## 5.0 DESCRIPTION OF INCIDENT/CASE

experienced.

Personal Information recovered well in hospital and was discharged day 4 following the procedure following an uneventful initial post-operative period. A plan was made for Personal Information to return for further follow up with Consultant 1 on day 7 and day 10 post op in the first instance.

Personal Information attended her review appointments on 11 and 14 January 2019 with Consultant 1 and she was found to be recovering well at this time.

Following discharge Personal Information required follow up and management of bowel activity which has impacted on her daily activities and work.

## 6.0 FINDINGS

The review team identified that in view of the patient's clinical symptoms the procedure was deemed necessary and that Personal Information met the criteria (see appendix 1). During a discussion with Consultant 1 various options were discussed and Personal Information made a decision to proceed with the endometrial thermablation procedure. The procedure was discussed in the clinic and written consent was obtained as would be normal practice.

There was appropriate supervision of the procedure which was performed by Doctor 1 under direct supervision from Consultant 1 who had been trained and was experienced in the use of the device.

As no risk assessment of the device was undertaken there were no SHSCT guidelines in place for the procedure at this time; however training had been provided by the manufacturer's medical representative with guidance from the device information leaflet. This information leaflet was available in theatres in STH and following discussion the staff were aware of where to access it. Training records were available, however and did not demonstrate the exact content of the training material which was provided nor which competencies staff were required to achieve. The review team would advise that training should be evidenced with copies of training materials and records of competencies achieved including timeframes for updated training.

The review team identified that there was no safety mechanism with the Thermablate equipment to detect perforation or integrity of the uterine cavity. It was also determined that the disposable part of the instrument was not isolated and retained for inspection as would be expected but that it was discarded at the time of the incident. Isolation of this part of the device for investigation would have identified if there were any equipment faults which could have been considered a causal factor.

The review team found that good leadership and multidisciplinary communication was evident when the complication of uterine perforation was identified. The appropriate measures were implemented quickly to manage care and maintain patient safety. This involved immediate transfer and emergency surgery involving the surgical team. The Consultant advised Personal Information of her findings as soon as she was awake and explained the plan of care reviewing her throughout and following up post operatively.

## 7.0 CONCLUSION

### CAUSAL FACTORS

Personal Information suffered a uterine perforation during an elective endometrial thermal ablation procedure.

### CONTRIBUTARY FACTORS

**Equipment**

There was no alert with the thermablation equipment for early detection of uterine perforation or the integrity of the uterine cavity.

**Staff Factors/Education and Training Factors**

The Thermablate disposable cartridge used was disposable and discarded at the time of the procedure, therefore the review team were unable to identify if there were any faults contributing to the incident. However the hand held control unit was returned to manufacturer through the Northern Ireland Adverse incident Centre who reported that the unit functioned to its expected specification. (NIAIC Reference ST-15438)

### GOOD PRACTICE POINTS

Personal Information symptoms of heavy menstrual bleeding was treated according to the current guidelines (NICE 2018)[1]

The procedure was performed according to the device instructions under direct supervision from an experienced Consultant Obstetrician and Gynaecologist. The Consultant had been trained in the use of the device by the device representative who had observed a number of procedures during the training.

Swift action was taken when the perforation was suspected with appropriate patient management by the senior gynaecological and surgical teams.

### DISCUSSION

While uterine perforation is one of the recognised complications of endometrial ablation it is only expected in around 0.1% of cases as recorded in the patient information leaflet. The procedure was not contraindicated and had been discussed with Personal Information previously to allow for questions and written consent was obtained.

The procedure was directly supervised by an experienced Consultant Obstetrician and Gynaecologist who had been trained in its use and had experience of many procedures. The review team cannot conclude why the perforation occurred. The uterine cavity was viewed intact before the thermal ablation was performed and the procedure was carried out according to the manufacturers training. Retention of the disposable cartridge for inspection by health and safety would have provided evidence of any faults contributing to the incident.

Training records for this procedure were minimal and didn't include copies of training materials used or of the competencies which were needed or assessed and there was no Trust guideline on this procedure. The review team are of the opinion that these would be considered best practice and would evidence staff competency for future procedures. Training records should also stipulate when updated training is considered necessary.

The review team found evidence of excellent team working and communication between teams in South Tyrone Hospital day procedure unit and Craigavon area hospital in organizing emergency transfer and surgery. There was also a comprehensive post-operative follow up.

**Family Engagement**

As part of this investigation the review team asked Personal Information redacted to provide any questions she had regarding the incident and they are included here.

1. **Does the machine have an alarm on it to alert if the procedure is going wrong?**

   The machine has 27 error codes which alert the user to any malfunction or system failure. The device also runs a system check prior to beginning a treatment cycle; the treatment cycle will not operate unless the system check has been passed. If the machine issues an error code it stops operating. None of these alarms were activated before, during or following the procedure.

2. **If there is no alarm why not?**

   None of the alarms were activated before, during or after the procedure and the devices own system check was normal pre-treatment. The review team have established that the alarm will only be activated in the event of a leak or when there is any other fault detected. Uterine perforations are not detectable by the device.

3. **How did the doctor not realise that the procedure was going wrong at the start?**

   The procedure was carried out as normal based on the instructions with no signs of any problems. The device completed the initial system check satisfactorily and at no time was an error code issued.

4. **Why is there no information to tell patients what can happen if the procedure goes wrong?**

   All patients are counselled in the clinic when the surgery is offered. This usually includes the procedure details with benefits and risks. Also the leaflet is provided. On the day of the surgery, the patients are also provided with details while completing the consent. The consent can also be done in the clinic and reconfirmed on the day of the surgery.

5. **How much water does the balloon hold?**

The balloon can hold a maximum of 26 mls. The procedure used 24 mls, this is only known at the end of the treatment cycle.

6. **Does the person operating the machine know how much water is going into the balloon during the procedure?**

The volume of fluid used differs with each patient depending on the patients anatomical differences. The total volume of fluid used during the procedure is only shown after the treatment cycle is completed.

**7. What are you going to do to make sure this doesn't happen to anyone else?**

- Updated staff training to include competencies achieved and timeframe for training update.
- Staff made aware of the need to retain any medical device involved in an incident for investigation.
- To continue to use hysteroscopy before inserting the ablation device to establish the condition of the uterus and confirm that there is no evidence of uterine perforation or false passage, which was done during your procedure.
- Consider manufacturers advice that ultrasound may be used to ensure correct uterine placement of the ablation device; if the device uses a balloon.

## 8.0 LESSONS LEARNED

The thermal ablation procedure was required and carried out according to training and supervision by the manufacturer however training records did not record the staff competencies. The use of the Thermablate procedure has not been found to be the causative factor and therefore is no longer suspended in the Southern Trust.

Retention of the Thermablate disposable cartridge would have enabled identification of any potential faults which may have contributed to the incident. Staff should be advised of how to retain and isolate a medical device involved in an incident as part of their training on the device and induction to the Trust.

When the uterine perforation was identified an appropriate plan was made for transfer and further investigation. The review team found that there was good multidisciplinary management and communication including senior surgical and gynaecological teams.

## 9.0 RECOMMENDATIONS AND ACTION PLANNING

Trust risk assessment of all thermablation devices should be carried out according to Trust Policy

A Standard Operating Procedure (SOP) should be devised for endometrial thermal ablation devices. Copies of the SOP should be available in all areas where the device is in use for easy access for all staff and also on the intranet.

Training records should be developed and maintained by the individual and their line

## 9.0 RECOMMENDATIONS AND ACTION PLANNING

manager and should include a copy of training content and staff competencies. This should also include the management of a medical device when an incident occurs or a fault is suspected.

Training should be updated on a 3 yearly basis.

When a medical device is identified in an incident it needs to be immediately quarantined and all material evidence retained, clearly identified and stored securely for investigation. Medical devices should not be discarded, repaired or returned to the manufacturer before investigation by the Northern Ireland Adverse Incident Centre (NIAIC).

The Thermablate device manufacturer should consider creating a safety mechanism to enable early identification of uterine perforation for the user.

## 10.0 DISTRIBUTION LIST

Personal information and her family

Director of Acute Services

Assistant Director of Acute Services

Clinical Directors of Obstetrics and Gynaecology

Head of Maternity and Gynaecology

Acute Governance Co-ordinator

Lead Midwives

Staff involved

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

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

| Reporting Organisation SAI Ref Number: | Personal Information redacted by USI | HSCB Ref Number: | S14582 |
|---|---|---|---|

**SECTION 1**

## INFORMING THE SERVICE USER[1] / FAMILY / CARER

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

**For completion by HSCB/PHA Personnel Only** (Please select as appropriate (✓))

| Content with rationale? | YES | | NO | |
|---|---|---|---|---|

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

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

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

[1]*Service User or their nominated representative*

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

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

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

| | | | |
|---|---|---|---|
| ***Continued overleaf*** | **e)** | No response to correspondence | |
| | **f)** | Withdrew fully from the SAI process | |
| | **g)** | Participated in SAI process but declined review report | |
| | ***(if you select any of the options below please also complete 'l' below)*** | | |
| | **h)** | concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer | |
| | **i)** | case involved suspected or actual abuse by family | |
| | **j)** | identified as a result of review exercise | |
| | **k)** | other rationale | |
| | **l)** | If you have selected **c), h), i), j), or k)** above please provide further details: | |

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

**SECTION 2**

## INFORMING THE CORONER'S OFFICE
## (under section 7 of the Coroners Act (Northern Ireland) 1959)

*(complete this section for all death related SAIs)*

| | | | | |
|---|---|---|---|---|
| 1) Was there a Statutory Duty to notify the Coroner at the time of death? **Please select as appropriate (✓)** | **YES** | | **NO** | **X** |
| | If **YES**, insert **date informed**: | | | |
| | If **NO**, please provide details: NOT APPLICABLE | | | |
| 2) Following or during the review of the SAI was there a Statutory Duty to notify the Coroner? **Please select as appropriate (✓)** | **YES** | | **NO** | **X** |
| | If **YES**, insert **date informed**: | | | |
| | If **NO**, please provide details: NOT APPLICABLE | | | |
| 3) If you have selected 'YES' to any of the above **'1' or '2'** has the review report been shared with the Coroner? **Please select as appropriate (✓)** | **YES** | | **NO** | |
| | If **YES**, insert **date report shared**: | | | |
| | If **NO**, please provide details: | | | |

| **DATE CHECKLIST COMPLETED** | |
|---|---|

[1]*Service User or their nominated representative*

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

**Proposed model of bereavement support to 4 haematology families**

The standard approach to all bereaved families over the past 6 months is to make contact by phone ideally within 2 weeks to offer condolences on behalf of the Trust and to check how the family are. A key focus of this call is to listen, to respond empathically to the grieving person and to address any needs that come to the fore through the call. Frequently such needs are addressed by sending out information or by signposting or referring onto other services such as Cruse Tele-friending service which makes regular phone contact with bereaved, isolated or lonely people. These cases are closed following one or two contact calls.

For some families, the added constraints associated with dying in hospital compound their grief. This is often associated with gaps in their understanding/knowledge of their loved one's final days/hours when they have not been present, guilt and frustration that not all family members had the opportunity to see their loved one before death or anger when they, or their loved one, experienced poor care. These cases remain open for longer, as the bereavement team endeavours to resolve the outstanding queries and concerns. Addressing these issues is important as they often become the focus for the grieving person, blocking more normative grieving processes and increasing the risk of longer term complicated grief. We have maintained contact with these families until we have got an outcome, although for some it has not been the outcome they were hoping for.

For the four families whose loved ones were under the care of the haematology team and subsequently developed Covid-19 and died, there is yet another dimension to their grief because they came to harm in the hospital. We can anticipate that, as in similar situations, their grief will be heightened because they are angry and because they will need answers to a myriad of questions. These families require a more nuanced approach to bereavement support due to the circumstances of their loved one's death and because of the parallel serious adverse incident review that will take place. These elements will be embedded in their grief.

From my perspective, making timely contact with the families in an empathic, compassionate manner in keeping with what is provided to other families is critical and that they are offered ongoing bereavement support which they can accept or decline. For those who accept, the goal will be as above and to respond to whatever their needs might be. It is difficult to predict what they will need, but it is likely that holding their anger, hearing their questions and bringing them back to the Trust will be part of the support. If these needs come to the fore, it will not be possible to say to the family that they are outside my scope of responsibility. This introduces an interface with the SAI review. I see the bereavement support role as being independent of the SAI process and different from the family liaison role but there are elements of overlap. It will therefore be important to have a clear line of communication with the governance team. The bereavement support role would remain fluid with the family and may move 'into the background' as the family liaison role becomes more critical as the SAI progresses.

Capacity

The bereavement support model has been in place for six months in response to Covid-19. The bereavement team currently consists 0.6 WTE nurse and myself. As bereavement co-ordinator, I am endeavouring to maintain this enhanced service as well as delivering on my core responsibilities. Providing bereavement support to these families has the potential to further increase my workload.

There are more haematology patients whose outcome is uncertain and who may die increasing the number of families who may require an increased level of support. I would be responsible for supporting these families.

The intensity of engagement is difficult to predict because it will be family led. It is possible that some families will decline support. While initial contacts may take more time, it is anticipated that ongoing contact will be by phone on a two weekly basis. Christine Armstrong who is co-ordinating the implementation of Care Opinion may have some capacity to undertake this work as additional hours. Christine was working with the bereavement team and has prior experience of supporting families through SAIs.

Suggested way forward

There are a number of unknowns but it is important that bereavement support is not stalled as timely, compassionate engagement may in itself prove of therapeutic benefit to these families. I therefore suggest the following actions:

- Clarify who plans to maintain contact with families and the purpose of their contact (to avoid duplication and to ensure that, everyone who needs to, is aware of who else is communicating with the family and the nature of their engagement).
- Undertake outreach calls in a similar manner to the calls made to all families whose loved one dies in hospital and determine whether families request or decline support.
- Respond to expressed needs as re current processes.
- Establish communication pathway to the governance team.
- Keep roles under review, with the potential to flex as circumstances change.
- Monitor work levels and seek additional support to facilitate this work if overloaded.

Southern Health and Social Care Trust

*Quality Care - for you, with you*

**Our Ref:**

**Private & Confidential**

Mrxxx
Xxxx
Xxxx

Dear Mr

The Southern Health and Social Care Trust has been providing your treatment and care in relation to your urology condition.

The Trust is currently reviewing the cancer pathways in relation to the urology service. The purpose of this review is to identify if there has been any deviation from the recommended pathways in relation to your care and a number of other patients within the Trust which may have impacted on your treatment and care.

When the Trust is concerned that a patient has not received the treatment and care we expect, it is practice to commission a Serious Adverse Incident (SAI) of the care provided to ascertain if there were any lessons to be learned so that Trust services can be improved in the future. In order to have a degree of independence, the review is chaired by an external independent expert who does not work within the Southern Health and Social Care Trust. The Chair of this review is Dr Dermot Hughes, retired medical director from the Western Heath and Social Care Trust.

Dr Hughes would welcome a chance to engage with you or a family member nominated by you, to contribute to this review.

Alternatively if you would prefer to wait until the review is completed I will write to you again to offer the sharing of the draft report and provide you with an opportunity to comment on the report from the perspective of the family. At that stage I will arrange, if you so wish, for the appropriate members of the review team to meet with you in order to discuss any issues or concerns you may have in relation to the draft findings.

I hope you that you will consider giving the Trust an opportunity to gather all key information including your thoughts and comments. I have enclosed a guide for Service Users and their Family / Carers on the SAI process. If you would like to discuss the content of this letter, please do not hesitate to contact Mrs Patricia Kingsnorth on telephone no: Personal Information redacted by the USI or by emailing the Clinical and Social Care Governance Department on acute.governance@southerntrust.hscni.net.

Yours sincerely,

_____

Southern Health and Social Care Trust

*Quality Care - for you, with you*

Acute Clinical Governance and Social Care

# MEETING WITH ACUTE DIRECTOR

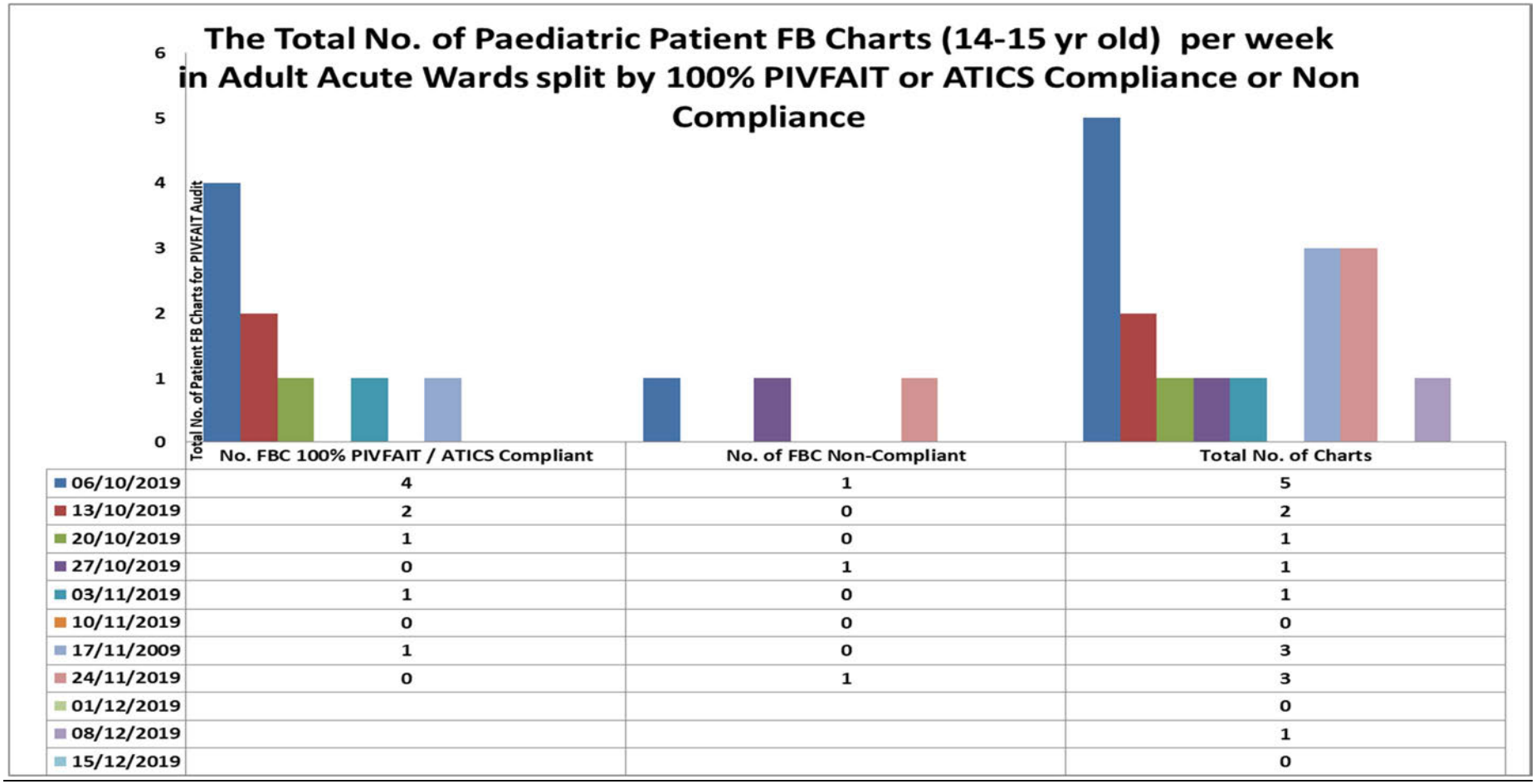
Date: Monday 27 January 2020

# AGENDA

| | |
|---|---|
| **1.0** | **SAI/ SEA reports**<br><br>**16 SEA**<br>**12 SAI plus urology cases**<br><br>**Litigation response** Personal Information |
| | **Complaints**<br><br>**Ombudmans response.** |
| **6.0** | **AOB**<br>**IPT in progress.**<br><br>IVF audit_Acute and CYP summary for wee |

# Acute: IV fluids cases completed using the PIVFAIT or the ATICS audit tool at 15/12/19

## Overall summary




| | No. FBC 100% PIVFAIT / ATICS Compliant | No. of FBC Non-Compliant | Total No. of Charts |
|---|---|---|---|
| 06/10/2019 | 4 | 1 | 5 |
| 13/10/2019 | 2 | 0 | 2 |
| 20/10/2019 | 1 | 0 | 1 |
| 27/10/2019 | 0 | 1 | 1 |
| 03/11/2019 | 1 | 0 | 1 |
| 10/11/2019 | 0 | 0 | 0 |
| 17/11/2009 | 1 | 0 | 3 |
| 24/11/2019 | 0 | 1 | 3 |
| 01/12/2019 | | | 0 |
| 08/12/2019 | | | 1 |
| 15/12/2019 | | | 0 |

| Week ending | No. FBC 100% PIVFAIT Compliant | No. of FBC Non-Compliant | Total No. of Charts | PIVFAIT cases | PIVFAIT cases compliant | ATICS cases | ATICS cases compliant | Overall % Compliant cases |
|---|---|---|---|---|---|---|---|---|
| 22/09/2019 | 2 | 0 | 2 | 1 | 1 | 1 | 1 | 100 |
| 29/09/2019 | N/A | N/A | 0 | 0 | N/A | 0 | N/A | N/A |
| 06/10/2019 | 4 | 0 | 5 | 1 | 0 | 4 | 4 | 80 |
| 13/10/2019 | 2 | 0 | 2 | 1 | 1 | 1 | 1 | 100 |
| 20/10/2019 | 1 | 0 | 1 | 0 | N/A | 1 | 100 | 100 |
| 27/10/2019 | 0 | 1 | 1 | 1 | 0 | 0 | N/A | 0 |
| 03/11/2019 | N/A | N/A | 1 | 0 | N/A | 1 | 1 | 100 |
| 10/11/2019 | N/A | N/A | 0 | 0 | N/A | 0 | N/A | N/A |
| 17/11/2019 | N/A | N/A | 3 (2*) | 0 | N/A | 1 | 1 | 100 |
| 24/11/2019 | N/A | N/A | 3 (2*) | 0 | N/A | 1 | 0 | 0 |
| 01/12/2019 | | | 0 | | | | | |
| 08/12/2019 | | | 1* | | | | | |
| 15/12/2019 | | | 0 | | | | | |

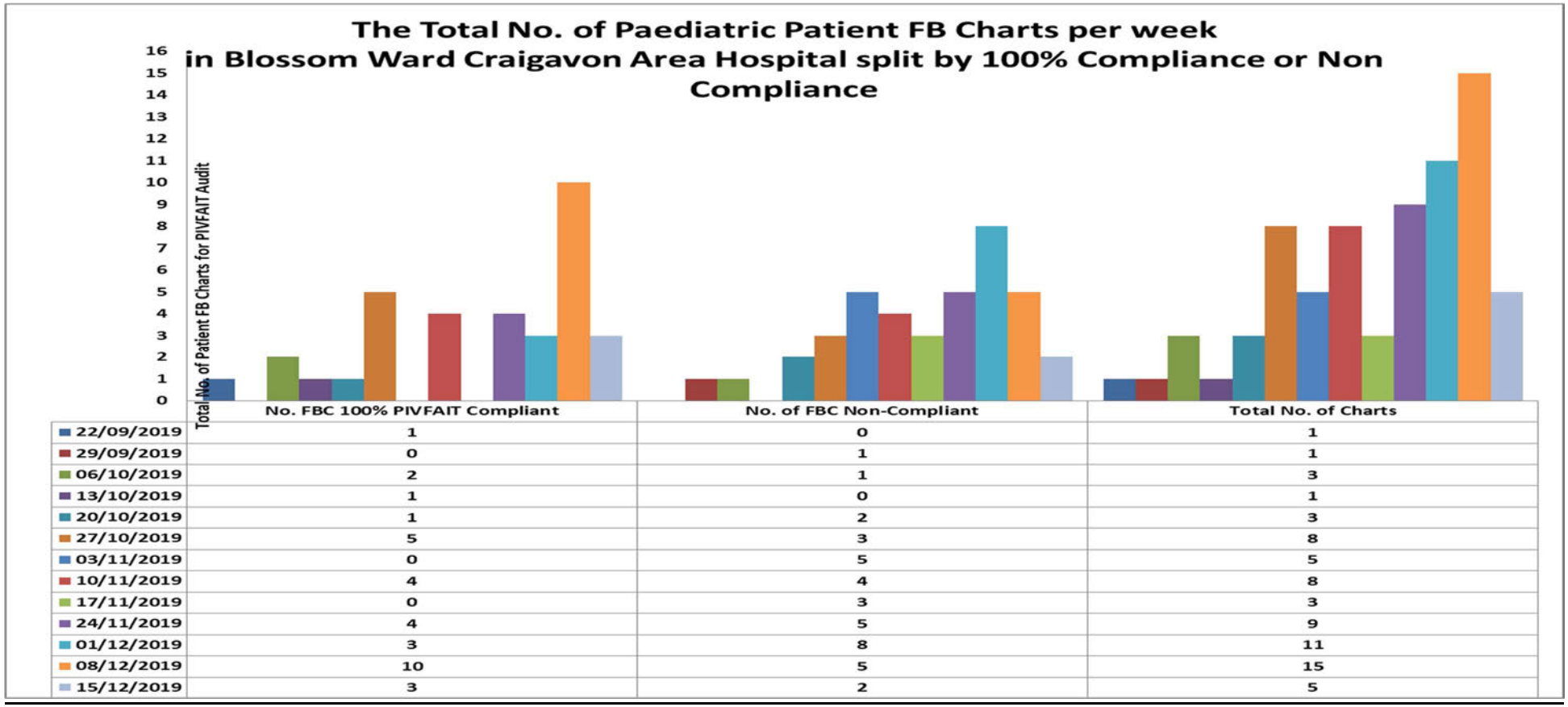
*This denotes cases awaiting review with clinical sisters

## Outstanding returns

| Hospital | Ward |
|---|---|
| Daisy Hill (w/e 1/12/19) | Female Surgical |
| Daisy Hill (w/e 8/12/19) | Female Surgical |
| Daisy Hill (w/e 15/12/19) | Female Surgical |
| Craigavon (w/e 8/12/19) | Elective Admission |
| Craigavon (w/e 15/12/19) | Elective Admission |
| Craigavon (w/e 15/12/19) | Day Procedure Unit |
| Craigavon (w/e 15/12/19) | CCU 1 North |
| Craigavon (w/e 15/12/19) | 3 South |

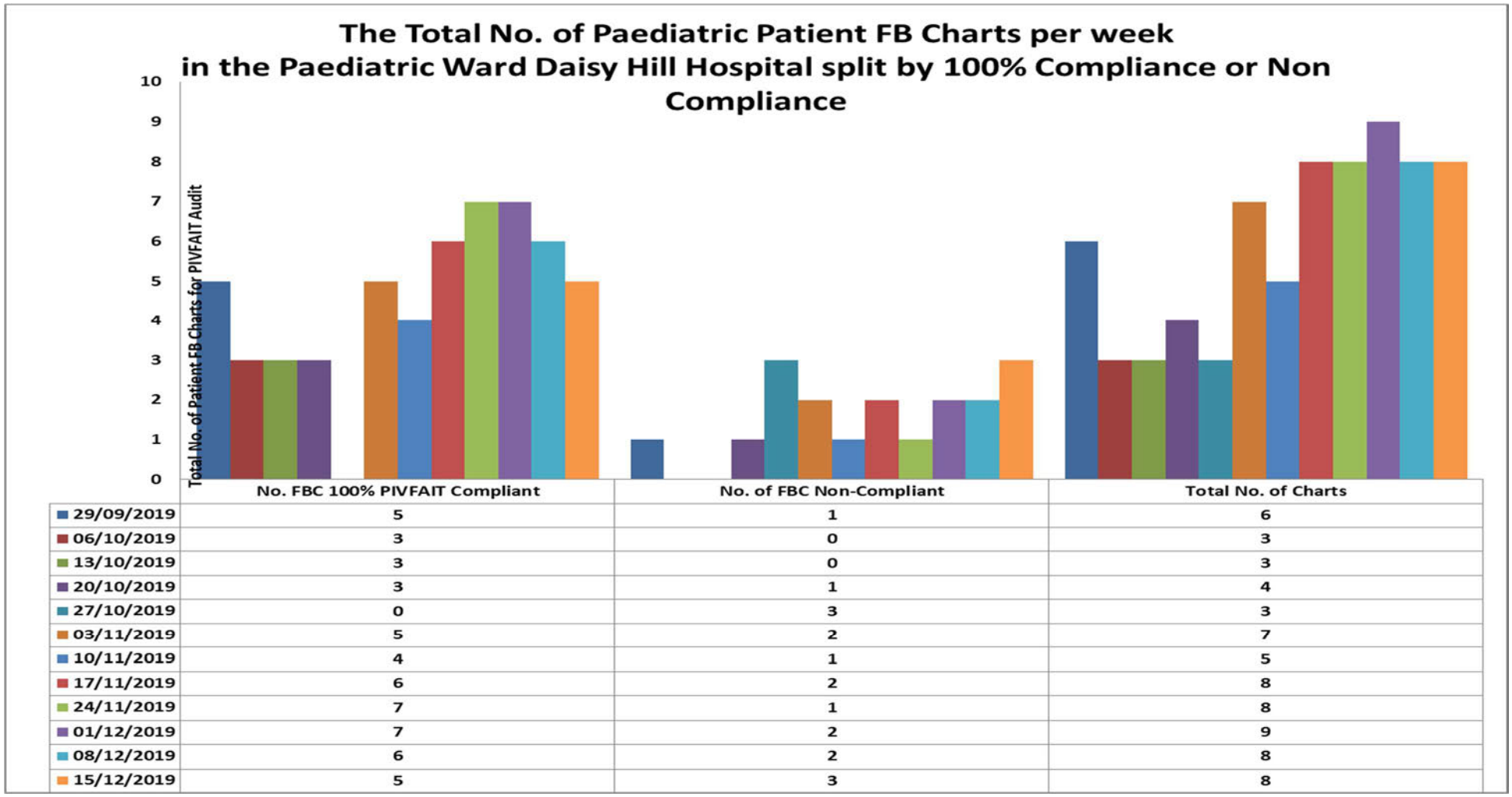
# Children and Young People: IV fluids cases completed using the PIVFAIT audit tool at 8/12/19

## Craigavon Area Hospital



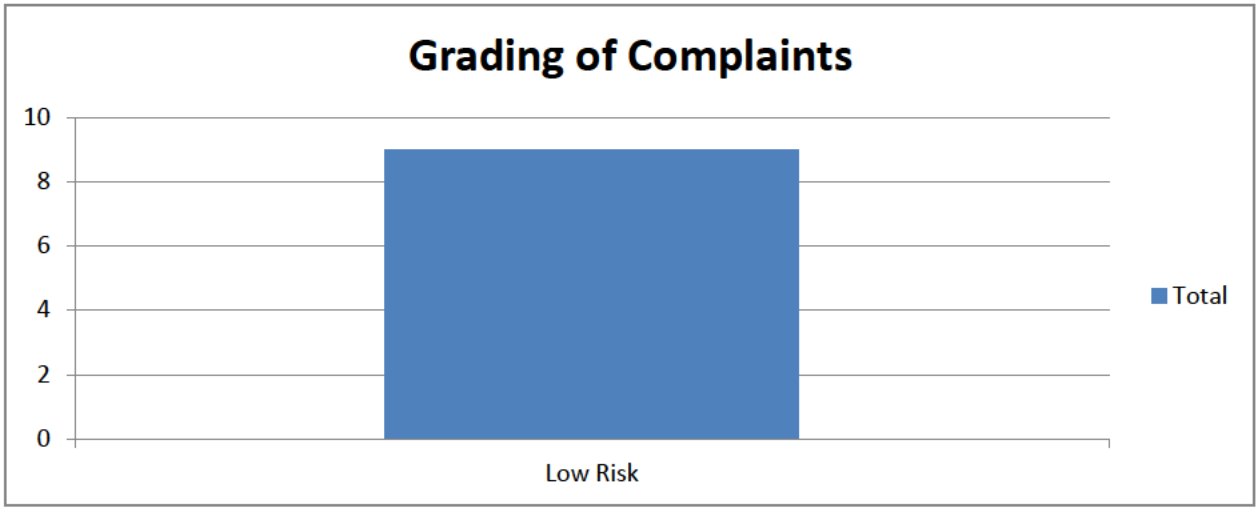

| | No. FBC 100% PIVFAIT Compliant | No. of FBC Non-Compliant | Total No. of Charts |
|---|---|---|---|
| 22/09/2019 | 1 | 0 | 1 |
| 29/09/2019 | 0 | 1 | 1 |
| 06/10/2019 | 2 | 1 | 3 |
| 13/10/2019 | 1 | 0 | 1 |
| 20/10/2019 | 1 | 2 | 3 |
| 27/10/2019 | 5 | 3 | 8 |
| 03/11/2019 | 0 | 5 | 5 |
| 10/11/2019 | 4 | 4 | 8 |
| 17/11/2019 | 0 | 3 | 3 |
| 24/11/2019 | 4 | 5 | 9 |
| 01/12/2019 | 3 | 8 | 11 |
| 08/12/2019 | 10 | 5 | 15 |
| 15/12/2019 | 3 | 2 | 5 |

## Daisy Hill Hospital (includes data from 4 additional cases for week ending 8/12/19)




| | No. FBC 100% PIVFAIT Compliant | No. of FBC Non-Compliant | Total No. of Charts |
|---|---|---|---|
| 29/09/2019 | 5 | 1 | 6 |
| 06/10/2019 | 3 | 0 | 3 |
| 13/10/2019 | 3 | 0 | 3 |
| 20/10/2019 | 3 | 1 | 4 |
| 27/10/2019 | 0 | 3 | 3 |
| 03/11/2019 | 5 | 2 | 7 |
| 10/11/2019 | 4 | 1 | 5 |
| 17/11/2019 | 6 | 2 | 8 |
| 24/11/2019 | 7 | 1 | 8 |
| 01/12/2019 | 7 | 2 | 9 |
| 08/12/2019 | 6 | 2 | 8 |
| 15/12/2019 | 5 | 3 | 8 |

## Grading Bar Chart Formal Complaints received 07.12.2020 – 13.12.2020




## ACUTE DIRECTORATE

**Data provided by Corporate Office from the Datix Incident Management System to the Weekly Governance De-Brief (Thursday mornings - 9am – 10am)**

1. **Status of SAI's** - Summary of the status of SAI's between 07.12.2020 – 13.12.2020
   Any reports received after Friday will not be reflected in the numbers below until the following week

| More than 26 weeks | Less than 26 weeks | Within Timescales | Level 3 | Total |
|---|---|---|---|---|
| 5 | 9 | 5 | 9 | 28 |

2. **Reopened Complaint-** [redacted] **alleged assault – Being taken foward.**

3. **Ombudsman Case -** [redacted] **Final report received 09/12/2020.**

**4. Issues escalated by Corporate or Directorate office at meeting –**

Complaint received re attendance at DHH ED and Gynae – *Shared with relative team for investigation*
W125386/129902 Staff member felt her registration was in danger while working in CAH ED department
W125229/129734 Patient is an inpatient in HDU Daisy hill hospital, was booked for CT TAVI on Thursday 10/12/20 at South Tyrone hospital. Emergency ambulance for transfer back, crew never arrived; patient remained in department for a further 4.5 hours. *Redirected to HDU for investigation*
W125246/ 129762 Not reviewed as scheduled in march 2020 due to covid was then placed on drs waiting list without a comment warning that he was on a biologic and therefore not picked up. *To be presented at screening*
W125256/129772 Patient had respiratory arrest on ward secondary to aspiration on lunch – *Ongoing issue with SLT*
W125267/ 129783 COVID and overcrowding in ED
W125329 Ambulance crew left patient who had been vomiting and pain score 9/10 – *Intertrust with NIAS*
W125382 / 129898 PSNI left patient unattended before triage – *PSNI to respond to incident*
W125387 Pt booked onto ED system at 16:00 but remained in ambulance until 22:00 due to no space in dept. Missed insulin administration
W125393 / 129909 Child Prescribed And Received Wrong Dose Of Medication (Dexamethasone)

## MENTAL HEALTH AND DISABILITY DIRECTORATE

**Data provided by Corporate Office from the Datix Incident Management System to the Weekly Governance De-Brief (Thursday mornings - 9am – 10am)**

**5. Status of SAI's**

Summary of the status of SAI's between 07.12.2020 – 13.12.2020

Any reports received after Friday will not be reflected in the numbers below until the following week

| More than 26 weeks | Less than 26 weeks | Within Timescales | Level 3 – No timescale | Total |
|---|---|---|---|---|
| 19 | 21 | 5 | 4 | 49 |

**6. Early Alert**

Update re Dorsy Joint Protocol

**7. RIDDOR**

129472 –Slipping on ice on path attended ED, very bad whiplash

**8. Issues escalated by Corporate or Directorate office at meeting.**

**9. Ombudsman Case** – 17902 Final report received 15/12/2020

CHILDREN AND YOUNG PEOPLE SERVICES DIRECTORATE

Data provided by Corporate Office from the Datix Incident Management System to the Weekly Governance De-Brief (Thursday mornings - 9am – 10am)

**10. Status of SAI's**

Summary of the status of SAI's between 07.12.2020 – 13.12.2020

Any reports received after Friday will not be reflected in the numbers below until the following week

| Less than 26 weeks | More than 26 weeks | Within Timescales | On Hold | Total |
|---|---|---|---|---|
| 2 | 3 | 3 | 1 | 9 |

The CYPS Governance Team is in regular contact re: the 3 SAIs which are currently on hold.

**11. Ombudsman**

Draft report received for 19150 25/11/2020

**12. Issues escalated by Corporate or Directorate office TBC at meeting**

## OLDER PEOPLE AND PRIMARY CARE SERVICES DIRECTORATE

Data provided by Corporate Office from the Datix Incident Management System to the Weekly Governance De-Brief (Thursday mornings - 9am – 10am)

**13. Status of SAI's**

Summary of the status of SAI's between 07.12.2020 – 13.12.2020

Any reports received after Friday will not be reflected in the numbers below until the following week

| More Than 26 weeks | Within Timescale | Less Than 26 Weeks | Total |
|---|---|---|---|
| 2 | 1 | 3 | 6 |

**14. Early Alert**

2 x GP OOH

**15. Ombudsman Case**

17262 Final report received 10/12/2020.

**16. Issues escalated by Corporate or Directorate office TBC at meeting**

2 SAI's to be de-escalated

Incident [redacted] to be followed up and update to be provided

LITIGATION

## 17. New Clinical negligence

| Ref | Directorate | Division | Incident type | Incident date | Claim date | Opened date | Description |
|---|---|---|---|---|---|---|---|
| MNS | ACUTE | CCS | Covid-19 | 03/11/2020 | 14/12/2020 | 11/12/2020 | COVID DELAY IN TREATMENT Plaintiff alleges was due red flag surgery to remove cancerous lump in breast and then to commence radiotherapy, this surgery has been delayed due to closure of the breast clinic and all theatres in Daisy Hill only emergency surgeries to be completed |
| MNS71/1256 | ACUTE | IMWH | Failure to diagnose/delay in diagnosis | 17/04/2014 | 30/11/2020 | 11/12/2020 | Plaintiff alleges failure to diagnose an obstetric sphincter injury and failure to carry out full exam prior to repairing episiotomy |

## 18. Clinical Negligence Claims Listed for Hearing in December 2020

| Ref | Directorate | Division | Incident type | Incident date | Claim date | Opened date | Description |
|---|---|---|---|---|---|---|---|
| MN S71/552 | ACUTE | MUC | Inappropriate Treatment | 06/11/2008 | 07/05/2010 | 13/06/2010 | Hearing was listed for 07/12/2020. Case subject to formal withdrawal with Trust bearing their own costs.<br><br>Negligence surrounding stent procedure. Allegations of negligence relate to damage to left common removal artery at angioplasty. Angioseal failed. |

## 19. Coroner's Inquiries and Inquests

| Ref | Directorate | Division | Incident date | Claim date | Opened date | Description |
|---|---|---|---|---|---|---|
| CO 3298/2020 | ACUTE | SEC | 16/11/2020 | 05/12/2020 | 07/12/2020 | Preliminary finding is :Aspiration Pneumonia, Small Bowel LLeus, Pancreatitis. Request for statements received. |
| CO | ACUTE | MUC | 24/06/2019 | 09/12/2020 | 09/12/2020 | Child death, cardiac arrest. Coroner request for statements and medical records. |

- No full Inquest Hearings listed in December 2020

- The following preliminary Inquest Hearings scheduled in December 2020

| Ref | Directorate | Division | Incident date | Claim date | Opened date | Description |
|---|---|---|---|---|---|---|
| CO 4281/2019 | ACUTE | SEC | 18/12/2019 | 23/12/2019 | 23/12/2019 | ***Preliminary Hearing - Tuesday 15th December 2020 @ 11:00am via Sightlink***<br><br>Patient in 4 North, CAH, absconded from ward on 17/12/2019. Patient was found deceased the next day off hospital grounds. |

**20. Vaginal Mesh Cases**

The Trust has 17 open cases where the allegations relate to vaginal mesh.

| Stage | Number of Mesh Cases |
|---|---|
| **Letter of Claim** | **1** |
| **Discovery** | **4** |
| **Investigation** | **8** |
| **Proceedings Issued** | **3** |
| **Trial date Set** | **1** |

A trial date of 17th May 2021 has been set for one of the cases. This is the first case regionally to reach a trial date. DLS advices are that there is some vulnerability in this case. Updates will be provided as the case progresses.

**21. Urology Cases**

Due to the announcement by the Minister for Health that a public inquiry is to be carried out in relation to the work of Urology Consultant who was employed the Trust it is anticipated that there will be an increase in related medico-legal requests and litigation cases. To date no new medico-legal requests or litigation claims have been received which specifically refer to this matter.

**22. Number of Subject Access Requests exceeding timeframe for completion.**

The Medico-Legal Team are unable to comply with the General Data Protection Regulations (GDPR) 2018 in respect of responding to Subject Access Requests within the statutory time-frames. This had been due to the sheer volume of requests (which had increased by approx. 1000 per year) and a lack of staffing to cope with the demand. The Governance Committee have been advised of the ongoing back-log; it has been brought to the attention of the Trust's SIRO and placed on the HROD Risk Register. An application was made to the Strategic Investment Committee for additional funding for staff. This was considered by the

Strategic Investment Committee on 27th July 2020, and approval was provided in principle. Finance are now seeking to identify a recurring funding stream for these posts.

There is currently a back-log of 195 requests that are in excess of 90 days across the following areas:-

The back-log has increased slightly from the previous week, the week-end days are included in counting towards the 90+days and therefore impacts on the work carried out during the week. As outlined previously, the reasons for back-log include (in addition to the staffing and volume issues) - difficulties accessing notes and records, and issues relating to redaction and consent to release.

| Directorate | Acute Services | MH&D | C&YP | OPPC | TOTAL |
|---|---|---|---|---|---|
| Number of Outstanding Requests | 143 | 20 | 29 | 3 | 195 |

## MEDICATION INCIDENTS

**23. Medication Incidents between 07.12.2020 – 13.12.2020**

| Medication Incidents between 07.12.2020 – 13.12.2020 | |
|---|---|
| 129903 | Patient booked onto ED system at 16:00 but remained in ambulance until 22:00 due to no space in dept. Missed insulin administration |
| 129909 | Child Prescribed and Received Wrong Dose Of Medication (Dexamethasone) |
| 129951 | IV Antibiotic dose missed in ED |
| 130009 | Female admitted being treated with neutropenic sepsis and hyponatremia., Tazocin missed in ED |
| 129789 | Administered the wrong patient's medication to patient in ED |
| 129923 | Patient receiving rivaroxaban and enoxaparin concurrently for 2 weeks.<br>Patient came from ICU, where rivaroxaban was on hold. On return to ward 1 South, this was initially on hold and patient covered with enoxaparin (prophylactic dose). Rivaroxaban restarted on 2/12/20 at 13:30 and enoxaparin not stopped. |
| 129892 | One drop of ear drop was inserted into patient's eye rather than his ears where it was prescribed for. |
| 129844 | Fidaxomicin had been advised but was not available and this was not escalated to medical staff for an alternative to be given. C. diff treatment is urgent and should be given without delay.Patient developed diarrhoea in hospital and there was delay in isolation and sampling |
| 129731 | Pt [redacted] was prescribed Hartmanns sol along with other drugs. The patient [redacted] Blood pressure rapidly rose from 90 systolic to 250 systolic. Tried to |

| | |
|---|---|
| | obtain a NIBP but it would not read on either arm, I informed Dr. S & asked her to review [redacted]. I (CD) erected GTN infusion at 10mls/hr as per Dr.S. [redacted]'s BP remained high, up to 275 systolic. The fluids alarmed & checked the pump to discover noradrenaline had been given instead. |

**24.** Issue raised around the recording on incidents on actual harm and potential harm – A meeting to be arranged to discuss

## SAFEGUARDING

**25.** Link to SharePoint site regarding RQIA Notifications/Alerts

http://sharepoint/pr/perfimp/scc/_layouts/15/WopiFrame.aspx?sourcedoc=/pr/perfimp/scc/RQIA%20Notifications%20and%20Alerts/Alert%20Notice%20Board.xlsx&action=default

**26.** Valley Nursing Home – The potential buyer has withdrawn from the agreement. The Trust has commenced movement of the clients.
**27.** 1 Ongoing SAI in MHD
**28.** 1 Ongoing complaint within OPPC , adult safeguarding
**29.** Safeguarding have asked for a process for reporting incidents and complaints to them where there is a safeguarding issue. Complaints team to forward any complaints received to Safeguarding if they feel there are any concerns and Deborah will confirm if it is a safeguarding issue.

## INFORMATION GOVERNANCE

**30. Number of Subject Access Requests exceeding timeframe for completion.**

| Directorate | ACUTE | OPPC | MHD | CYPS | FINANCE | P&R | HROD | CX |
|---|---|---|---|---|---|---|---|---|
| Number of outstanding Requests | 9 | 2 | 11 | 17 | - | - | 1 | - |

These relate to Subject Access Requests which have not been completed within the legislative timescale (legal timeframe 30 days or 90 days for complex requests). These delays are in relation to the demands on Services to carry out redactions of these notes etc. In some cases there are requests which were made in 2019 and have not been progressed. In the last three months we have received three different complaints from the ICO in relation to the time taken to respond to requests.

**31. Data Breaches reported to the ICO**

| Directorate | ACUTE | OPPC | MH&D | CYPS | FINANCE | P&R | HROD | CX |
|---|---|---|---|---|---|---|---|---|
| Breaches | - | - | - | - | - | - | - | - |

There have been no data breaches reported to the ICO in this period. There has been one Complaint to the ICO In this period and this was in relation to the time taken to provide information to an individual in response to a Subject Access Request has now been closed and a response received from the ICO. They have indicated that the Trust is in breach of the Data Protection Act 2018 and retaining this on file in the event that future similar complaints are received.

## NEW STANDARDS AND GUIDELINES RECEIVED AND ASSURANCES DUE OR SUBMITTED

**32. Responses Due and Sent.**

| Title of Correspondence | Full Implementation Date for S&G | Directorates applicability |
|---|---|---|
| OPS and AS - Care Home Admission and Initial Review | Response Due 18/09/2020 – Email sent to HSCB 27/11/2020 | OPPC |
| Reducing the Risk of Oxygen Tubing being Attached to Medical Air | Response due Thursday 17th December | Estates Acute, CYPS, MHD |
| Fit Testing Settings | Response due Friday 18 December | H&S Finance, OPPC, Acute |
| Safer Temporary Identification Criteria for Unknown or Unidentified | Update Required - Response sent 16/12/2020 | Acute |

**33. Work Ongoing**

- Safe use of Valproate in women of childbearing potential (HSC (SQSD)19/17 and HSS(MD) 8/2018) - valproate register sub group meeting held on 26/11/2020 and demonstration of potential use of NIECR is being explored with BSO ITS. Cross directorate MDT working group meeting is

scheduled for 10/12/2020 and outcomes from this register subgroup meeting to be presented and a consensus determined that can be fed back to the ECR Project Board meeting that is being held on 10/12/2020

- Foreign Body Aspiration during intubation, advanced airway management or ventilation – meeting held with Medical Technical Team and Mark Bloomer on 27/11/2020 and it was agreed that in regards to recommendations 1,2 and 3 of the alert these would be discussed at the next Trust Procurement Board meeting in January 2021. Alert was reviewed at Acute S&G forum meeting on 30/11/2020 and the alert is now to be circulated to relevant front line teams so that a risk assessment can be undertaken and any required action taken to mitigate against the risk.

**34.** Care of women presenting with post-menopausal bleeding – Follow up email sent to HSCB regarding the query in relation to recommendation 3 – email sent by SHSCT to the HSCB on 26/11/2020, acknowledged by HSCB on 02/12/2020 confirming email has been forwarded to regional lead for response

**35.** IV Fluid management and prevention of harm from hyponatraemia. Connie to advise Jilly the contact in PHA to speak to raise concerns already raised by SHSCT but not addressed in the revised letter. Dr Hugo Van Woerden is retired as of 27/11/2020 so Connie is seeking an alternative point of contact.

**36.** Caroline has requested an update on the S&G system with Datix – Nicole to follow up

**37. S&G Received**

| Title of Correspondence | Date of Issue from External Agency | Reference | Guidance Type | NICE Assurance 3 month | Full Implementation Date for S&G |
|---|---|---|---|---|---|
| COVID-19 - Guidance for Funeral Directors | 11/12/2020 | HE1/20/596916 | CMO Letter | n/a | n/a |
| Adrenaline for Anaphylaxis Kits – A Reminder to Health Care Professionals | 11/12/2020 | HSS(MD) 85/2020 | CMO Letter | n/a | n/a |
| Peripheral Arterial Disease Diagnosis and Management | 11/12/2020 | CG 147 | NICE Clinical Guideline Update | n/a | n/a |

| | | | | | |
|---|---|---|---|---|---|
| Osteoarthritis Care and Management | 11/12/2020 | CG 177 | NICE Clinical Guideline Update | n/a | n/a |
| Low Back Pain and Sciatica in over 16s Assessment and Management | 11/12/2020 | NG 59 | NICE Clinical Guideline Update | n/a | n/a |
| UPDATE Advice for Carers and Young Carers during Covid-19 Pandemic | 10/12/2020 | COVID | DOH Letter | n/a | n/a |
| Pfizer Biontech COVID-19 Vaccine - Updated Guidance on Managing Allergic Reactions | 10/12/2020 | HSS(MD)84 /2020 | CMO Letter | n/a | n/a |
| Continuation of Seasonal Flu Programme by Peer Vaccinator | 09/12/2020 | HSS(MD) 83/2020 | CMO Letter | n/a | n/a |
| Safe Storage of Epidurals and Checking Processes for the Administration of Controlled Drug Infusions | 09/12/2020 | SQR-SL-2020-073 (AS) | Safety and Quality Reminder of Best Practice Guidance | n/a | 03/03/2021 |
| Position Statement in relation to Covid-19 Vaccine Clinics | 08/12/2020 | COVID | PHA | n/a | n/a |
| Deployment of the Covid-19 Vaccine in Northern Ireland | 07/12/2020 | HSS(MD)82/2020 | CMO Letter | n/a | n/a |
| Atracurium Besilate Solution for Injection Vials and Ampoules (All Strengths) – Supply Disruption Alert | 07/12/2020 | HSS(MD)81/2020 | CMO Letter | n/a | Actions Required |
| Winter Vaccines and Research | 05/12/2020 | HSS(MD)80/2020 | CMO Letter | n/a | n/a |

HYPONATRAEMIA

**38. Regional PIVFAIT Audits**

- CAH CYP week ending 13/12/2020 - await return
- DHH CYP – week ending 06/12/2020 - await return
- DHH CYP – week ending 13/12/2020 - await return

IVF audit_Acute and CYP summary for wee

**Acute**

- Acute - week ending 13/12/2020 -0 cases
- Outstanding cases to review –3 cases all ATICS - awaiting review

**39.** Re-instatement of Regional Operational Policy Templates – June 2020. An extension is being requested re this. Early Alerts, Adverse Incidents and the Being Open have been worked on and will be shared with the Governance teams. Connie had received the draft version of being open, this will be presented at the Steering Group for validation and circulated to the Directorates for comment. Draft templates to be circulated to Coordinators

Memo reinstating HSC (SQSD) 24 19 Re

**40.** PPE Incidents – There is currently not enough information provided within the Datix incidents to provide sufficient detail in relation to PPE.

PPE Report.xlsx

**Attendees**: Dr O'Kane, Connie Connolly, Dr Damian Gormley, Patricia Kingsnorth, Nicole O'Neill, Tony Black, Nicola Bawn, Marita Magennis, Lindsey Liggett, Catherine Weaver, Jilly Redpath, Caroline Beattie, Stephen Wallace, Rebecca Murray, Diane Sloane
**Apologies:** Lynne Hainey

**Alerts Notice Board**

**Section 1a - Homes contracted with the SHSCT Closures to Business /Enforcement Activity/Formal Performance Management Arrangements in place (Voluntary, Trust, RQIA) - to be completed by CCT**

*This section excludes Providers where the issue is being dealt with exclusively via a SHSCT lead PVA, Complaints, SAI or Internal Audit Priority 1 process*

| Name of Provider | Associated Group | Sector | Host Trust | SHSCT Contract In Place | SHSCT Clients Placed | Type of Alert/Process | First Date Alert Added to Noticeboard | Date of Alert (If Enforcement/FTC add date action taken) | Compliance Required by (FTC only) | Closed to SHSCT New Admissions /Referrals | Restrictions to Admissions by RQIA/ Other Trusts | Date Closed to New Business (Date Sanction Initiated) | Sanction Initiated by | Date Agreed to Review Decision/ Continuation of Process | SHSCT Lead Professional Contact |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Date of last update: 04/03/2022** | | | | | | | | | | | | | **KEY:** | **Closed to SHSCT New Admissions/New Referrals**<br>**Provider voluntarily closed to admissions** | |
| **Section 1a - Homes contracted with the SHSCT Closures to Business /Enforcement Activity/Formal Performance Management Arrangements in place (Voluntary, Trust, RQIA) - to be completed by CCT**<br>*This section excludes Providers where the issue is being dealt with exclusively via a SHSCT lead PVA, Complaints, SAI or Internal Audit Priority 1 process* | | | | | | | | | | | | | | | |
| Chestnut Lodge Care Home | Healthcare Ireland | Nursing Home | SHSCT | Yes | Yes | Letter of unsatisfactory performance | 02/08/2021 | 30/07/2021 | | No | No | 30/07/2021 Sanction lifted December 2021. | SHSCT | 30/07/2021: Chestnut lodge closed to new admissions due to 9 contract compliances and 4 Adult Safeguarding investigations.<br>16/08/2021: An exceptional contract meeting to be scheduled for this week when the manager returns from leave<br>21/10/2021: SHSCT representatives have reviewed the Unsatisfactory Performance Process to date and have decided to continue with the suspension on Chestnut Lodge Care Home from being included on the SHSCT's list of available residential care accommodation.<br>22/10/2021: Performance Notice issued.<br>03/12/2021: Reopened to new admissions, still in performance management, | Aileen Mulligan |
| Carlingford Lodge Care Home including the docks residential unit | Priory | Nursing Home | SHSCT | Yes | Yes | Performance Notice 1<br><br>Performance Notice 2 | 22/11/2021 | 19/22/2021 | | Yes | No | 19/11/2021 | SHSCT | 19/11/2021: Further to recent meetings on the 12/11/2021 and 19/11/2021, SHSCT has closed home to new admissions. Performance Notice also has been issued due to unsatisfactory performance due to areas of concern identified through the complaints process, adult safeguarding process and RQIA quality improvement plan and medication inspections of the home.<br>Action plan to be received by 03/12/2021 with all actions having a resolution date no later than the 31/01/2022. Action plan was received 02/12/2021 and is being reviewed. | Aileen Mulligan |
| The Firs Home | None | Nursing Home | SHSCT | Yes | Yes | N/A | 17/12/2021 | N/A | N/A | Yes | Yes | See column O | N/A | <u>For Information</u><br>Not a compliance issue - The Firs is in termination process.<br>The Firs Home have given three months notice of termination effective 24 Feb.<br>Firs Home have given three months notice of termination effective 24 Feb 2022. This has now been extended until the 24 June 2022. | Roisin O'Hare |
| **Section 1b - Domiciliary Care Agencies contracted with the SHSCT Closures to Business /Enforcement Activity/Formal Performance Management Arrangements in place (Voluntary, Trust, RQIA) - to be completed by CCT**<br>*This section excludes Providers where the issue is being dealt with exclusively via a SHSCT lead PVA, Complaints, SAI or Internal Audit Priority 1 process* | | | | | | | | | | | | | | | |
| Provincial Care | | Dom Care | SHSCT | Yes | | Performance Notice 1<br><br>Performance Notice 2 | 24/09/2020<br><br>26/10/2020 | 06/03/2020<br><br>22/10/2021 | Action plan required 19/11/2021 | Yes | | 22/10/2021 | Trust | 03/03/2020: Performance Notice 1 issued by Trust due to failure around care commission, unsatisfactory management including on call arrangements and poor monitorng and reporting.<br>25/06/2020: Action plan recieved and reviewed, feedback provided. New action plan required by 11/08/2020.<br>22/10/2021: Performance Notice 2 issued due to weaknesses identified by BSO Internal Audit in the system of governance, risk management and control, which resulted in an overall, "Limited" level of assurance with Five Priority 2 and Four Priority 3 Recommendations. This audit was commissioned by the Trust to validate the system of internal control within Provincial Care. New buisness continues to be suspended. | Roisin Fitzpatrick-Harkin |
| Ann's Homecare | | Dom Care | SHSCT | Yes | | Performance Notice 1<br><br>Performance Notice 2 | 24/09/2020<br><br>24/09/2021 | 28/08/2019<br><br>04/08/2021 | 30/09/2021 | No | No | NA | Trust | 28/08/2019: Performance Notice issued as a result of findings in IA<br>27/09/2021: Performance Notice 2 as a result of a number of issues such as poor record keeping, medicaiton areas, professionalism and staffing<br>Action plan has been received and is being reviewed.<br>21/02/22: Performance Notice 2 closed. (Performance Notice 1 remains open) | Roisin Fitzpatrick-Harkin/Melanie McClement's |
| T-Gem Health Care | | Dom Care | SHSCT | Yes | | Letter of unsatisfactory performance<br>3 FTCs | 29/07/2021 | 23/07/2021<br><br>18/08/2021 | 02/11/2021 | No | No | 23/07/2021 | Trust/ RQIA | 23/07/2021: SHSCT has placed an interim suspension on T-Gem whereby the Trust temporarily ceased to refer Service Users to the Agency, due to staffing issues and safeguarding concerns.<br>16/08/2021: 3 FTCs have been issued due to regulations in regards to the Registered Person, (Reg 11, 15.6 and 21.1).<br>18/08/2021: Performance Notice issued, action plan to be submitted 03/09/2021<br>04/11/2021: Compliance achieved on the following 3 FTC; FTC000158, 159 and 160.<br>18/11/2021:Performance Notice closed and reopened to accepting new referrals.<br>Safeguarding issue remains open. | Roisin Fitzpatrick-Harkin |
| Quality Care | | Dom Care | SHSCT | Yes | | Letter of unsatisfactory performance | 04/11/2021 | 28/10/2021 | | Yes | No | 20/10/2021 | Trust | 28/10/2021: Letter of serious concern issued by the Trust regarding concerns over lack of continuity planning following the resignation of the Newry branch registered manager.<br>20/12/2021: Issue of Performance Notice, remedial action plan required, ceasing referrals until further notice.<br>23/12/2021: Letter issued by RQIA, no enforcement action taken at present but RQIA may consider this should there be any further issues raised regarding oversight and governance of the RI.<br>02/02/2022: Action plan recieved, feedback given by the Trust<br>03/02/2022: Updated actions recieved from Provider, cessation of new packages to be lifted however Performance Management Process remains in place. | Roisin Fitzpatrick-Harkin |

| Name of Provider | Associated Group | Sector | Host Trust | SHSCT Contract In Place | SHSCT Clients Placed | Type of Alert/Process | First Date Alert Added to Noticeboard | Date of Alert (If Enforcement/FTC add date action taken) | Compliance Required by (FTC only) | Closed to SHSCT New Admissions /Referrals | Restrictions to Admissions by RQIA/ Other Trusts | Date Closed to New Business (Date Sanction Initiated) | Sanction Initiated by | Date Agreed to Review Decision/ Continuation of Process | SHSCT Lead Professional Contact |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Homecare Independent Living | | Dom Care | SHSCT | Yes | | Performance Notice | 20/10/2021 | 20/10/2021 | | See column O | No | | Trust | Unsatisfactory performance identified through contract compliances HOIL286 to HOIL301, Quality Monitoring officers findings and continuity issues.<br>Provider self suspended within 2 areas: Portadown and Dungannon, under review as part of the performance notice.<br><br>Action plan received 15/11/2021<br>Have submitted revised action plan on 18/01/2022 as agreed.<br>A futher updated action plan was submitted 03 Feb 2022, currently with AD for review and action | Roisin Fitzpatrick-Harkin |
| The Firs Dom Care Agency | | Dom Care | SHSCT | Yes | | N/A | 17/12/2021 | N/A | N/A | Yes | Yes | See column O | N/A | **For Information**<br>Not a compliance issue - The Firs is in termination process.<br>Firs Dom care have given six months notice of termination effective 24 May. | Roisin Fitzpatrick-Harkin |
| Kingdom Healthcare - Trackars | | Dom Care | SHSCT | Yes | Yes | FTC | 04/03/2022 | 10/02/2022 | 11/04/2022 | No | No | N/A | RQIA | **10/02/2022:** Five Failure to Comply Notices were issued to Kingdom Healthcare Ltd. in relation to governance and management oversight, recruitment, induction and training of staff. | Roisin Fitzpatrick-Harkin |
| **Section 1c - C&V organisations & Supported Living contracted with the SHSCT Closures to Business /Enforcement Activity/Formal Performance Management Arrangements in place (Voluntary, Trust, RQIA) - to be completed by CCT**<br>*This section excludes Providers where the issue is being dealt with exclusively via a SHSCT lead PVA, Complaints, SAI or Internal Audit Priority 1 process* | | | | | | | | | | | | | | | |
| Mindwise | None | C&V | SHSCT | Yes | Yes | SHSCT - Performance Management Process | | 13/04/2015 | n/a | No | No | n/a | SHSCT | 10/09/2018: Meeting with Provider to review PM process. Contract activity noted in amber rating. PM process to continue with a date to review 10/12/2018.<br>10/12/2018 Provider remains in PM<br>03/04/19 - Trust agreed with Provider a new model of care which will be piloted for 1 year<br>9/09/19 - Trust reviewed progress with Provider on the new model of care now in place.<br>Contract Owner to make a decision on whether the PM process can now be closed. | Adrian Corrigan |
| Praxis Castle Lane | Praxis Care Group | SL | SHSCT | Yes | Yes | SHSCT - Performance Management Process | 09/11/2017 | 31/10/2017 | n/a | No | No | n/a | SHSCT | 10.9.18: PM process reviewed with Provider. PM process to continue with a date set to review with Provider on 19.11.18<br>6/12/18 - Contract review/exceptional review completed – agreement reached around funding due back to Trust re failure to meet contracted volumes – invoice issued by Trust 27 December 2018.<br>5/04/19 - Meeting to discuss repayment and hours on block contract. Repayment completed. Provider asked to provide a report to Trust on reconfigured hours. PM process ongoing | Geraldine Rushe |
| Parkanaur College Supported Living | | SL | SHSCT | No | No | NOP&NOD | | 21/01/2021 | n/a | | | | | 21/01/2020 - NOP - Condition has been proposed as the service was not operating. | |
| **Section 1d - Other, outside SHSCT (Dom Care Providers outside Trust area will not be included)** | | | | | | | | | | | | | | | |
| Flaxfield | | Independent Hospital | SEHSCT | No | No | NOP | 21/04/2020 | 20/04/2020 | N/A | Yes | Yes | | RQIA | **No contract with SHSCT, noted for information.**<br>**26/11/2019:** RQIA issued NOP due to serious concerns outlined in the FTCs. These conditions will continue under compliance with the relevant regulations has been achieved and sustained.<br>**06/01/2020:** No new admissions until compliance has been achieved.<br>RQIA gives Notice of Proposal to remove the following conditions to the registration of Flaxfield; no new admissions until compliance is achieved and sustained in relation to medicine, employment of staff and visits by registered provider.<br>The reasons for this Notice of Proposal are; 17/04/2020 -a representative from the SEHSCT requested the condition on Flaxfield registration is removed to allow a young person to be accommodated. An inspection on 26/02/2020 found improved practices had been implemented. RQIA also received 3 monthly monitoring reports for the SEHSCT providing further evidence the required improvements have been implemented and sustained. | |
| Camlo Homes | | RH | BHSCT | No | No | NOP | 25/06/2021 | 03/02/2021 | NA | No | No | No | RQIA | **No contract with SHSCT, noted for information.**<br>03/02/2021: A Notice of Proposal to impose a condition on the registration of Camlo Homes, was issued.<br>19/01/2021: An inspection of Camlo Homes was undertaken, identified that the manager's registration with the Nursing and Midwifery Council (NMC) had lapsed in 2006. It was confirmed that the manager of the home was no | |
| Carn-vaddy | | RH | NHSCT | No | No | FTC | 25/06/2021 | 16/12/2020 | 21/01/2021 | No | No | No | RQIA | **No contract with SHSCT, noted for information.**<br>16/12/2020: Three Failure to Comply Notices were issued to Carn-vaddy on 16 December 2020 and extended on 21 January 2021 in relation to governance | |
| Brooklands | | NH | SEHSCT | No | No | PN | 18/10/2021 | 15/10/2021 | NA | No | No | N/A | SEHSCT | **No contract with SHSCT, noted for information.**<br>15/10/2021- Performance Notice issued by the SEHSCT due to incidents, complaints and issues. There is a serious concern meeting Thursday 21 October 2021 | |
| The Three Rivers | | NH | WHSCT | No | Yes -1 | N/A | 22/11/2021 | 22/11/2021 | | No | No | N/A | | **Contract in place with SHSCT, one client placed.**<br>22/11/2021:The Western Trust are currently responding to a safeguarding issue which has arisen in Three Rivers in Omagh.<br>SHSCT linking in re SHSCT client (1 client placed). SHSCT Key worker is to seek assurance re safety of placement of current SHSCT resident and to inform re any risk to future placements, closing to new SHSCT placements etc. | |
| Summerhill Residential Home | | RH | SEHSCT | No | No | FTC | 26/11/2021 | 25/11/2021 | 25/01/2022 | No | No | N/A | RQIA | **No contract with SHSCT, noted for information.**<br>26/11/2021:Issues found regarding record keeping of staff profiles, managerial and governance arrangements, quality assurance and issues within raising concerns with RQIA. No clients or contract, noted for information | |
| Arbour House | | RH | | No | No | NOP<br>NOD | 01/11/2021 | 30/11/2021<br>07/12/2021 | NA | No | Yes | N/A | RQIA | **No contract with SHSCT, noted for information.**<br>30/11/2021: The Regulation and Quality Improvement Authority gives notice of a proposal to impose the condition of no admissions to the home without the prior approval of RQIA. Arbour House has been non-operational since the beginning of the Covid 19 pandemic in spring 2020 and there is currently no timeframe for returning the service to operation. Considering the time period to date in which the home has not been occupied or utilised, RQIA has issued a Notice of Proposal to impose the above condition on the registration of Arbour House. | |
| Praxis Care Group / Challenge | | RH | SEHSCT | | No | FTC | 21/01/2022 | 15/12/2021 | 09/02/2022 | No | No | N/A | RQIA | **No clients placed, noted for information.**<br>FTC000170 – failings within IPC guidelines<br>FTC000171 – staffing issues in relation to night time cover<br>FTC000172 – monthly monitoring reports not completed robustly | |
| Shaftesbury Mews | | NH | NHSCT | | No | NOP | 21/01/2022 | 14/12/2021 | N/A | No | No | N/A | RQIA | **No clients placed, noted for information.**<br>RQIA gives notice of a proposal to refuse application of an individual as registered manager in respect of Shaftesbury Mews due to a number of concerns such as care delivery, managerial duties and governance - see alert for more info | |

**Section 3 - Governance - SAI/Complaints/Adverse Incidents etc. (To be completed by Governance Team)**
**Date of last update:**

| Name of Provider | Associated Group | Sector | Host Trust | SHSCT Contract In Place | SHSCT Clients Placed | Type of Alert/Process | First Date Alert Added to Noticeboard | Date of Alert (If Enforcement/FTC add date action taken) | Compliance Required by (FTC only) | Closed to SHSCT New Admissions /Referrals | Restrictions to Admissions by RQIA/ Other Trusts | Date Closed to New Business (Date Sanction Initiated) | Sanction Initiated by | Date Agreed to Review Decision/ Continuation of Process | SHSCT Lead Professional Contact |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Name of Provider | | Sector | Host Trust | Trust Lead | Type of Investigation (SAI/Complaint/ Adverse Incident) | Date Investigation Initiated | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |

**Section 4 - Finance Issues - IA Priority 1 Issues etc. (To be completed by Finance)**
**Date of last update:**

| Name of Provider | | Sector | Host Trust | Financial Lead | No. of outstanding P1 Issues |
|---|---|---|---|---|---|
| | | | | | |
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Health and Social Care Board

Public Health Agency

# SAFETY AND QUALITY
# REMINDER OF BEST PRACTICE GUIDANCE

| Subject | Care Home Admission and Initial Review |
|---|---|
| HSCB reference number | SQR-SAI-2020-065 (OPS & AS) |
| Programme of care | Acute Services (AS) / Older People's Services (OPS) |

| LEARNING SOURCE | | | |
|---|---|---|---|
| SAI/Early Alert/Adverse incident | ✓ | Complaint | |
| Audit or other review | | Coroner's inquest | |
| Other (Please specify) | | | |

## SUMMARY OF EVENT

The resident had two admissions to a Nursing Home in January and February 2018, both following admissions to hospital as a result of a noted decline in the residents physical and cognitive functioning.

The resident was found in the bedroom in the nursing home lying on their side on the floor and immediately transferred to the local acute hospital and admitted. A CT head scan indicated bruising on the brain, attributed to the fall. The resident remained in hospital until sadly passing away 7 days after admission.

The resident was placed into a Care Home by the Trust prior to the Home reading the pre-admission assessments or confirming they were in a position to deliver the care being commissioned.

Care Home management failed to update the resident's care plan, records or risk assessments, resulting in nursing and care staff delivering care which was not aligned to the resident's assessed needs. Care Home management failed to notify the Trust Key Worker of all care incidents involving the resident.

## REQUIREMENTS UNDER CURRENT GUIDANCE

**Care Standards for Nursing Homes (DHSSPS 2015) sets the following Standards for practice:**

**Standard 1 – Before Admission**

***Prospective residents (and where appropriate their relatives) have all the information they need to make an informed choice about moving into the home. No resident moves into the home without having their needs assessed and been assured that these will be met.***

Trusts are reminded that in order to ensure compliance with this Standard, the following actions are required:

- Trusts should review their hospital discharge placement policies and ensure residents are not placed with an Independent Sector Provider without prior confirmation that the Provider has read the pre-admission documentation and can meet the particulars of the care being commissioned.

- Independent sector Care Home managers should review their admissions policy and ensure Trust residents are not accepted without prior confirmation that all pre-admission documentation has been read and that the Home can meet the particulars of the care being commissioned.

**Standard 4 – Individualised Care and Support**

***Each resident's health, personal and social care needs are set out in an individual care plan which provides the basis of the care to be delivered and is re-evaluated in response to the resident's changing needs***

Trusts are reminded that in order to ensure compliance with this Standard, the following actions are required:

- Trusts should review their current initial care review Standard Operating Procedures and develop guidance for key workers conducting such reviews within Independent Sector settings to ensure that care is re-evaluated in a timely way and in response to changing needs.

- Any such Standard Operating Procedure and guidance should direct key workers on the content of the initial reviews, including consideration of care delivery, resident related incidents and any necessary follow-ups in accordance with existing Trust Governance arrangements.

## ACTION REQUIRED

**HSC Trusts should:**

1. Disseminate this letter to all relevant staff, and discuss it at team meetings/safety briefings;

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2. Review and as necessary, update your Trust's Hospital Discharge Planning systems in light of the information in the Requirements Under Current Guidance section;

3. Confirm by **18 September 2020** to Alerts.HSCB@hscni.net that actions 1 to 2 have been completed.

**RQIA should:**

1. Disseminate this letter to relevant independent sector providers.

| | | | |
|---|---|---|---|
| **Date issued** | 24 June 2020 | | |
| **Signed:** | Personal Information redacted by USI | Personal Information redacted by USI | Personal Information redacted by USI |
| **Issued by** | Dr Hugo Van Woerden<br>Director of Public Health | Mr Rodney Morton<br>Director of Nursing, Midwifery and Allied Health Professionals | Mrs Marie Roulston<br>Director of Social Care and Children's Services |

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**RE: SQR-SAI-2020-065 (OPS & AS) - Care Home Admission and Initial Review – Distribution List**

| | To – for Action | Copy | | To – for Action | Copy |
|---|---|---|---|---|---|
| **HSC Trusts** | | | **PHA** | | |
| CEXs | ✓ | | CEX | | ✓ |
| First point of contact | | ✓ | Medical Director/Director of Public Health | | ✓ |
| | | | Director of Nursing/AHPs | | ✓ |
| **NIAS** | | | Director of HSCQI | | |
| CEX | | | PHA Duty Room | | |
| First point of contact | | | AD Health Protection | | |
| | | | AD Service Development/Screening | | |
| **RQIA** | | | AD Health Improvement | | |
| CEX | ✓ | | ADs Nursing | | |
| Director of Quality Improvement | | ✓ | AD Allied Health Professionals | | |
| Director of Quality Assurance | | ✓ | Clinical Director Safety Forum | | |
| **NIMDTA** | | | **HSCB** | | |
| CEX / PG Dean | | | CEX | | |
| **QUB** | | | Director of Integrated Care | | |
| Dean of Medical School | | | Director of Social Services | | ✓ |
| Head of Nursing School | | | Director of Commissioning | | |
| Head of Social Work School | | | Alerts Office | | ✓ |
| Head of Pharmacy School | | | Dir PMSI & Corporate Services | | |
| Head of Dentistry School | | | **Primary Care (through Integrated Care)** | | |
| **UU** | | | GPs | | |
| Head of Nursing School | | | Community Pharmacists | | |
| Head of Social Work School | | | Dentists | | |
| Head of Pharmacy School | | | **BSO** | | |
| Head of School of Health Sciences (AHP Lead) | | | Chief Executive | | |
| **Open University** | | | Director of Human Resources | | |
| Head of Nursing Branch | | | Head of procurement | | |
| **Clinical Education Centre** | | | | | |
| **NIPEC** | | | **DoH** | | |
| **NICPLD** | | | CMO office | | ✓ |
| **NI Medicines Governance Team Leader for Secondary Care** | | | CNO office | | |
| **NI Social Care Council** | | | CPO office | | |
| **Safeguarding Board NI** | | | CSSO office | | ✓ |
| **NICE Implementation Facilitator** | | | CDO office | | |
| **Coroners Service for Northern Ireland** | | | Safety, Quality & Standards Office | | ✓ |

Health and Social Care Board

Public Health Agency

# SAFETY AND QUALITY
# REMINDER OF BEST PRACTICE GUIDANCE

| Subject | Reducing the risk of oxygen tubing being attached to medical air |
|---|---|
| HSCB reference number | SQR-SAI-2020-066 (All PoCs) |
| Programme of care | All Programmes of Care |

| LEARNING SOURCE | | | |
|---|---|---|---|
| SAI/Early Alert/Adverse incident | ✓ | Complaint | |
| Audit or other review | | Coroner's inquest | |
| Other (Please specify) | | | |

## SUMMARY OF EVENT

Since the issue of PL/2018/019 Reducing the risk of oxygen tubing being attached to air flowmeters in March 2018 and assurance being provided by Trusts regarding the actions required, there have been 5 subsequent SAIs across different inpatient settings where a patient has inadvertently had oxygen tubing connected to medical air via an air flowmeter rather than the oxygen supply.

## REQUIREMENTS UNDER CURRENT GUIDANCE

NHS Improvement issued a Patient Safety Alert "Reducing risk of oxygen tubing being connected to air flowmeters" in 2016 with supporting information including a video.

https://www.england.nhs.uk/publication/patient-safety-alert-reducing-risk-oxygen-tubing-being-connected-air-flowmeters/

Three barriers to human error have already been recommended by the NPSA and British Thoracic Society (BTS) but continuing incidents suggest they have not been universally implemented:

1. Medical air terminal units (wall outlets) are covered with designated caps in areas where there is no need for medical air. Medical air outlets were traditionally built into most clinical areas for the delivery of nebulised treatment but not all areas need them (eg they never have patients who need nebulisers, or they have access to electrically driven compressors or ultrasonic nebulisers).

2. Medical air flowmeters are removed from terminal units (wall outlets) and stored in an allocated place when not in active use. Removing unnecessary equipment is a more effective method of reducing human error than adding labels or warnings alone.
3. Air flowmeters are fitted with a labelled, movable flap. The lettering on the flap is larger and more visible than on the flowmeter itself and this flap has to be lifted to attach a tube. This acts as a further barrier to unintended connection if staff occasionally forget to remove medical air flowmeters after a period of active use.

Actions required by Trusts in Northern Ireland were outlined as follows:

https://www.health-ni.gov.uk/sites/default/files/publications/health/HSC-SQSD-57-16.pdf

1. Identify a named individual to take responsibility for coordinating the delivery of the actions required within this circular.
2. Review current policies and procedures and if appropriate develop an action plan to ensure that the three barrier methods described in the NHS Improvement Patient Safety Alert to prevent misconnection of oxygen tubing to air flowmeters are instigated in all relevant clinical areas within your organisation.
3. Establish ongoing annual systems of audit or equipment checks to ensure that these policies and procedures are maintained and correctly followed.
4. Ensure that any learning or locally developed good practice information is shared via the Medical Device Liaison Officers network.

This alert was reissued in 2018 to seek assurance from Trusts on the actions required. Unintentional connection of a patient requiring oxygen to an air flowmeter is now classed as a Never Event.

## ACTION REQUIRED

**Trusts should:**

1. Disseminate this letter to relevant staff and discuss it at relevant team meetings/safety briefings.

2. Confirm by **18 September 2020** to Alerts.HSCB@hscni.net that that there are ongoing systems of regular audit of equipment checks in place as referenced in the above guidance.

**NIMDTA should:**

1. Share this Reminder of Best Practice Letter with all relevant doctors in training.

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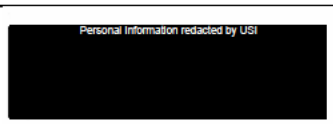
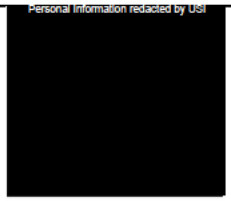
| | | |
|---|---|---|
| **Date issued** | 24 June 2020 | |
| **Signed:** |   |   |
| **Issued by** | Dr Hugo Van Woerden<br>Director of Public Health | Mr Rodney Morton<br>Director of Nursing, Midwifery and Allied Health Professionals |

Health and Social Care Board  Public Health Agency

**RE: SQR-SAI-2020-066 (All PoCs) - Reducing the risk of oxygen tubing being attached to medical air – Distribution List**

| | To – for Action | Copy | | To – for Action | Copy |
|---|---|---|---|---|---|
| **HSC Trusts** | | | **PHA** | | |
| CEXs | ✓ | | CEX | | ✓ |
| First point of contact | | ✓ | Medical Director/Director of Public Health | | ✓ |
| | | | Director of Nursing/AHPs | | ✓ |
| **NIAS** | | | Director of HSCQI | | ✓ |
| CEX | | ✓ | PHA Duty Room | | |
| First point of contact | | ✓ | AD Health Protection | | |
| | | | AD Service Development/Screening | | |
| **RQIA** | | | AD Health Improvement | | |
| CEX | ✓ | | ADs Nursing | | |
| Director of Quality Improvement | | ✓ | AD Allied Health Professionals | | |
| Director of Quality Assurance | | ✓ | Clinical Director Safety Forum | | |
| **NIMDTA** | | | **HSCB** | | |
| CEX / PG Dean | ✓ | | CEX | | |
| **QUB** | | | Director of Integrated Care | | |
| Dean of Medical School | | ✓ | Director of Social Services | | |
| Head of Nursing School | | ✓ | Director of Commissioning | | |
| Head of Social Work School | | | Alerts Office | | ✓ |
| Head of Pharmacy School | | ✓ | Dir PMSI & Corporate Services | | |
| Head of Dentistry School | | | **Primary Care (through Integrated Care)** | | |
| **UU** | | | GPs | | |
| Head of Nursing School | | ✓ | Community Pharmacists | | |
| Head of Social Work School | | | Dentists | | |
| Head of Pharmacy School | | ✓ | **BSO** | | |
| Head of School of Health Sciences (AHP Lead) | | | Chief Executive | | |
| **Open University** | | | Director of Human Resources | | |
| Head of Nursing Branch | | ✓ | Head of procurement | | ✓ |
| **Clinical Education Centre** | | ✓ | | | |
| **NIPEC** | | | **DoH** | | |
| **NICPLD** | | | CMO office | | ✓ |
| **NI Medicines Governance Team Leader for Secondary Care** | | ✓ | CNO office | | ✓ |
| **NI Social Care Council** | | | CPO office | | |
| **Safeguarding Board NI** | | | CSSO office | | |
| **NICE Implementation Facilitator** | | | CDO office | | |
| **Coroners Service for Northern Ireland** | | | Safety, Quality & Standards Office | | ✓ |

Health and Social Care Board

Public Health Agency

# SAFETY AND QUALITY LEARNING LETTER

| Subject | Fit testing settings |
|---|---|
| HSCB ref number | LL/SAI/2020/038 (All PoCs) |
| Programme of care | All Programmes of Care |

| LEARNING SOURCE | | | |
|---|---|---|---|
| SAI/Early Alert/Adverse incident | ✓ | Complaint | |
| Audit or other review | | Coroner's inquest | |
| Other (Please specify) | | | |

## SUMMARY OF EVENT

A serious adverse incident (SAI) notification has been received from a Trust in respect of fit testing of personal protective equipment (PPE). A number of staff had been informed they had passed their fit test which has now been found to be incorrect based on the UK standard of testing.

Previously early alerts had been received from some Trusts regarding this issue.

Since this incident covers all HSCT it has been decided that an independent panel will conduct a level 2 review of the issues under the responsibility of the Public Health Agency. All Trusts and other involved sectors will be involved in the review.

Health and Social Care Board

Public Health Agency

## TRANSFERABLE LEARNING

All fit testing for PPE should be carried out in line with UK standard. Therefore please ensure that steps are taken to ensure fit testing settings for all tests are set to UK requirements. We therefore require you to ensure the following;

1. All fit testing is in line with UK requirement, (https://www.hse.gov.uk/pubns/indg479.pdf ) ensuring that the competency framework within the HSE INDG 479 standard is met and that all training records are accurate and up to date.
2. Prior to each fit testing session that an independent check is made to ensure the software setting aligns with UK requirements and that this is proactively recorded.
3. All fit test certificate outcomes are reviewed to ensure the outcomes align with UK requirements.
4. All staff are given a copy of their fit test certificate and the outcome fully explained. It is also important staff are also advised of the arrangement for raising concerns about their fit test.
5. All records for previous fit tests should be secured and be available for the review panel for the SAI.
6. Improve recording of data to be highly traceable both internally and by any external providers.
7. Put in place an end to end monthly fit testing audit programme.

## ACTION REQUIRED

**All HSC Trusts, primary care and the independent sector providers must ensure that steps 1-7 above are carried out immediately**.

**HSC Trusts should:**

1. Confirm by **10 July 2020** to alerts.hscb@hscni.net that actions 1-7 as outlined in the 'Transferrable Learning' section of this letter have been completed.

**HSCB should:**

1. Disseminate this letter to GP Practices, GP Out-of-hours services, Dental Practices, and Community Pharmacies.

**RQIA should:**

1. Disseminate this letter to relevant independent sector providers.

Health and Social Care Board

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| | | | |
|---|---|---|---|
| **Date issued** | 1 July 2020 | | |
| **Signed:** | Personal Information redacted by USI | Personal Information redacted by USI | Personal Information redacted by USI |
| **Issued by** | Dr Hugo Van Woerden<br><br>Director of Public Health | Mr Rodney Morton<br><br>Director of Nursing, Midwifery and Allied Health Professionals | ***PP*** Dr Sloan Harper<br><br>Director of Integrated Care |

Health and Social Care Board

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**RE: LL/SAI/2020/038 (All PoCs) – Fit Testing Settings – Distribution List**

| | To – for Action | Copy | PHA | To – for Action | Copy |
|---|---|---|---|---|---|
| **HSC Trusts** | | | CEX | | ✓ |
| CEXs | ✓ | | Acting Director of Public Health | | ✓ |
| First point of contact | ✓ | | Director of Nursing, Midwifery and AHPs | | ✓ |
| | | | Director of HSCQI | | ✓ |
| **NIAS** | | | AD Service Development, Safety and Quality | | ✓ |
| CEX | ✓ | | PHA Duty Room | | ✓ |
| First point of contact | ✓ | | AD Health Protection | | ✓ |
| | | | AD Screening and Professional Standards | | |
| **RQIA** | | | AD Health Improvement | | |
| CEX | ✓ | | ADs Nursing | | ✓ |
| Director of Quality Improvement | | ✓ | AD Allied Health Professionals | | ✓ |
| Director of Quality Assurance | | ✓ | Clinical Director Safety Forum | | ✓ |
| | | | | | |
| **NIMDTA** | | | **HSCB** | | |
| CEX / PG Dean | | | CEX | | ✓ |
| **QUB** | | | Director of Integrated Care | ✓ | |
| Dean of Medical School | | | Director of Social Services | | |
| Head of Nursing School | | | Director of Commissioning | | |
| Head of Social Work School | | | Alerts Office | | ✓ |
| Head of Pharmacy School | | | Interim Director of PMSI | | |
| Head of Dentistry School | | | **Primary Care (through HSCB Integrated Care)** | | |
| **UU** | | | GPs | ✓ | |
| Head of Nursing School | | | Community Pharmacists | ✓ | |
| Head of Social Work School | | | Dentists | ✓ | |
| Head of Pharmacy School | | | GP Out-of-hours services | ✓ | |
| Head of School of Health Sciences (AHP Lead) | | | Dispensing GPs | ✓ | |
| **Open University** | | | | | |
| Head of Nursing Branch | | | **BSO** | | |
| | | | Chief Executive | | ✓ |
| **Clinical Education Centre** | | | | | |
| **NIPEC** | | | **DoH** | | |
| **NICPLD** | | | CMO office | | ✓ |
| **NI Medicines Governance Team Leader for Secondary Care** | | | CNO office | | ✓ |
| **NI Social Care Council** | | | CPO office | | ✓ |
| **Safeguarding Board NI** | | | CSSO office | | ✓ |
| **NICE Implementation Facilitator** | | | CDO office | | ✓ |
| **Coroners Service for Northern Ireland** | | | Safety, Quality and Standards Office | | ✓ |

Southern Health and Social Care Trust

# ACTION PLAN for Acute Services

| | |
|---|---|
| **Reference** | **PL/2019/032** |
| **Title of Clinical Guideline** | Safer Temporary Identification criteria for unknown or unidentified patients (Initial correspondence issued: 30/01/2019) |
| **Original Submission Date for Assurance Response / Action Plan to HSCB:** | 5th June 2019 with a further update on progress submitted on 20/08/2020 Further request for an update on progress received by SHSCT on 10/12/2020 |
| **Further Update Position submitted to HSCB** | 16 December 2020 |
| **Operational Director** | Mrs Melanie McClements |
| **Clinical Change Lead/ Designation** | Dr Hilda Nicholl, Mrs Helen Forde and wider MDT *(ED, Radiology, Laboratory, Information Technology, Administration Services)* |

| Recommendation | Current Control Measures | Current level compliance (%) | Action plan | Designated Lead | Deadline for completion |
|---|---|---|---|---|---|
| ***Actions to be taken by Chief Executives of Trusts*** | | | | | |
| ***Recommendation 1:***<br>Identify a leader who can bring together key parties including hospital informatics, emergency admissions, major incident response and pathology services | Dr Hilda Nicholl is the clinical change lead for implementation of the recommendations outlined in this patient safety alert.<br>The working group that has been established to take forward this alert, under the leadership of Dr Nicholl, has confirmed that the Trust's Emergency Departments are the only 2 entry points for these patients. | | No further action is required | | Completed |
| ***Recommendation 2:***<br>Develop a system for the unique temporary identification of unknown patients using: the numbering system outlined in this alert, sex, estimated DOB, and 'name' based on non-sequential phonetic alphabet. | On 12 August 2020 the Regional Information Standards Board sent out the link for the new approved guidance:<br>ISB019 Regional Guidance for the Registration of 'Unidentified' Patients V1.0 (June 2020)<br>This guidance adheres to the recommendations outlined in this patient safety alert, ensuring there is a system in | | . | Dr Hilda Nicholl<br>Mrs Helen Forde<br>Mrs Mary Burke<br>Mr Paul Smith | Completed |

| | | | | | |
|---|---|---|---|---|---|
| | place for the unique temporary identification of unknown patients using the numbering system outlined in this alert, sex, estimated DOB, and 'name' based on non-sequential phonetic alphabet<br><br>An implementation / training plan was subsequently put in place to ensure all relevant staff members are informed of this new regional guidance.<br><br>The new system went live on 14 December 2020 across both CAH / DHH ED sites.<br><br>Following full implementation of the new guidance there will be ongoing monitoring and review of processes | | | | |

| | | | | | |
|---|---|---|---|---|---|
| ***Recommendation 3:***<br>Ensure all IT systems can accept the names and numbers in these formats. | On 12 August 2020 the Regional Information Standards Board sent out the link for the new approved guidance:<br><br>ISB019 Regional Guidance for the Registration of 'Unidentified' Patients V1.0 (June 2020)<br><br>This guidance adheres to the recommendations outlined in this patient safety alert, ensuring there is a system in place for the unique temporary identification of unknown patients using the numbering system outlined in this alert, sex, estimated DOB, and 'name' based on non-sequential phonetic alphabet<br><br>An implementation / training plan was subsequently put in place to ensure all relevant staff members are informed of this new regional guidance.<br><br>The new system went live on 14 December 2020 across both CAH | | | Mr Conor Murphy (ITS)<br><br>Mrs Helen Forde | Completed |

| | | | | | |
|---|---|---|---|---|---|
| | / DHH ED sites<br><br>Following full implementation of the new guidance there will be ongoing monitoring and review of processes | | | | |
| ***Recommendation 4:***<br><br>Develop a robust system for merging medical records once a patient's identity is confirmed | The SHSCT has in place a Procedure for Merging Patient Records on PAS that has been aligned to the current processes that are in place for identifying an unknown or unidentified patient. This will be reviewed against the new regional guidance and will form part of the training programme to support the implementation plan.<br><br>As part of the response to this patient safety alert this procedure has been re-circulated to all staff to remind them of the procedural arrangements that are in place, especially in the context of the learning outlined. | | No further action is required | | Completed |

| | | | | | |
|---|---|---|---|---|---|
| ***Recommendation 5:***<br><br>Communicate the key messages in this alert and your organisation's plan for safer identification systems to all relevant staff | ***SHSCT Emergency Departments***<br><br>This patient safety alert has been circulated to all ED medical and nursing staff. It has been discussed at the medical specialty meeting held on 06/03/2019 and raised at the ED Governance meeting held on 24/04/2019<br><br>A copy of the Patient Safety Alert and Standard Operating Procedures (Registration of Unknown Patient' / Merging Patient Records on PAS) will be shared to all relevant staff working in ED / Minor Injuries units.<br><br>This patient safety alert has been discussed at the following forums:<br><br>***Acute S&G forum***:<br>5 February 2019<br><br>***Acute S&G Professional Leads forum***:<br>29 April 2019 | | No further action is required | | Completed |

| | |
|---|---|
| Please confirm to the HSCB/PHA Alerts office at alerts.HSCB@hscni.net by **5 June 2019** that actions 1-5 above have been completed | Following approval by Acute SMT this was originally sent to the Trust's Corporate Governance Team for onward submission to the HSCB on 5th June 2019.<br><br>***Update July 2020***<br>This guidance was listed on the HSCB update Safety Alerts request report that was to the SHSCT on 29 July 2020. This action plan has been reviewed and approved at the Acute S&G forum held on 20 August 2020. Submitted by the Trust's Corporate Governance team to the HSCB on 20 August 2020<br><br>***Update December 2020***<br>Following an update on progress request by the HSCB on 10th December 2020 the action plan was reviewed, updated and submitted by the clinical implementation team for approval by Acute SMT on 15 December 2020. Following approval the updated action plan was submitted by the Trust's Corporate Governance team to the HSCB on 16 December 2020. |

***Compliance Scale***

| | | | | | |
|---|---|---|---|---|---|
| **100% Compliance** | **70-99% Compliance** | **40-69% Compliance** | **0-39% Compliance** | **Pending** | **Not Applicable** |

**From the Chief Medical Officer**
Dr Michael McBride

Department of
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Castle Buildings
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Our Ref: HE1/20/596916

Date: 10 December 2020

**BY EMAIL**

Chief Executives, HSC Trusts
SOLACE NI (for dissemination to all Local Council Chief Executives)
Joan McCaffrey, Local Government Regional Officer
National Association of Funeral Directors (NI Federation)
Society of Allied Independent Funeral Directors
British Institute of Funeral Directors
Irish Association of Funeral Directors
British Institute of Embalmers
Nicola Brady, Irish Council of Churches

Dear Colleagues

**COVID-19 – GUIDANCE FOR FUNERAL DIRECTORS**

On 21 October, the Department of Health issued revised regional guidance for handling infection risks when caring for the deceased and managing their funerals during the COVID-19 pandemic.

Following the decision to amend the Health Protection (Coronavirus, Restrictions) (No 2) Regulations from 11 December, it is necessary to revise the guidance again to ensure that it aligns with the current situation. Those operating, organising or attending a funeral must comply with this revised guidance.

The main changes relate to the number of people permitted to attend a funeral. The maximum number of 25 mourners has been removed and is now determined by the size and circumstances of the venue (place of worship or funeral home), subject to a risk assessment and ensuring that mourners maintain social distancing of at least 2 metres. This also applies to committals at a graveside or at the City of Belfast Crematorium.

For non COVID-related deaths only, remains can be taken to a private dwelling to allow people to pay their respects or provide comfort for the bereaved and for funeral services to be conducted. In such circumstances, a maximum of 10 people from up to 4 households are permitted to gather at the home. This includes the clergy/officiant and any children under the age of 12.

Face coverings are now mandatory for mourners entering, leaving and throughout at a funeral service in places of worship and funeral homes.

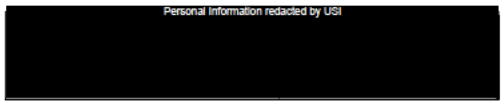
**Where the death is COVID-related, remains are not be taken home and funeral services from private dwellings are not permitted.**

As regulations are amended, I will endeavour to update the guidance as quickly as possible in line with the changing situation.

The revised document can also be found on the DoH and PHA websites at https://www.health-ni.gov.uk/sites/default/files/publications/health/interim-guidance-for-funeral-directors.pdf and https://www.publichealth.hscni.net/covid-19-coronavirus/guidance-professionals-and-organisations#guidance-for-funeral-directors-on-managing-infection-risks-when-handling-the-deceased.

I would ask that this information is cascaded to all relevant stakeholders as a matter of urgency.

Yours sincerely




**DR MICHAEL McBRIDE**
**Chief Medical Officer**

**From the Chief Medical Officer**
**Dr Michael McBride**

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

**HSS(MD) 85/2020**

**For Action**
Chief Executives, Public Health Agency/Health and Social Care Board/HSC Trusts/ NIAS
GP Medical Advisers, Health and Social Care Board
All General Practitioners and GP Locums (for onwards distribution to practice staff)
OOHs Medical Managers (for onward distribution to staff)
RQIA

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Our Ref: HSS(MD) 85/2020
Date: 10 December 2020

**PLEASE SEE ATTACHED FULL CIRCULATION LIST**

Dear Colleague

**ADRENALINE FOR ANAPHYLAXIS KITS – A REMINDER TO HEALTH CARE PROFESSIONALS**

Those of you who prescribe and dispense Emerade devices will be aware of the patient level recalls of Emerade 150 microgram, 300 microgram and 500 microgram devices on 4 March 2020, 7 April 2020 and 18 May 2020 respectively.

As set out previously in HSS(MD) 24/2018, our advice remains to conserve supplies of adrenaline auto-injectors (AAIs) for patients who truly need them. Some healthcare professionals may be holding EpiPen® or similar AAI devices, in preference to adrenaline ampoules, to treat anaphylactic reactions; this should not be necessary.

All healthcare professionals providing services where anaphylaxis treatment may be required, including flu vaccination or COVID-19 vaccination services, should have the competency to draw up and administer adrenaline from ampoules with a normal syringe and needle.

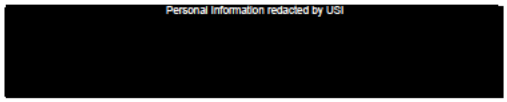
We ask that when you renew the adrenaline in your anaphylaxis kits, you alert all your staff to please stock ampoules (ensuring you also include dosing charts, needles and syringes) and not AAIs. This will reduce the reliance on AAIs and therefore preserve essential supplies for patients, parents, carers, teachers etc. who, as lay persons, cannot be expected to administer adrenaline via a needle and syringe.

The British National Formulary, Green Book and Resus Council guidance provides additional advice to healthcare professionals on the use of adrenaline in response to anaphylaxis.

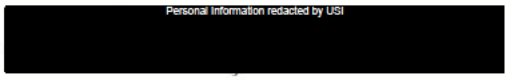
Supplies of adrenaline ampoules are currently available and there is an expectation that healthcare professionals should use these in preference to AAIs.

Thank you in advance for your help with this matter

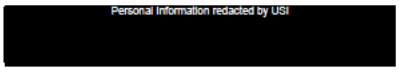
Yours sincerely



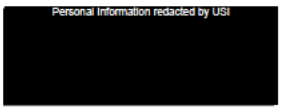

**Dr Michael McBride**
**Chief Medical Officer**




**Cathy Harrison**
**Chief Pharmaceutical Officer**




**Michael Donaldson**
**Acting Chief Dental Officer**




**Professor Charlotte McArdle**
**Chief Nursing Officer**

**CIRCULATION LIST**

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Family Practitioner Service Leads, Health and Social Care Board *(for cascade to GP Out of Hours services)*
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RQIA (*for onward transmission to all independent providers including independent hospitals*)
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Professor Colin Adair, Director of the NI Centre for Pharmacy Learning and Development, QUB
Donncha O'Carolan, HSCB *(for distribution to all General Dental Practitioners)*
Raymond Curran, Head of Ophthalmic Services, HSCB *(for distribution to Community Optometrists)*

This letter is available on the Department of Health website at https://www.health-ni.gov.uk/topics/professional-medical-and-environmental-health-advice/hssmd-letters-and-urgent-communications

NICE National Institute for Health and Care Excellence

NICE guideline

# Peripheral arterial disease: diagnosis and management

Clinical guideline

Published: 8 August 2012
www.nice.org.uk/guidance/cg147

# Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

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This guideline is the basis of QS52.

# Overview

This guideline covers diagnosing and managing peripheral arterial disease (PAD) in people aged 18 and over. Rapid changes in diagnostic methods, endovascular treatments and vascular services associated with new specialties in surgery and interventional radiology have resulted in considerable uncertainty and variation in practice. This guideline aims to resolve that uncertainty and variation.

In December 2020 we reviewed our guidance on opioids for non-cancer pain in response to a Public Health England evidence review on dependence on, and withdrawal from, prescribed medicines. To support discussion with patients about opioid prescribing, and safe withdrawal management, we are developing guidance on safe prescribing and withdrawal management of prescribed drugs associated with dependence and withdrawal and shared decision making. In the meantime, we have added links in this guideline to other NICE guidelines and other resources that support this aim'.

# Who is it for?

- Healthcare professionals
- Commissioners and providers
- Adults, and their families and carers

# Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

## 1.1 Information requirements

1.1.1 Offer all people with peripheral arterial disease oral and written information about their condition. Discuss it with them so they can share decision-making, and understand the course of the disease and what they can do to help prevent disease progression. Information should include:

- the causes of their symptoms and the severity of their disease
- the risks of limb loss and/or cardiovascular events associated with peripheral arterial disease
- the key modifiable risk factors, such as smoking, control of diabetes, hyperlipidaemia, diet, body weight and exercise (see also the recommendation on secondary prevention of cardiovascular disease in people with peripheral arterial disease)
- how to manage pain
- all relevant treatment options, including the risks and benefits of each
- how they can access support for dealing with depression and anxiety.

Ensure that information, tailored to the individual needs of the person, is available at diagnosis and subsequently as required, to allow people to make decisions throughout the course of their treatment. [2012]

1.1.2 NICE has produced guidance on the components of good patient experience in

adult NHS services. Follow the recommendations in NICE's guideline on patient experience in adult NHS services. [2012]

## 1.2 Secondary prevention of cardiovascular disease in people with peripheral arterial disease

1.2.1 Offer all people with peripheral arterial disease information, advice, support and treatment regarding the secondary prevention of cardiovascular disease, in line with published NICE guidance on:

- smoking cessation
- diet, weight management and exercise
- lipid modification and statin therapy
- the prevention, diagnosis and management of diabetes
- the prevention, diagnosis and management of high blood pressure
- antiplatelet therapy. [2012]

## 1.3 Diagnosis

1.3.1 Assess people for the presence of peripheral arterial disease if they:

- have symptoms suggestive of peripheral arterial disease or
- have diabetes, non-healing wounds on the legs or feet or unexplained leg pain or
- are being considered for interventions to the leg or foot or
- need to use compression hosiery. [2012]

1.3.2 Assess people with suspected peripheral arterial disease by:

- asking about the presence and severity of possible symptoms of intermittent claudication and critical limb ischaemia
- examining the legs and feet for evidence of critical limb ischaemia, for example ulceration

- examining the femoral, popliteal and foot pulses
- measuring the ankle brachial pressure index (see recommendation 1.3.3). [2012]

1.3.3 Measure the ankle brachial pressure index in the following way:

- The person should be resting and supine if possible.
- Record systolic blood pressure with an appropriately sized cuff in both arms and in the posterior tibial, dorsalis pedis and, where possible, peroneal arteries.
- Take measurements manually using a doppler probe of suitable frequency in preference to an automated system.
- Document the nature of the doppler ultrasound signals in the foot arteries.
- Calculate the index in each leg by dividing the highest ankle pressure by the highest arm pressure. [2012]

## Diagnosing peripheral arterial disease in people with diabetes

1.3.4 Do not exclude a diagnosis of peripheral arterial disease in people with diabetes based on a normal or raised ankle brachial pressure index alone. [2018]

1.3.5 Do not use pulse oximetry for diagnosing peripheral arterial disease in people with diabetes. [2018]

For a short explanation of why the committee made these 2018 recommendations see the rationale and impact section on diagnosis.

Full details of the evidence and the committee's discussion are in evidence review A: determining diagnosis and severity of peripheral arterial disease in people with diabetes.

# 1.4 Imaging for revascularisation

1.4.1 Offer duplex ultrasound as first-line imaging to all people with peripheral arterial disease for whom revascularisation is being considered. [2012]

1.4.2 Offer contrast-enhanced magnetic resonance angiography to people with peripheral arterial disease who need further imaging (after duplex ultrasound)

before considering revascularisation. [2012]

1.4.3 Offer computed tomography angiography to people with peripheral arterial disease who need further imaging (after duplex ultrasound) if contrast-enhanced magnetic resonance angiography is contraindicated or not tolerated. [2012]

# 1.5 Management of intermittent claudication

## Supervised exercise programme

1.5.1 Offer a supervised exercise programme to all people with intermittent claudication. [2012]

1.5.2 Consider providing a supervised exercise programme for people with intermittent claudication which involves:

- 2 hours of supervised exercise a week for a 3-month period
- encouraging people to exercise to the point of maximal pain. [2012]

## Angioplasty and stenting

1.5.3 Offer angioplasty for treating people with intermittent claudication only when:

- advice on the benefits of modifying risk factors has been reinforced (see the recommendation on secondary prevention of cardiovascular disease in people with peripheral arterial disease) and
- a supervised exercise programme has not led to a satisfactory improvement in symptoms and
- imaging has confirmed that angioplasty is suitable for the person. [2012]

1.5.4 Do not offer primary stent placement for treating people with intermittent claudication caused by aorto-iliac disease (except complete occlusion) or femoro-popliteal disease. [2012]

1.5.5 Consider primary stent placement for treating people with intermittent claudication caused by complete aorto-iliac occlusion (rather than stenosis).

[2012]

1.5.6 Use bare metal stents when stenting is used for treating people with intermittent claudication. [2012]

## Bypass surgery and graft types

1.5.7 Offer bypass surgery for treating people with severe lifestyle-limiting intermittent claudication only when:

- angioplasty has been unsuccessful or is unsuitable and
- imaging has confirmed that bypass surgery is appropriate for the person. [2012]

1.5.8 Use an autologous vein whenever possible for people with intermittent claudication having infra-inguinal bypass surgery. [2012]

## Naftidrofuryl oxalate

1.5.9 Consider naftidrofuryl oxalate for treating people with intermittent claudication, starting with the least costly preparation, only when:

- supervised exercise has not led to satisfactory improvement and
- the person prefers not to be referred for consideration of angioplasty or bypass surgery.

Review progress after 3–6 months and discontinue naftidrofuryl oxalate if there has been no symptomatic benefit. [2012]

# 1.6 Management of critical limb ischaemia

1.6.1 Ensure that all people with critical limb ischaemia are assessed by a vascular multidisciplinary team before treatment decisions are made. [2012]

## Revascularisation

1.6.2 Offer angioplasty or bypass surgery for treating people with critical limb ischaemia who require revascularisation, taking into account factors including:

- comorbidities
- pattern of disease
- availability of a vein
- patient preference. [2012]

1.6.3 Do not offer primary stent placement for treating people with critical limb ischaemia caused by aorto-iliac disease (except complete occlusion) or femoro-popliteal disease. [2012]

1.6.4 Consider primary stent placement for treating people with critical limb ischaemia caused by complete aorto-iliac occlusion (rather than stenosis). [2012]

1.6.5 Use bare metal stents when stenting is used for treating people with critical limb ischaemia. [2012]

1.6.6 Use an autologous vein whenever possible for people with critical limb ischaemia having infra-inguinal bypass surgery. [2012]

## Management of critical limb ischaemic pain

1.6.7 Offer paracetamol, and either weak or strong opioids depending on the severity of pain, to people with critical limb ischaemic pain.

To support discussions with patients about the benefits and harms of opioid treatment, and safe withdrawal management, see:

- the NICE guideline on patient experience in adult NHS services for recommendations on shared decision making
- the NICE guideline on medicines optimisation for recommendations on structured medication reviews
- the key therapeutic topic on medicines optimisation in chronic pain, the opioids aware website and the section in the BNF on controlled drugs and drug dependence. [2012, amended 2020]

1.6.8 Offer drugs such as laxatives and anti-emetics to manage the adverse effects of

strong opioids, in line with the person's needs and preferences. [2012]

1.6.9 Refer people with critical limb ischaemic pain to a specialist pain management service if any of the following apply:

- their pain is not adequately controlled and revascularisation is inappropriate or impossible
- ongoing high doses of opioids are required for pain control
- pain persists after revascularisation or amputation. [2012]

1.6.10 Do not offer chemical sympathectomy to people with critical limb ischaemic pain, except in the context of a clinical trial. [2012]

## Major amputation

1.6.11 Do not offer major amputation to people with critical limb ischaemia unless all options for revascularisation have been considered by a vascular multidisciplinary team. [2012]

# Recommendations for research

In 2012 the guideline committee has made the following recommendations for research. The committee's full set of research recommendations is detailed in the full guideline.

As part of the 2018 update, the standing committee made new research recommendations on the effectiveness and reliability of tools for diagnosing peripheral arterial disease in people with diabetes. Details can be found in the evidence review.

## 1 Effectiveness of tools for diagnosing peripheral arterial disease in people with diabetes

What is the most clinically and cost-effective tool for diagnosing peripheral arterial disease in people with diabetes?

### Why this is important

People with diabetes are at higher risk of cardiovascular events and foot problems such as diabetic neuropathy (nerve damage or degeneration), foot ulcer and limb loss. So it is important to have an effective test for diagnosing peripheral arterial disease in this group. At present there are only studies of very low quality (retrospective and prospective cross-sectional studies) containing small sample sizes. Diagnostic accuracy studies are needed to address this issue, ideally containing cost–utility analysis, comparing diagnostic tools with imaging. In order to explore the importance of early diagnosis, different clinical settings where diagnostic tests are performed should be explored. [2018]

## 2 Effectiveness of tools for establishing the severity of peripheral arterial disease in people with diabetes

What is the most clinically and cost-effective tool for establishing the severity of peripheral arterial disease and the impact on mortality, morbidity and limb amputation in people with diabetes?

### Why this is important

Limited evidence suggests that doppler ankle brachial pressure index, toe brachial index and oscillometric ankle brachial index accurately diagnose severity of peripheral arterial disease.

However, further research is needed using a robust diagnostic study design (such as a randomised controlled trial) to explore the clinical and cost effectiveness of tools in establishing the severity of disease and outcomes in people with diabetes. Studies should also explore the use of tools in different populations, such as those with neuropathy, and in different settings, for example, nursing homes, where access to services and diagnostic equipment may differ. [2018]

# 3 Inter- and intra-rater reliability of assessment tools in the diagnosis of peripheral arterial disease in people with diabetes

What is the inter- and intra-rater reliability of assessment tools in the diagnosis of peripheral arterial disease in people with diabetes?

## Why this is important

Identifying peripheral arterial disease can be a challenge because diagnostic tests are conducted in a number of different settings by healthcare professionals with varying experience of using assessment tools. Data on inter- and intra-rater reliability of point-of-care assessment tools are needed to inform future recommendations for practice. The study should compare diagnostic tests with gold standard imaging. Different clinical and community settings, such as UK primary care setting, should also be taken into account. [2018]

# 4 Angioplasty versus bypass surgery for treating people with critical limb ischaemia caused by disease of the infra-geniculate arteries

What is the clinical and cost effectiveness of a 'bypass surgery first' strategy compared with an 'angioplasty first' strategy for treating people with critical limb ischaemia caused by disease of the infra-geniculate (below the knee) arteries?

## Why this is important

Many people with critical limb ischaemia, especially those with diabetic vascular disease, also have disease of the infra-geniculate (below the knee) arteries in the calf. For many years, the standard of care has been bypass surgery. Although such surgery may be associated with significant morbidity, the resulting long-term amputation-free survival rates are generally good. In recent years there has been a trend towards treating infra-geniculate disease with angioplasty, on the grounds that it is

associated with less morbidity than surgery. However, this change in practice is not evidence-based, and serious concerns remain about the durability of angioplasty in this anatomical area. A multicentre, randomised controlled trial with a full health economic analysis is required to address this. The primary endpoint should be amputation-free survival, with secondary endpoints including overall survival, health-related quality of life, healing of tissue loss, and relief of ischaemic pain. [2012]

# 5 Supervised exercise programmes for treating people with intermittent claudication

What is the clinical and cost effectiveness of supervised exercise programmes compared with unsupervised exercise for treating people with intermittent claudication, taking into account the effects on long-term outcomes and continuing levels of exercise?

## Why this is important

Research has shown that taking part in exercise and physical activity can lead to improvements in symptoms in the short term for people with intermittent claudication. However, the benefits of exercise are quickly lost if it is not frequent and regular. Supervised exercise programmes have been shown to produce superior results when compared with advice to exercise (unsupervised) in the short term, but they are more expensive, and there is a lack of robust evidence on long-term effectiveness. A community-based randomised controlled trial is required to compare the long-term clinical and cost effectiveness of a supervised exercise programme and unsupervised exercise. The trial should enrol people with peripheral arterial disease-related claudication, but exclude those with previous endovascular or surgical interventions. The primary outcome measure should be maximal walking distance, with secondary outcome measures including quality of life, function, levels of uptake of exercise programmes and long-term engagement in physical activity. [2012]

# 6 Patient attitudes and beliefs about peripheral arterial disease

What is the effect of people's attitudes and beliefs about their peripheral arterial disease on the management and outcome of their condition?

## Why this is important

The evidence reviewed suggested that, among people with peripheral arterial disease, there is a

lack of understanding of the causes of the disease, a lack of belief that lifestyle interventions will have a positive impact on disease outcomes, and unrealistic expectations of the outcome of surgical interventions. Much of the research has been conducted on the subpopulation of people with peripheral arterial disease who have been referred for surgical intervention, but little evidence is available for the majority of people diagnosed with peripheral arterial disease in a primary care setting. Research is needed to further investigate attitudes and beliefs in relation to peripheral arterial disease, interventions that might influence these and how these may have an impact on behavioural changes in relation to risk factors for peripheral arterial disease, attitudes to intervention and clinical outcomes. [2012]

# 7 Primary versus secondary stenting for treating people with critical limb ischaemia caused by disease of the infra-geniculate arteries

What is the clinical and cost effectiveness of selective stent placement compared with angioplasty plus primary stent placement for treating people with critical limb ischaemia caused by disease of the infra-geniculate arteries?

## Why this is important

Studies comparing angioplasty plus selective stent placement with primary stent placement have been limited to the aorto-iliac and femoro-popliteal segment. There is also a significant group of people with critical ischaemia caused by disease of the infra-geniculate vessels in which there is a potential for endovascular treatment. Infra-geniculate disease is more complex to treat by endovascular means, and the risks and benefits of different treatment options may differ from those for the more proximal vessels. A multicentre, randomised controlled trial with a full health economic analysis is required to address the optimum policy as regards the choice of method for angioplasty and stent placement for the infra-geniculate arteries. The primary endpoint should be amputation-free survival, with secondary endpoints including overall survival, re-intervention rates, health-related quality of life, healing of tissue loss, and relief of ischaemic pain. [2012]

# 8 Chemical sympathectomy for managing critical limb ischaemic pain

What is the clinical and cost effectiveness of chemical sympathectomy in comparison with other methods of pain control for managing critical limb ischaemic pain?

## Why this is important

Approximately 1 in 5 people with critical limb ischaemia cannot be offered procedures to improve the blood supply to their leg because of either the pattern of their disease or other comorbidities. In this group the therapeutic options are pain control or primary amputation. Chemical lumbar sympathectomy, which involves the destruction of the lumbar sympathetic chain (usually the L2 and L3 ganglia), has been suggested to reduce pain and improve wound healing, and may prevent amputation in some patients. Initially achieved surgically, it is now most commonly performed using chemical agents such as phenol to destroy the lumbar sympathetic chain. Despite having been used for over 60 years, the role of chemical lumbar sympathectomy remains unclear. Improvement in skin blood flow and modification of pain perception control have been demonstrated, and this has prompted the use of chemical lumbar sympathectomy for treating a range of conditions such as regional pain syndrome, vasospastic conditions and critical limb ischaemia. However, in critical limb ischaemia the use of chemical lumbar sympathectomy varies widely between units in England, the mode of action and indications are unclear, and there is currently no randomised controlled trial evidence demonstrating its clinical value. Therefore a randomised control trial comparing chemical lumbar sympathectomy with other methods of pain relief is recommended. [2012]

# Rationale and impact for new recommendations

## Diagnosis

Recommendations 1.3.4 and 1.3.5.

### Why the committee made the recommendations

Evidence showed that doppler ankle brachial pressure index below an agreed cut-off increased the probability of diagnosing peripheral arterial disease. However, people with diabetes and peripheral arterial disease may have a normal or raised index because of hardening of the arteries. The committee agreed that it was important to highlight this so that healthcare professionals do not exclude peripheral arterial disease in people with diabetes based on a normal or raised ankle brachial pressure index alone.

There was a lack of evidence on the use of pulse oximetry for diagnosing peripheral arterial disease in people with diabetes. The committee noted that a universal cut-off point had not been established. This could lead to variation in the interpretation of results. It was also noted that pulse oximetry is rarely used in clinical practice for assessing peripheral arterial disease and there was general clinical agreement that it is not a useful test in this context. Therefore, the committee recommended against the use of pulse oximetry for this purpose.

There was not enough evidence on the use of other tests (doppler waveform analysis and toe brachial index) for diagnosing peripheral arterial disease in people with diabetes. However, the committee agreed it was not appropriate to make recommendations against the use of these tests, as there were good theoretical arguments as to why these tests might provide useful diagnostic value. The committee therefore agreed to make research recommendations to inform future practice and any further update of this guidance.

Full details of the evidence and the committee's discussion are in evidence review A: determining the diagnosis and severity of peripheral arterial disease in people with diabetes.

Full details of the evidence and committee discussion for the original (2012) guideline are in: Peripheral arterial disease: full guideline.

## How the recommendations might affect practice

The new recommendations should improve the holistic assessment of peripheral arterial disease in people with diabetes. This is important because this group has a higher risk of cardiovascular events and foot problems such as diabetic neuropathy, foot ulcer and limb loss. The recommendation clarifies the use of ankle brachial pressure index and highlights the importance of interpreting pulse measurements in relation to clinical context, including symptoms.

# Putting this guideline into practice

Putting recommendations into practice can take time. How long may vary from guideline to guideline, and depends on how much change in practice or services is needed. Implementing change is most effective when aligned with local priorities.

Changes recommended for clinical practice that can be done quickly – like changes in prescribing practice – should be shared quickly. This is because healthcare professionals should use guidelines to guide their work – as is required by professional regulating bodies such as the General Medical and Nursing and Midwifery Councils.

Changes should be implemented as soon as possible, unless there is a good reason for not doing so (for example, if it would be better value for money if a package of recommendations were all implemented at once).

Different organisations may need different approaches to implementation, depending on their size and function. Sometimes individual practitioners may be able to respond to recommendations to improve their practice more quickly than large organisations.

Here are some pointers to help organisations put NICE guidelines into practice:

1. Raise awareness through routine communication channels, such as email or newsletters, regular meetings, internal staff briefings and other communications with all relevant partner organisations. Identify things staff can include in their own practice straight away.

2. Identify a lead with an interest in the topic to champion the guideline and motivate others to support its use and make service changes, and to find out any significant issues locally.

3. Carry out a baseline assessment against the recommendations to find out whether there are gaps in current service provision.

4. Think about what data you need to measure improvement and plan how you will collect it. You may want to work with other health and social care organisations and specialist groups to compare current practice with the recommendations. This may also help identify local issues that will slow or prevent implementation.

5. Develop an action plan, with the steps needed to put the guideline into practice, and make sure it

is ready as soon as possible. Big, complex changes may take longer to implement, but some may be quick and easy to do. An action plan will help in both cases.

6. For very big changes include milestones and a business case, which will set out additional costs, savings and possible areas for disinvestment. A small project group could develop the action plan. The group might include the guideline champion, a senior organisational sponsor, staff involved in the associated services, finance and information professionals.

7. Implement the action plan with oversight from the lead and the project group. Big projects may also need project management support.

8. Review and monitor how well the guideline is being implemented through the project group. Share progress with those involved in making improvements, as well as relevant boards and local partners.

NICE provides a comprehensive programme of support and resources to maximise uptake and use of evidence and guidance. See our into practice pages for more information.

Also see Leng G, Moore V, Abraham S, editors (2014) Achieving high quality care – practical experience from NICE. Chichester: Wiley.

# Context

Lower limb peripheral arterial disease (or peripheral arterial disease for short) is a marker for increased risk of cardiovascular events even when it is asymptomatic. The most common initial symptom of peripheral arterial disease is leg pain while walking, known as intermittent claudication. Critical limb ischaemia is a severe manifestation of peripheral arterial disease, and is characterised by severely diminished circulation, ischaemic pain, ulceration, tissue loss and/or gangrene.

The incidence of peripheral arterial disease increases with age. Population studies have found that about 20% of people aged over 60 years have some degree of peripheral arterial disease. Smoking is also an important risk factor, with people who smoke having a greater risk than people who have never smoked. Incidence is also high in people with coronary artery disease and in people with diabetes, meaning that early diagnosis and management of peripheral arterial disease is important . In most people with intermittent claudication the symptoms remain stable, but approximately 20% will develop increasingly severe symptoms with the development of critical limb ischaemia.

Mild symptoms are generally managed in primary care, with referral to secondary care when symptoms do not resolve or deteriorate. There are several treatment options for people with intermittent claudication. These include advice to exercise, management of cardiovascular risk factors (for example, with aspirin or statins) and vasoactive drug treatment (for example, with naftidrofuryl oxalate).

People with severe symptoms that are inadequately controlled are often referred to secondary care for assessment for endovascular treatment (such as angioplasty or stenting), bypass surgery, pain management and/or amputation.

Rapid changes in diagnostic methods, endovascular treatments and vascular services, associated with the emergence of new sub-specialties in surgery and interventional radiology, has resulted in considerable uncertainty and variation in practice. This guideline aims to resolve that uncertainty and variation.

In 2018 we reviewed the evidence on tests for diagnosing peripheral arterial disease in people with diabetes and added new recommendations for this group.

# Finding more information and committee details

You can see everything NICE says on this topic in the NICE Pathway on lower limb peripheral arterial disease.

To find NICE guidance on related topics, including guidance in development, see the NICE webpage on peripheral circulatory conditions.

For full details of the evidence and the guideline committee's discussions, see the evidence. You can also find information about how the guideline was developed, including details of the committee.

For general help and advice on putting our guidelines into practice, see resources to help you put NICE guidance into practice.

# Update information

December 2020: we reviewed our guidance on opioids for non-cancer pain in response to a Public Health England evidence review on dependence on, and withdrawal from, prescribed medicines. We added links in recommendation 1.6.7 to other NICE guidelines and resources that support discussion with patients about opioid prescribing, and safe withdrawal management.

February 2018: We reviewed the evidence on diagnosing peripheral arterial disease in people with diabetes and added new recommendations and recommendations for research. Recommendations are marked as [2018] or [2012]. [2018] indicates that the evidence was reviewed and the recommendation added in 2018. [2012] indicates that the evidence was last reviewed in 2012.

Minor changes since publication

October 2018: The antiplatelet therapy link in recommendation 1.2.1 was updated.

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# Accreditation

NICE National Institute for Health and Care Excellence

NICE guideline

# Osteoarthritis: care and management

Clinical guideline

Published: 12 February 2014
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# Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

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This guideline replaces CG59.

This guideline is the basis of QS87.

# Overview

This guideline covers assessing and managing osteoarthritis in adults. It covers both pharmacological and non-pharmacological treatments. It promotes effective treatment options to control joint pain and improve function in people with osteoarthritis.

In December 2020 we reviewed our guidance on opioids for non-cancer pain in response to a Public Health England evidence review on dependence on, and withdrawal from, prescribed medicines. To support discussion with patients about opioid prescribing, and safe withdrawal management, we are developing guidance on safe prescribing and withdrawal management of prescribed drugs associated with dependence and withdrawal and shared decision making. In the meantime, we have added links in this guideline to other NICE guidelines and other resources that support this aim.

## Who is it for?

- Healthcare professionals
- Adults with osteoarthritis and their families and carers

# Introduction

Osteoarthritis refers to a clinical syndrome of joint pain accompanied by varying degrees of functional limitation and reduced quality of life. It is the most common form of arthritis, and one of the leading causes of pain and disability worldwide. The most commonly affected peripheral joints are the knees, hips and small hand joints. Pain, reduced function and effects on a person's ability to carry out their day-to-day activities can be important consequences of osteoarthritis. Pain in itself is also a complex biopsychosocial issue, related in part to a person's expectations and self-efficacy (that is, their belief in their ability to complete tasks and reach goals), and is associated with changes in mood, sleep and coping abilities. There is often a poor link between changes visible on an X-ray and symptoms of osteoarthritis: minimal changes can be associated with a lot of pain, or modest structural changes to joints can occur with minimal accompanying symptoms. Contrary to popular belief, osteoarthritis is not caused by ageing and does not necessarily deteriorate. There are a number of management and treatment options (both pharmacological and non-pharmacological), which this guideline addresses and which represent effective interventions for controlling symptoms and improving function.

Osteoarthritis is characterised pathologically by localised loss of cartilage, remodelling of adjacent bone and associated inflammation. A variety of traumas may trigger the need for a joint to repair itself. Osteoarthritis includes a slow but efficient repair process that often compensates for the initial trauma, resulting in a structurally altered but symptom-free joint. In some people, because of either overwhelming trauma or compromised repair, the process cannot compensate, resulting in eventual presentation with symptomatic osteoarthritis; this might be thought of as 'joint failure'. This in part explains the extreme variability in clinical presentation and outcome that can be observed between people, and also at different joints in the same person.

There are limitations to the published evidence on treating osteoarthritis. Most studies have focused on knee osteoarthritis, and are often of short duration using single therapies. Although most trials have looked at single joint involvement, in reality many people have pain in more than one joint, which may alter the effectiveness of interventions.

# Guideline update 2014

This guideline update was originally intended to include recommendations based on a review of new evidence about the use of paracetamol, etoricoxib and fixed-dose combinations of NSAIDs (non-steroidal anti-inflammatory drugs) plus gastroprotective agents in the management of osteoarthritis. Draft recommendations based on the evidence reviews for these areas were

presented in the consultation version of the guideline. Stakeholder feedback at consultation indicated that the draft recommendations, particularly in relation to paracetamol, would be of limited clinical application without a full review of evidence on the pharmacological management of osteoarthritis. NICE was also aware of an ongoing review by the MHRA (Medicines and Healthcare Products Regulatory Agency) of the safety of over-the-counter analgesics. Therefore NICE intends to commission a full review of evidence on the pharmacological management of osteoarthritis, which will start once the MHRA's review is completed, to inform a further guideline update.

Until that update is published, the original recommendations (from 2008) on the pharmacological management of osteoarthritis remain current advice. However, the Guideline Development Group (GDG) would like to draw attention to the findings of the evidence review on the effectiveness of paracetamol that was presented in the consultation version of the guideline. That review identified reduced effectiveness of paracetamol in the management of osteoarthritis compared with what was previously thought. The GDG believes that this information should be taken into account in routine prescribing practice until the planned full review of evidence on the pharmacological management of osteoarthritis is published (see the NICE website for further details).

The current update addresses issues around decision-making and referral thresholds for surgery, and includes new recommendations about diagnosis and follow-up. The update also contains recommendations based on new evidence about the use of nutraceuticals, hyaluronans and acupuncture in the management of osteoarthritis.

# Drug recommendations

The guideline will assume that prescribers will use a drug's summary of product characteristics to inform decisions made with individual patients.

# Key priorities for implementation

The following recommendations have been identified as priorities for implementation. The full list of recommendations is in section 1.

## Diagnosis

- Diagnose osteoarthritis clinically without investigations if a person:
  - is 45 or over and
  - has activity-related joint pain and
  - has either no morning joint-related stiffness or morning stiffness that lasts no longer than 30 minutes. [2014]

## Holistic approach to osteoarthritis assessment and management

- Offer advice on the following core treatments to all people with clinical osteoarthritis.
  - Access to appropriate information (see recommendation on patient information).
  - Activity and exercise (see the recommendation on exercise and manual therapy).
  - Interventions to achieve weight loss if the person is overweight or obese (see the recommendation on weight loss and the NICE clinical guideline on obesity prevention). [2008, amended 2014]

## Education and self-management

- Offer accurate verbal and written information to all people with osteoarthritis to enhance understanding of the condition and its management, and to counter misconceptions, such as that it inevitably progresses and cannot be treated. Ensure that information sharing is an ongoing, integral part of the management plan rather than a single event at time of presentation. [2008]

- Agree individualised self-management strategies with the person with osteoarthritis. Ensure that positive behavioural changes, such as exercise, weight loss, use of suitable footwear and pacing, are appropriately targeted. [2008]

# Non-pharmacological management

- Advise people with osteoarthritis to exercise as a core treatment (see recommendation 1.2.5), irrespective of age, comorbidity, pain severity or disability. Exercise should include:

  - local muscle strengthening and

  - general aerobic fitness.

  It has not been specified whether exercise should be provided by the NHS or whether the healthcare professional should provide advice and encouragement to the person to obtain and carry out the intervention themselves. Exercise has been found to be beneficial but the clinician needs to make a judgement in each case on how to effectively ensure participation. This will depend upon the person's individual needs, circumstances and self-motivation, and the availability of local facilities. [2008]

# Referral for consideration of joint surgery

- Base decisions on referral thresholds on discussions between patient representatives, referring clinicians and surgeons, rather than using scoring tools for prioritisation. [2008, amended 2014]

- Refer for consideration of joint surgery before there is prolonged and established functional limitation and severe pain. [2008, amended 2014]

# Follow-up and review

- Offer regular reviews to all people with symptomatic osteoarthritis. Agree the timing of the reviews with the person (see also recommendation 1.7.2). Reviews should include:
  - monitoring the person's symptoms and the ongoing impact of the condition on their everyday activities and quality of life
  - monitoring the long-term course of the condition
  - discussing the person's knowledge of the condition, any concerns they have, their personal preferences and their ability to access services
  - reviewing the effectiveness and tolerability of all treatments
  - support for self-management. [2014]
- Consider an annual review for any person with one or more of the following:
  - troublesome joint pain
  - more than one joint with symptoms
  - more than one comorbidity
  - taking regular medication for their osteoarthritis. [2014]

# 1 Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

## 1.1 Diagnosis

1.1.1 Diagnose osteoarthritis clinically without investigations if a person:

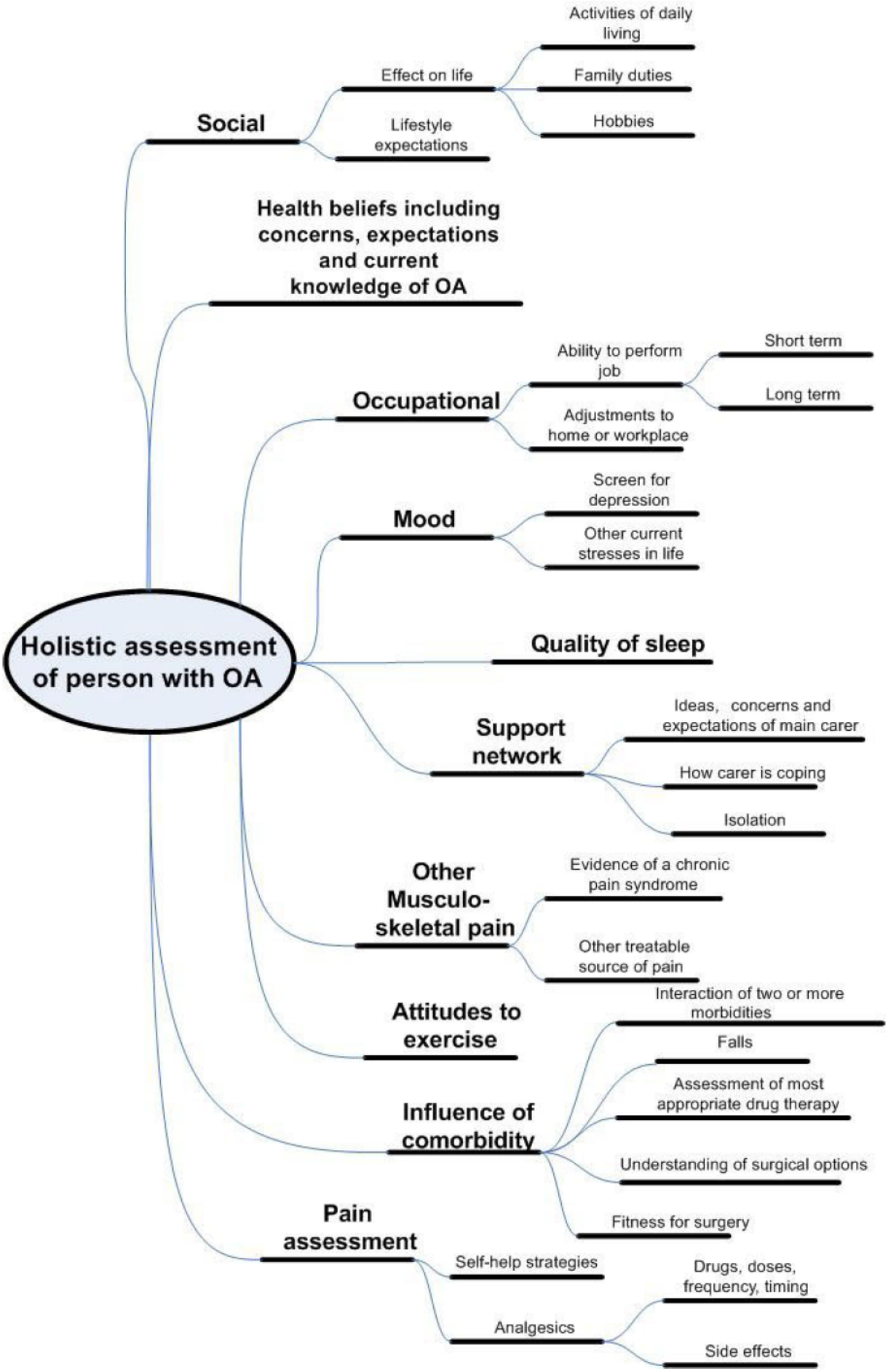
- is 45 or over and
- has activity-related joint pain and
- has either no morning joint-related stiffness or morning stiffness that lasts no longer than 30 minutes. [2014]

1.1.2 Be aware that atypical features, such as a history of trauma, prolonged morning joint-related stiffness, rapid worsening of symptoms or the presence of a hot swollen joint, may indicate alternative or additional diagnoses. Important differential diagnoses include gout, other inflammatory arthritides (for example, rheumatoid arthritis), septic arthritis and malignancy (bone pain). [2014]

## 1.2 Holistic approach to osteoarthritis assessment and management

1.2.1 Assess the effect of osteoarthritis on the person's function, quality of life, occupation, mood, relationships and leisure activities. Use figure 1 as an aid to prompt questions that should be asked as part of the holistic assessment of a person with osteoarthritis. [2008]

Figure 1 Holistic assessment of a person with osteoarthritis (OA)



This figure is intended as an 'aide memoir' to provide a breakdown of key topics that are of common concern when assessing people with osteoarthritis. For most topics there are a few suggested specific points that are worth assessing. Not every topic will be of concern for everyone with osteoarthritis, and there are other topics that may warrant consideration for particular people.

1.2.2 Agree a plan with the person (and their family members or carers as appropriate) for managing their osteoarthritis. Apply the principles in the NICE guideline on patient experience in adult NHS services in relation to shared decision making. [2014]

1.2.3 Take into account comorbidities that compound the effect of osteoarthritis when formulating the management plan. [2008]

1.2.4 Discuss the risks and benefits of treatment options with the person, taking into account comorbidities. Ensure that the information provided can be understood. [2008]

1.2.5 Offer advice on the following core treatments to all people with clinical osteoarthritis.

- Access to appropriate information (see recommendation 1.3.1).
- Activity and exercise (see recommendation 1.4.1).
- Interventions to achieve weight loss if the person is overweight or obese (see recommendation 1.4.3 and the NICE guideline on obesity: identification, assessment and management). [2008, amended 2014]

# 1.3 Education and self-management

## Patient information

1.3.1 Offer accurate verbal and written information to all people with osteoarthritis to enhance understanding of the condition and its management, and to counter misconceptions, such as that it inevitably progresses and cannot be treated. Ensure that information sharing is an ongoing, integral part of the management plan rather than a single event at time of presentation. [2008]

## Patient self-management interventions

1.3.2 Agree individualised self-management strategies with the person with osteoarthritis. Ensure that positive behavioural changes, such as exercise, weight loss, use of suitable footwear and pacing, are appropriately targeted. [2008]

1.3.3 Ensure that self-management programmes for people with osteoarthritis, either individually or in groups, emphasise the recommended core treatments (see recommendation 1.2.5), especially exercise. [2008]

## Thermotherapy

1.3.4 The use of local heat or cold should be considered as an adjunct to core treatments. [2008]

# 1.4 Non-pharmacological management

## Exercise and manual therapy

1.4.1 Advise people with osteoarthritis to exercise as a core treatment (see recommendation 1.2.5), irrespective of age, comorbidity, pain severity or disability. Exercise should include:

- local muscle strengthening and
- general aerobic fitness.

It has not been specified whether exercise should be provided by the NHS or whether the healthcare professional should provide advice and encouragement to the person to obtain and carry out the intervention themselves. Exercise has been found to be beneficial but the clinician needs to make a judgement in each case on how to effectively ensure participation. This will depend upon the person's individual needs, circumstances and self-motivation, and the availability of local facilities. [2008]

1.4.2 Manipulation and stretching should be considered as an adjunct to core treatments, particularly for osteoarthritis of the hip. [2008]

## Weight loss

1.4.3 Offer interventions to achieve weight loss as a core treatment (see recommendation 1.2.5) for people who are obese or overweight. [2008]

## Electrotherapy

Healthcare professionals should consider the use of transcutaneous electrical nerve stimulation (TENS) as an adjunct to core treatments for pain relief.

TENS machines are generally loaned to the person by the NHS for a short period, and if effective the person is advised where they can purchase their own. [2008]

## Nutraceuticals

1.4.4 Do not offer glucosamine or chondroitin products for the management of osteoarthritis. [2014]

## Acupuncture

1.4.5 Do not offer acupuncture for the management of osteoarthritis. [2014]

## Aids and devices

1.4.6 Offer advice on appropriate footwear (including shock-absorbing properties) as part of core treatments (see recommendation 1.2.5) for people with lower limb osteoarthritis. [2008]

1.4.7 People with osteoarthritis who have biomechanical joint pain or instability should be considered for assessment for bracing/joint supports/insoles as an adjunct to their core treatments. [2008]

1.4.8 Assistive devices (for example, walking sticks and tap turners) should be considered as adjuncts to core treatments for people with osteoarthritis who have specific problems with activities of daily living. If needed, seek expert advice in this context (for example, from occupational therapists or Disability Equipment Assessment Centres). [2008]

## Invasive treatments for knee osteoarthritis

1.4.9 Do not refer for arthroscopic lavage and debridement as part of treatment for osteoarthritis, unless the person has knee osteoarthritis with a clear history of mechanical locking (as opposed to morning joint stiffness, 'giving way' or X-ray evidence of loose bodies). [2008, amended 2014]

# 1.5 Pharmacological management

NICE intends to undertake a full review of evidence on the pharmacological management of osteoarthritis. This will start after a review by the MHRA (Medicines and Healthcare Products Regulatory Agency) of the safety of over-the-counter analgesics is completed. For more information, see the Introduction.

In the meantime, the original recommendations (from 2008) remain current advice. However, the Guideline Development Group (GDG) would like to draw attention to the findings of the evidence review on the effectiveness of paracetamol that was presented in the consultation version of the guideline. That review identified reduced effectiveness of paracetamol in the management of osteoarthritis compared with what was previously thought. The GDG believes that this information should be taken into account in routine prescribing practice until the planned full review of evidence on the pharmacological management of osteoarthritis is published (see the NICE website for further details).

## Oral analgesics

1.5.1 Healthcare professionals should consider offering paracetamol for pain relief in addition to core treatments (see recommendation 1.2.5); regular dosing may be required. Paracetamol and/or topical non-steroidal anti-inflammatory drugs (NSAIDs) should be considered ahead of oral NSAIDs, cyclo-oxygenase 2 (COX-2) inhibitors or opioids. [2008]

1.5.2 If paracetamol or topical NSAIDs are insufficient for pain relief for people with osteoarthritis, then the addition of opioid analgesics should be considered. Risks and benefits should be considered, particularly in older people.

To support discussions with patients about the benefits and harms of opioid treatment, and safe withdrawal management, see:

- the NICE guideline on patient experience in adult NHS services for recommendations on shared decision making
- the NICE guideline on medicines optimisation for recommendations on structured medication reviews
- the key therapeutic topic on medicines optimisation in chronic pain, the opioids aware website and the section in the BNF on controlled drugs and drug dependence. [2008, amended 2020]

## Topical treatments

1.5.3 Consider topical NSAIDs for pain relief in addition to core treatments (see recommendation 1.2.5) for people with knee or hand osteoarthritis. Consider topical NSAIDs and/or paracetamol ahead of oral NSAIDs, COX-2 inhibitors or opioids. [2008]

1.5.4 Topical capsaicin should be considered as an adjunct to core treatments for knee or hand osteoarthritis. [2008]

1.5.5 Do not offer rubefacients for treating osteoarthritis. [2008]

## NSAIDs and highly selective COX-2 inhibitors

Although NSAIDs and COX-2 inhibitors may be regarded as a single drug class of 'NSAIDs', these recommendations use the two terms for clarity and because of the differences in side-effect profile.

1.5.6 Where paracetamol or topical NSAIDs are ineffective for pain relief for people with osteoarthritis, then substitution with an oral NSAID/COX-2 inhibitor should be considered. [2008]

1.5.7 Where paracetamol or topical NSAIDs provide insufficient pain relief for people with osteoarthritis, then the addition of an oral NSAID/COX-2 inhibitor to paracetamol should be considered. [2008]

1.5.8 Use oral NSAIDs/COX-2 inhibitors at the lowest effective dose for the shortest possible period of time. [2008]

1.5.9 When offering treatment with an oral NSAID/COX-2 inhibitor, the first choice should be either a standard NSAID or a COX-2 inhibitor (other than etoricoxib

60 mg). In either case, co-prescribe with a proton pump inhibitor (PPI), choosing the one with the lowest acquisition cost. [2008]

1.5.10 All oral NSAIDs/COX-2 inhibitors have analgesic effects of a similar magnitude but vary in their potential gastrointestinal, liver and cardio-renal toxicity; therefore, when choosing the agent and dose, take into account individual patient risk factors, including age. When prescribing these drugs, consideration should be given to appropriate assessment and/or ongoing monitoring of these risk factors. [2008]

1.5.11 If a person with osteoarthritis needs to take low-dose aspirin, healthcare professionals should consider other analgesics before substituting or adding an NSAID or COX-2 inhibitor (with a PPI) if pain relief is ineffective or insufficient. [2008]

### Intra-articular injections

1.5.12 Intra-articular corticosteroid injections should be considered as an adjunct to core treatments for the relief of moderate to severe pain in people with osteoarthritis. [2008]

1.5.13 Do not offer intra-articular hyaluronan injections for the management of osteoarthritis. [2014]

## 1.6 Referral for consideration of joint surgery

1.6.1 Clinicians with responsibility for referring a person with osteoarthritis for consideration of joint surgery should ensure that the person has been offered at least the core (non-surgical) treatment options (see recommendation 1.2.5). [2008]

1.6.2 Base decisions on referral thresholds on discussions between patient representatives, referring clinicians and surgeons, rather than using scoring tools for prioritisation. [2008, amended 2014]

1.6.3 Consider referral for joint surgery for people with osteoarthritis who experience joint symptoms (pain, stiffness and reduced function) that have a substantial impact on their quality of life and are refractory to non-surgical

treatment. [2008, amended 2014]

1.6.4 Refer for consideration of joint surgery before there is prolonged and established functional limitation and severe pain. [2008, amended 2014]

1.6.5 Patient-specific factors (including age, sex, smoking, obesity and comorbidities) should not be barriers to referral for joint surgery. [2008, amended 2014]

1.6.6 When discussing the possibility of joint surgery, check that the person has been offered at least the core treatments for osteoarthritis (see recommendation 1.2.5), and give them information about:

- the benefits and risks of surgery and the potential consequences of not having surgery
- recovery and rehabilitation after surgery
- how having a prosthesis might affect them
- how care pathways are organised in their local area. [2014]

## 1.7 Follow-up and review

1.7.1 Offer regular reviews to all people with symptomatic osteoarthritis. Agree the timing of the reviews with the person (see also recommendation 1.7.2). Reviews should include:

- monitoring the person's symptoms and the ongoing impact of the condition on their everyday activities and quality of life
- monitoring the long-term course of the condition
- discussing the person's knowledge of the condition, any concerns they have, their personal preferences and their ability to access services
- reviewing the effectiveness and tolerability of all treatments
- support for self-management. [2014]

1.7.2 Consider an annual review for any person with one or more of the following:

- troublesome joint pain

- more than one joint with symptoms
- more than one comorbidity
- taking regular medication for their osteoarthritis. [2014]

1.7.3 Apply the principles in the NICE guideline on patient experience in adult NHS services with regard to an individualised approach to healthcare services and patient views and preferences. [2014]

# 2 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future. The Guideline Development Group's full set of research recommendations is detailed in the full guideline.

## 2.1 Treatments for osteoarthritis in very old people

What are the short-term and long-term benefits of non-pharmacological and pharmacological treatments for osteoarthritis in very old people (for example, aged 80 years and older)?

### Why this is important

Very little data exist on the use of pharmacological and non-pharmacological treatments for osteoarthritis in very old people. This is highly relevant, not only because of the ageing population but also because of the high incidence of comorbidities in this population – osteoarthritis may be one of many health problems affecting function, and this may influence the appropriateness of management options. The acceptability, nature and setting for exercise strategies for this population is one area suggested for further study. Any non-pharmacological intervention for which a reduction in the need for drug treatment can be demonstrated is desirable. NSAIDs are frequently contraindicated in older people with comorbidities (such as renal failure, cardiovascular or gastrointestinal intolerance), and effective pharmacological options for this group warrant further study. Outcome and intervention studies are also needed for very old people in whom joint replacement surgery is not recommended because of risks associated with comorbidities.

## 2.2 Combinations of treatments for osteoarthritis

What are the benefits of combinations of treatments for osteoarthritis, and how can these be included in clinically useful, cost-effective algorithms for long-term care?

### Why this is important

Most people with osteoarthritis have symptoms for many years, and over this time they will receive several treatments, sometimes in combination. This may involve a combination of non-pharmacological and pharmacological treatments, such as using a walking stick and taking analgesics at the same time. Perhaps more commonly, a person may take different analgesics at the same time (for example, NSAIDs and opioids). However, most of the osteoarthritis trial evidence

only evaluates single treatments, and often such trials are of short duration (for example, 6 weeks). We need to understand the benefits of combination treatments relevant to particular anatomical sites of osteoarthritis (for example, hand compared with knee) and whether particular combinations provide synergistic benefit in terms of symptom relief. Also needed is an understanding of how combinations of treatments can be included in algorithms (for example, dose escalation or substitution designs) for use in clinical practice. Trials to address this area may need to utilise complex intervention methodologies with health economic evaluations, and will need to stratify for comorbidities that affect the use of a particular intervention.

## 2.3 Treating common presentations of osteoarthritis for which there is little evidence

What are effective treatments for people with osteoarthritis who have common but poorly researched problems, such as pain in more than one joint or foot osteoarthritis?

### Why this is important

Although people with osteoarthritis typically have symptoms that affect one joint at any particular time, there are still many people, especially older people, who have more than one painful joint. For example, it is common for osteoarthritis to affect both knees, or for a person to have pain in one knee and in one or more small joints such as the base of the thumb or the big toe. The mechanisms that cause pain may differ in people with one affected joint compared with those who have pain in several joints. For example, altered use because of pain in one joint often leads to increased mechanical stress and pain at other sites, and having chronic pain at one site can influence the experience of pain elsewhere in the body. However, almost all trials of treatments for osteoarthritis focus on a single joint, and if a participant has bilateral symptoms or additional symptoms at a different joint site only one 'index' joint (the most painful) is assessed. Whether systemic treatments for osteoarthritis work less well if a person has more than one painful site, and whether local treatment of one joint (for example, injection of corticosteroid into a knee) can lead to benefits at other sites (for example, the foot) remains unknown. A further caveat to current research evidence is that most trials focus on treatment of knee osteoarthritis, and to a lesser extent hip or hand osteoarthritis, but there are very few trials that examine other prevalent sites of osteoarthritis such as the first metatarsophalangeal (bunion) joint, the mid-foot joints, the ankle or the shoulder. Trials should be undertaken to determine the efficacy of available treatments, both local and systemic, at such sites. New outcome instruments to measure pain, stiffness and function specific to osteoarthritis at each site may need to be developed and validated for use in such trials.

## 2.4 Biomechanical interventions in the management of

# osteoarthritis

Which biomechanical interventions (such as footwear, insoles, braces and splints) are most beneficial in the management of osteoarthritis, and in which subgroups of people with osteoarthritis do they have the greatest benefit?

## Why this is important

In many people, osteoarthritis is made worse by weight-bearing or biomechanical forces through an affected joint. For example, base of thumb pain may be worse with grabbing and lifting items. Local support for the joint, in this case via a thumb splint, may improve pain and function. A large range of devices are available to help people with osteoarthritis in different joints, but there are very few trials to demonstrate their efficacy, and in particular little data to guide healthcare professionals on which people would benefit most from these aids. For example, there are many knee braces available, but few well designed randomised controlled trials of their efficacy, and few suggestions for clinicians on which patient subgroups might benefit from their use. Trials in the device area require careful attention to design issues such as the selection of control or sham interventions, blinded assessments and the choice of validated outcome measures that reflect the specific joint or functional ability being targeted.

# 2.5 Treatments that modify joint structure in people with osteoarthritis

In people with osteoarthritis, are there treatments that can modify joint structure, resulting in delayed structural progression and improved outcomes?

## Why this is important

There is evidence from observational studies that factors affecting structural joint components, biomechanics and inflammation in and around the joint influence the progression of osteoarthritis. Symptoms appear to be more closely linked to structure than was once thought, so preventing progression of the structural deterioration of a joint is expected to deliver symptomatic benefits for people with osteoarthritis, as well as delaying joint replacement in some. There have been published randomised controlled trials with interventions targeting structural components of cartilage (glucosamine sulphate) and bone (strontium ranelate). However, several limitations have been identified with the glucosamine sulphate studies, and it is unclear whether cardiovascular concerns will prevent approval of strontium ranelate for treating osteoarthritis. Randomised, placebo-controlled trials of adequate power and duration (related to the structural end point under

consideration) should be undertaken to determine the benefits and side effects of agents with disease-modifying osteoarthritis drug potential for treating both hip and knee osteoarthritis (separately). Appropriate structural end points may include progression of radiographic joint space narrowing or MRI features of osteoarthritis. Associated clinical end points could include measures of pain, function and health-related quality of life. Studies should also include rates of subsequent joint replacement (preferably maintaining original blinding, even if extensions are open label). Later phase trials should include a health economic evaluation.

# Finding more information and committee details

You can see everything NICE says on this topic in the NICE Pathway on osteoarthritis.

To find NICE guidance on related topics, including guidance in development, see the NICE webpage on arthritis.

For full details of the evidence and the guideline committee's discussions, see the evidence. You can also find information about how the guideline was developed, including details of the committee.

For general help and advice on putting our guidelines into practice, see resources to help you put NICE guidance into practice.

# Update information

December 2020: we reviewed our guidance on opioids for non-cancer pain in response to a Public Health England evidence review on dependence on, and withdrawal from, prescribed medicines. We added links in recommendation 1.5.2 to other NICE guidelines and resources that support discussion with patients about opioid prescribing, and safe withdrawal management.

February 2014: We have reviewed the evidence and made new recommendations on diagnosis, follow up, referral for surgery, nutraceuticals hyaluronan and acupuncture. These recommendations are marked [2014].

We have also made some changes without an evidence review to clarify terms. These recommendations are marked [2008, amended 2014].

Recommendations marked [2008] last had an evidence review in 2008. In some cases minor changes have been made to the wording to bring the language and style up to date, without changing the meaning.

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# Accreditation

NICE National Institute for Health and Care Excellence

NICE guideline

# Low back pain and sciatica in over 16s: assessment and management

NICE guideline

Published: 30 November 2016
nice.org.uk/guidance/ng59

## Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or service users. The application of the recommendations in this guideline are not mandatory and the guideline does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Local commissioners and/or providers have a responsibility to enable the guideline to be applied when individual health professionals and their patients or service users wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with compliance with those duties.

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This guideline replaces CG88.

## Overview

This guideline covers assessing and managing low back pain and sciatica in people aged 16 and over. It outlines physical, psychological, pharmacological and surgical treatments to help people manage their low back pain and sciatica in their daily life. The guideline aims to improve people's quality of life by promoting the most effective forms of care for low back pain and sciatica.

### *Who is it for?*

- Healthcare professionals
- Commissioners and providers of healthcare
- People with low back pain or sciatica, and their families and carers

# Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

## *1.1 Assessment of low back pain and sciatica*

### Alternative diagnoses

1.1.1 Think about alternative diagnoses when examining or reviewing people with low back pain, particularly if they develop new or changed symptoms. Exclude specific causes of low back pain, for example, cancer, infection, trauma or inflammatory disease such as spondyloarthritis. If serious underlying pathology is suspected, refer to relevant NICE guidance on:

- Metastatic spinal cord compression in adults
- Spinal injury
- Spondyloarthritis
- Suspected cancer

### Risk assessment and risk stratification tools

1.1.2 Consider using risk stratification (for example, the STarT Back risk assessment tool) at first point of contact with a healthcare professional for each new episode of low back pain with or without sciatica to inform shared decision-making about stratified management.

1.1.3 Based on risk stratification, consider:

- simpler and less intensive support for people with low back pain with or without sciatica likely to improve quickly and have a good outcome (for example, reassurance, advice to keep active and guidance on self-management)

- more complex and intensive support for people with low back pain with or without sciatica at higher risk of a poor outcome (for example, exercise programmes with or without manual therapy or using a psychological approach).

### Imaging

1.1.4 Do not routinely offer imaging in a non-specialist setting for people with low back pain with or without sciatica.

1.1.5 Explain to people with low back pain with or without sciatica that if they are being referred for specialist opinion, they may not need imaging.

1.1.6 Consider imaging in specialist settings of care (for example, a musculoskeletal interface clinic or hospital) for people with low back pain with or without sciatica only if the result is likely to change management.

## *1.2 Non-invasive treatments for low back pain and sciatica*

### Non-pharmacological interventions

#### *Self-management*

1.2.1 Provide people with advice and information, tailored to their needs and capabilities, to help them self-manage their low back pain with or without sciatica, at all steps of the treatment pathway. Include:

- information on the nature of low back pain and sciatica
- encouragement to continue with normal activities.

#### *Exercise*

1.2.2 Consider a group exercise programme (biomechanical, aerobic, mind–body or a combination of approaches) within the NHS for people with a specific episode or flare-up of low back pain with or without sciatica. Take people's specific needs, preferences and capabilities into account when choosing the type of exercise.

### *Orthotics*

1.2.3 Do not offer belts or corsets for managing low back pain with or without sciatica.

1.2.4 Do not offer foot orthotics for managing low back pain with or without sciatica.

1.2.5 Do not offer rocker sole shoes for managing low back pain with or without sciatica.

### *Manual therapies*

1.2.6 Do not offer traction for managing low back pain with or without sciatica.

1.2.7 Consider manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage) for managing low back pain with or without sciatica, but only as part of a treatment package including exercise, with or without psychological therapy.

### *Acupuncture*

1.2.8 Do not offer acupuncture for managing low back pain with or without sciatica.

### *Electrotherapies*

1.2.9 Do not offer ultrasound for managing low back pain with or without sciatica.

1.2.10 Do not offer percutaneous electrical nerve simulation (PENS) for managing low back pain with or without sciatica.

1.2.11 Do not offer transcutaneous electrical nerve simulation (TENS) for managing low back pain with or without sciatica.

1.2.12 Do not offer interferential therapy for managing low back pain with or without sciatica.

### *Psychological therapy*

1.2.13 Consider psychological therapies using a cognitive behavioural approach for managing low back pain with or without sciatica but only as part of a treatment package including exercise, with or without manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage).

### *Combined physical and psychological programmes*

1.2.14 Consider a combined physical and psychological programme, incorporating a cognitive behavioural approach (preferably in a group context that takes into account a person's specific needs and capabilities), for people with persistent low back pain or sciatica:

- when they have significant psychosocial obstacles to recovery (for example, avoiding normal activities based on inappropriate beliefs about their condition) **or**
- when previous treatments have not been effective.

### *Return-to-work programmes*

1.2.15 Promote and facilitate return to work or normal activities of daily living for people with low back pain with or without sciatica.

## Pharmacological interventions

1.2.16 For recommendations on pharmacological management of sciatica, see NICE's guideline on neuropathic pain in adults.

1.2.17 Consider oral non-steroidal anti-inflammatory drugs (NSAIDs) for managing low back pain, taking into account potential differences in gastrointestinal, liver and cardio-renal toxicity, and the person's risk factors, including age.

1.2.18 When prescribing oral NSAIDs for low back pain, think about appropriate clinical assessment, ongoing monitoring of risk factors, and the use of gastroprotective treatment.

1.2.19 Prescribe oral NSAIDs for low back pain at the lowest effective dose for the shortest possible period of time.

1.2.20 Consider weak opioids (with or without paracetamol) for managing acute low back pain only if an NSAID is contraindicated, not tolerated or has been ineffective.

1.2.21 Do not offer paracetamol alone for managing low back pain.

1.2.22 Do not routinely offer opioids for managing acute low back pain (see recommendation 1.2.20).

1.2.23 Do not offer opioids for managing chronic low back pain.

1.2.24 Do not offer selective serotonin reuptake inhibitors, serotonin–norepinephrine reuptake inhibitors or tricyclic antidepressants for managing low back pain.

1.2.25 Do not offer anticonvulsants for managing low back pain.

## *1.3 Invasive treatments for low back pain and sciatica*

### Non-surgical interventions

#### *Spinal injections*

1.3.1 Do not offer spinal injections for managing low back pain.

#### *Radiofrequency denervation*

1.3.2 Consider referral for assessment for radiofrequency denervation for people with chronic low back pain when:

- non-surgical treatment has not worked for them **and**
- the main source of pain is thought to come from structures supplied by the medial branch nerve **and**
- they have moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral.

1.3.3 Only perform radiofrequency denervation in people with chronic low back pain after a positive response to a diagnostic medial branch block.

1.3.4 Do not offer imaging for people with low back pain with specific facet join pain as a prerequisite for radiofrequency denervation.

### *Epidurals*

1.3.5 Consider epidural injections of local anaesthetic and steroid in people with acute and severe sciatica.

1.3.6 Do not use epidural injections for neurogenic claudication in people who have central spinal canal stenosis.

## Surgical interventions

### *Surgery and prognostic factors*

1.3.7 Do not allow a person's BMI, smoking status or psychological distress to influence the decision to refer them for a surgical opinion for sciatica.

### *Spinal decompression*

1.3.8 Consider spinal decompression for people with sciatica when non-surgical treatment has not improved pain or function and their radiological findings are consistent with sciatic symptoms.

### *Spinal fusion*

1.3.9 Do not offer spinal fusion for people with low back pain unless as part of a randomised controlled trial.

### *Disc replacement*

1.3.10 Do not offer disc replacement in people with low back pain.

## Putting this guideline into practice

NICE has produced tools and resources to help you put this guideline into practice.

Putting recommendations into practice can take time. How long may vary from guideline to guideline, and depends on how much change in practice or services is needed. Implementing change is most effective when aligned with local priorities.

Changes recommended for clinical practice that can be done quickly – like changes in prescribing practice – should be shared quickly. This is because healthcare professionals should use guidelines to guide their work – as is required by professional regulating bodies such as the General Medical and Nursing and Midwifery Councils.

Changes should be implemented as soon as possible, unless there is a good reason for not doing so (for example, if it would be better value for money if a package of recommendations were all implemented at once).

Different organisations may need different approaches to implementation, depending on their size and function. Sometimes individual practitioners may be able to respond to recommendations to improve their practice more quickly than large organisations.

Here are some pointers to help organisations put NICE guidelines into practice:

1. **Raise awareness** through routine communication channels, such as email or newsletters, regular meetings, internal staff briefings and other communications with all relevant partner organisations. Identify things staff can include in their own practice straight away.

2. **Identify a lead** with an interest in the topic to champion the guideline and motivate others to support its use and make service changes, and to find out any significant issues locally.

3. **Carry out a baseline assessment** against the recommendations to find out whether there are gaps in current service provision.

4. **Think about what data you need to measure improvement** and plan how you will collect it. You may want to work with other health and social care organisations and specialist groups to compare current practice with the recommendations. This may also help identify local issues that will slow or prevent implementation.

5. **Develop an action plan**, with the steps needed to put the guideline into practice, and make sure it is ready as soon as possible. Big, complex changes may take longer to implement, but some may be quick and easy to do. An action plan will help in both cases.

6. **For very big changes** include milestones and a business case, which will set out additional costs, savings and possible areas for disinvestment. A small project group could develop the action plan. The group might include the guideline champion, a senior organisational sponsor, staff involved in the associated services, finance and information professionals.

7. **Implement the action plan** with oversight from the lead and the project group. Big projects may also need project management support.

8. **Review and monitor** how well the guideline is being implemented through the project group. Share progress with those involved in making improvements, as well as relevant boards and local partners.

NICE provides a comprehensive programme of support and resources to maximise uptake and use of evidence and guidance. See our into practice pages for more information.

Also see Leng G, Moore V, Abraham S, editors (2014) Achieving high quality care – practical experience from NICE. Chichester: Wiley.

## Context

Low back pain that is not associated with serious or potentially serious causes has been described in the literature as 'non-specific', 'mechanical', 'musculoskeletal' or 'simple' low back pain. For consistency, we have used the term 'low back pain' throughout this guideline. However, 'non-specific low back pain' was used when creating the review questions. Worldwide, low back pain causes more disability than any other condition. Episodes of back pain usually do not last long, with rapid improvements in pain and disability seen within a few weeks to a few months. Although most back pain episodes get better with initial primary care management, without the need for investigations or referral to specialist services, up to one-third of people say they have persistent back pain of at least moderate intensity a year after an acute episode needing care, and episodes of back pain often recur.

One of the greatest challenges with low back pain is identifying risk factors that may predict when a single back pain episode will become a long-term, persistent pain condition. When this happens, quality of life is often very low and healthcare resource use high.

Unlike the previous NICE guidance on the management of persistent low back pain between 6 weeks and 12 months, we have moved away from the traditional duration-based classification of low back pain (acute, sub-acute and chronic) and have looked at low back pain as a whole where risk of poor outcome at any time point is almost always more important than the duration of symptoms.

This guideline gives guidance on the assessment and management of both low back pain and sciatica from first presentation onwards in people aged 16 years and over.

We use 'sciatica' to describe leg pain secondary to lumbosacral nerve root pathology rather than the terms 'radicular pain' or 'radiculopathy', although they are more accurate. This is because 'sciatica' is a term that patients and clinicians understand, and it is widely used in the literature to describe neuropathic leg pain secondary to compressive spinal pathology.

This guideline does not cover the evaluation or care of people with sciatica with progressive neurological deficit or cauda equina syndrome. All clinicians involved in the management of sciatica should be aware of these potential neurological emergencies and know when to refer to an appropriate specialist.

We hope to address the inconsistent provision and implementation of the previous guidance and provide patients, carers and healthcare professionals with sensible, practical and evidence-based advice for managing this important and common problem.

## *More information*

You can also see this guideline in the NICE pathway on low back pain and sciatica.

To find out what NICE has said on topics related to this guideline, see our web page on low back pain.

## Recommendations for research

The guideline committee has made the following recommendations for research. The committee's full set of research recommendations is detailed in the full guideline.

### *1 Pharmacological therapies*

What is the clinical and cost effectiveness of benzodiazepines for the acute management of low back pain?

#### Why this is important

Guidelines from many countries have said that muscle relaxants should be considered for short-term use in people with low back pain when the paraspinal muscles are in spasm. The evidence for this mainly comes from studies on medications that are not licensed for this use in the UK. The 2009 NICE guideline on low back pain recommends to consider prescribing diazepam as a muscle relaxant in this situation, but the evidence base to support this particular medicine is extremely small. Benzodiazepines are not without risk of harm, even for short-term use. Because of this, there is a need to find out if diazepam is clinically and cost effective in the management of acute low back pain.

### *2 Pharmacological therapies*

What is the clinical and cost effectiveness of codeine with and without paracetamol for the acute management of low back pain?

#### Why this is important

Codeine, often together with paracetamol, is commonly prescribed in primary care to people presenting with acute low back pain. This often happens with people who cannot tolerate non-steroidal anti-inflammatory drugs (NSAIDs) or when a person has contraindications to these medications. Although there is evidence that opioids are not effective in chronic low back pain, there are relatively few studies that look at their use for acute low back pain (a problem commonly seen in primary care). Also, it is not known if using paracetamol and codeine together has a synergistic effect in the treatment of back pain.

## *3 Radiofrequency denervation*

What is the clinical and cost effectiveness of radiofrequency denervation for chronic low back pain in the long term?

### Why this is important

Radiofrequency denervation is a minimally invasive and percutaneous procedure performed under local anaesthesia or light intravenous sedation. Radiofrequency energy is delivered along an insulated needle in contact with the target nerves. This focused electrical energy heats and denatures the nerve. This may allow axons to regenerate with time, requiring the repetition of the radiofrequency procedure.

The length of pain relief after radiofrequency denervation is uncertain. Data from randomised controlled trials suggest relief is at least 6–12 months but no study has reported longer-term outcomes. Pain relief for more than 2 years would not be an unreasonable clinical expectation. The economic model presented in this guideline suggested that radiofrequency denervation is likely to be cost effective if pain relief is above 16 months.

If radiofrequency denervation is repeated, we do not know whether the outcomes and duration of these outcomes are similar to the initial treatment. If repeated radiofrequency denervation is to be offered, we need to be more certain that this intervention is both effective and cost effective.

## *4 Epidurals*

What is the clinical and cost effectiveness of image-guided compared with non-image-guided epidural injections for people with acute sciatica?

### Why this is important

Epidural injection of treatments, including corticosteroids, is commonly offered to people with sciatica. Epidural injection might improve symptoms, reduce disability and speed up return to normal activities. Several different procedures have been developed for epidural delivery of corticosteroids. Some practitioners inject through the caudal opening to the spinal canal in the sacrum (caudal epidural), but others inject through the foraminal space at the presumed level of nerve root irritation (transforaminal epidural).

Some people believe transforaminal epidurals might be most effective because they deliver corticosteroids directly to the region where the nerve root might be compromised. But because

transforaminal epidural injection needs imaging, usually within a specialist setting, this potentially limits treatment access and increases costs. Caudal epidural injection can be done without imaging, or with ultrasound guidance in a non-specialist setting. But it has been argued the treatment might not reach the affected nerve root, meaning this method might not be as effective as transforaminal injection.

Evidence that one method is clearly better than the other is currently lacking. Use of the 2 methods varies between healthcare providers, and people whose sciatica does not respond to caudal corticosteroid injection might go on to have image-guided epidural injection. This means people with sciatica might currently experience unnecessary symptoms at unnecessary cost to the NHS than they would if the most clinically and cost-effective way of delivering epidural corticosteroid injections was always used.

## *5 Spinal fusion*

Should people with low back pain be offered spinal fusion as a surgical option?

### Why this is important

An increasing number of procedures have been proposed for surgically managing low back pain. One of these procedures is surgical fixation with internal metalwork applied from the back, front, side, or any combination of the 3 routes. The cost of these operations has risen, and now that minimally invasive approaches are used, more of these operations are done with uncertain benefit.

As well as the cost, surgery can lead to complications – some studies report around a 20% complication rate in the short to medium term. There have been several studies (both randomised and cohort) looking at the clinical effectiveness of spinal fusion versus usual care, no surgery, different surgeries, and other treatments. Overall, the studies do not show a clear advantage of fusion but do show some modest benefit for some elements of pain, function and quality of life. The studies also show healthcare use was lower. It is not known what treatments should be tried before surgery is considered. The evidence from the studies was weak because of low numbers of patients, large crossover and in-case selection bias. This means there is a need for a large, multicentre randomised trial with sufficient power to answer these important questions.

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## *Accreditation*

# COVID-19: ADVICE FOR CARERS AND YOUNG CARERS DURING COVID-19 PANDEMIC

Updated 03 December 2020 @ 13:00

This document offers advice to people who, without payment, provide help and support to a family member or a friend who may not be able to manage without this help because of frailty, illness or disability. Carers can be adults caring for other adults, parents caring for ill or disabled children or young people who care for another family member.

**Key Messages**


- **Follow** public health **advice**.
- Carers, people with care and support needs and people coming into the home of a person with care needs should follow **hygiene and infection control** guidelines.
- **Plan for contingencies** and check with your Trust what the emergency plan is.
- **Make the most of networks** now to plan for "what if?". Speak to family, friends and neighbours, and your local community organisations.
- Make sure you have **key information** to hand about the person you care for.
- **Make the most of technology** that can keep you in touch with the person for whom you care, or keep them in touch with others.
- This new situation for carers can be confusing and demanding, even tough. **Support is available** to help you to get through this.
- **Remember** to use the **Coronavirus Take 5 message** each day:

Take 5 Steps to Wellbeing

## Preparing for the winter months

As we see the numbers of infections rise and some restrictions being imposed, it is important to continue to follow the guidance in order to remain safe during the winter period.

Continue to take the advice of the Public Health Agency to help all of us stay safe.

To limit the spread of COVID-19 the World Health Organisation has recommended that everyone should avoid the Three C's:

- **Closed spaces with poor ventilation**
- **Crowded places with many people nearby**
- **Close-contact settings such as close-range conversations.**

Please remember this as you continue to care for your family members, friends or neighbours.

**Everyone who is eligible for a free flu vaccine should take up this opportunity and help protect themselves and those around them this winter.**

If you were born on or before 5 October 1954 you could get between £100 and £300 to help you pay your heating bills. This is known as a '**Winter Fuel Payment'**. To find out how to apply, telephone **0800 731 0160** (or 0800 731 0176 for deaf or hearing-impaired callers) or go to:
www.nidirect.gov.uk/contacts/contacts-az/winter-fuel-payment-centre

The Department for Communities is providing a one-off **Covid-19 Heating Payment** for those in receipt of Pension Credit, or in receipt of certain disability benefits at the higher rates, in recognition of additional costs arising from the Covid-19 pandemic. To find out more go to:
www.nidirect.gov.uk/articles/coronavirus-covid-19-and-benefits

In this edition we have provided further advice that we hope you will find helpful. If you are concerned about anything, please contact the **Carers NI advice line** which has extended opening hours during COVID-19. If you have services provided by the HSC Trust, contact your **named worker**.

Many health and social care services that were stopped as a result of COVID-19 have resumed in a limited way in keeping with government advice. HSC Trusts are contacting families who used particular services before lockdown to discuss how your family members can start using the service again. To find out about the resumption of services and how this will affect you, please speak to your **named worker**.

## What's New in this Update?

| Page Number | Sections updated | What's New |
|---|---|---|
| **3** | Preparing for the winter months | Information on Winter Fuel Payments and Covid-19 Heating Payment added |
| **9** | Support for Carers and Young Carers of Deafblind people | New section added |
| **9** | Physical and emotional wellbeing | Section updated |
| **11** | Listening Ear Service | New section added |
| **14** | Additional financial support during COVID-19 | Section updated |
| **14** | Carer's Cash Grant | Section updated |
| **14** | COVID-19 Testing and Contact Tracing | Section updated |
| **16** | Access to PPE | Section updated |
| **18** | Are you a young carer? | Section updated |
| **20** | Attending school | Section updated |
| **22** | Distance caring | Section updated |
| **22** | Palliative and End of Life Care | Section updated |
| **26** | Contacts | Contact details for Barnardo's added |

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## Introduction

This information provides advice and support for **(unpaid) carers, young carers and family members**. It pulls together already existing sources of information into one place and signposts carers to others who may be able to help. All links provided throughout this document are from reliable sources.

As the crisis with COVID-19 (Coronavirus) continues, this document will be regularly reviewed to update the information and advice.

**Always ensure you are reading current COVID-19 information from reliable sources as guidance may change frequently.**

This advice contains links to the **.gov.uk** website. The information contained in these links is very useful but you should be aware that, on occasions, it includes further web links to information specific to England.

A number of resources on COVID-19 in British and Irish Sign Language are available via this link:

www.publichealth.hscni.net/covid-19-coronavirus

## Planning ahead for an emergency

You might find this tool useful to help you plan during the COVID-19 period. It was developed specifically for Northern Ireland for emergency planning:

Planning for emergencies tool

It is vitally important that you have an emergency plan in place in the event that you become ill and are unable to provide care.

- If you don't have one, speak to your **named worker** about getting one in place.
- If you already have a plan, check with the Trust that it is still workable due to COVID-19 (and review periodically).
- Be prepared for the person being cared for needing to be admitted to hospital (have a bag packed, include a list of medication, contact details for their carer and family members).
- Know who your **named worker** is and what arrangements are in place for cover if they are off work.
- This plan may help you to record vital information in the event of an emergency. Keep it up to date and share with your **named worker** and other family members. This will help significantly if your family member needs to be hospitalised or if you become unwell.
- It might be worth giving neighbours and friends of the individual 'In case of Emergency' numbers and also placing these in personal items (e.g. handbag, purse, wallet) of the individual. This is particularly useful for people with dementia who may try to go out for exercise but become displaced or confused.

Carers UK - Planning for emergencies

## Health advice

**The Public Health Agency website has all the relevant information relating to COVID-19 (Coronavirus) in Northern Ireland. This includes advice on social distancing, self-isolation, looking after someone who is clinically vulnerable or extremely vulnerable, what to do if you think you have symptoms of COVID-19 and more. It can be accessed here:**

www.publichealth.hscni.net

## Seasonal Flu Vaccination

The current population groups eligible for a free flu vaccination are everyone aged 65 and over, pregnant women, those aged under 65 years of age in clinical “at risk” groups, all children aged 2 to 4, all primary school pupils, and health and social care workers in both the independent sector and the public sector.

Those in a clinical at risk group include anyone who has any of the following medical conditions:

- a chronic chest condition such as asthma;
- a chronic heart condition;
- chronic liver disease;
- chronic kidney disease;
- diabetes;
- lowered immunity due to disease or treatment such as steroids or cancer therapy (people living in the same house as someone with lowered immunity may also need to be vaccinated);
- a chronic neurological condition, such as stroke, multiple sclerosis or a condition that affects your nervous system, such as cerebral palsy;
- are seriously overweight (BMI>40); -
- any other serious medical condition – check with your doctor if you are unsure.

Vaccination should also be offered to:

a. household contacts of immunocompromised individuals i.e. individuals who expect to share living accommodation on most days over the winter

b. Those who are in receipt of a carer’s allowance, or those who are the main carer, or the carer of an elderly or disabled person whose welfare may be at risk if the carer falls ill.

Additional vaccine has been secured this year which will allow Year 8 pupils in the first year of secondary school, and for household contacts of those who received shielding letters during the COVID-19 pandemic to receive the free vaccine. Household contacts of those who shielded can request vaccination via their GP.

There is emerging evidence that co-infection with COVID-19 and flu may lead to a more severe illness. Reducing the pressure caused by seasonal flu will help preserve the capacity of the health and social care system to manage any future waves of COVID-19 as well as reducing the risk of co-infection in vulnerable people.

**Everyone who is eligible for a free flu vaccine should take up this opportunity and help protect themselves and those around them this winter.**

Further information on the flu vaccine can be found here

## Interpreting services

Since the outbreak and spread of COVID-19, many Health and Social Care services and essential information sources have switched to telephone contact only, creating significant challenges for deaf people and others who use sign language. A free, temporary service has been established to enable the Deaf community to communicate effectively via telephone and secure video link.

A free interpreting service provides the Deaf community in NI with access to:

- NHS111 services during the COVID-19 pandemic via a video relay system.
- All other Health and Social Care services including GPs via either a video relay system or video remote interpreting.

Further information can be found at the following link:

www.hscboard.hscni.net/interpreting-service-bsl-isl/

## Support for Carers and Young Carers of Deafblind people

Sense NI has established a new carers group open to carers of all ages who care for Deafblind people.

For more information, or to request a copy of Sense NI's dedicated carer's newsletter, *Sense of Purpose,* contact: nienquiries@sense.org.uk

## Physical and emotional wellbeing

COVID-19 has impacted on us all, leading to unprecedented changes in our everyday lives. The restricted living conditions and daily challenges we face can lead to feelings of stress and other difficult emotions.

Health and Social Care (HSC) in partnership with ORCHA (Organisation for Review of Care and Health Apps) has developed a library of high quality, convenient Apps to support health and social wellbeing during these difficult times.

The Apps included in the library provide useful support and information on how to manage stress and improve wellbeing, sleep management, staying fit and nutrition.

You can access the Apps Library via your smart phone or PC at:

apps4healthcareni.hscni.net

The resources below are designed to help promote positive mental health and wellbeing both during and after the COVID-19 pandemic and have some useful tips and advice on looking after your wellbeing:

Take 5 Steps to Wellbeing

The Minding Your Head (MYH) website has a range of information and resources to support and enhance your mental and emotional wellbeing, and information on how to help others and how to access help and support when needed:
www.mindingyourhead.info

Tailored information and self-help guides from local mental health and wellbeing charities are available at the COVID-19 Virtual Wellbeing Hub at www.covidwellbeingni.info.

Age NI has teamed up with Lady Mary Peters to develop an exercise programme aim specifically at keeping older people moving during the COVID-19 pandemic.

www.ageuk.org.uk/northern-ireland/information-advice/coronavirus-covid-19/movewithmary/

An excellent resource for people who are isolated or vulnerable can be found on the SCIE website:
www.scie.org.uk/support-for-people-who-are-isolated

A new free online stress control class is available through YouTube. To access these classes go to:

www.ni.stresscontrol.org

There are a range of crisis response helplines in Northern Ireland for adults or children who are experiencing distress or despair.

Helpline services are available 24 hours a day, seven days a week to listen and help, **in confidence**. The Helplines NI website provides a directory of over 60 helpline services operating across Northern Ireland. The helplines provide information, support, advice and guidance on a wide-range of health and wellbeing needs. The website also includes details of both national and local Coronavirus (COVID-19) specific helplines:
https://helplinesni.com/

People living in Northern Ireland can call Lifeline on **0808 808 8000**. Deaf and hard of hearing Text phone users can call Lifeline on 18001 0808 808 8000. Calls to Lifeline are free to people living in Northern Ireland who are calling from UK landlines and mobiles.

Lifeline: phone **0808 808 8000**

Website: www.lifelinehelpline.info/

Samaritans: **phone 116 123**

Website: www.samaritans.org

ChildLine: **phone 0800 1111**

Website: www.childline.org.uk

### Listening Ear Service

The Belfast Health and Social Care Trust's Listening Ear Service provides a confidential listening service to carers within the Belfast Trust area, providing reassurance and comfort as well as relaxation and mindfulness advice. If you would like to speak to someone you can refer yourself by contacting the Carer Support Service on:
Telephone: **028 9504 2126**
Email: CarerSuppSvcs@belfasttrust.hscni.net

The Southern Health and Social Care Trust has a contract in place with Carers Trust to provide support, advice, activities and training, along with opportunities to meet with other carers. If you need to talk to someone, the service has trained and experienced outreach workers who can provide a listening ear and will respond to your needs by signposting you to services and programmes which may support you in your caring role. This service is available Monday – Friday 9-5pm.

Please call **07826 930 508** if you need support in the Southern Trust area.

## Support for you in your caring role

If you are new to a caring role during COVID-19 it is very important that you contact your local Trust (see contact details at end of this Advice) and identify yourself as a carer. This will allow the Trust to be aware of you and your situation and give you access to various support and help provided by the Trust.

If the person you care for is already in receipt of services and you have any concerns about them, contact the **named worker** who will be best placed to give advice and support.

The Social Care Institute for Excellence (SCIE) has developed a series of videos about looking after someone at home. They cover subjects such as nutrition, preventing ulcers, mouth care, preventing falls, behaviours etc. These videos can be accessed here:

www.scie.org.uk/carers/informal-carers

## Can care workers continue to deliver care?

**Government advice is that people who need care and help should continue to receive it. Domiciliary care workers and community-based health and social care staff have access to Personal Protective Equipment (PPE) and will follow strict guidelines about hygiene in order to keep you safe.**

## If the person you care for needs to go to hospital

If the person you care for needs to go into hospital, the information contained in the link below will give you guidance about supporting the person whilst they are in hospital:

COVID-19: Regional Principles for Visiting in Care Settings in Northern Ireland

The visiting guidance was updated recently to reflect Level 4 surge.

## Carer's Assessment

As a carer you are entitled to a Carer's Assessment so that the Trust can identify your needs. During COVID-19 (Coronavirus) the Trust may need to contact you by phone or using video (e.g. Skype, Facetime etc.) to discuss your situation. Talk to your local Trust and/or Carer Co-ordinator about this.

For children's services, this will be via the Gateway Teams (list attached) but please note that each case will be on the basis of an individual assessment of need and may reflect the capacity of the service to respond during the current situation. Priority will be given to cases where children are at risk or family breakdown is likely.

For more information on Carer's Assessments visit:

www.nidirect.gov.uk - assessments for carers

www.carersuk.org/Factsheets/Asssments.pdf

## Self-Directed Support – Option1: Direct Payments

If you, as a carer, are in receipt of services, Direct Payments can be used to 'buy-in' care and support rather than using Trust arranged services. If you choose to have your assessed need in regards to care and support provided via Direct Payments you can discuss this with your **named worker** or your local Trust's **Carer Co-ordinator**. Contact details are included at the end of this document.

Direct Payments User Guide - April 2020

More detailed guidance on using Direct Payments during the COVID-19 pandemic is available here:

www.health-ni.gov.uk/publications/guidance-direct-payments

Please access the links below for further information and help:

www.nidirect.gov.uk - Direct Payments

Centre for Independent Living NI

Please note that Direct Payments is just one option in how you can choose to have your care and support needs met. The individual in receipt of services and/or their legally authorised person can choose how your assessed need is met. This can be through Direct Payments, Managed Budgets, Trust Arranged Services or a mixed option. Your care and support will be reviewed and any change in your circumstances will be discussed and the existing provision revised.

During the assessment process, Trusts will seek to engage with families regarding their specific circumstances and will try to be as flexible as possible in responding to your needs, looking at how support and care provided by family, community and the Trust can support you in achieving your outcomes.

## Carer's Allowance

If you are new to caring or are looking after someone and do not receive an allowance, you may be entitled to some financial support, called Carer's Allowance. It is paid by the Department for Communities. Information on the allowance can be accessed here:

www.nidirect.gov.uk - carers allowance

Existing carers will continue to be paid Carer's Allowance when they have temporarily ceased to care for a severely disabled person due to either of them self-isolating or being infected with coronavirus.

During the COVID-19 pandemic, emotional support can also count towards the 35 hours a week you spend caring for someone who is ill or has a disability.

## Additional financial support during COVID-19

You may also be entitled to additional financial support if you have been affected by COVID-19. Details on Discretionary Support, Discretionary Support Self Isolation Grant, Universal Credit Contingency Fund Short-term Living Expenses Grant, Short-term Benefit Advances, Social Fund Budgeting Loans and Social Fund Sure Start Maternity Grants and how to apply can be access via this link:

www.nidirect.gov.uk/articles/extra-financial-support

## Carer's Cash Grant

Following a Carer's Assessment your key worker may be able to apply for a Carer's Cash Grant for you to meet a need identified via your assessment. The application will be dependent on funds being available and, if successful, you will be required to provide evidence in the form of receipts of how you have spent the grant.

## COVID-19 Testing and Contact Tracing

Everyone in Northern Ireland with symptoms of coronavirus is now eligible for testing. For further information on testing see the PHA website:

www.publichealth.hscni.net/covid-19-coronavirus/testing-and-tracing-covid-19

The StopCOVID NI app was launched at the end of July 2020 for over 18s. The app was extended to children and young people aged 11–17 from September. The app, which is available to download free from Apple and Google app stores, uses an anonymised process to identify people who are at risk and break transmission chains by providing advice to users to self-isolate where relevant.

People are encouraged to download and activate the app which will alert users if they have been in close contact with other users who have tested positive for COVID-19. The app supports and supplements the Public Health Agency's telephone based contact tracing operation that already exists to minimise the spread of the virus.

## Voluntary/community support

The **Freephone COVID-19 Community Helpline** number is **0808 802 0020** or e-mail: covid19@adviceni.net or text: ACTION to 81025.

There is a **Family Support Hub** in your area and their work is continuing. They can provide access to a wide range of services including foodbanks, advice on parenting and children`s issues, and money matters. Details of services are available on:

- The Family Support NI website www.familysupportni.gov.uk
- Children & Young Peoples Strategic Partnership website www.cypsp.hscni.net or

- NI Direct website. www.nidirect.gov.uk - support hubs

## Short breaks

Residential Short Breaks services for children with disability which had been providing a limited service during the initial phase are beginning to expand those services but the capacity will remain restricted by the public health guidelines and social distancing requirements. Families who had been utilising those services previously should continue to link with their **named worker** in regard to any change in either their circumstances or needs of the young person.

It is important that you also look after your own health and well-being for your own sake and to enable you to continue caring. If you are concerned about your situation you should speak to your **named worker**.

Do look at the section above called **Physical and emotional wellbeing** about coping during this difficult period.

## Short breaks including residential short breaks for children with disability and those with complex health needs

Short break services are recognised as an important aspect of support, especially to families caring for disabled children. Services will strive to seek a balance between maintaining this support and ensuring the health of the person being cared for is not further compromised.

Details of support and the role of Family Support Hubs is noted above.

## What if I need medical supplies?

If you or the person you care for normally receives medical supplies from the Trust or through your GP prescription to your community pharmacy, or from your district Nurse, this will continue. **This process has not changed**. Those who are on regular prescriptions are being advised to order in good time and if there are difficulties to contact your **named worker**.

## Local pharmacy/prescriptions

If you are unable to collect a prescription from the community pharmacy you should:

- ask someone to do this on your behalf, such as a friend, neighbour, family member or local support network (this is the best option, if possible);
- If this cannot be arranged some community pharmacies may be able to arrange to deliver your prescription to your home.

To check if your pharmacy offers a prescription delivery service you can contact the COVID-19 Community Helpline on 0808 802 0020 or Carers NI on 028 9043 9843.

### Grocery shopping

The priority online food delivery service for people who were previously shielding has been suspended with effect from 31 July and is not accepting any new registrations. For those who registered to use this online food delivery service before 31 July you will be able to continue using the service after this date.

Volunteer Shopping Cards are available from various supermarkets, including Sainsbury's, Lidl, Asda and Marks and Spencer. Cards are pre-set with a specific amount of money and can be purchased by the cared for person via telephone or online. Cards can be posted out or emailed and printed off and given to the carer to carry out shopping duties. This can be a safer way to shop as it eliminates the need for cash or the exchange of bank details or bank cards.

### Carer's ID Card

A Carer's ID Card is available from Health and Social Care Trusts to all *informal (unpaid) carers* in Northern Ireland who are known to the Trust and in receipt of services. The Carer's ID Card provides proof of carer status and can be shown to Police Officers when carrying out essential travel or additional exercise during periods when travel may be restricted. The Carer's ID Card will also allow carers access to priority in-store shopping hours similar to key workers and essential workers. Carers can avail of priority shopping hours at any of the following stores throughout Northern Ireland: ASDA, Co-op, Lidl, Iceland, Marks and Spencer and Sainsbury's. Check with your local store to find out how the retailer can help you with access to priority in-store shopping.

Speak to your Trust's Carer Co-ordinator (contact detail at the end of this advice document) if you have not received a card but think you are eligible.

## Access to PPE (masks, aprons etc.)

If you provide direct hands on care, for example personal care and toileting, you should be provided with disposable gloves and disposable plastic aprons. Fluid-resistant surgical masks (face mask) and eye/face protection can be provided following a risk assessment which determines that there is a risk of contamination with splashes, droplets of blood or body fluids.

A risk assessment should also consider the Covid-19 status of the individual being cared for; are they displaying symptoms or waiting a test result?

Where carers consider there is a risk to themselves or the individuals they are caring for, they should wear a fluid resistant surgical mask with or without eye protection. Please note that the fluid resistant face mask should be replaced if it becomes damaged, soiled or uncomfortable. After you have provided care directly

to the individual, you should remove the face mask (and any other PPE), dispose of the PPE, wash your hands thoroughly and maintain a social distance of 2 metres or more.

You may not be required to wear PPE in certain circumstances, for example, if you are a part of a household bubble. If you are not a part of the household bubble, PPE should be worn when providing direct hands on care and a face covering will be required when within 2 metres of the individual even when not delivering direct personal care.

If you are concerned or in doubt please take advice from your **named worker** who may be able to address your concerns or sign post you to the correct advice and guidance.

**PPE will be provided by your local Trust and you will not be charged.** As a carer you should contact your **named worker** to secure access to PPE or contact the relevant Carer Support Service referenced on page 21 of this document. Likewise if your needs change or you are new to the caring role, again please contact your **named worker** or the relevant Carer Support Service.

If you require PPE due to the nature of the care you give, the Trust will give you the relevant advice on how the PPE should be used and disposed of.

Trusts must ensure that all **Direct Payment recipients** have a **named worker** in their Trust to contact about the need for PPE provision. In this situation the Direct Payment recipient should not be charged for the provision of PPE from Trust stocks.

## Working carers

You may be a carer who also has a full time or part-time job. Juggling your caring and working role can be difficult in normal times. Trying to do this during COVID-19 may place additional stress upon you. It is vital you seek the support of other family members where possible, and even more important to take time for yourself.

Keep in touch with the **named worker** who will be best placed to give advice and support.

Remember the **Take 5 Steps to Wellbeing** messages each day to help you and your family get through this.

### Employment rights

All employers have been asked to be flexible with their staff during COVID-19 (Coronavirus). Employers have a 'duty of care' for staff and, in practice, this means taking all steps they reasonably can to support the health, safety and wellbeing of their staff. If you need to take extra time off work because you have caring

responsibilities, you should check your employer's policy on Carers/Caring for Others and discuss your situation with them.

The Law Centre has produced useful information about your employment rights:

Law Centre NI - employee rights - Covid-19

Guidance on Statutory Sick Pay:

www.nidirect.gov.uk - Statutory Sick Pay

www.gov.uk - Statutory Sick Pay

The Equality Commission for NI also have help and advice on employment issues if you are a carer and are being asked to return to work:

www.equalityni.org//Caring-responsibilities-and-returning-to-work

### Benefits

For advice and assistance on other benefits such as housing, Universal Credit etc., please access the NI Direct website:

www.nidirect.gov.uk - information on benefits and financial support

www.communities-ni.gov.uk - benefits and pensions/make the call

Extra financial support may be available from the Finance Support Service if you have been affected by COVID-19. To find out what's available go to:

www.nidirect.gov.uk/articles/extra-financial-support

## Are you a young carer?

A young carer is someone aged between 8 and 18 who cares for a parent, sibling or relative. This may be due to disability, a mental health condition, long-term illness, or drug or alcohol addiction.

A Young Carers Service will continue to be provided:

- in the Southern, South Eastern and Belfast Trust areas by Action for Children who have recommenced small group activities, some outdoor activities and home visiting services, taking into account the relevant COVID-19 advice.

  Contact Aisling Reynolds, email: niyoungcarers@actionforchildren.org.uk

- in Northern and Western Trust areas by Barnardo's, email: ReceptionNI@barnardos.org.uk

**For further details please see the Contacts section at the back of this document.**

Referrals to the Young Carers service will continue in the usual way and in line with the regional guidance to HSC Trusts which identifies processes for:

- The assessment and identification of Young Carers
- The provision of services to Young Carers
- Young Carers entitlement to a Carer's Assessment

Both Barnardo's NI and Action for Children Young Carers services will continue to process referrals to their service in the usual way and will offer 1-2-1 support, assessment and reviews.

Most contact is currently remote/virtual however there has been and will continue to be doorstep visits and socially distanced walks. Action for Children are continuing to deliver small outdoor group activities in the Belfast, South Eastern and Southern Trust Areas. During the current crisis, the Young Carers Services will continue to maximise the use of phone, text, Skype, and any other means which are safe and acceptable to young carers and their families.

## Useful information for young carers

We have gathered together some information below to help support young carers to understand the current situation surrounding COVID-19 that we hope you will find useful.

For the latest news about Coronavirus for young people, CBBC Newsround - www.bbc.co.uk/newsround#more-stories-2

The charity Young Minds have written a blog about what young people can do if they are feel anxious about Coronavirus - www.youngminds.org.uk/blog/what-to-do-if-you-re-anxious-about-coronavirus/

There is lots of support surrounding young people's mental health on the Charlie Waller Memorial Trust website. They have free resources which you can download to support your wellbeing - www.cwmt.org.uk/

There is also a PDF workbook from Mindheart to download and print out, which you can use to colour or write down your thoughts about how you are feeling - www.mindheart.co/descargables

The Mix is a charity that provides free, confidential support for young people under 25 via online, social and mobile. The Mix can help you connect with other carers, celebrate your work, learn new skills and find the support and information you need - www.themix.org.uk/search/young+carers

### Attending school

The Department of Education has published *Coronavirus (COVID-19): Guidance for School and Educational Settings in Northern Ireland*. The guidance sets out what steps schools should take to help staff and pupils stay safe.

Information about attending school is in Section 7 of the guidance. All pupils should attend school even if they live with someone who is vulnerable or who is clinically extremely vulnerable and was previously shielding.

The guidance will be kept under review and should be checked on a regular basis.

www.education-ni.gov.uk/GuidanceforSchoolandEducationalSettings

Additional advice for schools and teachers relating to young carers at school can be accessed here.

## Caring for those with learning disabilities and Autism

Lifestyle changes such as social distancing and self-isolation can be particularly difficult for those with learning disabilities and Autism. Support for families/carers of people with learning disabilities through the Coronavirus restrictions can be found here:

bild.org.uk/Coronavirus-resources-for-use-by-families

scie.org.uk/learning-disabilities-autism

www.publichealth.hscni.net/covid-19-coronavirus/guidance-hsc-staff-healthcare-workers-and-care-providers/staff-health-and-0#supporting-people-with-learning-difficulties-and-or-autism

Carers who have a family member with a learning disability or autism may need to leave their homes several times a day for exercise or medical needs; this may include travel beyond their local area. To support these circumstances the Health and Social Care Board has shared a template letter with the Health and Social Care Trusts which is available, upon request, from the relevant Trust area. Families who would like a copy should contact their key worker in their local Trust.

Guidance on providing unpaid care to adults with learning disabilities and autistic adults can be found at the following link. While some of the guidance contained duplicates what is already in this document, these are useful:

www.gov.uk/government/publications/covid-19-providing-unpaid-care-to-adults-with-learning-disabilities-and-autistic-adults

A great resource for children and young people or those caring for children and young people can be found here:

www.cypsp.hscni.net/resource-pack-for-children-young-people/

## Caring for someone with a Dementia

Caring for someone with a dementia is particularly stressful, both emotionally and physically, as the person with the dementia may require continuous support and supervision. If the person you care for is involved with Trust services, keep in touch with the **named worker** who will be best placed to give advice and support.
For information about Dementia (including information booklets):
www.NIDirect.gov.uk/dementia
www.hscboard.hscni.net/dementia/
www.publichealth.hscni.net/publications?keys=dementia
www.publichealth.hscni.net/publications?keys=delirium

It is important for everyone including people with a dementia to keep active during this pandemic. The following links provide useful suggestions:
www.playlistforlife.org.uk
musicmemories.bbcrewind.co.uk
www.alzheimers.org.uk/get-support/coronavirus-activity-ideas-people-living-dementia#content-start

A number of Apps have been developed which provide support through self-monitoring and self-management of care for people living with a dementia. These are available at:
apps4dementia.orcha.co.uk

The Royal College of Psychiatrists have created a useful webinar entitled, '**Supporting carers and care staff to understand and respond to changes in behaviour in people with dementia during the COVID-19 pandemic'**. This can be downloaded from the following link:

www.northerntrust.hscni.net/services/dementia-services/clear/

This link also includes the guide used by all Trusts on “How to support people with Dementia during COVID-19”:

There are several charities offering support and help for dementia carers:

- Age NI
- Alzheimer’s Society
- Carers NI
- Dementia NI
- Together in Dementia Everyday (Tide)

Further details can be found in the Contacts section at the end of this document.

## Distance caring

Know the contact number of your relative's GP and **named worker** within the Trust and ensure they have your contact details as next of kin. Check that the current domiciliary care package is being maintained. Make sure the emergency planning tool is up to date Planning for emergencies tool

Consider setting up a rota/schedule for regular phone calls to keep in touch or using technology such as WhatsApp or Facetime to keep your family and friends connected over long distances.

## Palliative and End of Life Care

Caring for someone with palliative and end of life care needs can be emotionally and physically demanding and especially so during COVID-19. Where the person you are caring for has palliative or end of life care needs, services and care will be planned and delivered to ensure that appropriate arrangements are in place to meet these needs and continue to support you in your caring role.

Information to support people with palliative and end of life care needs and their family and carers, as well as information on palliative care services and support, can be found at the Palliative Care in Partnership website via the link below:

https://pcip.hscni.net/

Other sources of advice and support are also available including:

www.macmillan.org.uk/coronavirus

www.mariecurie.org.uk/help/support/coronavirus

## Bereavement Support

It is recognised that experiencing bereavement during COVID-19 will be especially difficult. Information and support have been developed which includes advice on dealing with grief as well as practical information on dealing with those aspects of a death that may be different during the pandemic period. Contact details for Bereavement Coordinators within each Health and Social Care Trust are also provided should you need further guidance and help.

www.publichealth.hscni.net/publications/covid-19-bereavement-resources

Cruse Bereavement Care provides free support, advice and information for adults, children and young people. They can be contacted via their National Freephone

Helpline: 0808 808 1677. Contact details for local services can be found on the Cruse NI website at:

www.cruse.org.uk/get-help/local-services/northern-ireland/northern-ireland

## Help with Technology

Are you struggling a bit with technology? Are you having problems with your tablet, laptop or phone, or would simply like more information?

Libraries NI has developed a series of fact sheets and Zoom-based sessions to help you. You can also phone on 028 9039 5989 (Mon - Fri 9:15am - 4:45pm) with a brief description of how you need IT help and library staff will phone you within 48 hours with free, helpful advice.

www.librariesni.org.uk/Digital-Support

## Contacts

### Online information and contact numbers for carers support in each Trust

Each Trust has organised a programme of supports and activities for carers in your area. Details can be obtained from:

Northern Trust
Telephone Carer Hub: 028 2766 1210 (available Monday to Friday 9am to 5pm)
E-mail: carers.coordinator@northerntrust.hscni.net

Carer Hub can be accessed at the following link:
northerntrust.hscni.net/services/carers-service/

www.carersdigital.org resources for the Northern Trust only can be downloaded and easily accessed and connection to other carers through the carers chat forum. Carers create their own personal account and download the Jointly app for free using the code DGTL2770.

Belfast Trust

The Belfast Trust Carers Support page:

belfasttrust.hscni.net/service/carers-services

Telephone Carer Service: 028 9504 6702 and leave a message or

Email: CarerSuppSvcs@belfasttrust.hscni.net

Southern Trust

The Southern Trust Carers Support page:

southerntrust.hscni.net/health-wellbeing/community-development-and-user-involvement/carers-information/

Telephone: 028 3756 6284

Email: carers.coordinator@southerntrust.hscni.net

Western Trust

The Western Trust Carers Support page:

westerntrust.hscni.net/service/carers-support-service/

Southern Sector (Fermanagh/Omagh/Castlederg)

Telephone: 028 6634 4163 or Mobile: 075 2589 8985

Email: Cathy.Magowan@westerntrust.hscni.net

Northern Sector (Strabane/L'Derry/Limavady)

Telephone: 028 7135 5023 or Mobile: 078 1015 6551

Email: GeraldineAnn.McLaughlin@westerntrust.hscni.net

South Eastern Trust

The South Eastern Trust Carers Support page:

https://setrust.hscni.net/service/carers-support-service/

SET Carers Development Officer

Telephone: 028 4372 1807

E-mail: carer.support@setrust.hscni.net

### Community COVID Helpline Freephone

Telephone: 0808 802 0020 (Every day 9am-5pm)

Email: covid19@adviceni.net

Text: ACTION to 81025

### Carers NI

Telephone: 028 9043 9843 (Monday-Friday 9am-5pm)

Email: advice@carersni.org

Website: www.carersuk.org/northernireland

### Carers Trust

For carers in the Southern Health and Social Care Trust area.

Telephone: 07826 930 508

Email: price@carers.org

Website: https://carers.org/our-work-in-northern-ireland/carers-support-service-northern-ireland

### Action for Children

Telephone: 028 9046 0500

Email: ask.us@actionforchildren.org.uk

Website: www.actionforchildren.org.uk/what-we-do/our-work-in-northern-ireland/

### Action for Children NI Regional Young Adult Carers

Supporting young **adult carers aged 18-25**, across all 5 trust areas in Northern Ireland.

Telephone: 028 9046 0500

Email: YoungAdultCarersNI@actionforchildren.org.uk

Website: www.actionforchildren.org.uk/

Contact via Facebook www.facebook.com/actionforchildrennorthernireland/

### Action for Children NI Regional Young Carers

Supporting **young carers aged 8-18** living in Belfast, South Eastern and Southern Trust areas.

Telephone: 028 9046 0500

Email: NIYoungCarers@ActionForChildren.org.uk

Website: www.actionforchildren.org.uk/in-your-area/services/young-carers/ni-regional-young-carers/

Contact via Facebook www.facebook.com/YoungCarersNI/

### Barnardo's

Telephone: 028 9067 2366

Email: ReceptionNI@barnardos.org.uk

Website: www.barnardos.org.uk/northern-ireland

### Age NI

Telephone: 08088 087 575

Email: info@ageni.org

Website: www.ageuk.org.uk/northern-ireland

### Alzheimer's Society

Telephone: 028 9066 4100

Helpline: 0300 222 1122

Email: nir@alzheimers.org.uk

Website: www.alzheimers.org.uk

### Dementia NI

Telephone: 028 9693 1555

Email: info@dementiani.org

Website: www.dementia.org

### CAUSE

Telephone: 082 9065 0650

Website: www.cause.org.uk

Facebook: www.facebook.com/CAUSEcarers

### Huntington's Disease Association

Telephone: 07982843907

Website: www.hdani.org.uk

### Together in Dementia Everyday (Tide)

Telephone: 07841 457596

Email: Fiona@tide.uk.net

Website: www.tide.uk.net/

## Other useful links

If you need to talk to someone about coping with the pressures, you may wish to call:

Lifeline on 0808 808 8000

www.samaritans.org

www.childline.org.uk

www.education-ni.gov.uk/

www.communities-ni.gov.uk/landing-pages/covid-19-service-updates

www.nidirect.gov.uk/campaigns/coronavirus-covid-19

www.publichealth.hscni.net/news/covid-19-coronavirus

The **A-Z Guide for Carers** has been revised and is available at:

www.nidirect.gov.uk/publications/a-to-z-guide-carers

**From the Chief Medical Officer**
**Dr Michael McBride**

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

Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

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

**HSS(MD)84 /2020**

Our Ref: HSS(MD)84/2020
Date: 10 December 2020

**FOR ACTION**
Chief Executives, Public Health Agency/Health and Social Care Board/HSC Trusts/ NIAS
GP Medical Advisers, Health & Social Care Board
All General Practitioners and GP Locums (for onward distribution to practice staff)
OOHs Medical Managers (for onward distribution to staff)
RQIA

**PLEASE SEE ATTACHED FULL CIRCULATION LIST**

Dear Colleague

**PFIZER BIONTECH COVID-19 VACCINE - UPDATED GUIDANCE ON MANAGING ALLERGIC REACTIONS**

**ACTION REQUIRED**

Chief Executives must ensure this information is drawn to the attention of all staff involved in the COVID-19 vaccination programme.

The PHA must ensure this information is cascaded to staff working on COVID-19 vaccine deployment and the health protection team.

The HSCB must ensure this information is cascaded to all General Practitioners and practice managers for onward distribution to all staff involved in the vaccination programme.

The RQIA must ensure this information is cascaded to all Independent Sector Care Homes.

**INTRODUCTION**

1. Since the Covid-19 vaccination programme began on Tuesday 8 December the Medicines and Healthcare products Regulatory Agency (MHRA) has been notified of two reports of anaphylaxis, and a further possible allergic reaction, shortly after receiving the Pfizer BioNtech COVID-19 vaccine. MHRA has carried out a thorough review and has issued updated guidance.

2. It is essential this updated guidance is brought to the attention of everyone involved in the COVID-19 vaccination programme and fully implemented. The updated guidance states:

    I. Any person with a history of immediate-onset anaphylaxis to a vaccine, medicine or food should not receive the Pfizer BioNtech vaccine. A second dose of the Pfizer BioNtech vaccine should not be given to those who have experienced anaphylaxis to the first dose of Pfizer BioNtech vaccination.

    II. Vaccine recipients should be monitored for 15 mins after vaccination, with a longer observation period when indicated after clinical assessment.

    III. A protocol for the management of anaphylaxis and an anaphylaxis pack must always be available whenever the Pfizer BioNtech vaccine is given. Immediate treatment should include early treatment with 0.5mg intramuscular adrenaline (0.5ml of 1:1000 or 1mg/ml adrenaline), with an early call for help and further IM adrenaline every 5 minutes. The health professionals overseeing the immunisation service must be trained to recognise an anaphylactic reaction and be familiar with techniques for resuscitation of a patient with anaphylaxis.

3. An Expert Group, chaired by Professor Sir Munir Pirmohamed, and attended by experts in Allergy & Clinical Immunology, met on the 9 December to review the cases and advised on action to mitigate the rare risk of anaphylaxis.

4. Anaphylaxis can be a rare risk of most vaccines and it is important that health professionals are vigilant in watching for the early signs and initiate prompt treatment, as occurred in these cases. The vast majority of people will not be at risk of anaphylaxis after being administered the Pfizer BioNtech vaccine and the benefits in preventing the serious complications of COVID outweigh the risks.

5. Anyone due to receive their vaccine should continue with their appointment and discuss any concerns or medical history of serious allergies with the healthcare professional prior to administration.

6. Please report any suspected adverse reactions via the Yellow Card scheme. To make a report or find out more about the Yellow Card COVID-19 reporting site please visit: Coronavirus Yellow Card reporting site

7. In addition to the guidance mentioned above it is important that all those involved on the vaccination programme and colleagues in the immediate environments of the vaccination sites are supported to recognise the early signs of anaphylaxis (recognition and quick early action is key).

8. Early responders should have and be prepared to give IM adrenaline, again quick action is key;

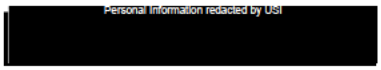
9. In the event that support from the Northern Ireland Ambulance Service is required please ensure that NIAS is contacted via 999 and not on any other call/contact number.

10. The person making the 999 call must provide clear unambiguous information about the incident and that it follows vaccination with COVID-19 vaccine.

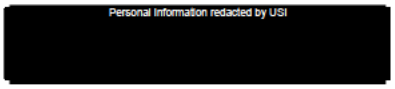
**Conclusion**

11. The COVID-19 vaccination programme is the best defence we have against the spread of the COVID-19. It is therefore essential that trust in the programme is fully maintained by ensuring this additional guidance is applied immediately.

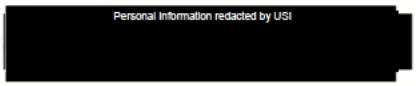
Yours sincerely




**Dr Michael McBride**
**Chief Medical Officer**




**Professor Charlotte McArdle**
**Chief Nursing Officer**




**Mrs Cathy Harrison**
**Chief Pharmaceutical Officer**

**Circulation List**

Director of Public Health/Medical Director, Public Health Agency (*for onward distribution to all relevant health protection staff*)
Assistant Director Public Health (Health Protection), Public Health Agency
Director of Nursing, Public Health Agency
Assistant Director of Pharmacy and Medicines Management, Health and Social Care Board *(for onward distribution to Community Pharmacies)*
Directors of Pharmacy HSC Trusts
Director of Social Care and Children, HSCB
Family Practitioner Service Leads, Health and Social Care Board *(for cascade to GP Out of Hours services)*
Medical Directors, HSC Trusts *(for onward distribution to all Consultants, Occupational Health Physicians and School Medical Leads)*
Nursing Directors, HSC Trusts *(for onward distribution to all Community Nurses, and Midwives)*
Directors of Children's Services, HSC Trusts
RQIA (*for onward transmission to all independent providers including independent hospitals*)
Medicines Management Pharmacists, HSC Board *(for cascade to prescribing advisers)*
Regional Medicines Information Service, Belfast HSC Trust
Regional Pharmaceutical Procurement Service, Northern HSC Trust
Professor Donna Fitzsimons, Head of School of Nursing and Midwifery QUB
Professor Sonja McIlfatrick, Head of School of Nursing, University of Ulster
Caroline Lee, CEC
Donna Gallagher, Open University
Professor Paul McCarron, Head of School of Pharmacy and Pharmaceutical Sciences, UU
Professor Colin McCoy, Head of School, School of Pharmacy, QUB
Professor Colin Adair, Director of the NI Centre for Pharmacy Learning and Development, QUB
Joe Brogan, Assistant Director of Integrated Care, HSCB
Donncha O'Carolan, HSCB *(for distribution to all General Dental Practitioners)*
Raymond Curran, Head of Ophthalmic Services, HSCB *(for distribution to Community Optometrists)*
Trade Union Side

This letter is available on the Department of Health website at https://www.health-ni.gov.uk/topics/professional-medical-and-environmental-health-advice/hssmd-letters-and-urgent-communications

**From the Chief Medical Officer**
**Dr Michael McBride**

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

Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

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

**HSS(MD) 83/2020**

Our Ref: HSS(MD) 83/2020
Date: 9 December 2020

**FOR ACTION**
Chief Executives, Public Health Agency/Health and Social Care Board/HSC Trusts/ NIAS
GP Medical Advisers, Health & Social Care Board
All General Practitioners and GP Locums (for onward distribution to practice staff)
OOHs Medical Managers (for onward distribution to staff)

**PLEASE SEE ATTACHED FULL CIRCULATION LIST**

Dear Colleague

**CONTINUATION OF SEASONAL FLU PROGRAMME BY PEER VACCINATORS**

***Action Required***

***Chief Executives must ensure that this information is drawn to the attention of all staff involved in administering seasonal influenza vaccine.***

## Introduction

1. The purpose of this letter is to inform you of changes in the seasonal flu vaccination programme aimed at increasing uptake among Health and Social Care Workers.

2. The COVID-19 Oversight Board previously determined that flu clinics in the Trust Occupational Health flu vaccination programme for Health and Social Care Workers (HSCW) would be stood down from 6 December to make way for the first phase of the COVID-19 vaccination programme.

3. However as there may be periods of time where there is not any COVID vaccine to deliver while awaiting new stock to arrive, it has been determined that peer HSCW flu vaccination should now continue on an opportunistic basis. In particular it is important that HSCWs working in care homes are still given the opportunity to receive the flu vaccine.

4. The peer vaccinator and HSCW staff member must adhere to the requirements relating to ensuring a 7 day gap between receiving a flu vaccine and subsequently receiving the COVID vaccine. Flu vaccinations can be

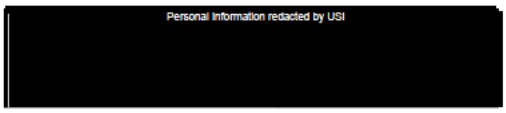
administered between COVID vaccination doses as long as the 7 day interval between vaccinations is observed.

5. I would like to express my sincere appreciation to all who have worked hard to administer flu vaccines so far this year. Uptake rates have increased from this time last year which is to be commended due to the challenges the programme has faced so far.

6. I would ask all staff who have not yet received their flu vaccine to make sure they are vaccinated as soon as possible to ensure the HSC is prepared for normal winter pressures and unexpected events, and to protect staff from the potentially serious consequences of concurrent infection with influenza virus and SARS-CoV-2 virus. Staff can continue to receive the vaccine via the community pharmacy scheme

7. I would also ask OH teams to continue to submit monthly flu uptake data to the PHA as this is essential to monitor vaccine uptake

Yours sincerely




**DR MICHAEL McBRIDE**
**Chief Medical Officer**

**Circulation List**

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Assistant Director Public Health (Health Protection), Public Health Agency
Director of Nursing, Public Health Agency
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Trade Union Side

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# SAFETY AND QUALITY
# REMINDER OF BEST PRACTICE GUIDANCE

| Subject | Safe storage of epidurals (Controlled Drug and non-Controlled Drug) and checking processes for the administration of Controlled Drug Infusions |
|---|---|
| HSCB reference number | SQR-SL-2020-073 (AS) |
| Programme of care | Acute Services (AS) |

| LEARNING SOURCE | | | |
|---|---|---|---|
| SAI/Early Alert/Adverse incident | ✓ | Complaint | |
| Audit or other review | | Coroner's inquest | |
| Other (Please specify) | | | |

## SUMMARY OF EVENT

**There have been two SAIs reported where a solution designed to be given by the epidural route for analgesia, has been given intravenously (IV) via a device for Patient Controlled Analgesia (PCA).**

**Incident 1**

An epidural infusion of levobupivacaine and fentanyl was incorrectly chosen instead of the prescribed fentanyl patient controlled analgesia (PCA) infusion and attached to a PCA device. The epidural infusion was subsequently administered IV. The infusion was stopped immediately and the patient was closely monitored. The patient remained stable throughout with no evident ill effects and the correct PCA fentanyl infusion was started.

**Incident 2**

While assisting with repositioning of the patient, the nurse in charge noticed that the infusion being administered through the patient's peripheral intravenous (IV) line was an epidural infusion of levobupivacaine 0.1% and fentanyl 2 micrograms in sodium chloride 0.9% 250 ml instead of the prescribed fentanyl 5mg/250ml infusion for PCA. The prescription was correct and the PCA machine was programmed correctly. The epidural infusion had been used for 48 hours before the mistake was detected. The patient did not come to harm.

**Epidural infusions are coloured yellow and the words 'For Epidural Use Only' are displayed on the outer labelling and packaging of epidural products.**
Images of the epidural levobupivacaine 0.1% and fentanyl 2 microgram and the fentanyl 5mg PCA infusions are shown in Appendix 1.

## REQUIREMENTS UNDER CURRENT GUIDANCE

The risk of administration errors of epidural infusions administered to patients via the intravenous route is a well-known and recognised patient safety risk. A Patient Safety Alert 'Safe Practice with Epidural Injections and Infusions' was issued in 2007 by the former National Patient Safety Agency (NPSA)

https://www.sps.nhs.uk/wp-content/uploads/2018/02/2007-NRLS-0396-Epidural-injectns-PSA-2007-03-28-v1.pdf

One of the recommendations of this Alert required organisations to:

*'Reduce the risk of the wrong medicine being selected by storing epidural infusions in separate cupboards or refrigerators from those holding intravenous and other types of infusions.'*

This Alert was endorsed by the Department of Health and issued to the HSC with additional supporting recommendations for implementation https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2028-07.pdf

The Royal College of Anaesthetists Guidelines for the Provision of Anaesthetic Services for Inpatient Pain Management 2020 also advises on the safe storage of epidurals;

'Drugs for epidural use or for continuous regional anaesthesia infusions should be prepared and stored in compliance with local and national medicines management policies' https://www.rcoa.ac.uk/gpas/chapter-11

Fentanyl is a CD and is subject to second checking requirements for; removal from the CD cupboard, controlled drug record keeping and patient administration. Guidance is provided by the DOH's Safer Management of Controlled Drugs – A Guide to Good Practice in Secondary Care (Northern Ireland) 2012.
https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/safer-management-of-controlled-drugs-a-guide-to-good-practice-in-secondary-care-2012.pdf

Administration of controlled drugs must comply with relevant legislation and organisational policies and procedures. This is recommended by The Royal College of Nursing and the Royal Pharmaceutical Society's Professional Guidance on the Administration of Medicines in Healthcare.

https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/SSHM%20and%20Admin/Admin%20of%20Meds%20prof%20guidance.pdf?ver=2019-01-23-145026-567

**For all staff responsible for the administration and preparation of controlled drug infusions**

- Where two practitioners are involved in the administration of controlled drugs they should both witness:
  - The preparation of the controlled drug to be administered (this includes the verification of stock balance and the calculation of the dose to be administered)
  - The controlled drug being administered to the patient.
- **2 registered practitioners** must check the Patient Controlled Analgesia / epidural infusion pump and medicine selected against the prescription at the bedside when connecting the device to the patient.
- Be familiar with the different presentations available of epidurals and PCAs and check for a yellow label on an infusion fluid as a visual indicator that the product is an epidural.

- Monitoring processes must be in place when using PCAs and epidural infusion devices which include a check of the device, the line and the infusion.

**For all managers where epidurals are stored**

- Ensure that epidural infusions are stored **separately** from all other infusions.
- Controlled drug epidural infusions must be stored in a separate CD cupboard.

## ACTION REQUIRED

**HSC Trusts should:**

1. Disseminate this letter to all relevant staff; and discuss it at team meetings/safety briefings.
2. In light of this letter, review and audit your current systems for the safe storage, checking and monitoring requirements of epidurals and PCA infusions.
3. Confirm by **3 March 2021** to alerts@hscb.hscni.net that actions 1 – 2 above have been completed.

**NIMDTA should**:

1. Disseminate this letter to doctors in training in relevant specialties.

**RQIA should**:

1. Disseminate this letter to relevant independent sector providers.

**Chair of Regional Medicines Governance Team to:**

1. Make contact with MHRA and the manufacturer of the levobupivacaine 0.1% and fentanyl 2 microgram epidural infusion to request improvements to the labelling and packaging of the product, so that it is immediately identifiable to the end user that the product is an epidural.

| | | | |
|---|---|---|---|
| **Date issued** | 9 December 2020 | | |
| **Signed:** | Personal Information redacted by USI | Personal Information redacted by USI | Personal Information redacted by USI |
| **Issued by** | Dr Hugo Van Woerden<br>Director of Public Health | Mr Rodney Morton<br>Director of Nursing, Midwifery and Allied Health Professionals | Mr Joe Brogan,<br>Head of Pharmacy and Medicines Management |

**Appendix 1**

Image (i) of over wrap label of levobupivacaine 0.1% and fentanyl 2 micrograms infusion

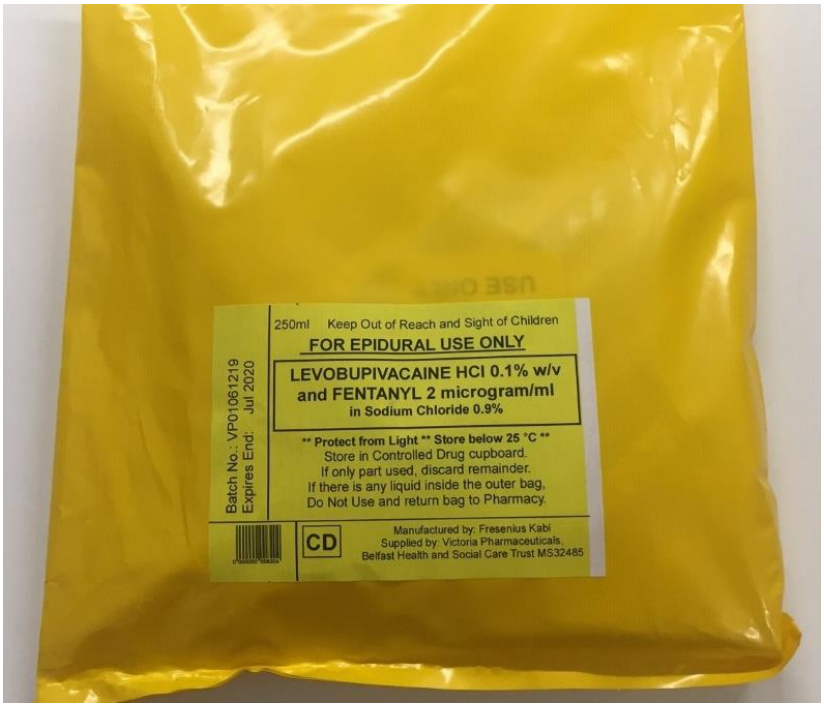



Image (ii) of levobupivacaine 0.1% and fentanyl 2 micrograms infusion with over wrap label removed.

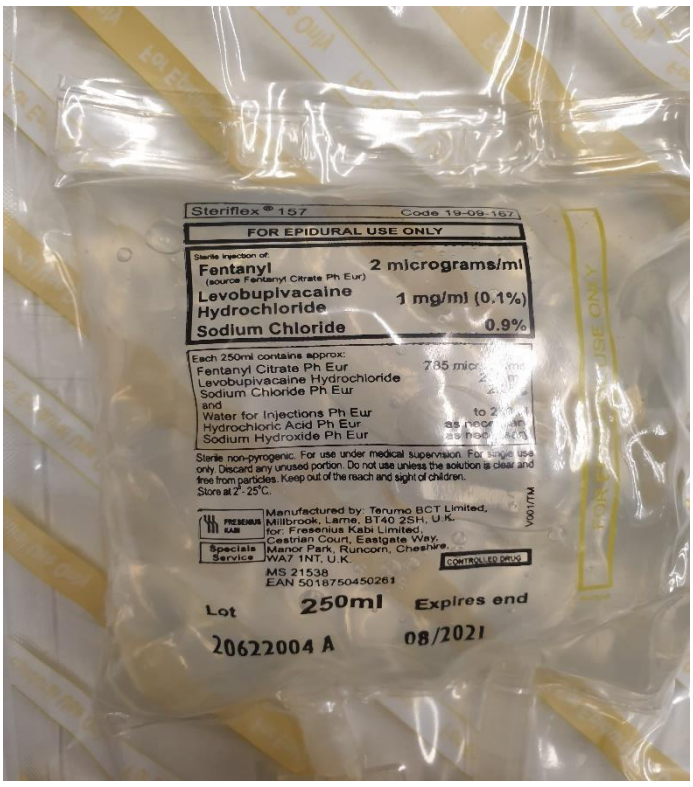


Image (iii) levobupivacaine 0.1% and fentanyl 2 micrograms infusion with the manufacturer's outer packaging removed, showing the labelling of the sterile fluid.

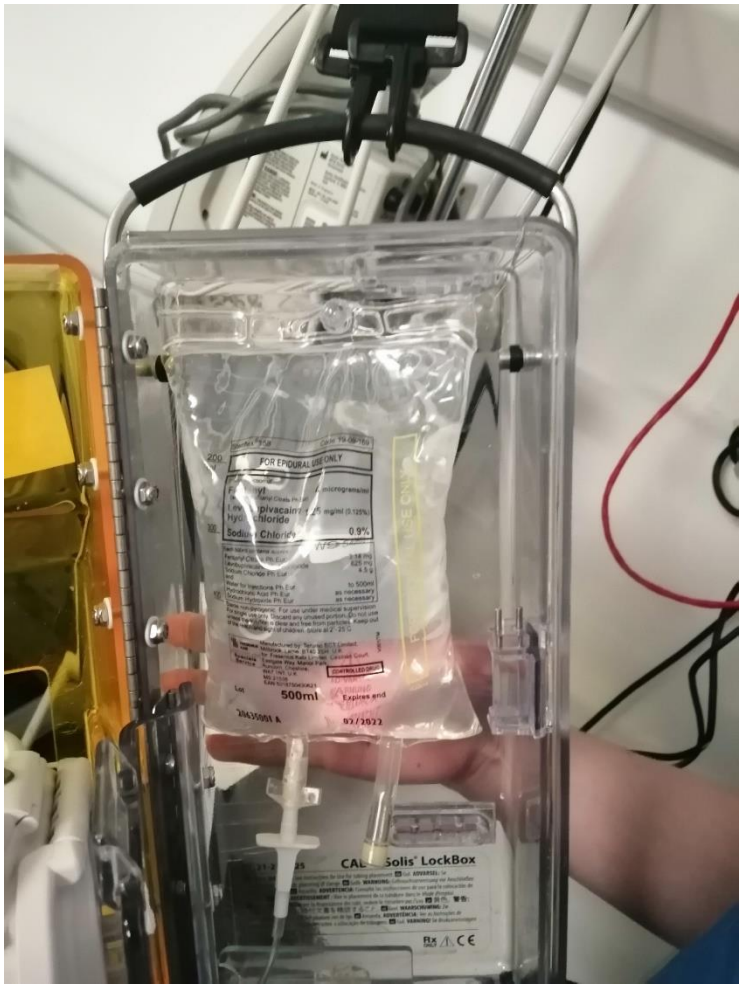
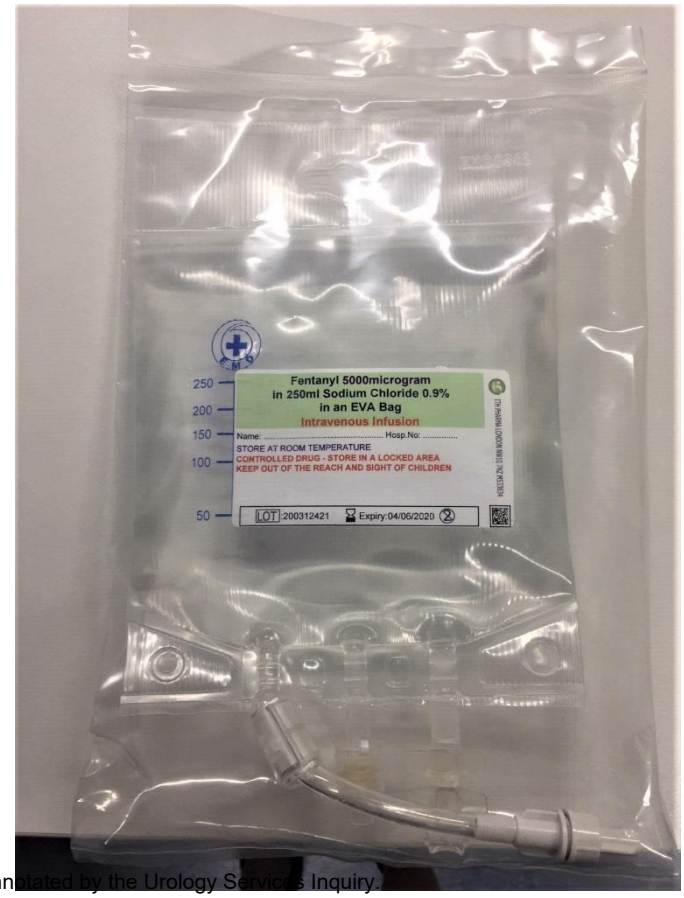



Image (iv) fentanyl 5mg in 250ml sodium chloride 0.9% infusion for PCA.



Health and Social Care Board

Public Health Agency

**RE: SQR-SL-2020-073 (AS)- Safe storage of epidurals (CD and non CD) and checking processes for the administration of CD Infusions – Distribution List**

| | To – for Action | Copy | | To – for Action | Copy |
|---|---|---|---|---|---|
| **HSC Trusts** | | | **PHA** | | |
| CEXs | ✓ | | CEX | | ✓ |
| First point of contact | ✓ | | Medical Director/Director of Public Health | | ✓ |
| | | | Director of Nursing/AHPs | | ✓ |
| **NIAS** | | | Director of HSCQI | | ✓ |
| CEX | | ✓ | PHA Duty Room | | |
| First point of contact | | ✓ | AD Health Protection | | |
| | | | AD Service Development/Screening | | |
| **RQIA** | | | AD Health Improvement | | |
| CEX | ✓ | | ADs Nursing | | |
| Director of Quality Improvement | | ✓ | AD Allied Health Professionals | | |
| Director of Quality Assurance | | ✓ | Clinical Director of HSCQI | | ✓ |
| **NIMDTA** | | | **HSCB** | | |
| CEX / PG Dean | ✓ | | CEX | | ✓ |
| **QUB** | | | Director of Integrated Care | ✓ | |
| Dean of Medical School | | ✓ | Director of Social Services | | |
| Head of Nursing School | | ✓ | Director of Commissioning | | ✓ |
| Head of Social Work School | | | Alerts Office | | ✓ |
| Head of Pharmacy School | | ✓ | Head of Corporate Services | | |
| Head of Dentistry School | | | **Primary Care (through Integrated Care)** | | |
| **UU** | | | GPs | | |
| Head of Nursing School | | ✓ | Community Pharmacists | | |
| Head of Social Work School | | | Dentists | | |
| Head of Pharmacy School | | ✓ | **BSO** | | |
| Head of School of Health Sciences (AHP Lead) | | | Chief Executive | | |
| **Open University** | | | Director of Human Resources | | |
| Head of Nursing Branch | | ✓ | Head of procurement | | |
| **Clinical Education Centre** | ✓ | | | | |
| **NIPEC** | | | **DoH** | | |
| **NICPLD** | | | CMO office | | ✓ |
| **NI Medicines Governance Team Leader for Secondary Care** | | ✓ | CNO office | | ✓ |
| **NI Social Care Council** | | | CPO office | | ✓ |
| **Safeguarding Board NI** | | | CSSO office | | |
| **NICE Implementation Facilitator** | | | CDO office | | |
| **Coroners Service for Northern Ireland** | | | Safety, Quality & Standards Office | | ✓ |

**Infection Prevention Control Guidance for Adult COVID-19 vaccination clinics**

As COVID-19 vaccination clinics commence the safety of all staff delivering the vaccines and the individuals requiring a vaccine is paramount. There is considerable pressure to ensure the safe and prompt delivery of this year's COVID-19 vaccine campaign in the context of the ongoing COVID-19 pandemic.

The following guidance modelled on ***COVID-19: infection prevention and control guidance***" (April 2020) PHE PPE Tables 1- 4 (https://www.publichealth.hscni.net/sites/default/files/2020-10/COVID-19_Infection_prevention_and_control_guidance_complete.%203.2%20%2818_06_2020%29.pdf) has been developed in recognition that not all COVID-19 vaccination clinics will be operated, managed and delivered in the same way due to the differences in premises and person's needs. This inevitably requires a risk based approach.

Therefore service providers/practitioners in GP Practices, Community Pharmacists and other outpatient/Care Home settings providing vaccination/injection clinics should:-

- Risk assess each COVID-19 clinic/administration environment to ensure they are COVID secure;
    - Use of face mask (clinical & care staff) and a face covering must be worn by all individuals attending for vaccination.
    - Effective hand hygiene must be undertaken between each patient.
    - PPE should be risk assessed for the potential exposure to blood or body fluids and/or risk of any patients reporting symptoms
    - Ensure enhanced environmental cleaning is carried out
    - Where possible, good ventilation should be maintained
- Appointment letters should provide advice on how to prepare for their appointment including ensuring individuals and those accompanying individuals wear a face covering and wear short sleeves where possible to allow the administration of the vaccination.
- All COVID-19 vaccine providers should consider the need for booking timeslots and include strategies such as asking individuals to wait to be called to the waiting/vaccination area with minimum wait times and ensure social distancing is facilitated in any waiting areas.
- All communications in relation to COVID-19 vaccination clinics should advise all individuals not to attend if they have symptoms of Covid-19 and/or they suspect they have been in contact with someone who has COVID-19 prior to their appointment.

- Invite letters should advise individuals of parking, entrances including one way systems and infection prevention and control precautions
- Individuals should be instructed to remain in waiting areas and not visit other parts of the facility
- Prior to admission to the waiting area all individuals and accompanying persons should be screened for COVID-19 symptoms and assessed for exposure to contacts
- Social distancing should be in place for all vaccinator stations and patients/clients who remain in the clinic for 15minutes post vaccination should be socially distanced; areas should be prepared in advance of any clinics to ensure this is achieved

In all settings staff administering vaccinations/injections should apply the highest standard of hand hygiene between each individual being vaccinated and wear a sessional fluid shield facemask. On a risk assessed basis use singles-use gloves, aprons and sessional eye protection.

A single session refers to a period of time where a health care worker is undertaking duties in a specific care setting/exposure environment providing ongoing care for an individual. A session ends when the health care worker leaves the care setting/exposure environment. Sessional use should always be risk assessed and should include consideration of the risk of infection to and from individuals, patients, residents and health and care workers where COVID-19 is circulating in the community and hospitals. PPE should be disposed of after each session or earlier if damaged, soiled, or uncomfortable.

Gloves and aprons are always recommended when there is (anticipated) exposure to blood/body fluids or non-intact skin.

The need for single or reusable face/eye protection/full face visor or goggles should also be risk assessed when there is an anticipated/likely risk of contamination with splashes, droplets of blood or body fluids (for example an individual who does not have a fever or other COVID-19 symptoms but reports having a chronic cough).

Staff administering vaccines should always take in to account additional considerations and carry out a careful risk assessment of their individual practice and surroundings and the individual circumstance and surroundings of the person and hence their PPE requirements, especially where there is sustained transmission of COVID-19.

When undertaking a risk assessment for vaccine administration, healthcare workers should take into account factors such as the prevalence of COVID-19 infection in their locality, the health status of the person being vaccinated, the route of administration, model of delivery and any relevant environmental factors.
Consideration of these factors will help the vaccinator understand the likely risk of exposure to blood, body fluids and respiratory droplets, which in turn will inform the need for any additional PPE.
If further help is needed, vaccinators should consult with their infection prevention and control team.

Remember:

1. Ensure a COVID-19 secure environment.
2. Strict adherence to hand hygiene between all recipients of the vaccine.
3. All staff should wear a fluid shield mask and all individuals attending the COVID-19 clinics should wear a face covering.
4. On a risk assessed basis, wear single use gloves, an apron and eye protection if there is a risk of contact with blood and bodily fluids.

People should be advised not attend the clinic if they have been unwell, have COVID-19 symptoms or have been in contact with someone who has COVID-19 symptoms. People self-isolating should not come to the COVID-19 clinics. People should of course be recalled for their COVID-19 vaccination when it is safe to do so.

**From the Chief Medical Officer**
**Dr Michael McBride**

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

**HSS(MD)82/2020**

**FOR ACTION**
Chief Executives, Public Health Agency/Health and Social Care Board/HSC Trusts/ NIAS
GP Medical Advisers, Health & Social Care Board
All General Practitioners and GP Locums (for onward distribution to practice staff)
OOHs Medical Managers (for onward distribution to staff)
RQIA

**PLEASE SEE ATTACHED FULL CIRCULATION LIST**

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BT4 3SQ

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

Our Ref: HSS(MD)82/2020
Date: 7 December 2020

Dear Colleague

**DEPLOYMENT OF THE COVID-19 VACCINE IN NORTHERN IRELAND**

**ACTION REQUIRED**

Chief Executives must ensure this information is drawn to the attention of all staff.

The PHA must ensure this information is cascaded to staff working on COVID-19 vaccine deployment and the health protection team.

The HSCB must ensure this information is cascaded to all General Practitioners and practice managers for onward distribution to all staff involved in the vaccination programme.

The RQIA must ensure this information is cascaded to all Independent Sector Care Homes. The RQIA should also actively encourage all Independent Sector Care Home staff to receive the COVID-19 vaccine as soon as possible.

**INTRODUCTION**

1. You will be aware that on 2 December the first COVID-19 vaccine for the UK, developed by Pfizer/BioNTech, was granted approval for use following a thorough review carried out by the Medicines and Healthcare products Regulatory Agency (MHRA).

2. Northern Ireland has been planning for the deployment of the COVID-19 vaccine for many months. This has involved collaborative working across the Health and Social Care system in conjunction with our wider stakeholders and partners. This letter sets out a broad overview of the programme and will be followed shortly by more detailed information in relation to the vaccine etc.

**Operational Deployment of Vaccine in Northern Ireland**

3. Planners in Northern Ireland have been working on a number of deployment models for roll out of the vaccine to the wider population. While the first batches of vaccine have now been received in Northern Ireland, it may be several weeks or months before substantial quantities of vaccine are widely available, therefore initially we will have to target the vaccine in order to protect those at greatest risk.

4. In the initial phase of the vaccination programme, given the constraints of the deployability of the Pfizer-BioNTech product, the vaccine will be administered mainly through vaccination centres operating under the direction and governance of Health and Social Care Trusts. The COVID-19 vaccination programme will officially begin on Tuesday 8 December when those who will be carrying out the vaccinations will be invited to receive the vaccine at a regional vaccination clinic at the Royal Victoria Hospital site.

5. Each of the Trusts have identified suitable premises where vaccinators will be able to administer the vaccine in a safe, controlled and socially distanced environment with the appropriate measures in place. This phase of the programme will begin week commencing 14 December. In advance of the Primary Care led element of the programme we are currently considering how these arrangements might be extended to include the over 80s in the community.

6. The model for vaccine deployment has been designed to be pragmatic, agile and flexible. Teams of vaccinators have been trained from a range of professional backgrounds in addition to extant HSC staff and primary care staff.

7. In order to facilitate maximum vaccine deployment and uptake, overall the vaccination model will include Trust mobile and roving teams who will focus on those groups for whom travel to a vaccination centre would be challenging, such as the elderly and care home residents or a supported living centre where the clinical risk was considered to be similar to a care home. When these Trust mobile teams are present at a care home they will also offer vaccination to all staff as well as residents. The mobile team element of the programme will also begin week commencing 14 December.

8. Subject to the availability of a suitable vaccine, from early January 2021, it is intended to roll out the programme through primary care led vaccination clinics which will be responsible for the vaccination of the vast majority of eligible individuals.

**Prioritisation of Vaccine in the early phase of the programme**

9. Northern Ireland along with the other Devolved Administrations will adhere to the Joint Committee on Vaccination and Immunisation (JCVI) advice on prioritisation of the vaccine as published on 2nd December 2020 https://www.gov.uk/government/publications/priority-groups-for-coronavirus-covid-19-vaccination-advice-from-the-jcvi-2-december-2020

10. The JCVI has now published advice on the immediate priority groups for the early phases of vaccine deployment. The JCVI specifically advises that

    *"the first priorities for any COVID-19 vaccination programme should be the prevention of COVID-19 mortality and the protection of health and social care staff and systems. Secondary priorities could include vaccination of those at increased risk of hospitalisation and at increased risk of exposure, and to maintain resilience in essential public services"*

11. JCVI acknowledges that the single greatest risk of mortality from COVID-19 is increasing age and that the risk increases exponentially with age. There is clear evidence that those living in care homes for older adults have been disproportionately affected by COVID-19 as they have had a high risk of exposure to infection and are at higher clinical risk of severe disease and mortality. Given the increased risk of outbreaks, morbidity and mortality in these enclosed settings, these adults are considered to be at very high risk as are care home workers who are therefore considered a very high priority for vaccination.

12. Frontline health and social care workers are at increased personal risk of exposure to infection with COVID-19 and of transmitting that infection to susceptible and vulnerable patients in health and social care settings. JCVI consider frontline health and social care workers who provide care to vulnerable people a high priority for vaccination. Protecting them protects the health and social care service and recognises the risks that they face in this service.

**A Framework for initial deployment in Northern Ireland**

13. All health and social care staff in Northern Ireland will be offered the COVID-19 vaccine as an early priority. In light of the planned delivery schedules of the vaccine in December and January this will be phased. Ultimately all health and social care workers will have the opportunity to be vaccinated to protect themselves, their families, and patients as soon as

sufficient quantities of a vaccine become available, which is expected to be within the first quarter of 2021 .

In considering the early deployment our aim is to:

1) To protect vulnerable patients and clients at higher risk of severe disease and mortality.
2) To protect staff working in high risk areas for exposure, and
3) To protect staff members at highest personal risk of morbidity and mortality

14. Whilst acknowledging the advice from JCVI on vaccine prioritisation an important additional factor is that of the ability to deploy the vaccine safely with minimum wastage. With this in mind a Framework has been developed to help guide the deployment of vaccination for all health and social care staff, including those in the independent care sector. The Framework is available at **Annex A**.

15. A booking system has been developed for all HSC staff. Staff will be able to book an appointment at a time and location that is convenient to them – this can be at any Trust vaccination site. Appointments can be made by priority groups from the 9th December 2020. Full details of the booking platform will be issued shortly.

**Conclusion**

16. We would once again like to express our sincere gratitude to every health and social care worker across Northern Ireland for the dedication and commitment that has been demonstrated throughout the COVID-19 pandemic. The COVID-19 vaccination programme represents one of the largest and most complex public health initiatives to be undertaken in Northern Ireland and across the UK as well as one of the most important.

17. The vaccine is the best defense we have against the spread of the COVID-19. We all have a professional and moral responsibility to take appropriate steps to protect our patients. Getting vaccinated, and endorsing the COVID-19 vaccination among colleagues, will help increase uptake rates and protect not only yourself but also your patients, your family and your community.

18. While the introduction of a vaccination programme is a very welcome development in the fight against COVID-19 we do not expect to see a population impact of the programme for some months, until a large section of the population are vaccinated. Therefore it is very important that all staff continue to adhere to all public health guidance in the coming months, including downloading the contact tracing app. As we move through the

winter months in particular it is vital that we all continue to wash our hands regularly, use a face covering and keep our distance from those not in our household.

Yours sincerely

Personal Information redacted by USI

**Dr Michael McBride**
**Chief Medical Officer**

Personal Information redacted by USI

**Professor Charlotte McArdle**
**Chief Nursing Officer**

Personal Information redacted by USI

**Mrs Cathy Harrison**
**Chief Pharmaceutical Officer**

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**Sean Holland**
**Chief Social Services Officer**

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**Michael Donaldson**
**Acting Chief Dental Officer**

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**Jenny Keane**
**Chief Allied Health Professions Officer**

**Circulation List**

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Assistant Director Public Health (Health Protection), Public Health Agency
Director of Nursing, Public Health Agency
Assistant Director of Pharmacy and Medicines Management, Health and Social Care Board *(for onward distribution to Community Pharmacies)*
Directors of Pharmacy HSC Trusts
Director of Social Care and Children, HSCB
Family Practitioner Service Leads, Health and Social Care Board *(for cascade to GP Out of Hours services)*
Medical Directors, HSC Trusts *(for onward distribution to all Consultants, Occupational Health Physicians and School Medical Leads)*
Nursing Directors, HSC Trusts *(for onward distribution to all Community Nurses, and midwives)*
Directors of Children's Services, HSC Trusts
RQIA (*for onward transmission to all independent providers including independent hospitals*)
Medicines Management Pharmacists, HSC Board *(for cascade to prescribing advisers)*
Regional Medicines Information Service, Belfast HSC Trust
Regional Pharmaceutical Procurement Service, Northern HSC Trust
Professor Donna Fitzsimons, Head of School of Nursing and Midwifery QUB
Professor Sonja McIlfatrick, Head of School of Nursing, University of Ulster
Caroline Lee, CEC
Donna Gallagher, Open University
Professor Paul McCarron, Head of School of Pharmacy and Pharmaceutical Sciences, UU
Professor Colin McCoy, Head of School, School of Pharmacy, QUB
Professor Colin Adair, Director of the NI Centre for Pharmacy Learning and Development, QUB
Joe Brogan, Assistant Director of Integrated Care, HSCB
Donncha O'Carolan, HSCB *(for distribution to all General Dental Practitioners)*
Raymond Curran, Head of Ophthalmic Services, HSCB *(for distribution to Community Optometrists)*
Trade Union Side

This letter is available on the Department of Health website at https://www.health-ni.gov.uk/topics/professional-medical-and-environmental-health-advice/hssmd-letters-and-urgent-communications

**Annex A**

## Early deployment of Covid-19 vaccination

All health and social care staff will be offered the COVID-19 vaccine as an early priority. In light of the planned delivery schedules of the vaccine in December and January this will be phased. Ultimately all health and social care workers will have the opportunity to be vaccinated to protect themselves, their families, patients and community. In considering the early deployment our aim is to:

1. To protect vulnerable patients and clients at higher risk of severe disease and mortality.
2. To protect staff working in high risk areas for exposure
3. To protect staff members at highest personal risk of morbidity and mortality

The **Joint Committee for Vaccination and Immunisation** (JCVI) advises that:

- The first priorities for any COVID-19 vaccination programme should be the prevention of COVID-19 mortality and the protection of health and social care staff and systems.

- Secondary priorities could include vaccination of those at increased risk of hospitalisation and at increased risk of exposure, and to maintain resilience in essential public services.

**Table 1: Early Deployment Framework for Northern Ireland**

| | **Rationale** | **Targeted in This Phase** |
|---|---|---|
| ***Care home residents*** (or a supported living centre where the clinical risk was considered to be similar to a care home) | • JCVI priority group 1 as they have a high risk of exposure to infection and higher clinical risk of severe disease and mortality. | • All residents of the 483 care homes in NI |
| ***Care home staff*** | • JCVI priority group 1 to protect the most vulnerable and reduce outbreaks | • All care home employees working in the 483 care homes<br>• This includes agency workers where the service is **heavily reliant** on agency and the member is doing at least 1 shift per week |

| | | |
|---|---|---|
| ***Vaccinators*** | • JCVI and CMO priority group as they are providing face to face clinical care | • Trust vaccinators<br>• Volunteer vaccinators |
| | ***Rationale*** | **Examples of staff working with patient/ client groups include but are not limited to**: |
| ***All staff working with patient groups at higher risk (including embedded support staff)*** | • JCVI priority cohort 2 to ensure the protection of vulnerable individuals, potentially reduce outbreaks and resilience of key services | • Core staff working in units where there are a significant proportion of cohorted patients/ clients with high risk conditions, as defined by JCVI – **Note 1**<br>• This will include:<br>- Staff in hospices, acute and community services<br>- See **Note 2** |
| ***Higher risk areas and settings for exposure for staff areas*** | • JCVI priority 2 as increased personal risk of exposure to COVID-19 | • Emergency Departments<br>• NIAS Emergency Responders<br>• Healthcare staff in COVID-19 centres or services |
| ***Increased Personal risk*** | • JCVI priority 2<br>• Staff risk groups as identified by JCVI and in CEV category. | • Staff within extremely vulnerable high risk categories – **Note 3**<br>• Members of staff over 70 years<br>• BAME (see mitigating inequality section in JCVI guidance[1])<br><br>**Exceptions** where vaccination not advised:<br>• Pregnant and breast feeding |

[1] JCVI advice that BAME **alone** does not indicate a higher risk

| | | |
|---|---|---|
| | | • Planning for pregnancy within the next 3 months |

**NOTE 1:**

The risk groups identified by the Joint Committee Vaccination and Immunisation are set out below.

• Chronic respiratory disease, including chronic obstructive pulmonary disease (COPD), cystic fibrosis and severe asthma
• Chronic heart disease (and vascular disease)
• Chronic kidney disease
• Chronic liver disease
• Chronic neurological disease including epilepsy
• Down's syndrome
• Severe and profound learning disability
• Diabetes
• Solid organ, bone marrow and stem cell transplant recipients
• People with specific cancers
• Immunosuppression due to disease or treatment
• Asplenia and splenic dysfunction
• Severe mental illness
• Morbid obesity

**NOTE 2:**

When applying this Trusts will wish to consider the frequency of staff working in those areas such as:

- Core staff working in the ward or staff working at least 1 shift per week in the area.

- To include agency workers where the member is doing at least 1 shift per week and where the service is heavily reliant on the agency workers.

**NOTE 3:**

**Extremely vulnerable Group**

The list of highest risk diseases includes:

- solid organ transplant recipients
- people with specific cancers:
  - people with cancer and are having chemotherapy
  - people with lung cancer and are having radical radiotherapy
  - people with cancers of the blood or bone marrow such as leukaemia,

  - lymphoma or myeloma who are at any stage of treatment
  - people having immunotherapy or other continuing antibody treatments for cancer
  - people having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors
  - people who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs

- people with severe respiratory conditions including all cystic fibrosis, severe asthma and severe COPD
- people with Motor Neurone Disease
- people with rare diseases and inborn errors of metabolism that significantly increase the risk of infections (such as SCID, homozygous sickle cell)
- people on immunosuppression therapies sufficient to significantly increase risk of infection
- people who have had a splenectomy
- those undergoing renal dialysis
- adults with Down's Syndrome
- adult patient with kidney impairment (Stage 5 Chronic Kidney Disease)

**From the Chief Medical Officer**
**Dr Michael McBride**

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

**HSS(MD)81/2020**

**FOR ACTION**
Chief Executives HSC Trusts

**PLEASE SEE ATTACHED FULL CIRCULATION LIST**

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Tel: Personal Information redacted by the USI
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Our Ref: HSS(MD)81/2020
Date: 7 December 2020

Dear Colleague

**ATRACURIUM BESILATE SOLUTION FOR INJECTION VIALS AND AMPOULES (ALL STRENGTHS) – SUPPLY DISRUPTION ALERT**

This letter is to make you aware of a supply issue affecting Atracurium Besilate solution for injection vials and ampoules (all strengths).

## Summary

Atracurium 250mg/25ml solution for injection is currently out of stock and there is limited supplies of all other strengths of atracurium injection remaining in the UK supply chain. This is due to the recent increase in demand to support the UKs COVID-19 response. Based on current demand it is expected that supplies of atracurium could be exhausted before the end of December and Trusts should continue to order a maximum of four days' supply in line with current national recommendations. Unlicensed imports are available but not in sufficient quantities to meet full forecasted demand.

Other neuromuscular blocking agents (NMBAs) which include cisatracurium, rocuronium and vecuronium continue to be available, and HSC Trusts which use these agents should continue to do so.

Rocuronium is available in sufficient quantities to support the increase in demand and should be considered the first line alternative should switching be required, as detailed in the guidance below. Should a switch to an alternative agent be necessary, Trusts are encouraged to switch before the Christmas period to ensure staff are fully briefed about changes in prescribing guidance.

## Actions for healthcare professionals

**HSC Trust clinical teams should:**

- Work with pharmacy colleagues to review current prescribing practice of NMBAs;

- Refer to the guidance issued by the Royal College of Anaesthetists and Association of Anaesthetists, to help support the local switching between neuromuscular blocking agents: https://icmanaesthesiacovid-19.org/drug-demand-supply-anaesthetic-drug-usage-and-administration
  And;

- Prepare prescribing guidance to support clinical areas when atracurium is not available, in line with the following national guidance:

  **For theatres**
  Use rocuronium for both induction and maintenance of anaesthesia, where possible.

  **For critical care**
  Use rocuronium for induction and maintenance, where possible. To maintain supplies of all NMBAs, bolus doses adjusted according to the clinical response may be used instead of an infusion.

**HSC Trust pharmacy teams should:**

- Continue to order all NMBAs in line with demand and no more than four days' stock;

- Work with your Trust's Medicines Governance Lead to consider how you will safely manage stock within your Trust; and

- Consider local management options to decrease waste locally for example by only drawing up what you will use. Further guidance about this can be found on the SPS website which you need a login to access: https://www.sps.nhs.uk/articles/minimising-wastage-of-critical-medicines-during-covid-19/

**The Regional Pharmaceutical Procurement Service should:**

- Ensure Trusts are regularly reviewing local stock holding;

- Work collaboratively with Trusts and suppliers/distributors to challenge excessive stock orders;

- Identify Trusts who have stock holding beyond actual demand and work with Trusts to redistribute this stock; and

- Support local stock sharing between Trusts where appropriate.

**Supporting Information**

Due to the use of various formulations and presentations of critical medicines that may be used during the Covid-19 outbreak, a poster has been created to highlight to clinical staff the importance of reading the product label. The poster can be found by following the attached link
https://www.sps.nhs.uk/articles/drug-packaging-and-labelling-during-covid-19-poster-and-screensaver-for-teams/

Yours sincerely

Personal Information redacted by USI

**Dr Michael McBride**
**Chief Medical Officer**

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**Mrs Cathy Harrison**
**Chief Pharmaceutical Officer**

**Circulation List**
Executive Medical Director/Director of Public Health, Public Health Agency *(for onward distribution to all relevant staff)*
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Department of Health & Social Care

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The Scottish Government
Riaghaltas na h-Alba

Llywodraeth Cymru
Welsh Government

Ref: CEM/CMO/2020/039

4th December 2020

Dear colleagues,

We wanted to write you about winter, vaccines and research.

Winter is always a challenging time for the NHS and wider health and social care service. This year will be especially hard due to COVID-19. Doctors and other health professionals throughout the system have responded magnificently throughout 2020 to this epidemic. Although the very welcome news about vaccines means that we can look forward to 2021 with greater optimism, vaccine deployment will have only a marginal impact in reducing numbers coming into the health service with COVID over the next three months. The actions and self-discipline of the whole population during lockdowns and other restrictions have helped reduce the peak and in most parts of the four nations hospital numbers are likely to fall over the next few weeks, but not everywhere. The social mixing which occurs around Christmas may well put additional pressure on hospitals and general practice in the New Year and we need to be ready for that. Many of you will be working exceptionally hard to manage COVID on top of other medical problems and have been doing so for a long time. We think it likely that by spring the effects of vaccination will begin to be felt in reducing COVID admissions, attendances and deaths significantly but there are many weeks before we get to that stage. We must support one another as a profession as we go to the next, hard months.

Deploying vaccines safely, rapidly and in a sequence which is most likely to reduce mortality and morbidity is going to be a very considerable logistical exercise for all of us. JCVI has recommended that health and social care workers are a high priority once the most vulnerable who are at highest risk of dying have been vaccinated. This is to provide some additional protection against nosocomial spread to the vulnerable. We do not however yet have firm data on the effects of these vaccines on transmission. It is going to be essential that people continue to maintain current PPE and other measures to reduce transmission even after vaccination as we accumulate that data. All healthcare workers would agree that the principal aim of the initial vaccination programme should be to protect the most vulnerable and those at highest risk of mortality.

Medical science is the engine that will bring down the impact of COVID. Colleagues across the entire health system have been remarkable in their contributions to researching this new disease. Drug trials, vaccine trials, testing new diagnostics, clinical studies and observational data have all been essential. We do not expect COVID to disappear even once full vaccination has occurred although it will be substantially less important as a cause of mortality and morbidity. It is therefore absolutely essential that we use the next months to learn as much as we can as we expect COVID to be less common in the future. This will allow us to have the best chance of a strong evidence base for managing it over the coming years. We would therefore strongly encourage colleagues to continue to recruit to or participate in drug trials such as RECOVERY, vaccine trials, and observational studies such as SIREN. We will all be very grateful for the results this will lead to in future years.

Once again we want to thank you for all your work. We are full of admiration for what all of you have done and continue to do.

Personal Information redacted by USI

Professor Chris Whitty
**Chief Medical Officer for England**

Personal Information redacted by USI

Dr Michael McBride
**Chief Medical Officer for Northern Ireland**

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Dr Gregor Smith
**Chief Medical Officer for Scotland**

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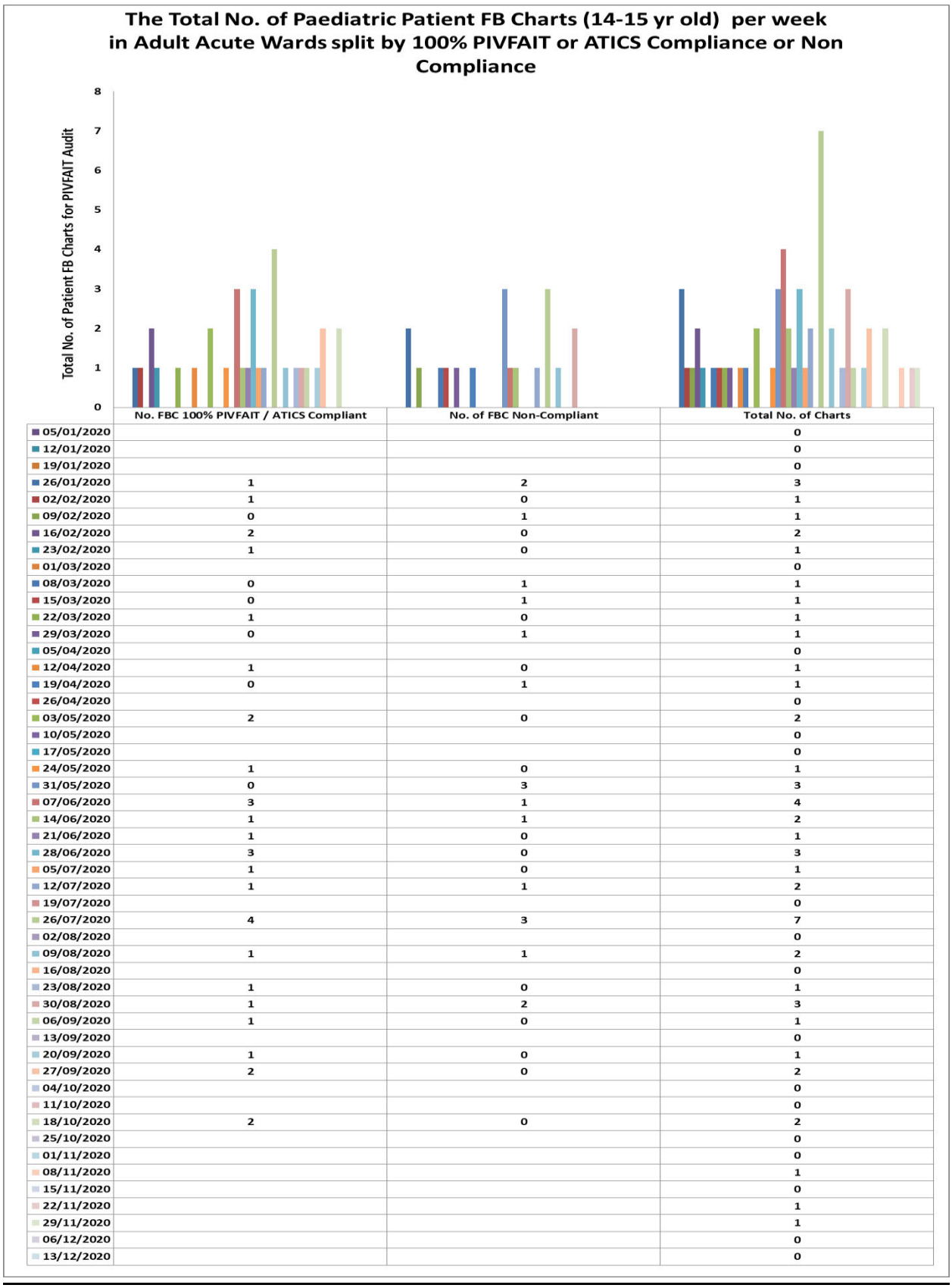
Dr Frank Atherton
**Chief Medical Officer for Wales**

# Acute: IV fluids cases completed using the PIVFAIT or the ATICS audit tool at 13/12/2020

## Overall summary




| | No. FBC 100% PIVFAIT / ATICS Compliant | No. of FBC Non-Compliant | Total No. of Charts |
|---|---|---|---|
| 05/01/2020 | | | 0 |
| 12/01/2020 | | | 0 |
| 19/01/2020 | | | 0 |
| 26/01/2020 | 1 | 2 | 3 |
| 02/02/2020 | 1 | 0 | 1 |
| 09/02/2020 | 0 | 1 | 1 |
| 16/02/2020 | 2 | 0 | 2 |
| 23/02/2020 | 1 | 0 | 1 |
| 01/03/2020 | | | 0 |
| 08/03/2020 | 0 | 1 | 1 |
| 15/03/2020 | 0 | 1 | 1 |
| 22/03/2020 | 1 | 0 | 1 |
| 29/03/2020 | 0 | 1 | 1 |
| 05/04/2020 | | | 0 |
| 12/04/2020 | 1 | 0 | 1 |
| 19/04/2020 | 0 | 1 | 1 |
| 26/04/2020 | | | 0 |
| 03/05/2020 | 2 | 0 | 2 |
| 10/05/2020 | | | 0 |
| 17/05/2020 | | | 0 |
| 24/05/2020 | 1 | 0 | 1 |
| 31/05/2020 | 0 | 3 | 3 |
| 07/06/2020 | 3 | 1 | 4 |
| 14/06/2020 | 1 | 1 | 2 |
| 21/06/2020 | 1 | 0 | 1 |
| 28/06/2020 | 3 | 0 | 3 |
| 05/07/2020 | 1 | 0 | 1 |
| 12/07/2020 | 1 | 1 | 2 |
| 19/07/2020 | | | 0 |
| 26/07/2020 | 4 | 3 | 7 |
| 02/08/2020 | | | 0 |
| 09/08/2020 | 1 | 1 | 2 |
| 16/08/2020 | | | 0 |
| 23/08/2020 | 1 | 0 | 1 |
| 30/08/2020 | 1 | 2 | 3 |
| 06/09/2020 | 1 | 0 | 1 |
| 13/09/2020 | | | 0 |
| 20/09/2020 | 1 | 0 | 1 |
| 27/09/2020 | 2 | 0 | 2 |
| 04/10/2020 | | | 0 |
| 11/10/2020 | | | 0 |
| 18/10/2020 | 2 | 0 | 2 |
| 25/10/2020 | | | 0 |
| 01/11/2020 | | | 0 |
| 08/11/2020 | | | 1 |
| 15/11/2020 | | | 0 |
| 22/11/2020 | | | 1 |
| 29/11/2020 | | | 1 |
| 06/12/2020 | | | 0 |
| 13/12/2020 | | | 0 |

# Acute: IV fluids cases completed using the PIVFAIT or the ATICS audit tool at 13/12/2020

| Week ending | Total No. of Charts | No of cases reviewed | No of cases to be reviewed | PIVFAIT cases | PIVFAIT cases compliant | ATICS cases | ATICS cases compliant | Overall % Compliant cases |
|---|---|---|---|---|---|---|---|---|
| 22/03/2020 | 1 | 1 | 0 | 0 | N/A | 1 | 1 | 100% |
| 29/03/2020 | 1 | 1 | 0 | 0 | N/A | 1 | 0 | 0% |
| 05/04/2020 | 0 | 0 | 0 | 0 | N/A | 0 | N/A | N/A |
| 12/04/2020 | 1 | 1 | 0 | 0 | N/A | 1 | 1 | 100% |
| 19/04/2020 | 1 | 1 | 0 | 0 | N/A | 1 | 0 | 0% |
| 26/04/2020 | 0 | 0 | 0 | 0 | N/A | 0 | N/A | N/A |
| 03/05/2020 | 2 | 2 | 0 | 0 | N/A | 2 | 2 | 100% |
| 10/05/2020 | 0 | 0 | 0 | 0 | N/A | 0 | N/A | N/A |
| 17/05/2020 | 0 | 0 | 0 | 0 | N/A | 0 | N/A | N/A |
| 24/05/2020 | 1 | 1 | 0 | 0 | N/A | 1 | 1 | 100% |
| 31/05/2020 | 3 | 3 | 0 | 0 | N/A | 3 | 0 | 0% |
| 07/06/2020 | 4 | 4 | 0 | 2 | 1 | 2 | 2 | 75% |
| 14/06/2020 | 2 | 2 | 0 | 0 | N/A | 2 | 1 | 50% |
| 21/06/2020 | 1 | 1 | 0 | 0 | N/A | 1 | 1 | 100% |
| 28/06/2020 | 3 | 3 | 0 | 0 | N/A | 3 | 3 | 100% |
| 05/07/2020 | 1 | 1 | 0 | 0 | N/A | 1 | 1 | 100% |
| 12/07/2020 | 2 | 2 | 0 | 1 | 1 | 1 | 0 | 50% |
| 19/07/2020 | 0 | 0 | 0 | 0 | N/A | 0 | N/A | N/A |
| 26/07/2020 | 7 | 7 | 0 | 1 | 0 | 6 | 4 | 57% |
| 02/08/2020 | 0 | 0 | 0 | 0 | N/A | 0 | N/A | N/A |
| 09/08/2020 | 2 | 2 | 0 | 1 | 0 | 1 | 1 | 50% |
| 16/08/2020 | 0 | 0 | 0 | 0 | N/A | 0 | N/A | N/A |
| 23/08/2020 | 1 | 1 | 0 | 0 | N/A | 1 | 1 | 100% |
| 30/08/2020 | 3 | 3 | 0 | 2 | 0 | 1 | 1 | 33% |
| 06/09/2020 | 1 | 1 | 0 | 0 | N/A | 1 | 1 | 100% |
| 13/09/2020 | 0 | 0 | 0 | 0 | N/A | 0 | N/A | N/A |
| 20/09/2020 | 1 | 1 | 0 | 0 | N/A | 1 | 1 | 100% |
| 27/09/2020 | 2 | 2 | 0 | 1 | 1 | 1 | 1 | 100% |
| 04/10/2020 | 0 | 0 | 0 | 0 | N/A | 0 | N/A | N/A |
| 11/10/2020 | 0 | 0 | 0 | 0 | N/A | 0 | N/A | N/A |
| 18/10/2020 | 2 | 2 | 0 | 0 | N/A | 2 | 2 | 100% |
| 25/10/2020 | 0 | 0 | 0 | 0 | N/A | 0 | N/A | N/A |
| 01/11/2020 | 0 | 0 | 0 | 0 | N/A | 0 | N/A | N/A |
| 08/11/2020 | 1* | 0 | 1 | | | | | |
| 15/11/2020 | 0 | | | | | | | |
| 22/11/2020 | 1* | 0 | 1 | | | | | |
| 29/11/2020 | 1* | | 1 | | | | | |
| 06/12/2020 | 0 | | | | | | | |
| 13/12/2020 | 0 | | | | | | | |

*This denotes some cases are awaiting review with clinical sisters

# Acute: IV fluids cases completed using the PIVFAIT or the ATICS audit tool at 13/12/2020

## Outstanding returns - Daisy Hill Hospital

| Hospital | Ward |
|---|---|
| Daisy Hill (w/e 09/02/2020) | ED |
| Daisy Hill (w/e 16/02/2020) | ED |
| Daisy Hill (w/e 23/02/2020) | ED |
| Daisy Hill (w/e 01/03/2020) | ED |
| Daisy Hill (w/e 08/03/2020) | ED |
| Daisy Hill (w/e 22/03/2020) | Theatres / Recovery |
| Daisy Hill (w/e 29/03/2020) | Theatres/Recovery |
| Daisy Hill (w/e 05/04/2020) | Theatres/Recovery |
| Daisy Hill (w/e 12/04/2020) | Theatres / Recovery |
| Daisy Hill (w/e 26/04/2020) | Theatres / Recovery |
| Daisy Hill (w/e 13/12/2020) | Theatres / Recovery |
| Daisy Hill (w/e 13/12/2020) | ED |

## Craigavon Area Hospital

| Hospital | Ward |
|---|---|
| Craigavon (w/e 02/02/2020) | 4 North |
| Craigavon (w/e 09/02/2020) | AMU |
| Craigavon (w/e 09/02/2020) | 3 South |
| Craigavon (w/e 09/02/2020) | 4 North |
| Craigavon (w/e 16/02/2020) | AMU |
| Craigavon (w/e 16/02/2020) | 3 South |
| Craigavon (w/e 16/02/2020) | 4 North |
| Craigavon (w/e 23/02/2020) | AMU |
| Craigavon (w/e 23/02/2020) | 3 South |
| Craigavon (w/e 23/02/2020) | 4 North |
| Craigavon (w/e 01/03/2020) | AMU |
| Craigavon (w/e 01/03/2020) | 3 South |
| Craigavon (w/e 01/03/2020) | 4 North |
| Craigavon (w/e 08/03/2020) | AMU |
| Craigavon (w/e 08/03/2020) | 3 South |
| Craigavon (w/e 08/03/2020) | 4 North |
| Craigavon (w/e 15/03/2020) | AMU |
| Craigavon (w/e 15/03/2020) | 3 South |
| Craigavon (w/e 15/03/2020) | 4 North |
| Craigavon (w/e 22/03/2020) | AMU |
| Craigavon (w/e 22/03/2020) | 3 South |
| Craigavon (w/e 22/03/2020) | 4 North |
| Craigavon (w/e 22/03/2020) | Orthopaedics |
| Craigavon (w/e 29/03/2020) | AMU |
| Craigavon (w/e 29/03/2020) | 3 South |
| Craigavon (w/e 29/03/2020) | 4 North |
| Craigavon (w/e 29/03/2020) | Trauma |
| Craigavon (w/e 29/03/2020) | Orthopaedics |
| Craigavon (w/e 05/04/2020) | AMU |

# Acute: IV fluids cases completed using the PIVFAIT or the ATICS audit tool at 13/12/2020

| | |
|---|---|
| Craigavon (w/e 05/04/2020) | 3 South |
| Craigavon (w/e 05/04/2020) | 4 North |
| Craigavon (w/e 05/04/2020) | Trauma |
| Craigavon (w/e 05/04/2020) | Orthopaedics |
| Craigavon (w/e 12/04/2020 | Day Procedure |
| Craigavon (w/e 12/04/2020) | AMU |
| Craigavon (w/e 12/04/2020) | 3 South |
| Craigavon (w/e 12/04/2020) | 4 North |
| Craigavon (w/e 12/04/2020) | Trauma |
| Craigavon (w/e 12/04/2020) | Orthopaedics |
| Craigavon (w/e 19/04/2020) | Day Procedure |
| Craigavon (w/e 19/04/2020) | AMU |
| Craigavon (w/e 19/04/2020) | 3 South |
| Craigavon (w/e 19/04/2020) | 4 North |
| Craigavon (w/e 19/04/2020) | Trauma |
| Craigavon (w/e 19/04/2020) | Orthopaedics |
| Craigavon (w/e 26/04/2020) | Day Procedure |
| Craigavon (w/e 26/04/2020) | AMU |
| Craigavon (w/e 26/04/2020) | 3 South |
| Craigavon (w/e 26/04/2020) | 4 North |
| Craigavon (w/e 26/04/2020) | Trauma |
| Craigavon (w/e 26/04/2020) | Orthopaedics |
| Craigavon (w/e 03/05/2020) | Day Procedure |
| Craigavon (w/e 03/05/2020) | AMU |
| Craigavon (w/e 03/05/2020) | 3 South |
| Craigavon (w/e 03/05/2020 | 4 North |
| Craigavon (w/e 03/05/2020) | Trauma |
| Craigavon (w/e 03/05/2020) | Orthopaedics |
| Craigavon (w/e 10/05/2020) | Day Procedure |
| Craigavon (w/e 10/05/2020) | AMU |
| Craigavon (w/e 10/05/2020) | 3 South |
| Craigavon (w/e 10/05/2020) | 4 North |
| Craigavon (w/e 17/05/2020) | Day Procedure |
| Craigavon (w/e 17/05/2020) | AMU |
| Craigavon (w/e 17/05/2020) | 3 South |
| Craigavon (w/e 17/05/2020) | 4 North |
| Craigavon (w/e 24/05/2020) | Day Procedure |
| Craigavon (w/e 24/05/2020) | AMU |
| Craigavon (w/e 24/05/2020) | 3 South |
| Craigavon (w/e 24/05/2020) | 4 North |
| Craigavon (w/e 31/05/2020) | Day Procedure |
| Craigavon (w/e 31/05/2020) | AMU |
| Craigavon (w/e 31/05/2020) | 3 South |
| Craigavon (w/e 31/05/2020) | 4 North |
| Craigavon (w/e 07/06/2020) | Day Procedure |
| Craigavon (w/e 07/06/2020) | AMU |
| Craigavon (w/e 07/06/2020) | 3 South |
| Craigavon (w/e 07/06/2020) | 4 North |
| Craigavon (w/e) 14/06/2020) | Day Procedure |
| Craigavon (w/e) 14/06/2020) | AMU |
| Craigavon (w/e) 14/06/2020) | 3 South |
| Craigavon (w/e) 14/06/2020) | 4 North |

# Acute: IV fluids cases completed using the PIVFAIT or the ATICS audit tool at 13/12/2020

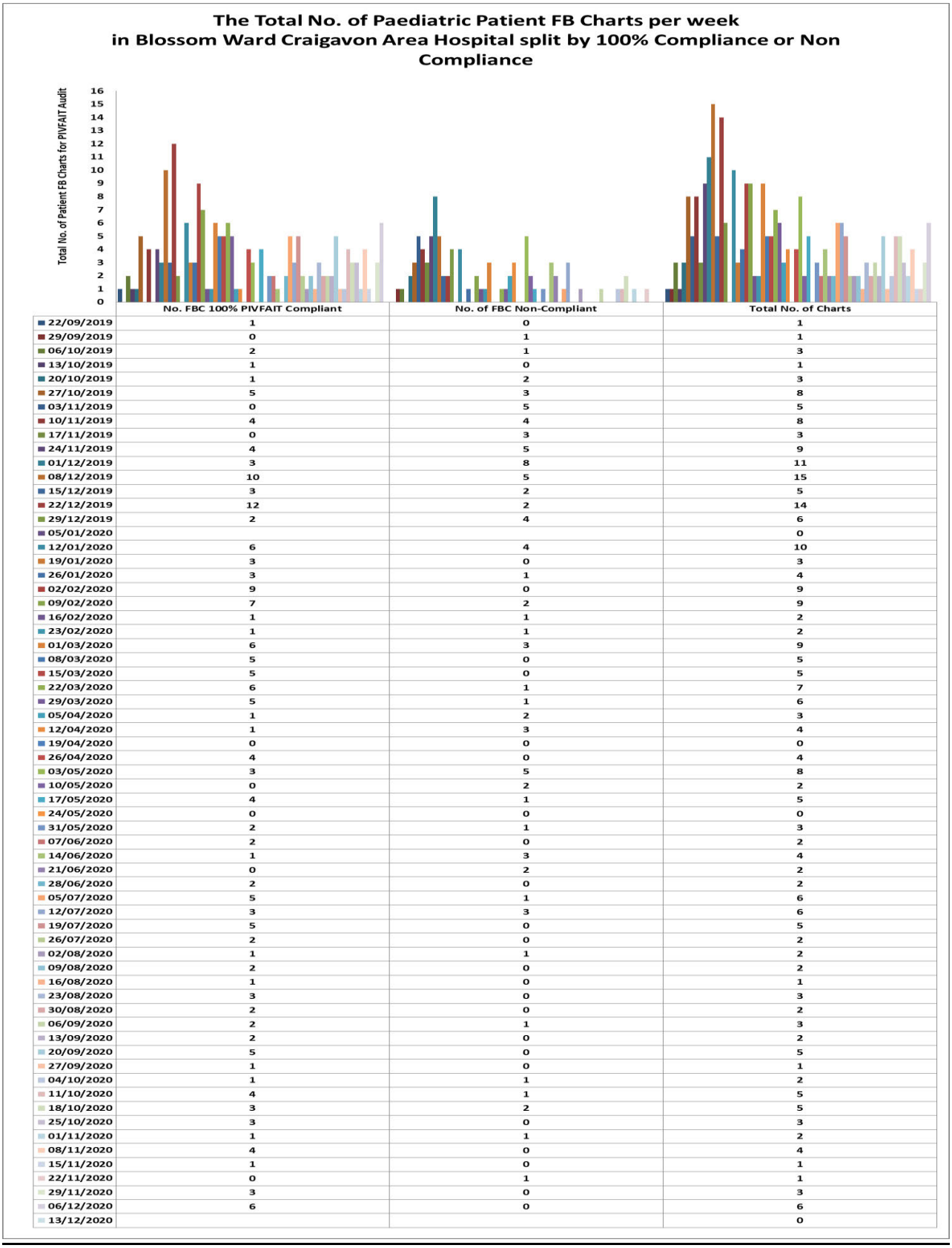
| | |
|---|---|
| Craigavon (w/e) 21/06/2020) | Day Procedure |
| Craigavon (w/e) 21/06/2020) | AMU |
| Craigavon (w/e) 21/06/2020) | 3 South |
| Craigavon (w/e) 21/06/2020) | 4 North |
| Craigavon (w/e) 28/06/2020) | Day Procedure |
| Craigavon (w/e) 28/06/2020) | AMU |
| Craigavon (w/e) 28/06/2020) | 3 South |
| Craigavon (w/e) 28/06/2020) | 4 North |
| Craigavon(w/e) 05/07/2020) | Day Procedure |
| Craigavon(w/e) 05/07/2020) | AMU |
| Craigavon(w/e) 05/07/2020) | 3 South |
| Craigavon(w/e) 05/07/2020) | 4 North |
| Craigavon(w/e) 12/07/2020) | Day Procedure |
| Craigavon(w/e) 12/07/2020) | AMU |
| Craigavon(w/e) 12/07/2020) | 3 South |
| Craigavon(w/e) 12/07/2020) | 4 North |
| Craigavon(w/e) 19/07/2020) | Day Procedure |
| Craigavon(w/e) 19/07/2020) | AMU |
| Craigavon(w/e) 19/07/2020) | 3 South |
| Craigavon(w/e) 19/07/2020) | 4 North |
| Craigavon(w/e) 26/07/2020) | Day Procedure |
| Craigavon(w/e) 26/07/2020) | AMU |
| Craigavon(w/e) 26/07/2020) | 3 South |
| Craigavon(w/e) 26/07/2020) | 4 North |
| Craigavon(w/e) 02/08/2020) | Day Procedure |
| Craigavon(w/e) 02/08/2020) | AMU |
| Craigavon(w/e) 02/08/2020) | 3 South |
| Craigavon(w/e) 02/08/2020) | 4 North |
| Craigavon(w/e) 09/08/2020) | Day Procedure |
| Craigavon(w/e) 09/08/2020) | AMU |
| Craigavon(w/e) 09/08/2020) | 3 South |
| Craigavon(w/e) 09/08/2020) | 4 North |
| Craigavon(w/e) 16/08/2020) | Day Procedure |
| Craigavon(w/e) 16/08/2020) | AMU |
| Craigavon(w/e) 16/08/2020) | 3 South |
| Craigavon(w/e) 16/08/2020) | 4 North |
| Craigavon(w/e) 23/08/2020) | Day Procedure |
| Craigavon(w/e) 23/08/2020) | AMU |
| Craigavon(w/e) 23/08/2020) | 3 South |
| Craigavon(w/e) 23/08/2020) | 4 North |
| Craigavon(w/e) 30/08/2020) | Day Procedure |
| Craigavon(w/e) 30/08/2020) | AMU |
| Craigavon(w/e) 30/08/2020) | 3 South |
| Craigavon(w/e) 30/08/2020) | 4 North |
| Craigavon(w/e) 06/09/2020) | Day Procedure |
| Craigavon(w/e) 06/09/2020) | AMU |
| Craigavon(w/e) 06/09/2020) | 3 South |
| Craigavon(w/e) 06/09/2020) | 4 North |
| Craigavon(w/e) 06/09/2020) | Trauma |
| Craigavon(w/e) 13/09/2020) | AMU |
| Craigavon(w/e) 13/09/2020) | 3 South |
| Craigavon(w/e) 13/09/2020) | 4 North |

# Acute: IV fluids cases completed using the PIVFAIT or the ATICS audit tool at 13/12/2020

| | |
|---|---|
| Craigavon(w/e) 20/09/2020) | AMU |
| Craigavon(w/e) 20/09/2020) | 3 South |
| Craigavon(w/e) 20/09/2020) | 4 North |
| Craigavon(w/e) 27/09/2020 | AMU |
| Craigavon(w/e) 27/09/2020 | 3 South |
| Craigavon(w/e) 27/09/2020 | 4 North |
| Craigavon(w/e) 04/10/2020 | AMU |
| Craigavon(w/e) 04/10/2020 | 3 South |
| Craigavon(w/e) 04/10/2020 | 4 North |
| Craigavon(w/e) 13/12/2020 | Trauma |

# Children and Young People: IV fluids cases completed using the PIVFAIT audit tool at 13/12/2020

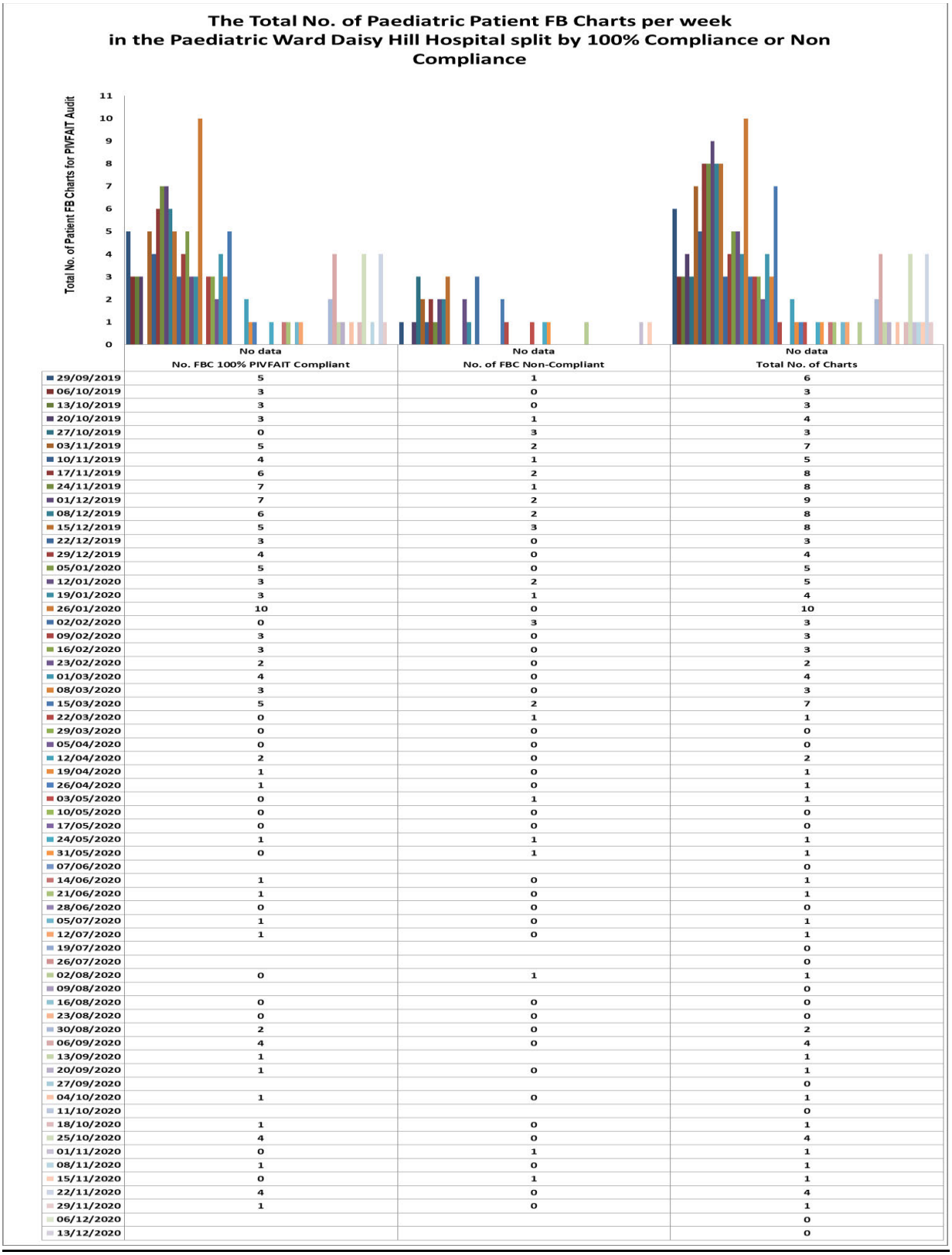
## Craigavon Area Hospital




| | No. FBC 100% PIVFAIT Compliant | No. of FBC Non-Compliant | Total No. of Charts |
|---|---|---|---|
| 22/09/2019 | 1 | 0 | 1 |
| 29/09/2019 | 0 | 1 | 1 |
| 06/10/2019 | 2 | 1 | 3 |
| 13/10/2019 | 1 | 0 | 1 |
| 20/10/2019 | 1 | 2 | 3 |
| 27/10/2019 | 5 | 3 | 8 |
| 03/11/2019 | 0 | 5 | 5 |
| 10/11/2019 | 4 | 4 | 8 |
| 17/11/2019 | 0 | 3 | 3 |
| 24/11/2019 | 4 | 5 | 9 |
| 01/12/2019 | 3 | 8 | 11 |
| 08/12/2019 | 10 | 5 | 15 |
| 15/12/2019 | 3 | 2 | 5 |
| 22/12/2019 | 12 | 2 | 14 |
| 29/12/2019 | 2 | 4 | 6 |
| 05/01/2020 | | | 0 |
| 12/01/2020 | 6 | 4 | 10 |
| 19/01/2020 | 3 | 0 | 3 |
| 26/01/2020 | 3 | 1 | 4 |
| 02/02/2020 | 9 | 0 | 9 |
| 09/02/2020 | 7 | 2 | 9 |
| 16/02/2020 | 1 | 1 | 2 |
| 23/02/2020 | 1 | 1 | 2 |
| 01/03/2020 | 6 | 3 | 9 |
| 08/03/2020 | 5 | 0 | 5 |
| 15/03/2020 | 5 | 0 | 5 |
| 22/03/2020 | 6 | 1 | 7 |
| 29/03/2020 | 5 | 1 | 6 |
| 05/04/2020 | 1 | 2 | 3 |
| 12/04/2020 | 1 | 3 | 4 |
| 19/04/2020 | 0 | 0 | 0 |
| 26/04/2020 | 4 | 0 | 4 |
| 03/05/2020 | 3 | 5 | 8 |
| 10/05/2020 | 0 | 2 | 2 |
| 17/05/2020 | 4 | 1 | 5 |
| 24/05/2020 | 0 | 0 | 0 |
| 31/05/2020 | 2 | 1 | 3 |
| 07/06/2020 | 2 | 0 | 2 |
| 14/06/2020 | 1 | 3 | 4 |
| 21/06/2020 | 0 | 2 | 2 |
| 28/06/2020 | 2 | 0 | 2 |
| 05/07/2020 | 5 | 1 | 6 |
| 12/07/2020 | 3 | 3 | 6 |
| 19/07/2020 | 5 | 0 | 5 |
| 26/07/2020 | 2 | 0 | 2 |
| 02/08/2020 | 1 | 1 | 2 |
| 09/08/2020 | 2 | 0 | 2 |
| 16/08/2020 | 1 | 0 | 1 |
| 23/08/2020 | 3 | 0 | 3 |
| 30/08/2020 | 2 | 0 | 2 |
| 06/09/2020 | 2 | 1 | 3 |
| 13/09/2020 | 2 | 0 | 2 |
| 20/09/2020 | 5 | 0 | 5 |
| 27/09/2020 | 1 | 0 | 1 |
| 04/10/2020 | 1 | 1 | 2 |
| 11/10/2020 | 4 | 1 | 5 |
| 18/10/2020 | 3 | 2 | 5 |
| 25/10/2020 | 3 | 0 | 3 |
| 01/11/2020 | 1 | 1 | 2 |
| 08/11/2020 | 4 | 0 | 4 |
| 15/11/2020 | 1 | 0 | 1 |
| 22/11/2020 | 0 | 1 | 1 |
| 29/11/2020 | 3 | 0 | 3 |
| 06/12/2020 | 6 | 0 | 6 |
| 13/12/2020 | | | 0 |

# Children and Young People: IV fluids cases completed using the PIVFAIT audit tool at 13/12/2020

## Daisy Hill Hospital




| | No data<br>No. FBC 100% PIVFAIT Compliant | No data<br>No. of FBC Non-Compliant | No data<br>Total No. of Charts |
|---|---|---|---|
| 29/09/2019 | 5 | 1 | 6 |
| 06/10/2019 | 3 | 0 | 3 |
| 13/10/2019 | 3 | 0 | 3 |
| 20/10/2019 | 3 | 1 | 4 |
| 27/10/2019 | 0 | 3 | 3 |
| 03/11/2019 | 5 | 2 | 7 |
| 10/11/2019 | 4 | 1 | 5 |
| 17/11/2019 | 6 | 2 | 8 |
| 24/11/2019 | 7 | 1 | 8 |
| 01/12/2019 | 7 | 2 | 9 |
| 08/12/2019 | 6 | 2 | 8 |
| 15/12/2019 | 5 | 3 | 8 |
| 22/12/2019 | 3 | 0 | 3 |
| 29/12/2019 | 4 | 0 | 4 |
| 05/01/2020 | 5 | 0 | 5 |
| 12/01/2020 | 3 | 2 | 5 |
| 19/01/2020 | 3 | 1 | 4 |
| 26/01/2020 | 10 | 0 | 10 |
| 02/02/2020 | 0 | 3 | 3 |
| 09/02/2020 | 3 | 0 | 3 |
| 16/02/2020 | 3 | 0 | 3 |
| 23/02/2020 | 2 | 0 | 2 |
| 01/03/2020 | 4 | 0 | 4 |
| 08/03/2020 | 3 | 0 | 3 |
| 15/03/2020 | 5 | 2 | 7 |
| 22/03/2020 | 0 | 1 | 1 |
| 29/03/2020 | 0 | 0 | 0 |
| 05/04/2020 | 0 | 0 | 0 |
| 12/04/2020 | 2 | 0 | 2 |
| 19/04/2020 | 1 | 0 | 1 |
| 26/04/2020 | 1 | 0 | 1 |
| 03/05/2020 | 0 | 1 | 1 |
| 10/05/2020 | 0 | 0 | 0 |
| 17/05/2020 | 0 | 0 | 0 |
| 24/05/2020 | 1 | 1 | 1 |
| 31/05/2020 | 0 | 1 | 1 |
| 07/06/2020 | | | 0 |
| 14/06/2020 | 1 | 0 | 1 |
| 21/06/2020 | 1 | 0 | 1 |
| 28/06/2020 | 0 | 0 | 0 |
| 05/07/2020 | 1 | 0 | 1 |
| 12/07/2020 | 1 | 0 | 1 |
| 19/07/2020 | | | 0 |
| 26/07/2020 | | | 0 |
| 02/08/2020 | 0 | 1 | 1 |
| 09/08/2020 | | | 0 |
| 16/08/2020 | 0 | 0 | 0 |
| 23/08/2020 | 0 | 0 | 0 |
| 30/08/2020 | 2 | 0 | 2 |
| 06/09/2020 | 4 | 0 | 4 |
| 13/09/2020 | 1 | | 1 |
| 20/09/2020 | 1 | 0 | 1 |
| 27/09/2020 | | | 0 |
| 04/10/2020 | 1 | 0 | 1 |
| 11/10/2020 | | | 0 |
| 18/10/2020 | 1 | 0 | 1 |
| 25/10/2020 | 4 | 0 | 4 |
| 01/11/2020 | 0 | 1 | 1 |
| 08/11/2020 | 1 | 0 | 1 |
| 15/11/2020 | 0 | 1 | 1 |
| 22/11/2020 | 4 | 0 | 4 |
| 29/11/2020 | 1 | 0 | 1 |
| 06/12/2020 | | | 0 |
| 13/12/2020 | | | 0 |

**From the Head of Safety Strategy Unit**
Brian Godfrey

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

**Reinstatement of HSC (SQSD) 24/19 Regional Operational Policy Templates**

**For Action:**
Chief Executives HSC Trusts
Chief Executive HSCB/PHA
Chief Executive RQIA
Chief Executive, NIMDTA
Chief Executive, NIAS

**Implementation**
30th June 2020

**Date of Issue: 21st January 2020**

Dear Colleagues

Circular HSC (SQSD) 24/19 was issued on 27th August 2019 covering the availability of a suite of regional operational policy templates developed by HSC governance leads for regional adoption by HSC Trusts.

In September 2019 the circular was suspended to allow further refinement of the MOU Investigating Patient Safety Incidents and ensure clarity in respect to the status of the Being Open template in respect to the Duty of Candour IHRD workstream.

This work has now been completed and clarification provided therefore the suspension of the circular has been lifted.

I have attached the following policies and we would recommend that HSC Trusts should work towards adoption of these templates to match local circumstances by 30th June 2020.

- Adverse Incident Policy;
- Policy on Early Alerts (updated to include recent DoH circular);
- Policy on Being Open;
- Policy on RIDDOR Incidents;
- Supporting Staff involved in Incidents, Claims and Complaints;
- Policy on MOU investigating Patient Safety Incidents

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

Safety Strategy Unit
Department of Health
Room D2.4, Castle Buildings
BELFAST, BT4 3SQ
**Tel:** Personal Information redacted by the USI
Personal Information redacted by the USI

Yours sincerely

Personal information redacted by USI

**Brian Godfrey**

| ID | nc dent date | T me | Directorate | Loc (Type) | Loc (Exact) | Spec a ty / Team | Descr pt on | nc dent affect ng | nc dent type t er one | nc dent type t er two | nc dent type t er three | Resu t | Sever ty | Grade | Act on taken | Act on taken ( nvest gat on) | Approva status | Date Not f cat on Sent to Externa Agency | Category. | Sub Category | Deta | Reported |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information redacted by the USI | 10/12/2020 | 12:30 | Mental Health and Disability | Supported Living Facility (Trust) | Ardaveen Manor, Bessbrook | Supported Living Facilities | On entering house 1 I witnessed a breach of PPE, staff member [redacted] was not wearing a face mask or visor when exiting the living room were there was two service users present. This is the third breach of PPE from this staff member. | Staff/Contractor/Vendor Incidents | Exposure to Environmental Hazards | Exposure to Unsafe Environmental Conditions | Infectious agent | No injury, harm or adverse outcome | Minor | Low Risk | I asked for the staff member to go to the donning area to get the correct PPE that should be worn at all times. Supervision to be arranged with staff member. Staff member has already had face to face IPC training and has also completed IPC training online. | Manager to link in with HR to discuss possible disciplinary procedures due to repeated incidents | Final approval | | Accident that may result in personal injury | Exposure to electricity, hazardous substance, infection etc | Hazardous and avoidable exposure to infection | 10/12/2020 |
| | 05/12/2020 | 09:00 | Acute Services | Anaesthetics/Theatres/ICU area | Theatres 5-8 CAH | Theatres | SN tested positive for Covid 19 | Staff/Contractor/Vendor Incidents | Exposure to Environmental Hazards | Exposure to Hazardous Substances | Biological agent | Counselled | Minor | Low Risk | To self isolate x 10 days as per Department of Health and OH guidelines | Picked up on swabbing following confirmed contact with friend while out for a walk. To isolate x 10 days as per Department of Health and OH Asymptomatic at time of positive swab result PPE and social distancing guidelines in place with no breeches reported Head of Service informed DATIX completed | | | Accident that may result in personal injury | Exposure to electricity, hazardous substance, infection etc | Exposure to biological hazard | 07/12/2020 |
| | 07/12/2020 | 08:30 | Older People and Primary Care | Administration/Multi Purpose Accommodation | Archway | ICSSC N&M | felt unwell Tuesday 1.12.20. Contacted line manager ad Occ Health. Swabbing for COVID-19 arranged. Swab returned positive result. To self isolate. | Staff/Contractor/Vendor Incidents | Exposure to Environmental Hazards | Exposure to Hazardous Substances | Biological agent | Ongoing pain or restricted movement | Moderate | Medium Risk | continue with self isolation. Close contact tracing initiated. No close contacts identified. | All staff reminded of COVID-19 guidelines and recommendations. All staff to continue to complete sign in sheet in office. Staff to work remotely were able. | Being reviewed | | Accident that may result in personal injury | Exposure to electricity, hazardous substance, infection etc | Exposure to biological hazard | 07/12/2020 |
| | 08/12/2020 | 11:30 | Acute Services | Ward or Care Area | 2 North Respiratory | General Medicine | PATIENT TESTED POSITIVE 08/12/2020 AFTER BECOMING UNWELL AND SPIKED TEMPERATURE.COMMENCED ON AIRVO. DAY 14 OF ADMISSION. SWABBED NEGATIVE ON ADMISSION AND ON DAY 5. DAY 7 SWABBED NOT COMPLETED. | Patient Incidents | Exposure to Environmental Hazards | Exposure to Hazardous Substances | Biological agent | Injury | Minor | Low Risk | PATIENT TRANSFERED TO COVID POSITIVE SIDE OF THE WARD. 2 OTHER PATIENTS IN THE BAY INFORMED AND SWABBED. AWAIT RESULTS. | ALL STAFF ARE AWARE TO SWAB ALL NEGATIVE PATIENTS ON DAY 5 AND DAY 7, SAME ON SAFETY BRIEF. TWO OTHER PATIENTS TESTED NEGATIVE AND DISCHARGED HOME. BOTH AWARE TO SELF ISOLTE AT HOME AND WRITTEN INFORMATION GIVEN TO PATIENTS. | Final approval | | Accident that may result in personal injury | Exposure to electricity, hazardous substance, infection etc | Exposure to biological hazard | 08/12/2020 |
| | 05/12/2020 | 09:00 | Acute Services | Ward or Care Area | Gillis Memory Centre | Domestic Services (A&D) | Infection attributable to specified work (schedule 3 No 27) Staff member tested positive Covid19 | Staff/Contractor/Vendor Incidents | Exposure to Environmental Hazards | Exposure to Hazardous Substances | Biological agent | Disruption to services | Moderate | Medium Risk | Referred to Contact Tracing | Tested after feeling covid symptoms | Final approval | | Accident that may result in personal injury | Exposure to electricity, hazardous substance, infection etc | Hazardous and avoidable exposure to infection | 09/12/2020 |
| | 04/12/2020 | 12:00 | Acute Services | Ward or Care Area | Ward 3b | General Medicine | Person TESTED POSITIVE FOR COVID19 4/12/20. "INFECTION ATTRIBUTABLE TO SPECIFIED WORK (SCHEDULE 3 NO.27) | Staff/Contractor/Vendor Incidents | Exposure to Environmental Hazards | Exposure to Hazardous Substances | Biological agent | No injury, harm or adverse outcome | Insignificant | Low Risk | ISOLATION NO PPE COMPROMISED AT WORK | CASE UNDER REVIEW | Being reviewed | | Accident that may result in personal injury | Exposure to electricity, hazardous substance, infection etc | Exposure to biological hazard | 08/12/2020 |
| | 04/12/2020 | 15:15 | Acute Services | Public/Common Area | Basement | Domestic Services (C/B) | Infection Attributable to specified work (schedule 3 No 27) Staff member tested positive covid19 Tested on Fri 04/12/2020 Last worked Thursday 03/12/2020 | Staff/Contractor/Vendor Incidents | Exposure to Environmental Hazards | Exposure to Hazardous Substances | Biological agent | Injury | Moderate | Medium Risk | Referred to Occupation health | Referred to OH Tested at the CAH Pod Isolating | Final approval | | Accident that may result in personal injury | Exposure to electricity, hazardous substance, infection etc | Exposure to biological hazard | 08/12/2020 |
| | 05/12/2020 | 15:00 | Acute Services | Clinical Area | Emergency Department CAH | Domestic Services (C/B) | Infection attributable to specified work (schedule 3 No. 27) Trust staff member tested positive Covid19 | Staff/Contractor/Vendor Incidents | Exposure to Environmental Hazards | Exposure to Hazardous Substances | Biological agent | Ongoing pain or restricted movement | Moderate | Medium Risk | Reported to O/H and attended CAH Pod, isolating | Referred to OH Tested at the hub | Final approval | | Accident that may result in personal injury | Exposure to electricity, hazardous substance, infection etc | Hazardous and avoidable exposure to infection | 10/12/2020 |
| | 07/12/2020 | 10:00 | Mental Health and Disability | Administration/Multi Purpose Accommodation | Jackson Hall | Physical Disability Team A&D | CONFIRMED COVID 19 POSITIVE INFECTION ATTRIBUTABLE TO SPECIFIED WORK (SCHEDULE 3 NO. 27)". | Staff/Contractor/Vendor Incidents | Exposure to Environmental Hazards | Exposure to Hazardous Substances | Biological agent | No injury, harm or adverse outcome | Insignificant | Low Risk | AT HOME SELF ISOLATING | STAFF MEMBER IS SELF-ISOLATION, PHA informed, track and tracing complete recorded on HRPTS | Final approval | | Infrastructure or resources (staffing, facilities, environment) | Environmental matters | Unsafe environment (personal safety, light, temp, noise, air) | 08/12/2020 |
| | 10/12/2020 | 18:00 | Acute Services | Ward or Care Area | Ward 3b | General Medicine | Personal 10/12/20 tested Covid Positive "INFECTION ATTRIBUTABLE TO SPECIFIED WORD (schedule 3 NO.27) | Staff/Contractor/Vendor Incidents | Exposure to Environmental Hazards | Exposure to Hazardous Substances | Biological agent | No injury, harm or adverse outcome | Insignificant | | ISOLATION | | Being reviewed | | Accident that may result in personal injury | Exposure to electricity, hazardous substance, infection etc | Exposure to biological hazard | 11/12/2020 |
| | 17/11/2020 | 08:30 | Older People and Primary Care | Administration/Multi Purpose Accommodation | Archway | ICSSC N&M | Staff member felt unwell when at home. Contact Occ Health and booked for COVID-19 swab. swab came back positive | Staff/Contractor/Vendor Incidents | Exposure to Environmental Hazards | Exposure to Hazardous Substances | Biological agent | Ongoing pain or restricted movement | Moderate | Medium Risk | Staff member informed line manager. Staff member to continue with self isolation. Close contact tracing initiated with staff sign in register. 1 close contact identified and to also self isolate. | ensuring all staff are aware of COVID-19 guidelines and recommendations. Remote working used were able. Sign in sheets held in office PPE available at all times | Being reviewed | | Accident that may result in personal injury | Exposure to electricity, hazardous substance, infection etc | Exposure to biological hazard | 07/12/2020 |
| | 08/12/2020 | 14:00 | Acute Services | Ward or Care Area | Ward 3b | General Medicine | Person TESTED POSITIVE FOR COVID19 ON 08/12/20 section 3 no 27 | Staff/Contractor/Vendor Incidents | Exposure to Environmental Hazards | Exposure to Hazardous Substances | Biological agent | No injury, harm or adverse outcome | Insignificant | | ISOLATION Person CONFIRMED HE DID NOT COMPROMISE PPE AT ANY TIME IN WORK | | Being reviewed | | Accident that may result in personal injury | Exposure to electricity, hazardous substance, infection etc | Exposure to biological hazard | 08/12/2020 |
| | 10/12/2020 | 12:30 | Mental Health and Disability | Supported Living Facility (Trust) | Ardaveen Manor, Bessbrook | Supported Living Facilities | On entering house 1 I witnessed a breach of PPE, staff member [redacted] was not wearing a face mask or visor when exiting the living room were there was two service users present. This is the third breach of PPE from this staff member. | Staff/Contractor/Vendor Incidents | Exposure to Environmental Hazards | Exposure to Unsafe Environmental Conditions | Infectious agent | No injury, harm or adverse outcome | Minor | Low Risk | I asked for the staff member to go to the donning area to get the correct PPE that should be worn at all times. Supervision to be arranged with staff member. Staff member has already had face to face IPC training and has also completed IPC training online. | Manager to link in with HR to discuss possible disciplinary procedures due to repeated incidents | Final approval | | Accident that may result in personal injury | Exposure to electricity, hazardous substance, infection etc | Hazardous and avoidable exposure to infection | 10/12/2020 |
| | 07/12/2020 | 07:50 | Older People and Primary Care | Other | Home of client | Domicillary Care N/M | Person was going out the back door of a service users house to put PPE into the bin, when she slipped on the icy steps, fell banged her head and elbow. | Staff/Contractor/Vendor Incidents | Accidents/Falls | Slip/Trip or Fall | Walking | Injury | Insignificant | Low Risk | Person advised to seek medical attention, another DCW contacted to cover the rest of the calls. Person attended her own GP, She was given information re minor concussion and what to do in the event she experiences same. Elbow bruised | Person to follow up with Person to se if she needs referral to OH | Final approval | | Accident that may result in personal injury | Slips, trips, falls and collisions | Slips on ice or snow | 07/12/2020 |

Level 3 SAI review

Introductory Meeting New Urology reviews.

**Date and time**: Thursday 10 September 2020 10:30 – 12:00
**Venue**: - Board Room Trust Headquarters CAH

**Attendees:**
External Chair – Dr Dermot Hughes.
Mrs Fiona Reddick – Head of Cancer Services
Ms Patricia Thompson – Clinical Nurse Specialist – urology
Mrs Patricia Kingsnorth – Acting Acute Clinical Governance Coordinator

Welcome

Patricia Kingsnorth welcomed everyone to the first meeting and introductions were made.

Dr Hughes explained the process and rationale for review to look at the service and map the pathway of the patients being presented. There would be separate reports with one overall umbrella section.

The cases 6 presented (one more to follow) will include mapping the patient's journey and compare with the existing pathway to identify deviations from the pathway.

**Cases discussed**.

1. Patient 1 a Personal Information redacted by USI man referred in view of increased PSA and tumour markers. Noted he had an MRI pelvis and was referred for discussion with MDT prior to biopsy. MDT recommended radiotherapy in Belfast. No done. Fiona will check out, who was present at the MDT meeting, were the appropriate people at the meeting and was the referral made to Belfast. There was some discussion about a failsafe from cancer trackers if a referral is not made how did non beam radiotherapy not happen?

2. Patient 5 - noted renal cell carcinoma. Noted the risks of surgery for this patient but patient wanted surgery. Following radiology investigation the result was not acted upon.
   There was some discussion around who follows the patient up – if surgeons then the review should be followed up in Thorndale unit, if oncology this would be done in Belfast. Patricia K will check with PACS manager if the MRI scan was viewed and by whom. Also she will check with Imran if the CT scan meets the definition of unexpected result.- index of suspicion.
   Need to map this patient's journey

3. Patient 9 patient received TURP as clinically suspicious of prostate cancer. Need to ascertain if all the tissue was there was a clinical suspicion of cancer –

what would be expected in this case. Fiona to identify who attended the MDT meeting and what was the pathway of care – pathway appears not to have been followed. Patient not reviewed until his emergency attendance at ED 7 months later.

4. Patient 8 – need to look at his entrance to the pathway. PK to provide a timeline and present to the team. Was his case discussed at MDT what was the decision making in his case. Who was present?

5. Is there a fail-safe coordinator for urology? There is for breast cancer services. We need to check with Martina Corrigan.

6. Patient 101 – the datix doesn't provide enough information in this case to identify the issues. Need a timeline to share with the panel.

Other issues identified. – Service of oncology lung and urology MDT meet on the same day. Access to services problems?

Dr Hughes advises we conduct a systematic review of what is expected in the pathway, what has occurred in the patients journey and are the variants.

| What should happen | What did happen | What are the variants |
|---|---|---|

A draft terms of reference were discussed.
Agreed the following

## *Terms of Reference*

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

- To carry out a systematic review in the process used in the diagnosis, MDT decision making and subsequent follow up provided, using a Root Cause Analysis (RCA) Methodology.
- To use a multidisciplinary team approach to the review.
- To identify those factors which may have had an influence, or may have contributed to the process.
- To agree the outcome of the review and subsequent recommendations.
- To action any recommendations and disseminate any lessons to be learnt.

- To report the findings and the recommendations of the review through the Director of Acute Services SHSCT, Medical Director of SHSCT and disseminate to the staff involved and XX.

Patricia advises that a urologist is being commissioned and we hope they will be available for the next meeting.

**Actions**

Patricia K will provide notes electronically for Dermot and Patricia T and hard copy for Fiona. Timelines are being written up and will be shared with the team for all patients.

Fiona will access the system to determine who was present at the MDT meetings and what was discussed. PK will forward the HCN to her separately.

Dermot will be on leave from next week.

PK to arrange the next meeting when the urology rep has been secured.

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**New Urology SAI Meeting 12.10.2020 @09:30.**

Attendance: Dr Dermot Hughes (Chair); Mr Hugh Gilbert Consultant Urologist; Patricia Kingsnorth ; Fiona Reddick; Patricia Thompson

Round of introductions given

PK asked was the agenda received by all. All present confirmed they had received this. Patricia Kingsnorth asked for everyone to check the notes of last meeting for accuracy. Record of what was agreed. At previous meeting they discussed 6 cases at high level and 2 cases were removed Personal Information redacted by USI following screening.

Dermot advised all cases are quite similar: 8 cases and it is important everyone has same information on each case to review.

Patricia Kingsnorth: Information can be accessed on Egress.

Patricia Kingsnorth advised there was one additional case for screening:

Dermot advised he was concerned he was asked to Chair the review in August and there are still cases added.

Patricia Kingsnorth advised will speak with directors re this.

Dermot advised everything that will be done will be scrutinised and advised it is important we take same approach to all cases. Asked to chair urology cases, quite similar, they have being independently triaged, currently 7 possibly with possibility of 8 cases. Dermot advised we can at the cases in 2 ways i.e. the processes in place and how the patients pathway progressed through.

Medical opinion: District general hospital consultant should be able to give peer opinion

Dermot explained the Urology services divided urology cancer MDTs, probably cover 400000 patients link together each week with regional MDT, there is a seamless flow of patients through the service,

Oncology services are separate; this is an outreach service that is variable throughout Trusts.

Patricia Kingsnorth advised previous introductory meeting prior to Hugh coming on board, looked at pathways briefly. The scope of the review and terms of reference, she advised we need to send draft TOR to HSCB and consider family involvement in TOR.

Patricia K read out TOR. Advised there will be separate individual reports and one overarching report with all information.

Dermot advised important we need to consider family expectation and involvement within the TOR. Normally would share TOR with family/ patient and ask them to review and contribute in some way. Usually family would have their concerns. Opportunity to express any concerns to be address in review.

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Hugh advised If it is to be a multi-disciplinary review should there be an oncologist on review panel.

Patricia K advised 2 ways we could do this. Have one on the review team or ask for an oncology opinion this won't delay process getting oncologist.

Hugh: Need to have Oncologist for reviewing case, he will do primary case review, what urologist or oncologist would do, better and fairer way to complete review.

Patricia K advised we need to provide questions for clarity for the oncologist on what is required for the review.

Dermot advised not everything would be pertinent to oncologist, we should seek opinion now

Hugh advised he has gone through cases and knows what they are about, not entirely black and white, happy to provide questions for oncologist to consider.

Hughes: We need to know how MDT process works. How effective MDT is, it is important to have MDT input into review.

Patricia K advised she had provided papers and asked if all could you access Egress system.

Hugh: Given huge files and have gone through them, all a part Patient 5.

Patricia K start going through cases, one step at a time, to see what we need from them. She will forward Patient 5 papers to him.

**Case 1** Patient 9

Hugh : Perso nal year old presented with urinary retention in May 19, he was assessed 3 weeks later PSA moderately elevated difficult to know if accurate level, clinical point of view suspicion of disease, June 2019 seen consultant and listed for TURP, to start on hormone therapy straight away , bicalutamide 50mgs. This is an unconventional dose.

Hormone therapy- try to block of testosterone on cancer, stop its fuel source, in 90% cases prostate cancer will stop growing and shrink. LHRH analogue given intramuscular injection every 6 months, this is standard treatment, blocks testosterone receptors, bicalutamide 150mg is not recommended, trials proven patients survive less longer, still used as introductory treatment, couple of weeks before definitive injection treatment. OK to give 50 mgs if there was intention to move over to LHRH in short term. Operation (TURP) was completed only 3grams tissue of removed. Note TURP is not diagnostic test. Cancer can be missed with TURP most cancers occur in the peripheral zone therefore trans rectal biopsy is best practice, Cannot rely on TURP – this management was unconventional.

2nd July after operation reviewed and still had some symptoms, give antibiotic with plan to review 2 /12 later. This did not happy, not clear why, definite note in the letter to say should be seen.

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Histology showed benign tumour, but there was not proper biopsy taken and treatment was stopped.

May 2020 patient presented to ED with urinary retention, on digital rectal examination noted clear advanced prostate cancer. Seen by urology and started on bicalutamide 50mgs as definitive treatment. This was inappropriate. Referred to general surgery as thought to be a rectal mass. examination showed mass and clear something was going on , biopsy taken by colorectal team confirmed prostate cancer and patient then commenced correct definitive treatment July 2020. MRI showed a fistula – faeces present in the catheter and urine through the rectum.

Hugh advised that one of the problems reading letters is that you don't really get the patients thoughts or feelings at the times. In this case the patient had had enough and did not want much done, suprapubic catheter insertion was reasonable.

In summary patient received inappropriate treatment in the hormone therapy unrecognisable dose not indicated there may have been some indication 150mg in the past, this is not practiced now, there was an inappropriate method or failed method of biopsy that really led to outcome. June patient was treated appropriately he may have had better outcome. Staging process was not effective, no bone scan CT.

Hugh advised he could formalise all of the above into a document.

PK: Look at the pathway, how did he fall below that.

Dermot advised it is important to know if decision made completely in isolation or patient not brought back for discussion.

Hugh advised the MDM decision in the timeline, I have not noted any discussion at MDM but there was no histopathological diagnosis of cancer and that was the problem, therefore not brought to MDM.

Dermot: Advised we can print of MDM discussions for each case.

Hugh that would be good could be added to timeline.

**2nd Case** [redacted]

This [redacted] year old gentleman, was exceptionally fit, MRI 2004 , in 2016 June had ultrasound scan revealed prevalence of cyst, solid mass renal cell carcinoma diagnosis radiological. 20mms size, surveillance option suitable at time and patient happy with this .

Going through all these cases, there were degrees of discussions given to patient but do not correspond terribly well. Patient may refute that, what was definitive and what actually happened was said.

Rescanned – measuring a lump fairly accurate thing (but there are observer variations sometimes. Don't be too fixed on exact figures), June 16 May 2017- looks stable had not really grown. July 2018

looks like rise in size from 23mm to 30 mm should have raised some concern. However March 2019 further scan believed stable changed mentioned in letter, fair although increase size. Nov 2019 it was 3.5cm. MDM team discussion throughout time, reference to meeting patient regarding partial nephrectomy July 2018, this did not happen, by November 2019, should have total nephrectomy. Cannot really decide without pictures if suitable for partial nephrectomy at the time. I would have to see actual picture for that.

Patricia K could get imaging sent over.

After that, that course probably reasonable, personally would be doing something around July 2018, prolong presentation and images, increase in size. If patient was involved in decision, then it was reasonable to observe. Patient had Cardiac history 2004, wife told cardiologist was expecting operation in 2019, but nothing happened, as if it was parked and waited. No harm done, query whether July 2016 if operation was to preserve kidney. Nov 2019 should have gone for nephrectomy, should have been done.

Dermot: discussion at MDM, throughout the time, reasonable to use surveillance through the time. July 2018 or around then there was a suggestion discussion about more active treatment.

March 2019 discussion should have happened, Letter around time the lesion was not changed. Pushing patient to have treatment in March as MDT had suggested it. Discussion re: radical surgery versus watchful waiting.

CT scan in November 2019, no report to patient or GP- seen or actioned.

Hugh: you would expect that, everything went cold around the time of the scan, would have expected scan to be discussed at MDT.

**Case 3** Patient 8

Personal year man, urinary tract symptoms, obstruction seen – flow rates on 27 Oct 2014. TURP PSA 1.2. Sat on waiting list for OPD appointment. Feb 2017 was, seen by registrar for flow rates, small residual volume, did not require treatment. GP letter late 2019, resulted in a letter of regret from consultant, people on waiting list from 2014 and that he was listed for TURP, routine operation the operation notes specify he should be followed up in April 2020, did not happen until August 2020. TURP histopathology showed prostate cancer, there would be an argument that discovery of prostate and low PSA further staging for disease, after period should have gone for CT scans lymph notes biopsy/ biopsy of peripheral zones. Again TURP is not the best method to determine prostate cancer, should have had completed investigations with further biopsy. 5 years ago watch and wait.

Issues in case: pathology not followed up for 6 months, would that effect the patient probably not, left strong argument, having discovered cancers should have considered further biopsy investigations. Not sure If patient came to harm, does highlight the case how patients get on.

Patricia K asked the question how much would covid have interfered with follow up in April 2020.

Hugh likely played a part whether it should have or not. Throughout Covid period I was continuing clinics throughout.