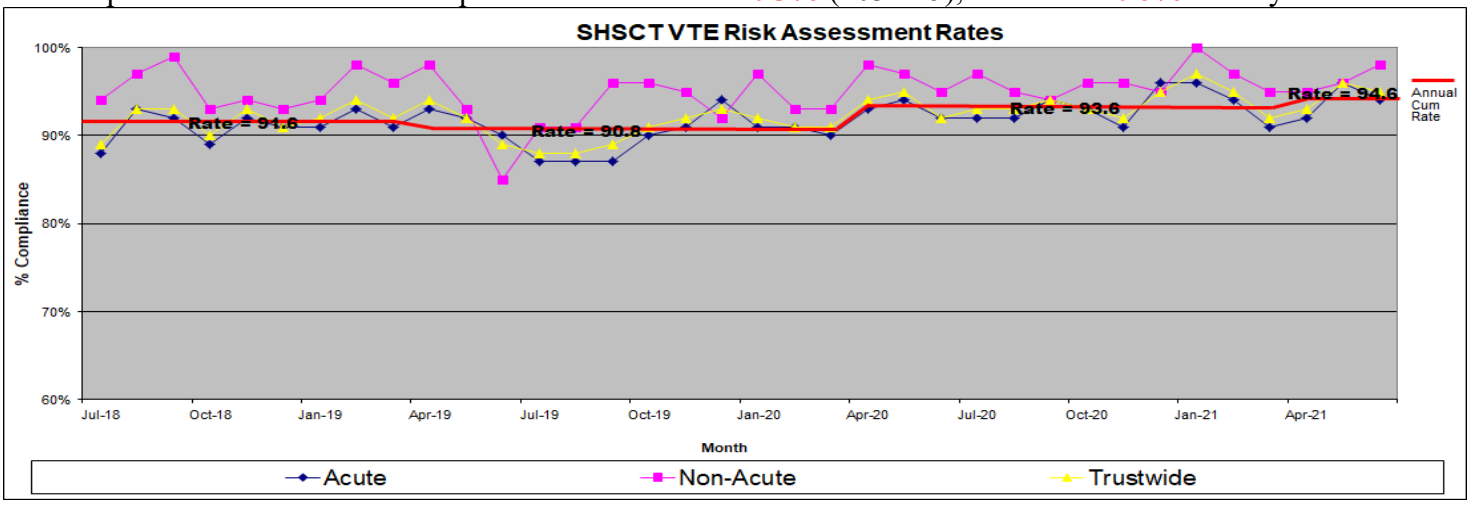
Quarter	Q1 21/22	Q4 20/21	Q3 20/21	Q2 20/21
ACUTE	1 (615)	1 (357)	1 (405)	2 (461)
TRUST	2 (775)	1 (500)	4 (549)	2 (582)

June 21 (Week Commencing 07/06/21 → Week Commencing 28/06/21)							
Division	**Site**	**Ward**	**Number of Weekly Audits not done**	**Charts with Fully Completed VTE Risk Assessment**	**Number of Charts Audited**	**Monthly Percentage Compliance**	**Quarter 1 21/22 Percentage Compliance**
S&EC	CAH	3 South	0	18	18	100% ↑	95% ↑
		4 North CESW	0	20	20	100% ↑	92% ↓
		4 South	0	16	17	94% ↓	95% ↑
		Elective Adm.	0	20	20	100% ↔	95% ↑
		Orthopaedic	0	16	19	84% ↓	90% ↓
		Trauma	0	19	19	100% ↔	100% ↑
	DHH	F/male Surg.	0	18	18	100% ↔	100% ↑
		MSW/HDU	N/A	N/A	N/A	N/A	N/A
M&UC	CAH	1 South	1	13	15	87% ↑	85% ↓
		1 North	0	16	20	80% ↓	86% ↓
		2 North Resp.	0	6	6	100% ↔	95% ↓
		Haematology	1	8	8	100% ↔	100% ↑
		3 North	0	15	17	88% ↓	93% ↓
		2 North Med	0	18	20	80% ↓	86% ↓
		AMU	0	19	20	95% ↓	97% ↑
		Frailty Ward	0	17	17	100% ↔	100% ↑
	DHH	F/male Med.	0	18	20	90% ↓	97% ↓
		CCC/MMW	0	17	18	94% ↑	92% ↓
		Stroke/Rehab	0	18	18	100% ↔	97% ↑
		Respiratory L3	0	20	20	100% ↔	97% ↓
IMWH	CAH	Gynae	1	9	11	82% ↓	90% ↔
TOTAL			3 ↓ (10)	321	341	94.1% ↓	94.1% ↑

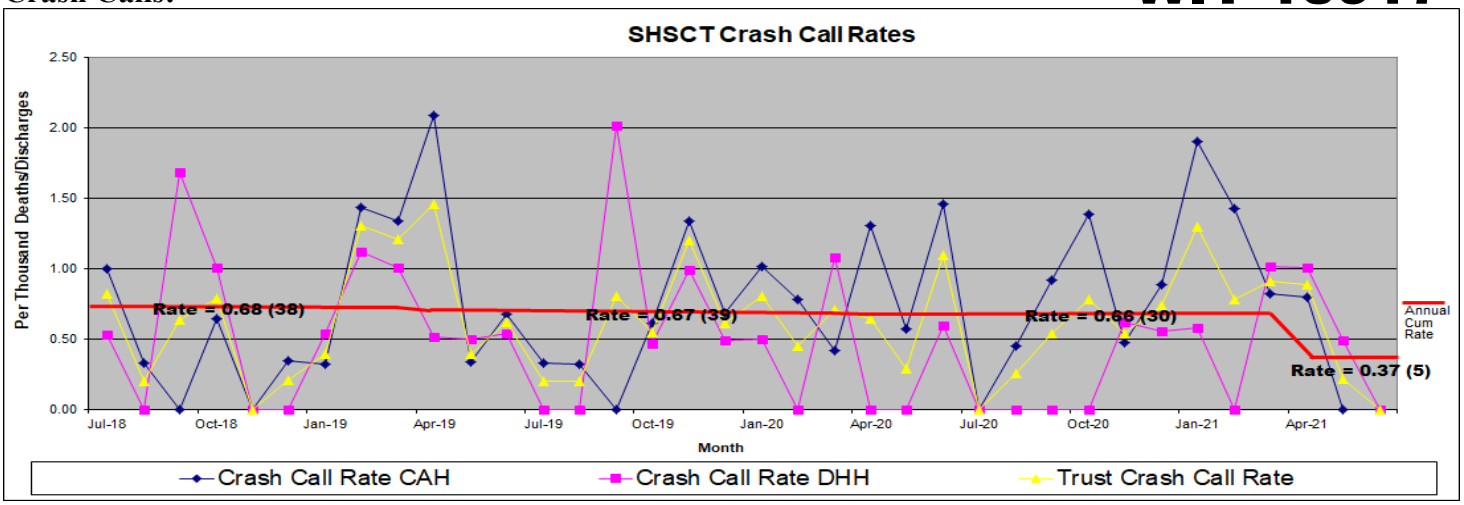
Key: Red – Under 85% compliance, Amber – Compliance between 85% & 94%, Green – Above 95% (Reg. target)

- In summary Overall Compliance with fully completed Risk Assessment on the Acute Wards was **94.1%** (321/341 charts audited) down from **95.9%** (372/388 charts audited) in May 21
- Total number of weekly audits not completed in June 21 was **3** down from 10 in May 21

The Run Chart below shows compliance against the Commissioning Plan target of **95%** compliance. The Trust Compliance includes the Non-Acute Wards & therefore their compliance has been included also for comparison. Trust Overall Compliance in June 21 was **95%** (403/425), down from **96%** in May 21



Crash Calls:

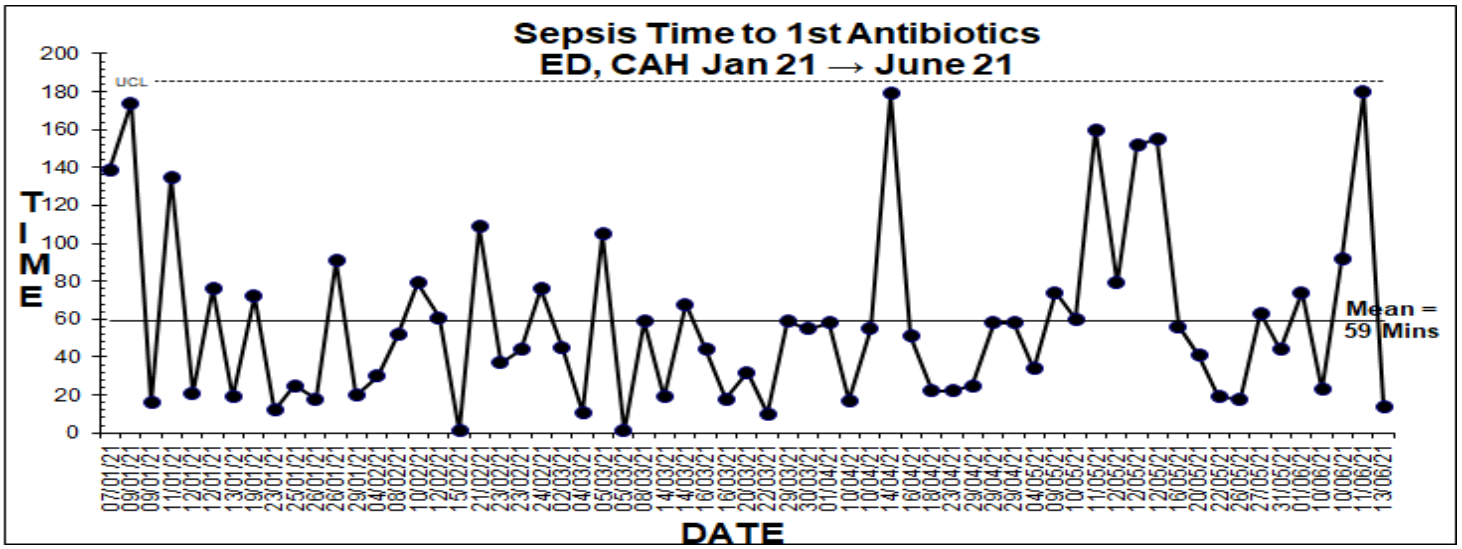


- CAH Rate **0** per 1,000 deaths/discharges (**0** Crash Calls) same as May 21
- DHH Rate **0** per 1,000 deaths/discharges (**0** Crash Calls) down from **0.49** (**1** Crash Call) in May 21
- Trust Rate **0** per 1,000 deaths/discharges (**0** Crash Calls) down from **0.22** (**1** Crash Call) in May 21
- Trust cumulative Crash Call Rate for 21/22 stands at **0.37 (5)** per 1,000 deaths/discharges, down from **0.66 (30)** in 20/21

Emergency Care QI Work: Sepsis 6 CAH & DHH:

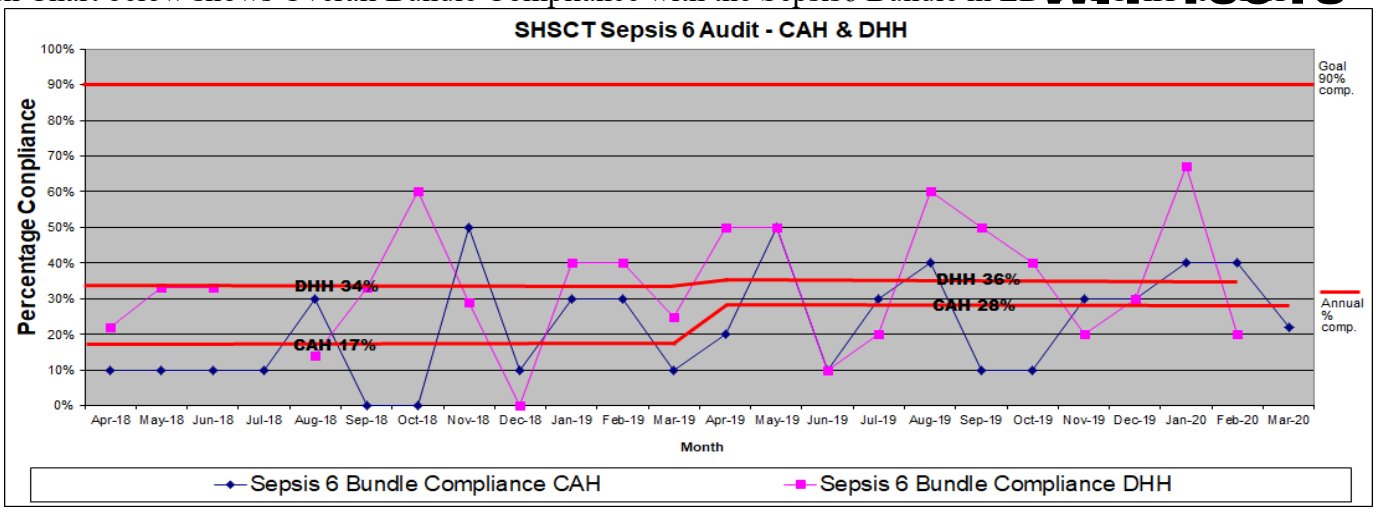
- The new Regional Sepsis QI initiative has been ongoing from Oct 19. The Regional Agreed aim is to improve the time to 1st antibiotics "In Hours" i.e. Mon → Fri 9:00am → 5:00pm. Work is underway in 3 Pilot Areas ED, CAH, (Oct 19 – Dr. Suzie Budd, Clinical Lead), AMU, CAH (Dec 19 – Dr. Emily Hannah, Clinical Lead) & ED, DHH (14th Jan 20 – Dr. Laura Lavery, Clinical Lead). In the ED's of CAH & DHH it was decided to measure compliance 24/7.

The Run Chart below shows progress made in ED, CAH



- June 21 compliance in-hours was **0%** (0/2 cases audited), same as May 21. Cases outside target timeframe were **74** mins & **92** mins.
- June 21 compliance out-of-hours was **67%** (2/3 cases audited), up from **58%** (7/12 cases audited) in May 21. Case outside target timeframe was **180** mins
- June 21 data subject to change due to delay in Coding
- Mean Time Jan 21 → June 21 = **59** mins, within Regional target timeframe of **60** minutes.
- In 2020 Mean Time = **76** minutes
- Auditing in ED, DHH & AMU have been suspended due to Covid-19

The Run Chart below shows Overall Bundle Compliance with the Sepsis6 Bundle in ED for CAH & DHH

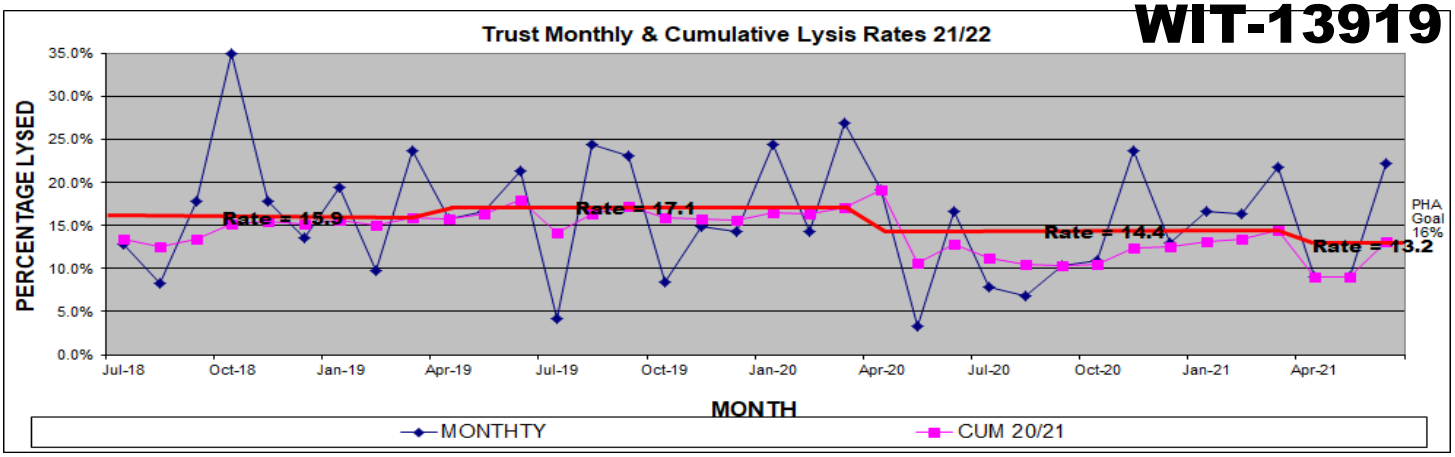


- Auditing has been suspended due to Covid-19

Stroke Collaborative:

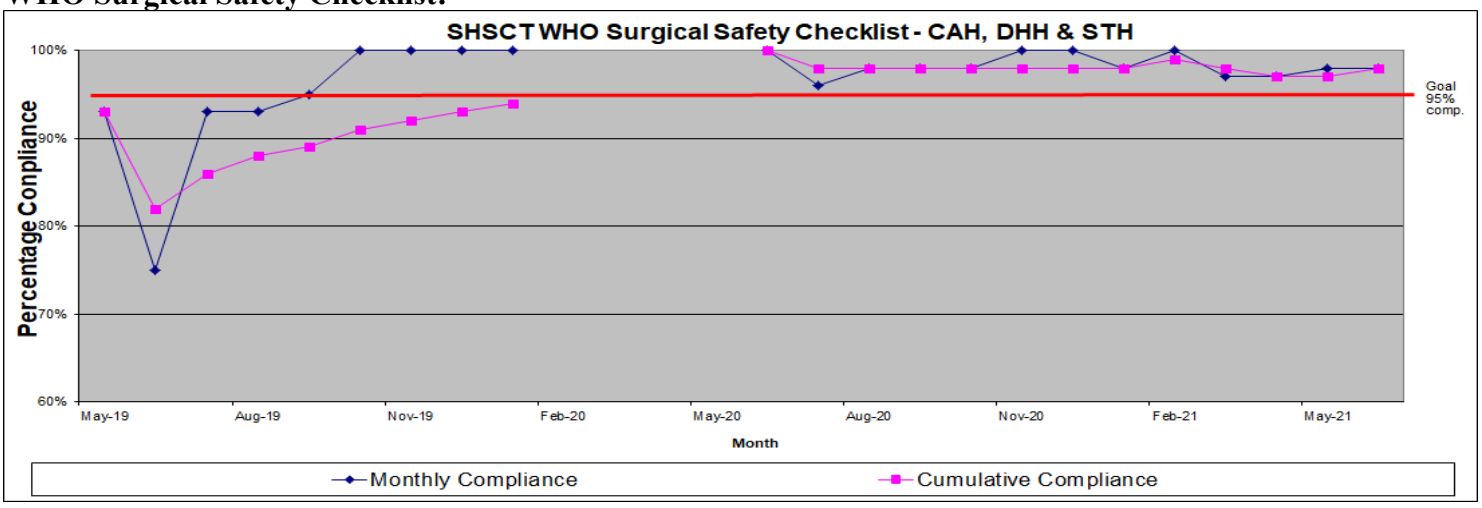
- Regional agreement to collect data on the following, however only Lysis Data will be reported to the PHA/DHSSPS on a quarterly basis:

	CAH		DHH		TRUST		
Measure		**Jun 21**		**Jun 21**		**Jun 21**	**Commentary Jun 21**
Patients who are potentially eligible for thrombolysis are assessed by Acute Stroke Team within 30 minutes of arrival	19/20 99% 20/21 100%	**100% (49/49)**	19/20 99% 20/21 100%	**100% (36/36)**	19/20 99% 20/21 100%	**100% (85/85)**	-
Patients who are potentially eligible for thrombolysis receive CT scan within 45 minutes	19/20 99% 20/21 100%	**100% (26/26)**	19/20 98% 20/21 98%	**100% (31/31)**	19/20 99% 20/21 99%	**100% (57/57)**	-
Patients deemed suitable for thrombolysis receive first bolus within 60 minutes	19/20 78% 20/21 90%	**86% (6/7)**	19/20 75% 20/21 73%	**100% (3/3)**	19/20 77% 20/21 86%	**90% (9/10)**	CAH: Patient presented out-of-hours. Outside target timeframe by 14 mins. Reason for delay – Consultant not contacted until after patient had CT Scan
Patients transferred to Hyper Acute Stroke Unit (or appropriate environment) within 90 mins	19/20 98% 20/21 100%	**100% (7/7)**	19/20 96% 20/21 93%	**100% (3/3)**	19/20 98% 20/21 98%	**100% (10/10)**	-
	CAH		**DHH**		**TRUST**		**AIM 20/21 (Based on Commissioning Plan) To ensure that the proportion of thrombolysis administration 16% 21/22 not known yet**
Outcome Measure	**2019/20**	**Jun 21**	**2019/20**	**Jun 21**	**2019/20**	**Jun 21**	
Monthly Thrombolysis Rate		**13.5% (7/31)**		**21.4% (3/14)**		**21.2% (10/45)**	
Thrombolysis Rate (Yearly)	17.6% (58/329)	**13.6% (14/104)**	16.1% (28/174)	**12.5% (5/40)**	15.9% (69/435)	**13.2% (19/144)**	



The above is "Real Time" data, which is subject to change. The Directorate of Performance & Reform is responsible for reporting to the RHSCB. From the above table only the lysis rates are reported. Furthermore their report is 3 months in arrears to allow Clinical Coding to reach an acceptable level.

WHO Surgical Safety Checklist:



- The Monthly Audits were reinstated in May 19 & were suspended Feb → May 20 due to Covid-19
- June 21 Compliance **98%** (59/60), same as May 21, Cumulative Compliance 21/22 stands at **98%**

SKIN Care (Pressure Ulcer):

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

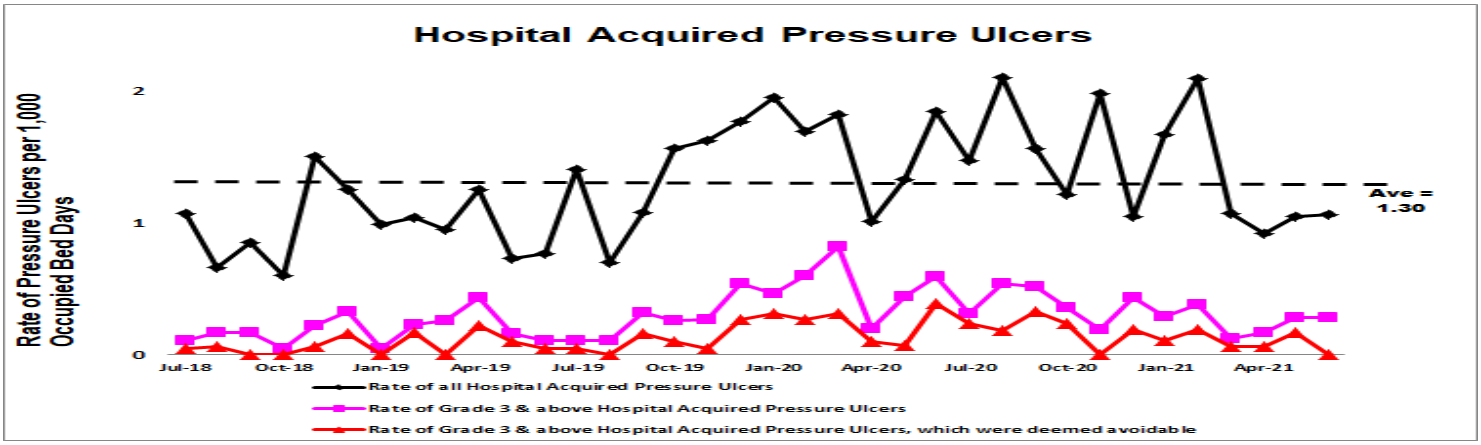
Quarter	Q1 21/22	Q4 20/21	Q3 20/21	Q2 20/21
ACUTE	83% (320/386)	85% (194/227)	88% (224/256)	84% (262/311)
TRUST	84% (420/499)	89% (294/331)	89% (324/366)	85% (331/389)

- There were **19** Hospital Acquired Pressure Ulcers reported in June 21. Of these, **5** were Grade 3/4 U or DTI's, (AMU, Gynae, 3 South & 4 South, CAH & Ward 2 Lurgan)

- In 21/22 Post Incident Reviews have been carried out on **9** cases to date with **4** deemed to have been avoidable. This represents **8%** of all Ward Acquired Pressure Ulcers reported in 21/22, down from **11%** in 20/21. The outstanding Post Incident Reviews (**4**) will be carried out in due course.

Ward Acquired Pressure Ulcers & Rate per 1,000 Occupied Bed Days 2021/22

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL	Rate 21/22	Rate & No 20/21
CAH															
Ward 4 South	1	2	1										4	1.34	1.16 (9) ↑
Ward 4 North	0	2	0										2	0.68	0.71 (6) ↓
Ward 3 South	3	2	3										8	2.70	3.50 (32) ↑
Trauma Ward	1	1	0										2	1.00	1.66 (12) ↓
Orthopaedic Ward	0	0	0										0	0	2.81 (13) ↓
Gynae Ward	0	2	2										4	5.38	1.84 (5) ↑
ICU	3	2	3										8	17.20	15.14(41) ↑
Ward 3 North Medicine	1	2	0										3	2.13	4.69 (24) ↓
Ward 3 North Stroke	1	0	0										1	0.67	0.77 (4) ↓
Ward 2 North	0	1	1										2	1.73	1.28 (12) ↑
Ward 5 Haematology	0	0	1										1	1.51	2.49 (6) ↓
Ward 1 South	0	2	0										2	0.63	1.19 (13) ↓
Ward 1 North	0	1	1										2	0.75	0.63 (6) ↑
AMU	0	1	1										2	0.81	1.07 (10) ↓
2 South Medical	1	0	1										2	0.65	1.90 (20) ↓
CEAW	0	0	0										0	0	0.95 (2) ↓
Emergency Department	0	0	1										1	N/A	N/A (16)
Ramone 4	2	0	0										2	1.52	1.24 (3) ↑
Other Areas e.g. Recovery	0	0	0										0	N/A	N/A (8)
DHH															
Male Surgical/DEAW/Resp.	0	0	1										1	0.83	0.60 (2) ↑
Female Surg/Gynae	0	0	0										0	0	0.67 (4) ↓
HDU	0	0	1										1	1.56	1.91 (4) ↓
Stroke/Rehab	0	0	0										0	0	0.43 (4) ↓
Male Med/CCU	0	0	0										0	0	0.31 (3) ↓
Female Medical	2	0	0										2	0.60	0.73 (8) ↓
Emergency Department	0	0	0										0	N/A	N/A (1)
Lurgan															
Ward 1	1	0	0										1	0.90	0.80 (3) ↑
Ward 2 Stroke	0	0	1										1	0.71	0.41 (2) ↑
Ward 3	0	0	0										0	0	0.69 (3) ↓
STH															
Ward 1 STH	0	0	0										0	0	1.21 (6) ↓
Ward 2 STH	0	1	1										2	1.59	0.42 (1) ↑
MHLD															
Gillis	0	0	0										0	0	0.91 (5) ↓
Willows	0	0	0										0	0	0 (0) ↔
TOTAL	16	19	19										54		
RATE	0.92	1.05	1.06											1.01	1.55 (288)↓



- The Trust's Monthly Hospital Acquired Pressure Ulcer Rate for June 21, based on **30** Wards was **1.06** (**19**/18,008) per 1, 000 Occupied Bed Days down up **1.05** (**19**/18,048) per 1,000 Occupied Bed Days in May 21

- The Trust's 21/22 Hospital Acquired Pressure Ulcer Rate, based on **30** Wards stated at **1.61 (54)** per 1,000 Bed Days, down from **1.55 (288)** in 2020/21.

Patient Falls:

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

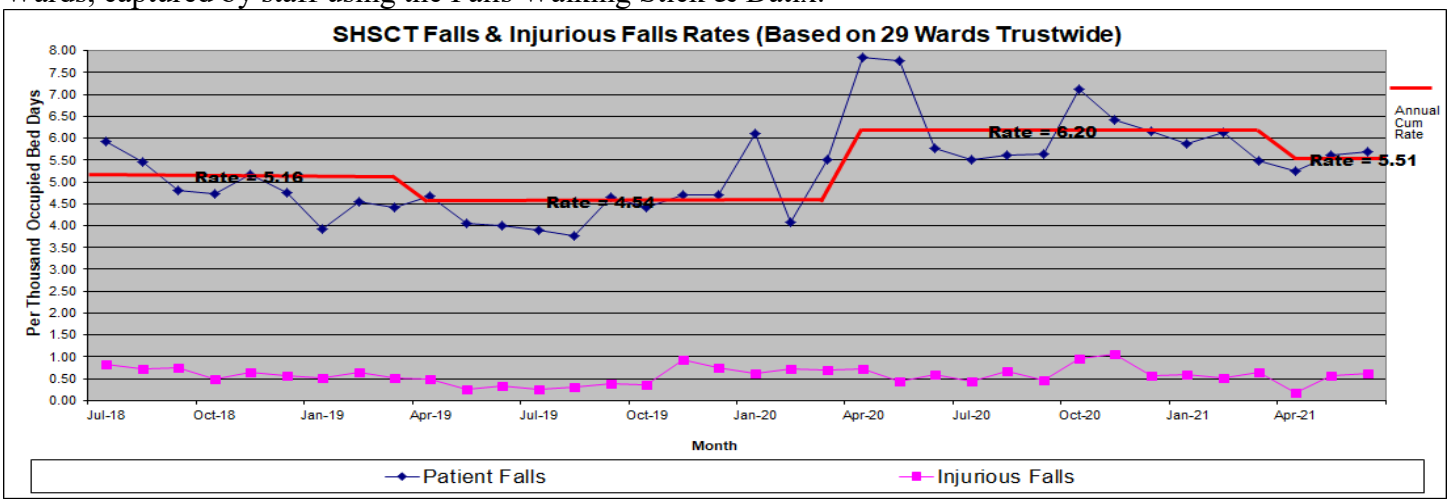
Quarter	Q1 21/22	Q4 20/21	Q3 20/21	Q2 20/21
Acute Bundle A Compliance	80% (498/619)	82% (291/355)	79% (321/405)	86% (401/467)
Trust Bundle A Compliance	83% (643/778)	84% (420/500)	81% (445/550)	87% (512/587)

Quarter	Q1 21/22	Q4 20/21	Q3 20/21	Q2 20/21
Acute Bundle B Compliance	81% (434/534)	79% (236/300)	82% (289/352)	83% (340/411)
Trust Bundle B Compliance	84% (578/688)	82% (359/437)	83% (412/495)	84% (444/526)

The table below gives details of individual Ward's Falls Numbers & Falls Rate 21/22:

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL	Rate 21/22	Rate 20/21
CAH															
Ward 4 South	0	2	2										4	1.34	2.32 (18) ↓
Ward 4 North	3	2	3										8	2.74	5.06 (43) ↓
Ward 3 South	9	3	9										21	7.08	8.10 (74) ↓
Trauma Ward	7	2	5										14	7.03	7.59 (55) ↓
Orthopaedic Ward	2	1	2										5	4.63	11.01 (51) ↓
Gynae Ward	0	2	3										5	6.73	4.42 (12) ↑
Ward 3 North Medicine	2	3	1										6	4.26	11.32 (58) ↓
Ward 3 North Stroke	1	2	1										4	2.66	7.46 (39) ↓
Ward 2 North	0	1	4										5	4.13	4.25 (40) ↓
Haematology Ward	1	0	0										1	1.51	2.49 (6) ↓
Ward 1 South	5	6	11										22	6.97	5.15 (56) ↑
Ward 1 North	1	1	3										5	1.87	2.82 (27) ↓
AMU	5	5	5										15	6.05	10.28 (96) ↓
2 South Medicine	7	2	2										11	3.57	5.69 (60) ↓
CEAW	0	0	0										0	0	0.48 (1) ↓
Ramone 4	3	5	2										10	7.60	6.19 (15) ↑
DHH															
Male Surgical/Resp	2	3	4										9	7.44	3.62 (12) ↑
Female Surg/Gynae	2	5	1										8	5.56	1.67 (10) ↑
HDU	1	1	0										2	3.12	1.91 (4) ↑
Stroke/Rehab	6	6	5										17	6.83	5.09 (47) ↑
Male Med/CCU	5	6	2										13	4.42	8.38 (82) ↓
Female Medical	6	9	10										25	7.44	6.38 (70) ↑
Lurgan															
Ward 1	1	3	2										6	5.42	9.02 (34) ↓
Ward 2 Stroke	1	4	1										6	4.27	4.46 (22) ↓
Ward 3	0	5	1										6	4.62	3.94 (17) ↑
STH															
Ward 1 STH	0	0	0										0	0	3.03 (15) ↓
Ward 2 STH	2	1	0										3	2.39	3.33 (8) ↓
MHLD															
Gillis	13	8	10										31	30.94	14.02 (77) ↑
Willows	4	12	12										28	15.63	9.84 (71) ↑
TOTAL	89	100	101										290		
RATE	5.23	5.62	5.68											5.51	6.20 (1120) ↓

The Run Chart below shows Patient Falls & Injurious Falls Rates per 1,000 Occupied Bed Days, based on 29 Wards, captured by staff using the Falls Walking Stick & Datix.



- Falls Rate **5.68** (**101**/17,777 Occupied Bed Days) up from **5.62** (**100**/17,799) in May 21
- Injurious Falls Rate **0.62** (**11**/17,777 Occupied Bed Days) up from **0.56** (**10**/17,799) in May 21
- Cumulative Falls Rate for 20/21 stands at **5.51**, compared to **6.20** in 20/21

Regional Delirium Audit:

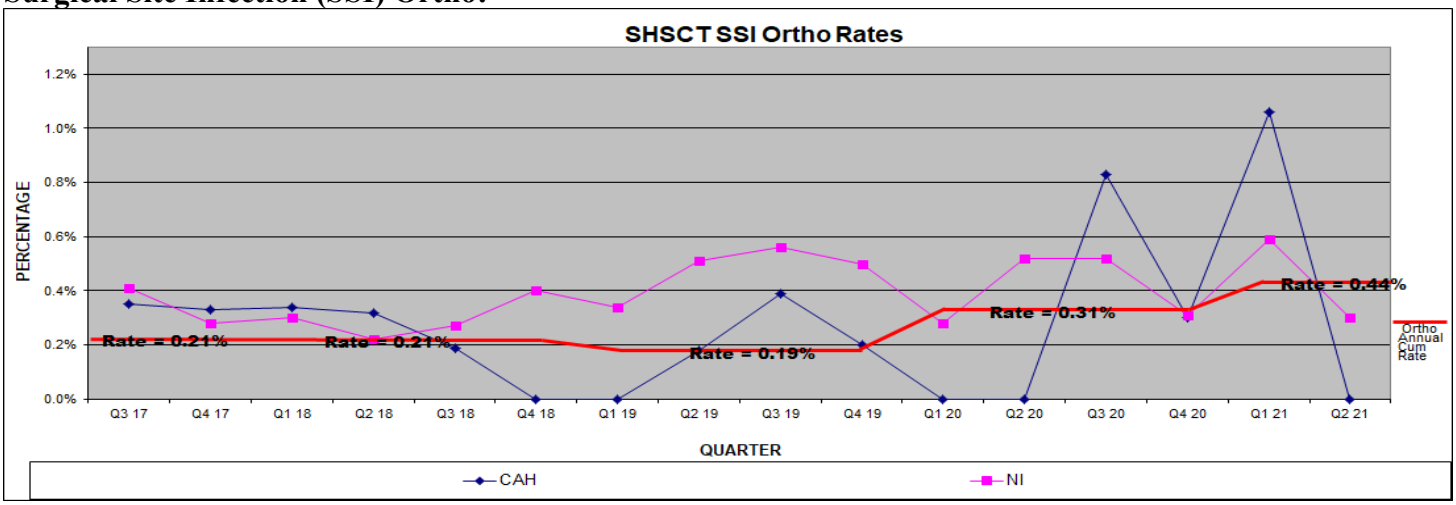
The table below shows compliance against the 3 Measures of the Delirium Bundle, for the Acute Wards, where auditing is underway. All 5 Non-Acute Wards also undertake a monthly audit.

Ward/Measure	At risk patients who have a SQiD carried out (single question in delirium)	Patients with a 4AT completed (tool to assess for delirium)	Patients with an Investigations & Management Plan completed
Trauma (Aug 20)	95% (19/20)	83% (5/6)	60% (3/5)
1 North (June 21)	100% (20/20)	N/A (0/0)	N/A (0/0)
3 North Med (June 21)	100% (20/20)	91% (10/11)	100% (8/8)
3 South (Dec 20)	100% (5/5)	100% (1/1)	N/A (0/0)
4 North (May 21)	95% (19/20)	100% (2/2)	100% (1/1)
4 South (June 21)	100% (20/20)	100% (1/1)	100% (1/1)
Ramone 4 (June 21)	100% (20/20)	100% (10/10)	100% (9/9)
Stroke/Rehab (Jun21)	100% (20/20)	100% (7/7)	100% (1/1)
Female Surg. (Jun 21)	100% (20/20)	100% (2/2)	100% (2/2)

- Audits received from Wards highlighted in red. Wards in blackaudit suspended due to Covid-19 or Audit not received in time to be included in this Report.

Patient Safety Report for Acute Governance Meeting Nov 2021

Surgical Site Infection (SSI) Ortho:



- Q2 2021 SSI Rates have been released by the PHA. CAH Rate was **0%** (0/394 procedures). NI Rate was **0.30%** (7/2,357 procedures). CAH Rate (last 8 quarters i.e. Q3 2019 → Q2 2021) was **0.33%** (10/3,003). NI Rate (last 8 quarters i.e. Q3 2019 → Q2 2021) was **0.44%** (74/16,745).
- The Cumulative Rate for 2021 stands at **0.44%**, up from **0.31%** in 2020
- The Annual SSI Audit, which was due to be undertaken in Sept 21 has been suspended due to Covid-19

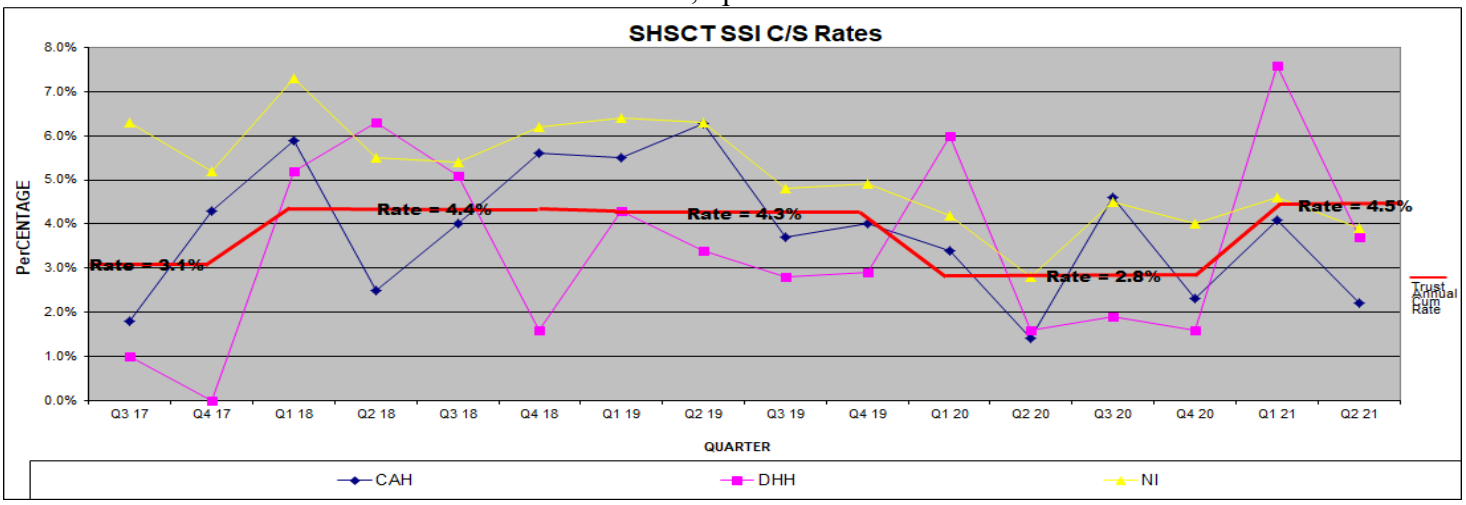
Surgical Site Infection (SSI) C/Section:

- Q2 2021 SSI rates have been released by the PHA. A summary of the data is as follows:

SSI Rates:
CAH **2.20%** **(4)** down from **4.08%** **(8)** in Q121
DHH **3.74%** **(7)** down from **7.62%** **(16)** in Q121
TRUST **2.98%** **(11)** down from **5.91%** **(24)** in Q121
NI Average **3.95%** **(56)** down from **4.60%** **(72)** in Q121

Surveillance Forms Returned to the PHA:
CAH **85.8%** up from **83.1%** in Q121
DHH **84.6%** down from **90.9%** in Q121
TRUST **85.2%** down from **86.9%** in Q121
NI Average **80.1%** down from **86.5%** in Q121

- CAH SSI Rate has been below the NI Average since Q4 20
- DHH SSI Rate back below the NI Average
- Trust's SSI Rate back below the NI Average
- Of the **8** Units in NI, CAH had the **4th** lowest SSI Rate in Q2 21 with DHH the **5th** lowest
- The Cumulative Rate for 2021 stands at **4.5%**, up from **2.8%** in 2020



- The quarterly SSI C/Section Audits took place in Sept 2021

Overall Bundle Compliance at CAH **90%** (18/20 patients audited), up from **60%** in June 21

Non-compliant element:

- Glucose Control (Diabetic patients only) – In 2 of 3 cases audited the mother's Serum Glucose Level was not measured/recorded/monitored Day 1 & or Day 2 post C/Section.

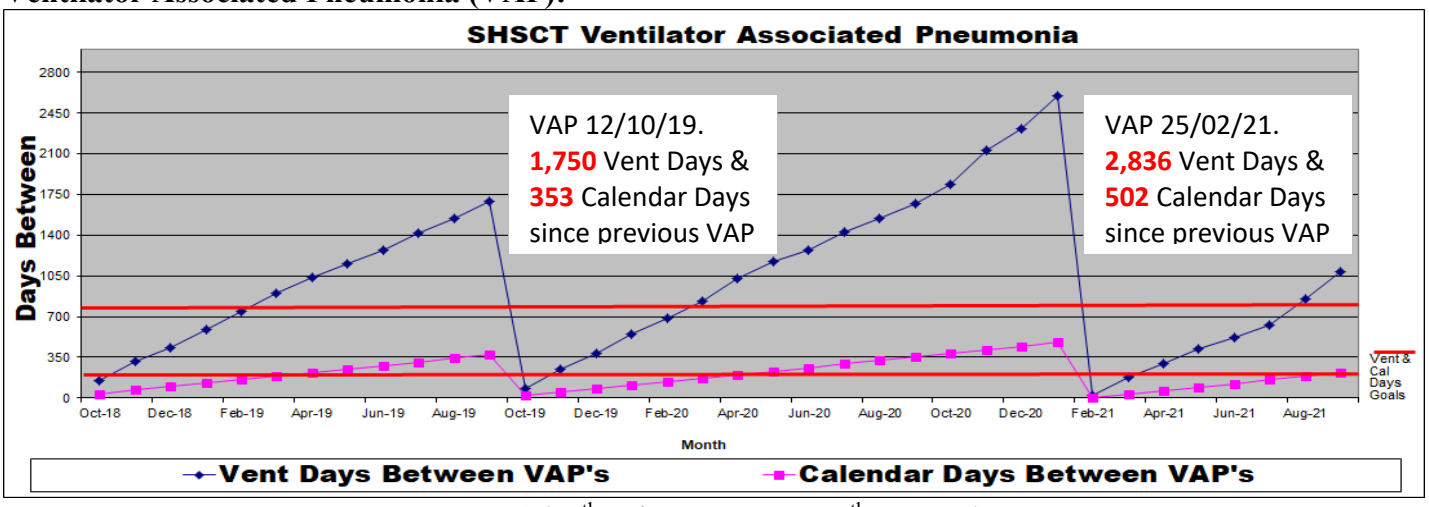
Overall Bundle Compliance at DHH **85%** (17/20 patients audited) – up from **80%** in June 21

Non-compliant element:

- Appropriate Hair Removal - In 3 of 20 cases audited the method of hair removal was inappropriate or not recorded & there was no evidence in the mother's chart that she had received a copy of the Trust's Information leaflet, which addresses same.

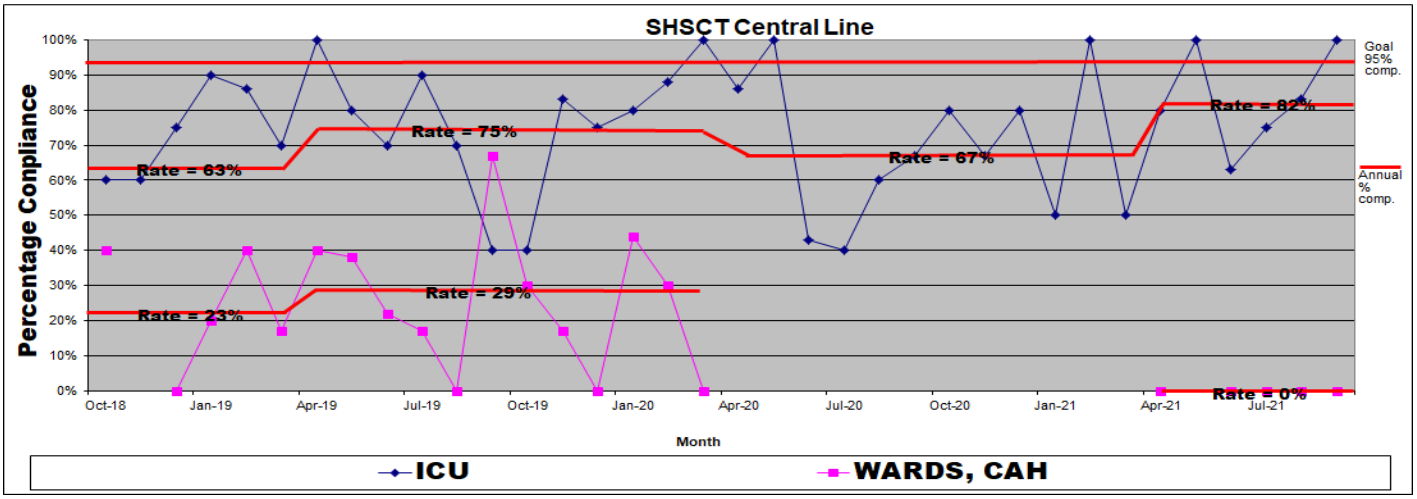
- As per revised NICE Guidelines, Appropriate use of Antibiotics is now "Knife to Skin" as opposed to "Prior to the Administration of Anaesthesia", which has led to an improvement in compliance with this element of the Bundle & hence Overall Bundle Compliance
- The next quarterly Audits will take place in Dec 2021

Ventilator Associated Pneumonia (VAP):



- Vent Days Between VAP's **1084** (26th February 21 → 30th Sept 21)
- Calendar Days Between VAP's **217** (26th February 21 → 30th Sept 21)

Central Line:



- Overall Bundle Compliance Sept 21, ICU **100%** (6/6 cases audited), up from **83%** (5/6 cases audited) in Aug 21
- Cumulative Compliance 21/22 stands at **82%**, up from **67%** in 20/21

- Overall Bundle Compliance Sept 21, Wards, CAH **0%** (0/3 cases audited)
- Cumulative Compliance 21/22 stands at **0%**, down from **29%** in 19/20 (audit not undertaken 20/21 due to Covid)

- Non-Compliant Cases:

  - In 1 of 3 cases audited the method of Hand Hygiene used was not recorded on the Central Line Insertion Record & Monitoring Form
  - In 2 of 3 cases audited the Jugular was used with no contraindication documented as to why the subclavian site was not used.
  - In 2 of 3 cases audited there were gaps in the monitoring of the Daily Review of the Line (1 case 2 days missed & 1 case 1 day missed)

- Results shared with Lead Clinician, Lead Nurse & Wards for this QI work to address areas of non-compliance. Dr. Chris Clarke has also agreed to review the evidence in respect of the use of the Subclavian in preference to the Jugular

NEWS/NEWS2:

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q2 21/22	Q1 21/22	Q4 20/21	Q3 20/21
ACUTE	92% (509/554)	91% (619/682)	95% (365/384)	94% (422/451)
TRUST	91% (637/700)	91% (767/842)	93% (494/531)	93% (554/596)

MUST (Malnutrition Universal Screening Tool):

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q2 21/22	Q1 21/22	Q4 20/21	Q3 20/21
ACUTE	88% (436/496)	91% (558/614)	89% (317/356)	90% (365/406)
TRUST	88% (615/695)	91% (702/770)	91% (453/498)	92% (502/548)

Critical Medicines Omitted:

The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

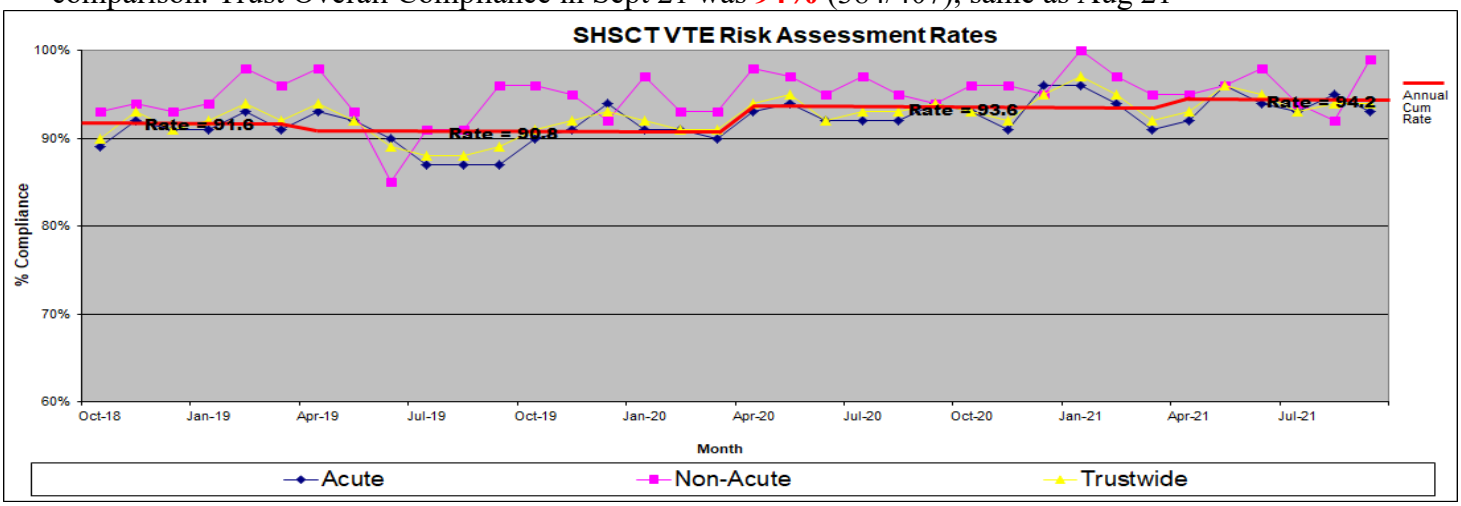
Quarter	Q2 21/22	Q1 21/22	Q4 20/21	Q3 20/21
ACUTE	0 (494)	1 (615)	1 (357)	1 (405)
TRUST	1 (806)	2 (775)	1 (500)	4 (549)

Sept 21 (Week Commencing 06/09/21 → Week Commencing 27/09/21)							
Division	**Site**	**Ward**	**Number of Weekly Audits not done**	**Charts with Fully Completed VTE Risk Assessment**	**Number of Charts Audited**	**Monthly Percentage Compliance**	**Quarter 2 21/22 Percentage Compliance**
S&EC	CAH	3 South	0	17	19	89% ↓	95% ↔
		4 North CESW	1	13	14	93% ↓	98% ↑
		4 South	0	18	19	95% ↓	92% ↓
		Elective Adm.	0	17	18	94% ↑	95% ↔
		Orthopaedic	0	18	18	100% ↔	100% ↑
		Trauma	4	N/A	N/A	N/A	100% ↔
	DHH	F/male Surg.	0	20	20	100% ↔	100% ↔
		MSW/HDU	N/A	N/A	N/A	N/A	N/A
M&UC	CAH	1 South	0	21	23	91% ↑	91% ↑
		1 North	0	16	19	84% ↓	81% ↓
		2 North Resp.	0	16	20	80% ↓	80% ↓
		Haematology	1	7	7	100% ↔	100% ↔
		3 North	0	15	17	88% ↑	92% ↓
		2 North Med	0	19	19	100% ↑	92% ↑
		AMU	0	18	19	95% ↑	89% ↓
		Frailty Ward	0	15	15	100% ↔	100% ↔
	DHH	F/male Med.	0	18	19	95% ↑	92% ↓
		CCC/MMW	0	17	19	89% ↓	95% ↑
		Stroke/Rehab	0	19	19	100% ↔	98% ↑
		Respiratory L3	0	19	19	100% ↔	100% ↑
IMWH	CAH	Gynae	2	6	8	75% ↓	90% ↔
TOTAL			8↓(13)	309	331	93.4% ↓	94.1% ↑

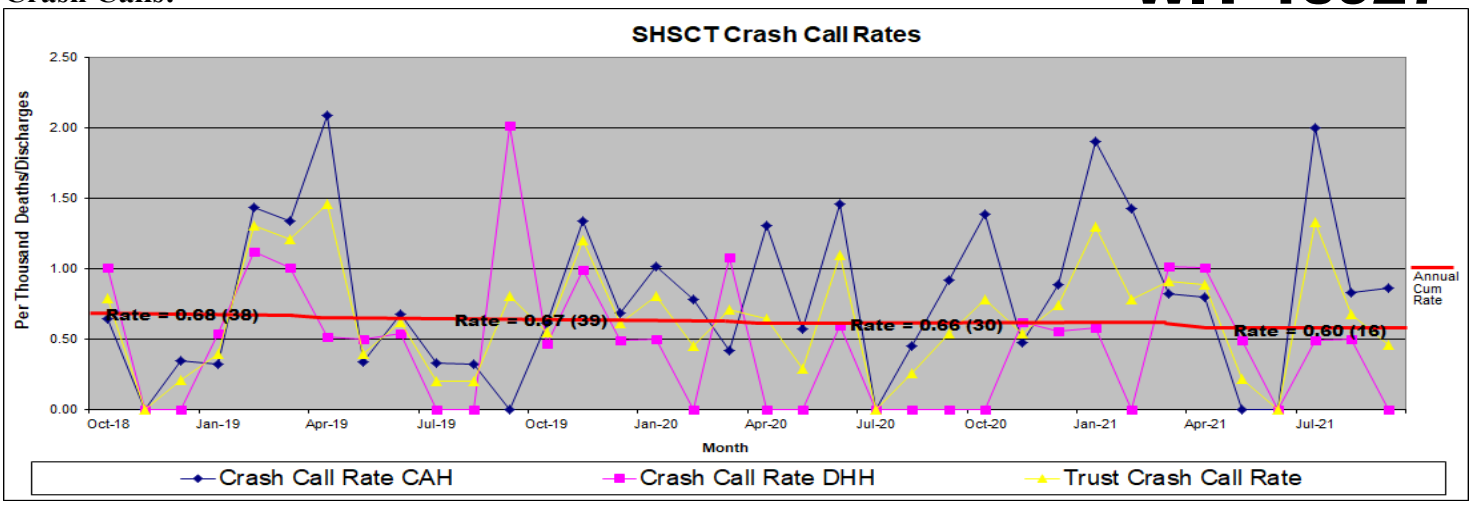
Key: Red – Under 85% compliance, Amber – Compliance between 85% & 94%, Green – Above 95% (Reg. target)

- In summary Overall Compliance with fully completed Risk Assessment on the Acute Wards was **93.4%** (309/331 charts audited) down from **94.6%** (368/389 charts audited) in Aug 21
- Total number of weekly audits not completed in Sept 21 was **8** down from **13** in Aug 21

The Run Chart below shows compliance against the Commissioning Plan target of **95%** compliance. The Trust Compliance includes the Non-Acute Wards & therefore their compliance has been included also for comparison. Trust Overall Compliance in Sept 21 was **94%** (384/407), same as Aug 21



Crash Calls:

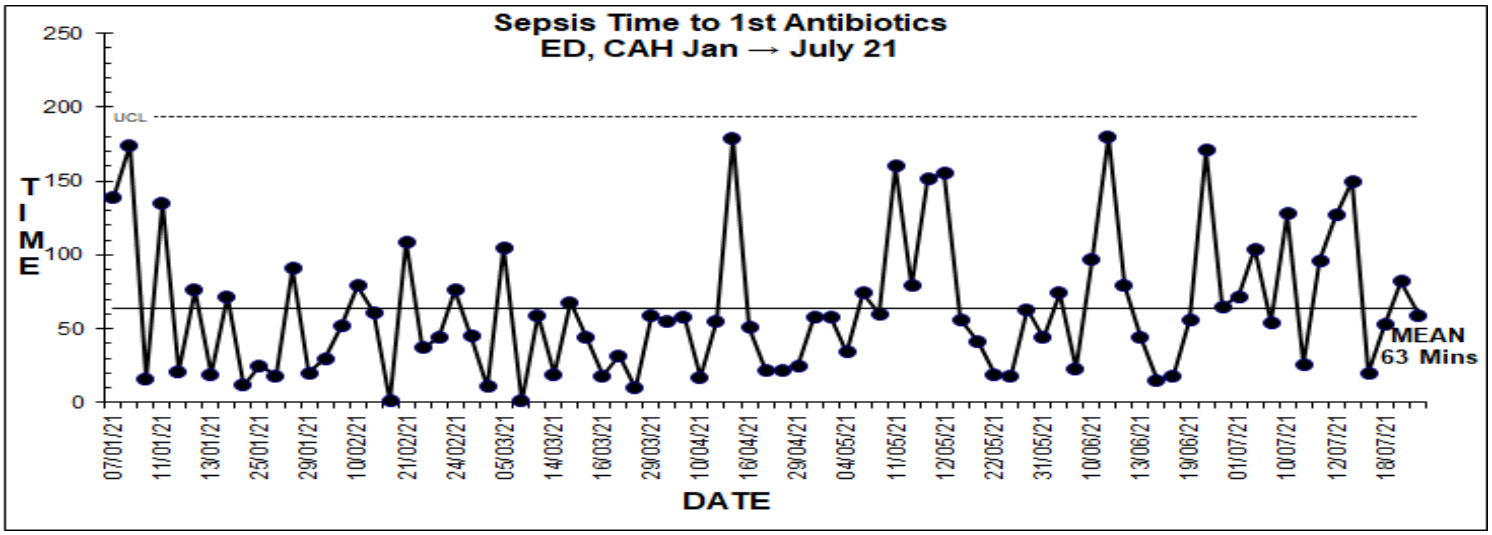


- CAH Rate **0.86** per 1,000 deaths/discharges (**2** Crash Calls) up from **0.83** (**2** Crash Calls) in Aug 21
- DHH Rate **0** per 1,000 deaths/discharges (**0** Crash Calls) down from **0.50** (**1** Crash Call) in Aug 21
- Trust Rate **0.46** per 1,000 deaths/discharges (**2** Crash Calls) down from **0.68** (**3** Crash Calls) in Aug 21
- Trust cumulative Crash Call Rate for 21/22 stands at **0.60 (16)** per 1,000 deaths/discharges, down from **0.66 (30)** in 20/21

Emergency Care QI Work: Sepsis 6 CAH & DHH:

- The new Regional Sepsis QI initiative has been ongoing from Oct 19. The Regional Agreed aim is to improve the time to 1st antibiotics "In Hours" i.e. Mon → Fri 9:00am → 5:00pm. Work is underway in 3 Pilot Areas ED, CAH, (Oct 19 – Dr. Suzie Budd, Clinical Lead), AMU, CAH (Dec 19 – Dr. Emily Hannah, Clinical Lead) & ED, DHH (14th Jan 20 – Dr. Laura Lavery, Clinical Lead). In the ED's of CAH & DHH it was decided to measure compliance 24/7.

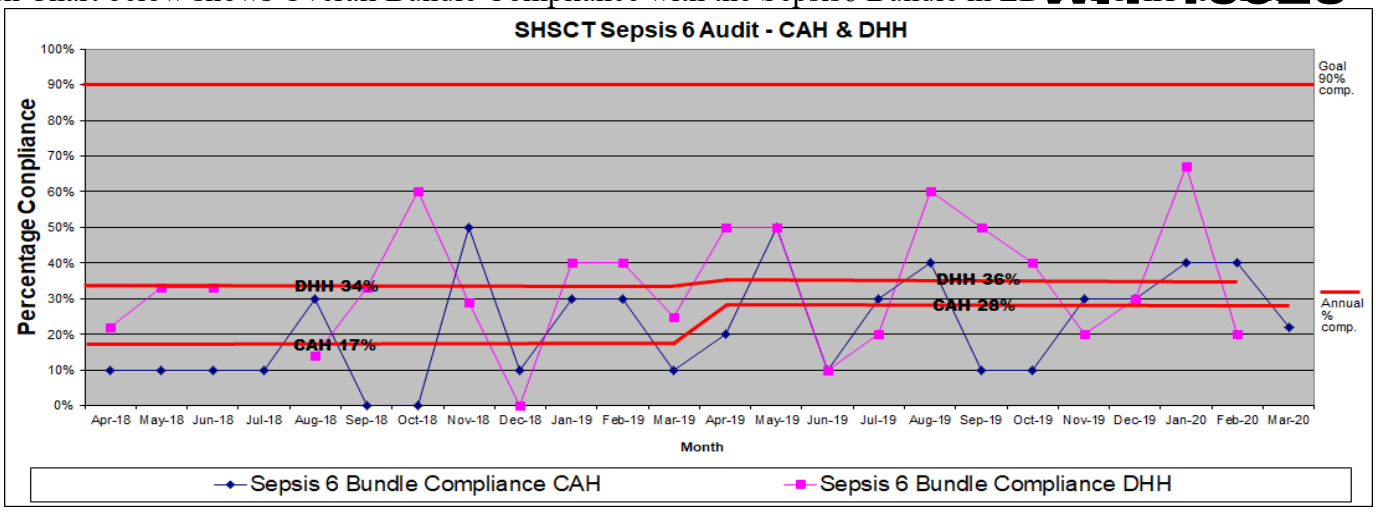
The Run Chart below shows progress made in ED, CAH



- July 21 compliance in-hours stands at **50%** (1/2 cases audited), up from **40%** (2 of 5 cases audited) in June 21. Cases outside target timeframe by **67** mins.
- July 21 compliance out-of-hours stands at **40%** (4/10 cases audited), down from **50%** (3/6 cases audited) in June 21. Cases outside target timeframe ranged between **12** mins & **90** mins
- **Late July 21, Aug 21 & Sept 21 cases have not been audited yet due to a significant delay in Coding**
- Mean Time Jan 21 → July 21 = **63** mins, just outside Regional target timeframe of **60** minutes.
- In 2020 Mean Time = **76** minutes
- Auditing in ED, DHH due to recommence in Nov 21, while AMU remains suspended due to Covid-19

Received from SHSCT on 16/05/22. Annotated by the Urology Services Inquiry.

The Run Chart below shows Overall Bundle Compliance with the Sepsis6 Bundle in ED for CAH & DHH

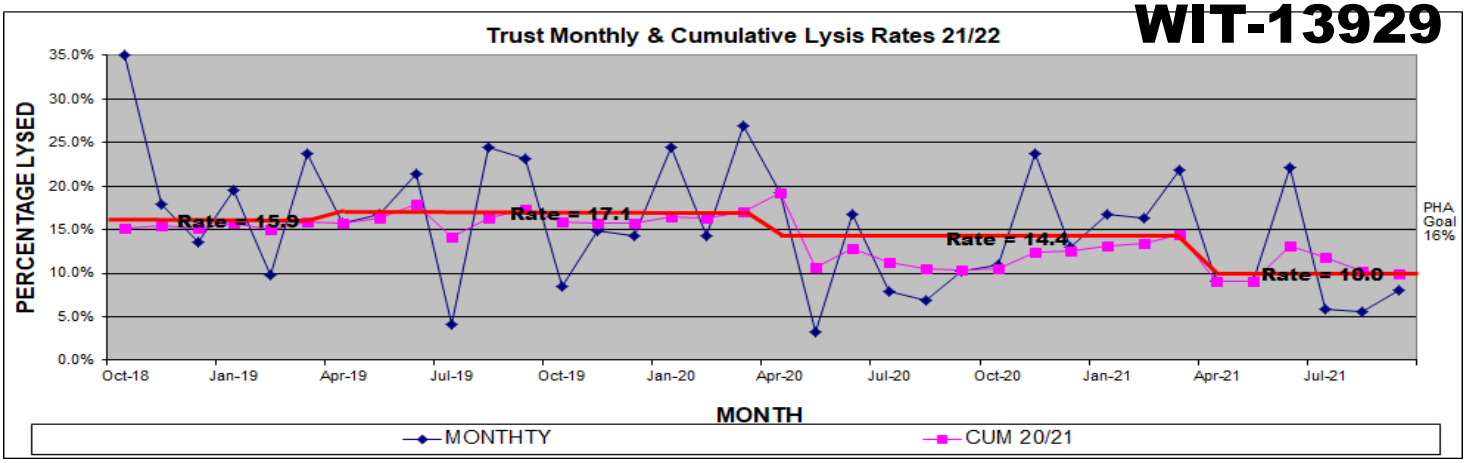


- Auditing has been suspended due to Covid-19

Stroke Collaborative:

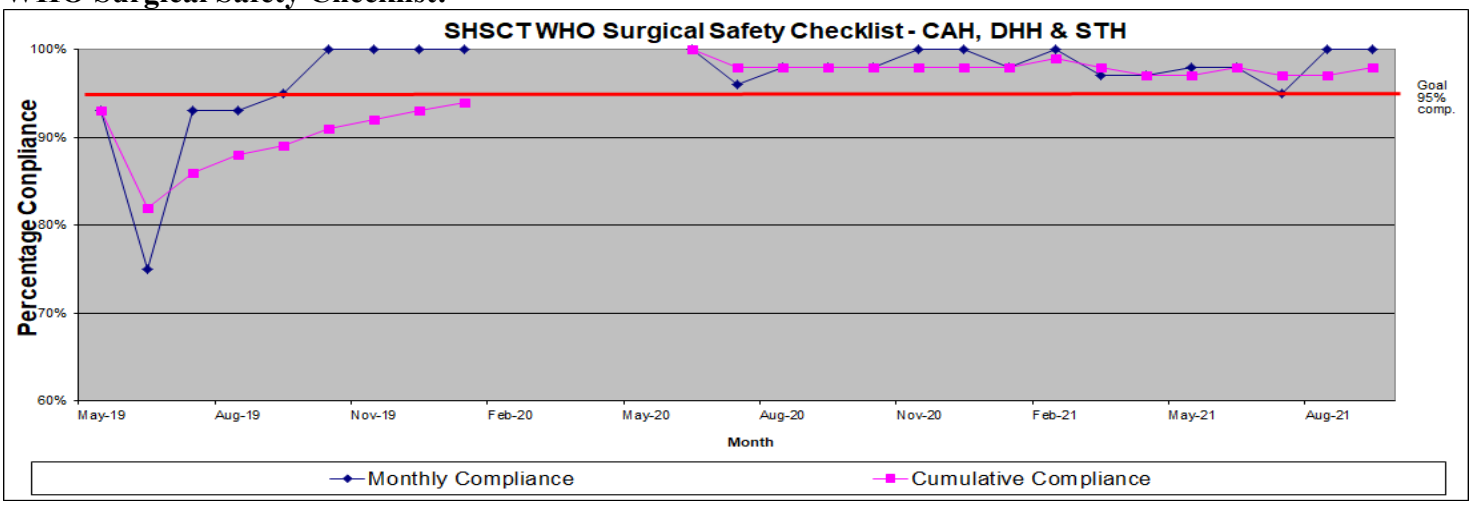
- Regional agreement to collect data on the following, however only Lysis Data will be reported to the PHA/DHSSPS on a quarterly basis:

	CAH		DHH		TRUST		
Measure		**Sept 21**		**Sept 21**		**Sept 21**	**Commentary Sept 21**
Patients who are potentially eligible for thrombolysis are assessed by Acute Stroke Team within 30 minutes of arrival	19/20 99% 20/21 100%	**100% (35/35)**	19/20 99% 20/21 100%	**100% (24/24)**	19/20 99% 20/21 100%	**100% (59/59)**	-
Patients who are potentially eligible for thrombolysis receive CT scan within 45 minutes	19/20 99% 20/21 100%	**100% (13/13)**	19/20 98% 20/21 98%	**100% (24/24)**	19/20 99% 20/21 99%	**100% (37/37)**	-
Patients deemed suitable for thrombolysis receive first bolus within 60 minutes	19/20 78% 20/21 90%	**0% (0/1)**	19/20 75% 20/21 73%	**50% (1/2)**	19/20 77% 20/21 86%	**33% (1/3)**	CAH: Patient presented out-of-hours. Outside target timeframe by 13 mins. Reason for delay not recorded DHH: Patient presented out-of-hours. Outside target timeframe by 25 mins. Reason for delay not recorded
Patients transferred to Hyper Acute Stroke Unit (or appropriate environment) within 90 mins	19/20 98% 20/21 100%	**100% (1/1)**	19/20 96% 20/21 93%	**100% (2/2)**	19/20 98% 20/21 98%	**100% (3/3)**	-
	CAH		**DHH**		**TRUST**		**AIM 21/22 (Based on Commissioning Plan) To ensure that the proportion of thrombolysis administration 16%**
Outcome Measure	**2019/20**	**Sept 21**	**2019/20**	**Sept 21**	**2019/20**	**Sept 21**	
Monthly Thrombolysis Rate		**3.8% (1/26)**		**18.2% (2/11)**		**8.1% (3/37)**	
Thrombolysis Rate (Yearly)	17.6% (58/329)	**10.0% (19/190)**	16.1% (28/174)	**10.1% (8/79)**	15.9% (69/435)	**10.0% (27/269)**	



The above is "Real Time" data, which is subject to change. The Directorate of Performance & Reform is responsible for reporting to the RHSCB. From the above table only the lysis rates are reported. Furthermore their report is 3 months in arrears to allow Clinical Coding to reach an acceptable level.

WHO Surgical Safety Checklist:



- The Monthly Audits were reinstated in May 19 & were suspended Feb → May 20 due to Covid-19
- Sept 21 Compliance **100%** (30/30), same as Aug 21, Cumulative Compliance 21/22 stands at **98%**

SKIN Care (Pressure Ulcer):

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

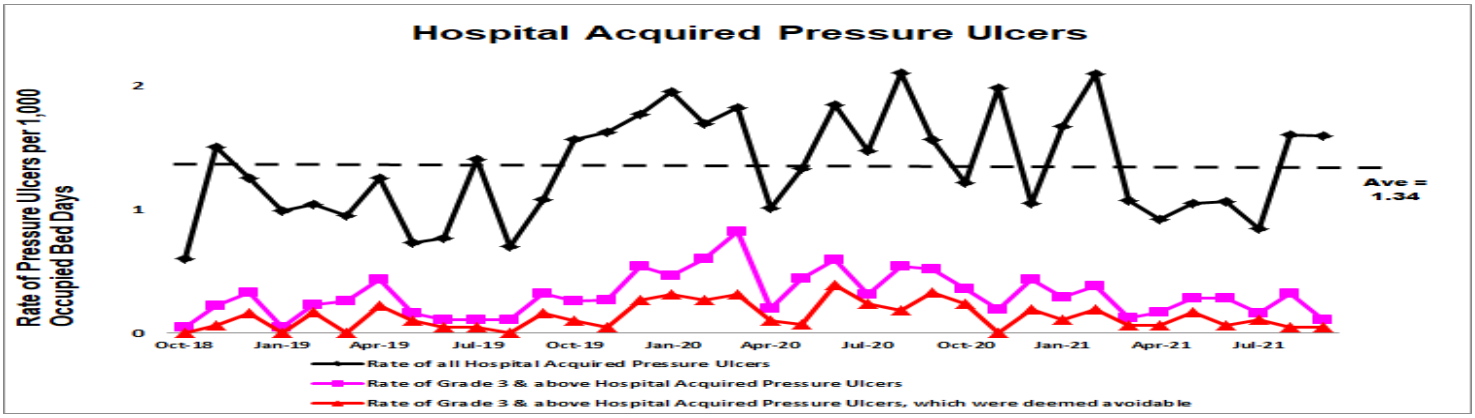
Quarter	Q2 21/22	Q1 21/22	Q4 20/21	Q3 20/21
ACUTE	86% (243/283)	83% (320/386)	85% (194/227)	88% (224/256)
TRUST	87% (336/387)	84% (420/499)	89% (294/331)	89% (324/366)

- There were **29** Hospital Acquired Pressure Ulcers reported in Sept 21. Of these, **2** were Stage 3/4 U or DTI's, (2 South Medical & Ward 4 North, CAH)

- In 21/22 Post Incident Reviews have been carried out on **22** cases to date with **9** deemed to have been avoidable. This represents **7%** of all Ward Acquired Pressure Ulcers reported in 21/22, down from **11%** in 20/21. The outstanding Post Incident Reviews (**2**) will be carried out in due course.

Ward Acquired Pressure Ulcers & Rate per 1,000 Occupied Bed Days 2021/22

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL	Rate 21/22	Rate & No 20/21
CAH															
Ward 4 South	1	2	1	0	0	0							4	0.70	1.16 (9) ↓
Ward 4 North	0	2	0	1	0	2							5	0.87	0.71 (6) ↑
Ward 3 South	3	2	3	2	5	1							16	2.69	3.50 (32) ↓
Trauma Ward	1	1	0	1	2	0							5	1.39	1.66 (12) ↓
Orthopaedic Ward	0	0	0	0	0	2							2	0.72	2.81 (13) ↓
Gynae Ward	0	2	2	0	0	0							4	2.26	1.84 (5) ↑
ICU	3	2	3	4	8	7							27	19.99	15.14(41) ↑
Ward 3 North Medicine	1	2	0	0	2	1							6	2.30	4.69 (24) ↓
Ward 3 North Stroke	1	0	0	0	0	2							3	1.04	0.77 (4) ↑
Ward 2 North	0	1	1	0	0	1							3	0.84	1.28 (12) ↓
Ward 5 Haematology	0	0	1	1	1	0							3	2.25	2.49 (6) ↓
Ward 1 South	0	2	0	0	1	0							3	0.49	1.19 (13) ↓
Ward 1 North	0	1	1	0	0	0							2	0.38	0.63 (6) ↓
AMU	0	1	1	2	0	1							5	0.96	1.07 (10) ↓
2 South Medical	1	0	1	0	0	2							4	0.70	1.90 (20) ↓
CEAW	0	0	0	0	0	0							0	0	0.95 (2) ↓
Emergency Department	0	0	1	1	1	6							7	N/A	N/A (16)
Ramone 4	2	0	0	1	1	0							4	1.47	1.24 (3) ↑
Other Areas e.g. Recovery	0	0	0	0	0	1							1	N/A	N/A (8)
DHH															
Male Surgical/DEAW/Resp.	0	0	1	0	0	1							2	0.89	0.60 (2) ↓
Female Surg/Gynae	0	0	0	0	0	0							0	0	0.67 (4) ↓
HDU	0	0	1	0	1	0							2	1.57	1.91 (4) ↓
Stroke/Rehab	0	0	0	1	2	1							4	0.80	0.43 (4) ↑
Male Med/CCU	0	0	0	0	2	0							2	0.35	0.31 (3) ↑
Female Medical	2	0	0	0	1	0							3	0.45	0.73 (8) ↓
Emergency Department	0	0	0	0	1	1							2	N/A	N/A (1)
Lurgan															
Ward 1	1	0	0	1	0	1							3	1.24	0.80 (3) ↑
Ward 2 Stroke	0	0	1	0	0	0							1	0.33	0.41 (2) ↓
Ward 3	0	0	0	1	2	0							3	1.08	0.69 (3) ↑
STH															
Ward 1 STH	0	0	0	0	0	1							1	0.36	1.21 (6) ↓
Ward 2 STH	0	1	1	0	0	0							2	0.76	0.42 (1) ↑
MHLD															
Gillis	0	0	0	0	0	0							0	0	0.91 (5) ↓
Willows	0	0	0	0	0	1							1	0.27	0 (0) ↑
TOTAL	16	19	19	16	30	29							129		
RATE	0.92	1.05	1.06	0.84	1.60	1.59								1.18	1.55 (288)↓



- The Trust's Monthly Hospital Acquired Pressure Ulcer Rate for Sept 21, based on **30** Wards was **1.59** (**29**/18,287) per 1, 000 Occupied Bed Days down from **1.60** (**30**/18,719) per 1,000 Occupied Bed Days in Aug 21

- The Trust's 21/22 Hospital Acquired Pressure Ulcer Rate, based on **30** Wards stated at **1.81 (111)** per 1,000 Bed Days, down from **1.55 (288)** in 2020/21.

Patient Falls:

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

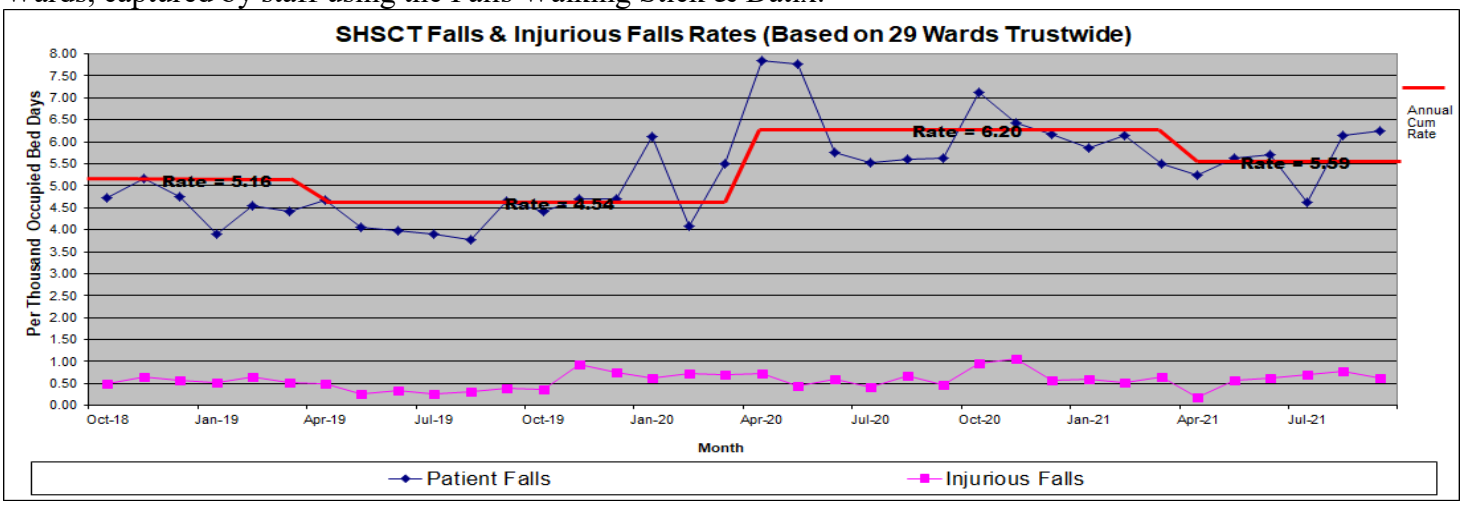
Quarter	Q2 21/22	Q1 21/22	Q4 20/21	Q3 20/21
Acute Bundle A Compliance	79% (391/495)	80% (498/619)	82% (291/355)	79% (321/405)
Trust Bundle A Compliance	84% (583/694)	83% (643/778)	84% (420/500)	81% (445/550)

Quarter	Q2 21/22	Q1 21/22	Q4 20/21	Q3 20/21
Acute Bundle B Compliance	81% (337/415)	81% (434/534)	79% (236/300)	82% (289/352)
Trust Bundle B Compliance	87% (533/613)	84% (578/688)	82% (359/437)	83% (412/495)

The table below gives details of individual Ward's Falls Numbers & Falls Rate 21/22:

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL	Rate 21/22	Rate 20/21
CAH															
Ward 4 South	0	2	2	3	1	6							14	2.46	2.32 (18) ↑
Ward 4 North	3	2	3	1	4	2							15	2.62	5.06 (43) ↓
Ward 3 South	9	3	9	2	4	7							34	5.72	8.10 (74) ↓
Trauma Ward	7	2	5	1	7	10							32	8.91	7.59 (55) ↑
Orthopaedic Ward	2	1	2	2	4	9							20	7.16	11.01 (51) ↓
Gynae Ward	0	2	3	1	1	2							9	5.09	4.42 (12) ↑
Ward 3 North Medicine	2	3	1	3	3	3							15	5.75	11.32 (58) ↓
Ward 3 North Stroke	1	2	1	1	2	2							9	3.11	7.46 (39) ↓
Ward 2 North	0	1	4	1	1	1							8	2.23	4.25 (40) ↓
Haematology Ward	1	0	0	0	0	1							2	1.50	2.49 (6) ↓
Ward 1 South	5	6	11	3	9	4							38	6.17	5.15 (56) ↑
Ward 1 North	1	1	3	2	5	4							16	3.06	2.82 (27) ↑
AMU	5	5	5	10	15	4							44	8.44	10.28 (96) ↓
2 South Medicine	7	2	2	6	3	3							23	4.00	5.69 (60) ↓
CEAW	0	0	0	1	0	0							1	0.68	0.48 (1) ↑
Ramone 4	3	5	2	1	3	4							18	6.64	6.19 (15) ↑
DHH															
Male Surgical/Resp	2	3	4	0	2	0							11	4.92	3.62 (12) ↑
Female Surg/Gynae	2	5	1	0	3	2							13	3.78	1.67 (10) ↑
HDU	1	1	0	0	0	0							2	1.57	1.91 (4) ↓
Stroke/Rehab	6	6	5	8	2	3							30	5.99	5.09 (47) ↑
Male Med/CCU	5	6	2	2	5	7							27	4.69	8.38 (82) ↓
Female Medical	6	9	10	10	11	6							52	7.75	6.38 (70) ↑
Lurgan															
Ward 1	1	3	2	4	1	2							13	5.38	9.02 (34) ↓
Ward 2 Stroke	1	4	1	1	6	3							16	5.33	4.46 (22) ↑
Ward 3	0	5	1	5	2	3							16	5.74	3.94 (17) ↑
STH															
Ward 1 STH	0	0	0	2	2	2							6	2.18	3.03 (15) ↓
Ward 2 STH	2	1	0	1	1	2							7	2.66	3.33 (8) ↓
MHLD															
Gillis	13	8	10	7	6	4							48	21.84	14.02 (77) ↑
Willows	4	12	12	8	9	15							60	15.92	9.84 (71) ↑
TOTAL	89	100	101	86	112	111							599		
RATE	5.23	5.62	5.70	4.63	6.14	6.25								5.59	6.20 (1120) ↓

The Run Chart below shows Patient Falls & Injurious Falls Rates per 1,000 Occupied Bed Days, based on 29 Wards, captured by staff using the Falls Walking Stick & Datix.



- Falls Rate **6.25** (**111**/17,755 Occupied Bed Days) up from **6.14** (**112**/18,229) in Aug 21
- Injurious Falls Rate **0.62** (**11**/17,755 Occupied Bed Days) down from **0.77** (**14**/18,229) in Aug 21
- Cumulative Falls Rate for 21/22 stands at **5.59**, compared to **6.20** in 20/21

Regional Delirium Audit:

The table below shows compliance against the 3 Measures of the Delirium Bundle, for the Acute Wards, where auditing is underway. All 5 Non-Acute Wards also undertake a monthly audit.

Ward/Measure	At risk patients who have a SQiD carried out (single question in delirium)	Patients with a 4AT completed (tool to assess for delirium)	Patients with an Investigations & Management Plan completed
Trauma (Aug 20)	95% (19/20)	83% (5/6)	60% (3/5)
1 North (Sept 21)	100% (15/15)	100% (2/2)	100% (2/2)
3 North Med (Aug 21)	100% (20/20)	100% (10/10)	100% (10/10)
3 South (Dec 20)	100% (5/5)	100% (1/1)	N/A (0/0)
4 North (May 21)	95% (19/20)	100% (2/2)	100% (1/1)
4 South (Sept 21)	100% (20/20)	100% (7/7)	N/A (0/0)
Ramone 4 (Sept 21)	100% (20/20)	100% (6/6)	50% (1/2)
Stroke/Rehab (Sept21)	100% (20/20)	100% (7/7)	N/A (0/0)
Female Surg. (Sept 21)	100% (20/20)	N/A (0/0)	N/A (0/0)

- Audits received from Wards highlighted in red. Wards in blackaudit suspended due to Covid-19 or Audit not received in time to be included in this Report.

Carroll, Ronan

From: Corrigan, Martina
Sent: 09 May 2022 17:21
To: Carroll, Ronan
Subject: FW: urology e-triage

From: Corrigan, Martina [redacted]
Sent: 03 March 2017 09:36
To: Glackin, Anthony [redacted]; Haynes, Mark [redacted]; O'Brien, Aidan [redacted]; ODonoghue, JohnP [redacted]; Young, Michael [redacted]
Cc: Carroll, Ronan [redacted]; Clayton, Wendy [redacted]
Subject: FW: urology e-triage

Hi all

See below – all in line for going 'live' with e-triage for urology on 29 March.

Martina

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

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

From: Cunningham, Kate
Sent: 03 March 2017 09:34
To: Corrigan, Martina
Subject: urology e-triage

Martina
All appears to be on line for rollout of urology e-triage on the 29/3. As discuss Katherine Robinson will need to attending to discuss roll out, discharge codes and other vital information required for smooth implementation. Can you ensure an invitation is sent to her. Thank you.
Kate

Good medical practice

Working with doctors Working for patients

General Medical Council

The duties of a doctor registered with the GMC

Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and make sure your practice meets the standards expected of you in four domains.

Knowledge, skills and performance

- Make the care of your patient your first concern.
- Provide a good standard of practice and care.
  - Keep your professional knowledge and skills up to date.
  - Recognise and work within the limits of your competence.

Safety and quality

- Take prompt action if you think that patient safety, dignity or comfort is being compromised.
- Protect and promote the health of patients and the public.

Communication, partnership and teamwork

- Treat patients as individuals and respect their dignity.
  - Treat patients politely and considerately.
  - Respect patients' right to confidentiality.
- Work in partnership with patients.
  - Listen to, and respond to, their concerns and preferences.
  - Give patients the information they want or need in a way they can understand.
  - Respect patients' right to reach decisions with you about their treatment and care.
  - Support patients in caring for themselves to improve and maintain their health.
- Work with colleagues in the ways that best serve patients' interests.

Maintaining trust

- Be honest and open and act with integrity.
- Never discriminate unfairly against patients or colleagues.
- Never abuse your patients' trust in you or the public's trust in the profession.

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.

Good medical practice

This guidance has been edited for plain English.

Published 25 March 2013
Comes into effect 22 April 2013.

This guidance was updated on 29 April 2014 to include paragraph 14.1 on doctors' knowledge of the English language. It was further updated on 29 April 2019 to remove the sub-heading 'honesty' from immediately before paragraph 65.

You can find the latest version of this guidance on our website at **www.gmc-uk.org/guidance**.

For the full website addresses of references in this guidance, please see the online version on our website.

Contents

About this guidance

Good medical practice includes references to explanatory guidance. A complete list of explanatory guidance is at the end of the booklet.

All our guidance is available on our website, along with:

- learning materials, including interactive case studies which bring to life the principles in the guidance and show how they might apply in practice

- cases heard by medical practitioners tribunals, which provide examples of where a failure to follow the guidance has put a doctor's registration at risk.

Professionalism in action

1 Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues,[1] are honest and trustworthy, and act with integrity and within the law.

2 Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible, whatever their illness or disability.

3 *Good medical practice* describes what is expected of all doctors registered with the General Medical Council (GMC). It is your responsibility to be familiar with *Good medical practice* and the explanatory guidance[2] which supports it, and to follow the guidance they contain.

4 You must use your judgement in applying the principles to the various situations you will face as a doctor, whether or not you hold a licence to practise, whatever field of medicine you work in, and whether or not you routinely see patients. You must be prepared to explain and justify your decisions and actions.

5 In *Good medical practice*, we use the terms 'you must' and 'you should' in the following ways.

- 'You must' is used for an overriding duty or principle.
- 'You should' is used when we are providing an explanation of how you will meet the overriding duty.
- 'You should' is also used where the duty or principle will not apply in all situations or circumstances, or where there are factors outside your control that affect whether or how you can follow the guidance.

6 To maintain your licence to practise, you must demonstrate, through the revalidation process, that you work in line with the principles and values set out in this guidance. Only serious or persistent failure to follow our guidance that poses a risk to patient safety or public trust in doctors will put your registration at risk.

Domain 1: Knowledge, skills and performance

Develop and maintain your professional performance

7 You must be competent in all aspects of your work, including management, research and teaching.[3, 4, 5]

8 You must keep your professional knowledge and skills up to date.

9 You must regularly take part in activities that maintain and develop your competence and performance.[6]

10 You should be willing to find and take part in structured support opportunities offered by your employer or contracting body (for example, mentoring). You should do this when you join an organisation and whenever your role changes significantly throughout your career.

11 You must be familiar with guidelines and developments that affect your work.

12 You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.

13 You must take steps to monitor and improve the quality of your work.

Apply knowledge and experience to practice

14 You must recognise and work within the limits of your competence.

14.1 You must have the necessary knowledge of the English language to provide a good standard of practice and care in the UK.[7]

15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

a adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient

b promptly provide or arrange suitable advice, investigations or treatment where necessary

c refer a patient to another practitioner when this serves the patient's needs.[8]

16 In providing clinical care you must:

- **a** prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs[9]
- **b** provide effective treatments based on the best available evidence
- **c** take all possible steps to alleviate pain and distress whether or not a cure may be possible[10]
- **d** consult colleagues where appropriate
- **e** respect the patient's right to seek a second opinion
- **f** check that the care or treatment you provide for each patient is compatible with any other treatments the patient is receiving, including (where possible) self-prescribed over-the-counter medications
- **g** wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship.[9]

17 You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research.[4, 11, 12]

18 You must make good use of the resources available to you.[3]

Record your work clearly, accurately and legibly

19 Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.

20 You must keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection law requirements.[14]

21 Clinical records should include:

- **a** relevant clinical findings
- **b** the decisions made and actions agreed, and who is making the decisions and agreeing the actions
- **c** the information given to patients
- **d** any drugs prescribed or other investigation or treatment
- **e** who is making the record and when.

Domain 2: Safety and quality

Contribute to and comply with systems to protect patients

22 You must take part in systems of quality assurance and quality improvement to promote patient safety. This includes:

- **a** taking part in regular reviews and audits of your work and that of your team, responding constructively to the outcomes, taking steps to address any problems and carrying out further training where necessary
- **b** regularly reflecting on your standards of practice and the care you provide
- **c** reviewing patient feedback where it is available.

23 To help keep patients safe you must:

- **a** contribute to confidential inquiries
- **b** contribute to adverse event recognition
- **c** report adverse incidents involving medical devices that put or have the potential to put the safety of a patient, or another person, at risk
- **d** report suspected adverse drug reactions
- **e** respond to requests from organisations monitoring public health.

When providing information for these purposes you should still respect patients' confidentiality.[14]

Respond to risks to safety

24 You must promote and encourage a culture that allows all staff to raise concerns openly and safely.[3, 15]

25 You must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised.

a If a patient is not receiving basic care to meet their needs, you must immediately tell someone who is in a position to act straight away.

b If patients are at risk because of inadequate premises, equipment[13] or other resources, policies or systems, you should put the matter right if that is possible. You must raise your concern in line with our guidance[15] and your workplace policy. You should also make a record of the steps you have taken.

c If you have concerns that a colleague may not be fit to practise and may be putting patients at risk, you must ask for advice from a colleague, your defence body or us. If you are still concerned you must report this, in line with our guidance and your workplace policy, and make a record of the steps you have taken.[14, 16]

26 You must offer help if emergencies arise in clinical settings or in the community, taking account of your own safety, your competence and the availability of other options for care.

27 Whether or not you have vulnerable[17] adults or children and young people as patients, you should consider their needs and welfare and offer them help if you think their rights have been abused or denied.[18, 19]

Risks posed by your health

28 If you know or suspect that you have a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must follow their advice about any changes to your practice they consider necessary. You must not rely on your own assessment of the risk to patients.

29 You should be immunised against common serious communicable diseases (unless otherwise contraindicated).

30 You should be registered with a general practitioner outside your family.

Domain 3: Communication, partnership and teamwork

Communicate effectively

31 You must listen to patients, take account of their views, and respond honestly to their questions.

32 You must give patients[20] the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.[21]

33 You must be considerate to those close to the patient and be sensitive and responsive in giving them information and support.

34 When you are on duty you must be readily accessible to patients and colleagues seeking information, advice or support.

Working collaboratively with colleagues

35 You must work collaboratively with colleagues, respecting their skills and contributions.[3]

36 You must treat colleagues fairly and with respect.

37 You must be aware of how your behaviour may influence others within and outside the team.

38 Patient safety may be affected if there is not enough medical cover. So you must take up any post you have formally accepted, and work your contractual notice period before leaving a job, unless the employer has reasonable time to make other arrangements.

Teaching, training, supporting and assessing

39 You should be prepared to contribute to teaching and training doctors and students.

40 You must make sure that all staff you manage have appropriate supervision.

41 You must be honest and objective when writing references, and when appraising or assessing the performance of colleagues, including locums and students. References must include all information relevant to your colleagues' competence, performance and conduct.[22]

42 You should be willing to take on a mentoring role for more junior doctors and other healthcare professionals.[3]

43 You must support colleagues who have problems with their performance or health. But you must put patient safety first at all times.[3]

Continuity and coordination of care

44 You must contribute to the safe transfer of patients between healthcare providers and between health and social care providers. This means you must:

a share all relevant information with colleagues involved in your patients' care within and outside the team, including when you hand over care as you go off duty, and when you delegate care or refer patients to other health or social care providers[8, 14]

b check, where practical, that a named clinician or team has taken over responsibility when your role in providing a patient's care has ended. This may be particularly important for patients with impaired capacity or who are vulnerable for other reasons.