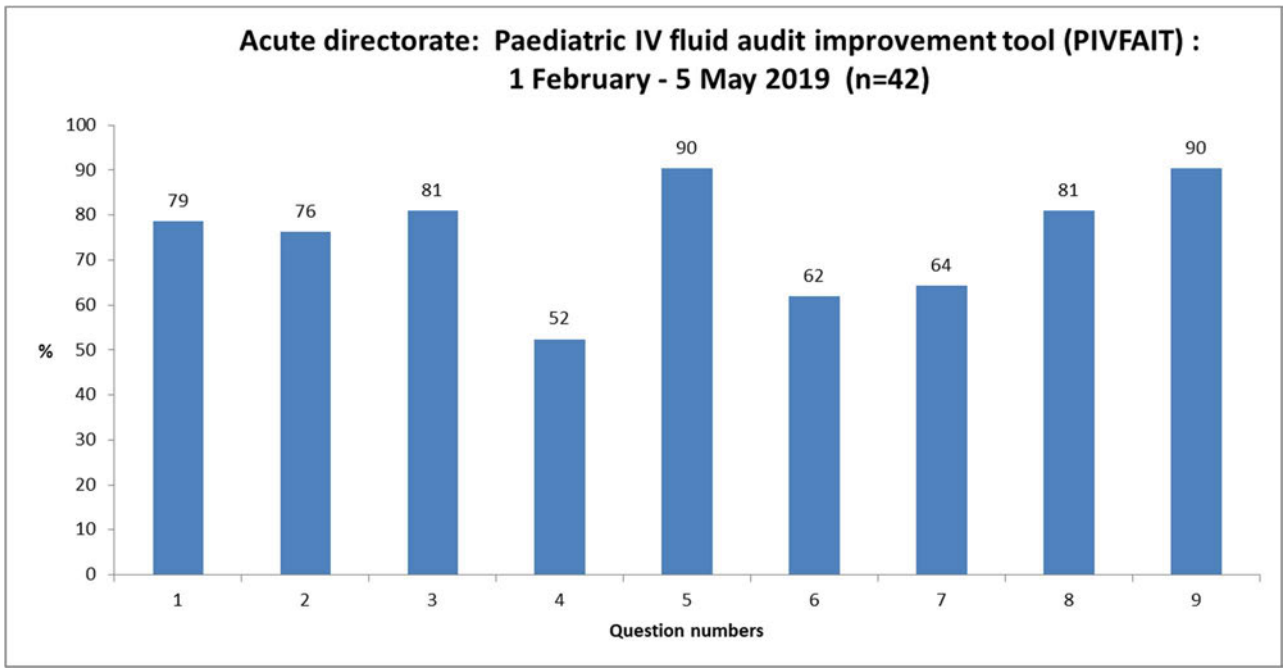
By Indicator / Question



Summary points

- 42 cases reviewed
- 8/42 cases fully compliant = 19%
- Indicators/ questions with poorest overall compliance were questions
    - 4 - Cumulative input and output totalling and fluid balance
    - 6 - Are the appropriate calculation guidance sections for the IV therapy completed?
    - 7 - Are there coded indications for the fluid administration provided?
- Remaining indicators / questions ranged from 76% to 90% compliance

Way forward

This report is to be shared with the monthly Acute Governance meeting and Mrs T Reid for the Southern Health and Social Care Trust Hyponatraemia Group.

SHSCT Clinical Audit Work Plan

Audit type (National, Regional, Local)	HQIP Audit Level tba=to be advised	Audit Year	Audit title	Name of Junior Doctor/HCP/ Auditor	Audit lead	Site	Acute Division	Status tba=to be advised
National HQIP	1	2019-20	NCEPOD Dysphagia in people with Parkinson's Disease study		NCEPOD Co-ordinators	CAH/DHH	?ATICS, CCS, IMWH, MUSC & SEC	Live audit
National HQIP	1	2018-19	National Comparative Audit of Blood Transfusion programme Audit of massive haemorrhage, Autumn 2018		Dr J Crockett	DHH	All	Completed
National HQIP	1	2016-17, 2017-18, 2018-19, 2019-20	Case Mix Programme (CMP) - ICNARC		Dr C Clarke	CAH	ATICS	Live audit
National HQIP	1	2018-19, 2019-20	NCEPOD Hospital management of out of hospital cardiac arrest		NCEPOD Co-ordinators	CAH/DHH	ATICS, CCS, IMWH, MUSC & SEC	Live audit
National HQIP	1	2018-19, 2019-20	NCEPOD Long Term Ventilation study		NCEPOD Co-ordinators	CAH/DHH	ATICS, CCS, IMWH, MUSC & SEC	Live audit
National HQIP	1	2018-19	Major Trauma Audit		Dr C Shevlin	CAH	ATICS, ICU	Regional workstream
National HQIP	1	2018-19, 2019-20	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Haemovigilance Team	Dr Mark Bridgham	CAH/DHH	CCS	Live audit
National HQIP	1	2018-19	National Audit of Care at the End of Life (NACEL)	In conjunction with HSCB, PHA Aileen Mulligan	Aileen Mulligan	CAH, DHH, Lurgan, STH & Gillis	Cross Directorate	Completed
National HQIP	1	2016-17, 2017-18, 2018-19	National Cardiac Arrest Audit (NCAA)		Resuscitation Officers Dr A Cullen	CAH, DHH	Cross specialty	Temporaily suspended due to GDPR issues
National HQIP	1	2017-18, 2018-19	*Peri-operative Management of Surgical Patients with Diabetes* (a) Informatics request to identify case selection by NCEPOD (b) Organisational questionnaire (c) Clinical case note review of cases selected by NCEPOD		Mr McArdle, Anne Quinn	CAH, DHH	Cross specialty	Completed
National HQIP	1	2018-19	National Comparative Audit of Blood Transfusion programme Audit of maternal anaemia, Autumn 2018 or Spring 2019 (to be performed by midwives and obstetricians only)		Dr Katherine Loane Dr Gillian Mc Keown	CAH/DHH	Cross specialty	Completed
National HQIP	1	2018-19	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Patient Safety Forum: Sepsis 6. Resource challenge -: Antibiotic resistance data & antimicrobial stewardship	Patient Safety Forum: Sepsis 6. Resource challenge -: Antibiotic resistance data & antimicrobial stewardship		Cross specialty	Regional Workstream
National HQIP	1	2018-19	Pulmonary Embolism		Mr G McArdle, DHH & NCEPOD Co-Ordinator, CAH	CAH, DHH	Cross specialty	Live audit
National HQIP	1	2019-20	Assessing Cognitive Impairment in Older People / Care in Emergency Departments		Dr Patton & Dr Mawhinney	CAH/DHH	ED	Planned audit
National HQIP	1	2019-20	Care of Children in Emergency Departments		Dr Patton & Dr Mawhinney	CAH/DHH	ED	Planned audit
National HQIP	1	2019-20	Mental Health - Care in Emergency Departments		Dr Patton & Dr Mawhinney	CAH/DHH	ED	Planned audit
National HQIP	1	2016-17, 2017-18, 2018-19, 2019-20	Maternal, Newborn and Infant Clinical Outcome Review Programme		Dr Adams Dr McCormick, Joan Boyce	CAH	IMWH	tba
National HQIP	1	2018-19	National Maternity and Perinatal Audit (NMPA)	Regional Workstream (NI Neonatal Network) Data collection England, Scotland and Wales.	Regional Workstream (NI Neonatal Network) Data collection England, Scotland and Wales.		IMWH	Regional Workstream
National HQIP	1	2018-19	National Diabetes Audit – Adults*		Dr M McConnell Data Collection in England	CAH	MUSC	Regional Workstream
National HQIP	1	2019-20	Sentinel Stroke National Audit Programme (SSNAP) Acute organisational questionnaire		Dr P McCaffrey, Dr B McGleenon	CAH/DHH	MUSC	Planned audit
National HQIP	1	2019-20	Society for Acute Medicine's Benchmarking Audit (SAMBA)		Dr C Byrne	CAH	MUSC	Planned audit
National HQIP	1	2017-18, 2018-19, 2019-20	National Audit of Percutaneous Coronary Interventions (PCI)		Dr I Menown, N Archer	CAH	MUSC, Cardiology	Live audit
National HQIP	1	2017-18, 2018-19, 2019-20	Cardiac Rhythm Management (CRM)		Dr D Flannery Natalie Archer	CAH	MUSC, Cardiology	Live audit
National HQIP	1	2017-18, 2018-19, 2019-20	Myocardial Ischaemia National Audit Project (MINAP)	Denise Nelson	Denise Nelson	CAH	MUSC, Cardiology	Live audit
National HQIP	1	2017-18, 2018-19, 2019-20	National Audit of Cardiac Rehabilitation		Sean Cartmill (CAH) Siobhan Quinn(DHH) Ruth Porter (A/D)	Cross site	MUSC, Cardiology	Continuous
National HQIP	1	2018-19	National Heart Failure Audit	data access issues, NI Dr P Campbell, in conjunction with UoU	Dr P Campbell	tba	MUSC, Cardiology	Data access issues being clarified
National HQIP	1	2018-19	Feverish Children (care in emergency departments)		Dr E McCormick, Dr Mawhinney	CAH, DHH	MUSC, ED	Completed
National HQIP	1	2018-19	VTE risk in lower limb immobilisation (care in emergency departments)		Mr Patton, Dr Mawhinney	CAH, DHH	MUSC, ED	Completed
National HQIP	1	2018-19	Vital Signs in Adults (care in emergency departments)		Dr H Nicholl, Dr Mawhinney	CAH, DHH	MUSC, ED	Completed
National HQIP	1	2018-19, 2019-20	National Audit of Community Acquired Pneumonia		Dr L Polley Dr R Convery	CAH	MUSC, General Medicine	Live audit
National HQIP	1	2018-19	National Audit of Non-invasive Ventilation		Dr R Convery	CAH	MUSC, General Medicine	Live audit
National HQIP	1	2018-19	Long-term ventilation		Mr G McArdle, DHH & NCEPOD Co-Ordinator, CAH	CAH, DHH	MUSC, General Medicine	Live audit
National HQIP	1	2016-17, 2017-18, 2018-19, 2019-20	National Sentinel Stroke National Audit programme (SSNAP)		Dr P McCaffrey, Dr B McGleenon	CAH, DHH	MUSC, General Medicine, AHP	Live audit
National HQIP	1	2018-19	National Lung Cancer Audit (NLCA)	Peer review processes in NI (NICaN), as data access issues, NI Data Collection England & Wales only.	Peer review processes in NI (NICaN), as data access issues, NI Data Collection England & Wales only.		MUSC, Respiratory	Regional Workstream

National HQIP	1	2018-19	National Audit of Breast Cancer in Older People	Peer review processes in NI (NICaN), as data access issues, NI Data Collection England & Wales only.	Peer review processes in NI (NICaN), as data access issues, NI Data Collection England & Wales only.		SEC	Regional Workstream
National HQIP	1	2018-19	National Prostate Cancer Audit	Peer review processes in NI (NICaN), as data access issues, NI Data Collection England & Wales only.	Peer review processes in NI (NICaN), as data access issues, NI Data Collection England & Wales only.		SEC	Regional Workstream
National HQIP	1	2018-19	National Oesophago-gastric Cancer (NAOGC)	Peer review processes in NI (NICaN), as data access issues, NI Data Collection England & Wales only.	Peer review processes in NI (NICaN), as data access issues, NI Data Collection England & Wales only.		SEC	Regional Workstream
National HQIP	1	2018-19	National Bowel Cancer Audit (NBOCA)	Peer review processes in NI (NICaN), as data access issues, NI Data Collection England & Wales only.	Peer review processes in NI (NICaN), as data access issues, NI Data Collection England & Wales only.		SEC	Regional Workstream
National HQIP	1	2018-19	Acute Bowel Obstruction		Mr G McArdle, DHH & NCEPOD Co-Ordinator, CAH	CAH, DHH	SEC	Live audit
National HQIP	1	2016-17, 2017-18, 2018-19	Falls and Fragility Fractures Audit Programme (FFFAP)* National Hip Fracture Database		Mr S Patton	CAH	SEC	Continuous
National HQIP	1	2018-19, 2019-20	NCEPOD Acute Bowel Obstruction study		NCEPOD Co-ordinators	CAH/DHH	SEC	Live audit
National HQIP	1	2019-20	National Emergency Laparotomy Audit (NELA)		Ms S Yoong	CAH	SEC	Planned audit
National HQIP	1	2018-19	National Emergency Laparotomy Audit (NELA)		Ms S Yoong	CAH, DHH	SEC, General Surgery	Data access issues being clarified
National HQIP	1	2018-19	Surgical Site Infection Surveillance Service		Patient Safety Forum: surgical site infection: C.Section and Orthopaedic surgery.	CAH, DHH	SEC, General Surgery IMWH, Maternity Atics, theatres	Regional Workstream
National HQIP	1	2016-17, 2017-18, 2018-19, 2019-20	National Joint Registry (NJR)	Dr R Pagoti	Mr M Murnaghan	CAH	SEC, T&O	Continuous
National HQIP	2	2017-18, 2018-19, 2019-20	UK Parkinson's audit transforming care		Dr D Craig Dr P McCaffrey	CAH	Cross Directorate	Completed
National Other	2	2018-19	REspiratory COmplications after abdomiNal Surgery (RECON)	Ivan Kewk	Mr R Brown Mr Epanomeritakis	CAH/DHH	ATICS, SEC, IMWH	Live audit
National Other	2	2017-18, 2018-19	National survey of assessment / management of older people in hospitals		Dr P McCaffrey Roisin Toner	tba	MUSC, General Medicine, OPPC, SEC	Completed
National Other	2	2018-19	Head and neck cancer surveillance audit, 2018	Dr N Hope	Mr R Gurunathan	CAH	SEC, ENT	Completed
Regional	1	2019-20	National End of Life Care (NACEL)	David Calvin	Barry Conway	CAH/DHH/ STH/Lurgan	ATICS, CCS, IMWH, MUSC & SEC, OPPC	Planned audit
Regional	2	2018-19	Adult asthma audit	Mrs K Carroll Cathrine Reid	Anne McVey, Roisin Toner Dr Christine McMaster (Public Health Agency)	CAH, DHH	All	Live audit
Regional	2	2018-19	RQIA/GAIN funded : Performance audit of ultrasound imaging systems within Northern Ireland	Josephine O'Connor	Barry Conway Dr George Dempsey, Head of Clinical Engineering & Physiological Sciences	tba	CCS	Regional workstream
Regional	2	2018-19	Regional audit of IV fluids in adults		Trudy Reid	CAH, DHH	Cross Directorate	Completed
Regional	2	2018-19	Audit of cost effective prescribing in outpatient clinics		Dr Boyce	CAH	Cross Directorate	Live audit
Regional	2	2018-19	IV fluids in Adults, SHSCT audit pre RQIA visit		Trudy Reid	CAH	Cross specialty	Completed
Regional	2	2018-19	Female genital mutilation		Patricia McStay Wendy Clarke Mrs H Trouton	CAH, DHH	IMWH	Live audit
Regional	2	2018-19	Snapshot audit : completion of clinical frailty scale on inpatients in CAH and off sites units to determine the % of inpatients requiring a comprehensive geriatric assessment		Dr P McCaffrey	Cross site	MUSC	Regional workstream
Regional	2	2019-20	Transforming MND Care 2019	Lisa Humphreys	Dr Colette Donaghy	RVH	MUSC	Due to commence 3rd April 19
Regional	2	2018-19	Audit of monitoring, compliance and discontinuation rates in patients with multiple sclerosis being treated with Tecfidera.	Jon McKee (Spr) & Fiona Thompson research nurse	Dr J Campbell	CAH	MUSC, General Medicine	Live audit
Regional	2	2018-19, 2019-20	Stroke Network Regional TIA Re-Audit	Noelleen Lambe	Emer Hopkins	CAH/DHH	MUSC, Stroke	Planned Mar 2019
Regional	3	2019-20	Total hips for trauma	Dr M McKee	Mr R McKeown	CAH	SEC T&O	live audit
Regional	tba	2018-19	Risk of Accidental Overdose of IV paracetamol (Safety & Quality Reminder of Best Practice (SQR / SAI 2017-031))		Sr L Spiers (CYP), Pat Nugent (OPPC), designated junior medical staff (Acute)	CAH, DHH	Cross Directorate	Live audit
Trust	2	2018-19	Audit of intravenous paracetamol		J Redpath	CAH	ATICS	Completed Reaudit scheduled for November 2018
Trust	2	2019-20	Cappuccini test Anaesthetics	Dr J Crockett, Dr G Gamble	Dr T Bennett, Dr J Brown	CAH/DHH	ATICS	Live audit
Trust	2	2019-20	Meropenem Audit	Geraldine Conlon-Bingham, Dr P Mckee	Dr S Hedderwick	CAH/DHH	ATICS, CCS, IMWH, MUSC & SEC	Live audit
Trust	2	2018-19	Improving the hand-over process from ICU to Medicine	Dr Wendy Baird, Dr Simon Wright, Dr Laura-Jane Mahon, Dr Bronagh Kelly	Dr Una Bradley, Dr C Clarke	CAH	ATICS, MUSC	Live audit
Trust	2	2016-17, 2017-18, 2018-19	Intravenous fluids in hospitalised children (1 month to the day before their 16th birthday)	Srs L Spiers & G Hill nominated leads (Acute)	Mrs B McGibbon (CYP) Assistant Directors (Acute)	CAH, DHH	Cross specialty	Live audit
Trust	2	2018-19	Importance of taking action on x-ray reports Learning letter (LL/SAI/2012/011 (AS) – 6 monthly audit requirement		tba	tba	Cross specialty	tba
Trust	2	2018-19	Documentation audit (Record keeping)	T McCann	W Clarke	tba	IMWH	Planned audit
Trust	2	2018-19	Re-audit on the management of epilepsy in pregnancy	tba	tba	tba	IMWH	tba
Trust	2	2018-19	Postnatal readmissions 2018	Laura Jane Mahon Rahul Savant Rebecca Spence	Dr E Boggs	CAH	IMWH	Live audit

Trust	2	2018-19	Audit of the outcomes of diabetic pregnancies 2013-2018		Dr S Finnegan	CAH	IMWH	Live audit
Trust	2	2018-19	Audit of the heart failure service in out-patients DHH	Dr B Kelly	Dr P Campbell	DHH	MUSC, Cardiology	Live audit
Trust	2	2019-20	Audit of intracerebral haemorrhage (ICH) Dr Watt DHH	Dr L Watt, Dr M Attard	Dr N Rizeq	DHH	MUSC, Care of Elderly / Stroke	Live audit
Trust	2	2018-19	Mental Health Risk Assessment Audit	Dr S Lenfesty	Dr M Perry	CAH	MUSC, ED	Completed
Trust	2	2018-19	Mental Health Risk Assessment Audit	Dr I Johnston	Dr R Spedding	DHH	MUSC, ED	Completed
Trust	2	2018-19	Oxygen prescribing audit		Dr R Convery	CAH	MUSC, General Medicine	Planned audit
Trust	2	2018-19	Use and appropriateness of AIRVO on inpatients	Dr D Cunningham	Dr U Bradley, Dr R Convery	CAH	MUSC, General Medicine	Completed
Trust	2	2018-19	Audit of non-invasive ventilation services, in line with NIV operational policy	Mrs K Carroll	Dr R Convery	CAH	MUSC, Respiratory	Planned Mar 2019
Trust	2	2018-19	Audit of Induction of warfarin in Southern Health and Social Care Trust	Pharmacy students	Sinead Doyle	CAH	Pharmacy	Live audit
Trust	2	2018-19	HSCNI Medication baseline Snap shot Audit February 2019	Clinical Pharmacists	Ann McCorry	Trust wide	Pharmacy	Live audit
Trust	2	2018-19	Magseed Characteristics	Dr S Small	Ms Helen Mathers	CAH	SEC, General Surgery	Live audit
Trust	2	2018-19	Anxiety related to Localisation technique in Breast Cancer	Dr S Small	Ms Helen Mathers	CAH	SEC, General Surgery	tba
Trust	2	2018-19	Headi injury driving advice	Susan Cull	Mr R Thompson	DHH	SEC, General Surgery	Live audit
Trust	2	2017-18, 2018-19	Small bowel obstruction	Miss Samantha Russell	Mr R Thompson	CAH, DHH	SEC, General Surgery	Awaiting presentation
Trust	2	2018-19	Shoulder Dislocation Audit	Phil McKeag	Dr R. McKeown	CAH	SEC, T&O	Completed
Trust	2	2018-19	Acute Kidney Injuries post-operatively in patients undergoing Total Hip Replacement	Dr C Goodland	Mr M Magill	CAH	SEC, T&O	Live audit
Trust	2	2018-19	Assessment of post op blood samples	Dr J Macdonald	Dr Rajkumar	CAH	SEC, T&O	Live audit
Trust	2	2018-19	Asymptomatic Bacteriuria: What is the evidence for current practice?	Dr A Mayne	Mr P Magill	CAH	SEC, T&O	Completed
Trust	2	2019-20	Audit of National Joint Registry consent process in Craigavon Area Hospital	David Milligan	Mr Jonathon Bunn	CAH	SEC, T&O	live audit
Trust	2	2018-19	Compliance to the NICE bladder cancer pathway	Dr Raymond Mark Evans	Mr A Glackin	CAH	SEC, Urology	Live audit
Trust	3	2018-19	ECHOs requested through the pre-op assessment clinic	Dr A Spence	tba	CAH	ATICS	Live audit
Trust	3	2019-20	First and Second generation Endometrial Ablation outcomes	C Skelly	Dr Kathy Niblock	CAH	IMWH	Live audit
Trust	3	2018-19	Fetal scalp Lactate as an alternative to fetal scalp pH.		Donna Mcloughlin	CAH	IMWH	Live audit
Trust	3	2018-19	Rates of Post Colonoscopy Colorectal Cancer in the Southern Trust	Dr P Rooney	Dr S Murphy	CAH/DHH	MUSC	Live audit
Trust	3	2019-20	Recording of chest x-ray interpreataion in ED Notes	Dr Michael Neill	Dr R Spedding	DHH	MUSC	Planned audit
Trust	3	2018-19	Review of management of acute heart failure in inpatient's in Craigavon area hospital	Dr E Banks	Dr McEneaney , Dr P Campbell	CAH	MUSC, Cardiology	Live audit
Trust	3	2018-19	Primary pneumothorax audit (inpatient)		Dr Convery	CAH	MUSC, General Medicine	Live audit
Trust	3	2018-19	Virtual neurology clinic		Dr J Campbell	CAH	MUSC, Neurology	Live audit
Trust	3	2018-19	Quantities of medications supplied at discharge for continuous subcutaneous infusion (CSCI) via syringe pump.	Anne McCord Claire Irwin	Ann McCorry	CAH	Pharmacy	Live audit
Trust	3	2018-19	Audit on the Implementation of the Warfarin Referral Form as part of the Electronic Discharge Letter	Pharmacy students	Sinead Doyle	CAH	Pharmacy	Live audit
Trust	3	2018-19	Prescribing of Lidocaine plasters on disharge precriptions from CAH	Sharon McCord	Lyn Watt	CAH	Pharmacy	Live audit
Trust	3	2018-19	An audit on the antibiotic use in Osteomyelitis patients in the Southern Trust	Cathy Jordan	Geraldine Conlon-Bingham	CAH	Pharmacy,AHP	Live audit
Trust	3	2018-19	Completion and documantation of pre operative mortality risk scoring in emergency laparotomy and level of post operative care	Dr C Aldworth	Mr C Weir	CAH	SEC	Live audit
Trust	3	2018-19	Retrospective audit of post tonsillectomy bleed rate	Dr D McCrory	Mr E Reddy	CAH	SEC, ENT	Completed
Trust	3	2018-19	Does orthogonal pelvic positioning at the beginning of surgery improve post-operative radiographic inclination of the acetabular component in Total Hip Replacement	Dr J MacDonald	Mr P Magill	CAH	SEC, T&O	Live audit
Trust	3	2018-19	Review of subacromial decompression outcomes	Dr Matthew Arneill	Mr Ronan McKeown	CAH	SEC, T&O	Live audit
Trust	3	2018-19	Osteochondral defect fixation early results	Dr A Bjourson	Mr S Rajkumar	CAH	SEC, T&O	Live audit
Trust	3	2018-19	Dexamethasone in the perioperative period for arthroplasty	Dr A Bjourson	Mr B Watson	CAH	SEC, T&O	Live audit
Trust	3	2018-19	Identification and Management of Urinary Tract Infections in Arthroplasty Patients	Dr M McKee	Dr G Findlayson	CAH	SEC, T&O	Live audit
Trust	3	2018-19	Analysis of wound swab usage and implication of results in clinical management for trauma ward patients September – November 2018	Niall Gallagher	Ms Lynn Wilson Mr Philip McCormac	Trust wide	SEC, T&O	Live audit
Trust	3	2018-19	Pre operative bloods for elective patients	Dr Robert Espey, Dr Muhammed Halil Zengin	Ms L Wilson	CAH	SEC, T&O	Live audit
Trust	3	2018-19	Stone MDT audit		Dr Mageean	CAH	SEC, Urology	Live audit
Trust	4	2018-19	Emergency equipment in theatre	Alison Blair	Dr Laure Martin	CAH	ATICS	Completed
Trust	4	2018-19	Survery of knowledge of drug interactions with Sugammadex	Alison Blair	Dr Kieran O'Connor	CAH	ATICS	Completed
Trust	4	2018-19	Perioperative lidnocaine infusion protocol	Dr Mark Maguire	Dr P Merjavy	Trust wide	ATICS	Live audit
Trust	4	2018-19	Day surgery analgesia	Dr Mark Maguire	Dr J Brown	Trust wide	ATICS	Live audit
Trust	4	2018-19	Completion of Mental Health Risk Assessment at Triage in the Emergency Department	Jayne Cuthbert	Dr Michael Perry	CAH	ED	Completed
Trust	4	2018-19	Audit of DCC over 120kg on NOAC within the last 6-12 months	Dr N McAleavey,	Dr M Moore, Dr A McClelland	CAH	MUSC, Cardiology	Deferred
Trust	4	2018-19	Recording of X ray interpretation in patient's notes: urgent and emergency cases	Dr L Cosbey	Not specified	CAH	MUSC, ED	Completed
Trust	4	2018-19	Asthma audit 2018	Noeleen Osborne, Eimear Devlin, Cliodhna Moriarty		CAH	MUSC, ED	Completed
Trust	4	2018-19	Hypoglycaemia Treatment Recommendations Audit	Barbara Pose	Laura Richardson	CAH	MUSC, Nursing 1 South	Live audit
Trust	4	2018-19	Audit of Controlled Drug Requisitions and their Compliance with Trust Standard Operating Procedures	Pharmacy students	Roberta Loughran Frances McKenna	CAH, DHH	Pharmacy	Live audit
Trust	4	2018-19	An audit of weight documentation and dose appropriateness on the medicines prescription and administration record (kardex)	Pharmacy students	Sara Laird	CAH	Pharmacy	Live audit
Trust	4	2018-19	To audit the use of Peripheral Parenteral Nutrition in adults, including the length of time patients receive PN and the amount of PN administered.	Pharmacy students	Karen Hewitt	CAH	Pharmacy	Live audit
Trust	4	2018-19	Inpatient prescriptions (kardex audit)	Pharmacy students	Jilly Redpath	CAH	Pharmacy	Live audit
Trust	4	2018-19	Antiemetic Prescribing for Postoperative Nausea & Vomiting	Pharmacy students	Sarah Wade	DHH	Pharmacy	Live audit
Trust	4	2018-19	Review of Antimicrobial Therapy within 48-72 hours	Pharmacy students	Geraldine Conlon-Bingham	CAH	Pharmacy	Live audit
Trust	4	2018-19	Audit of adherence to phosphate binders for patients on haemodialysis	Pharmacy students	Roisin Courtney / Joanne Lynch	DHH	Pharmacy	Live audit
Trust	4	2019-20	To determine if adding pre-admission medication to discharge summary improves discharge process	Shauna Brady	Heather Bell	CAH	Pharmacy	Planned audit
Trust	4	2019-20	Audit of thyroidectomy TMS	Dr A Kelly	Mr E Reddy	CAH	SEC	Live audit
Trust	4	2018-19	Success/Failure Septal perforation repair under Mr Farnan	Dr Marina Barron	Mr Turlough Farnan	CAH	SEC, ENT	Live audit
Trust	4	2018-19	Audit on rate of primary and post tonsillectomy haemorrhage in paediatric population.	Dr David McCrory	tba	CAH	SEC, ENT	tba
Trust	4	2018-19	Eosinophilic Oesophagitis- Are we missing it?	Dr G Jones	Mr R Thompson	DHH	SEC, General Surgery	Live audit
Trust	4	2018-19	A QI Project on examination of upper limb neurovascular status following injury and documentation of findings	Dr G Rainey, Dr J Corner	Mr D McMurray	CAH	SEC, T&O	Live audit
Trust	2	2018-19	Emergency Laparotomy performed during 01/03/17 - 01/03/18	Dr Nicola McKinley	Dr Nicola McKinley Ms Susan Yoong	CAH	SEC, General Surgery	tba
Trust	2	2018-19	Gastric Hyperplasia with OGD and biopsy	Dr S Small	Not specified	DHH	SEC, General Surgery	tba
Trust	2-4	2018-19	BCG audit		Ms Doherty	CAH	SEC, Urology	Completed
Trust	3	2018-19	Fascia Iliaca Blocks in Fractured Neck of Femur Patients	Dr R Walsh	Dr P Merjavy	CAH	ATICS	Completed
Trust	3	2018-19	Sinus surgery	Mr C Leonard	Not specified	CAH	SEC, ENT	tba
Trust	4	2018-19	Bronchosopy	Dr D McKeegan	Dr E Hayes	DHH	MUSC, General Medicine	tba
Trust	tba	2019-20	SHSCT Hyperkalaemia Audit		Dr P Sharpe	CAH	All	Completed
Trust	tba	2018-19	Rib Fracture Management: Introduction of a Rib Fracture Management Pathway	Dr S Cheuk	Dr C Shevlin	CAH	ATICS	Completed
Trust	tba	2018-19	Aspiration risk during General anaesthesia		tba	CAH	ATICS	Completed
Trust	tba	2017-18, 2018-19, 2019-20	Audit of twin clinic		Dr N Henderson	CAH	IMWH	Live audit

Trust	tba	2017-18, 2018-19	Audit of laparoscopic sacrocolpopexies/ cervicosacropexy, Craigavon Area Hospital	Dr C Daly	Dr E Boggs	CAH	IMWH	Completed
Trust	tba	2019-20	Prescribing of Enoxaparin on gynae ward	K Farley	Dr S Finnegan	CAH	IMWH	Live audit
Trust	tba	2019-20	Audit of 27 atypical hyperplasia	C Skelly	Dr G McCracken	CAH	IMWH	Live audit
Trust	tba	2019-20	Audit of the surgical checklist in maternity theatres	J Clendinning	Dr N Henderson	CAH	IMWH	Completed
Trust	tba	2019-20	Audit of midtrimester loss	G Radcliffe	Dr S Finnegan	CAH	IMWH	Live audit
Trust	tba	2019-20	Audit of primigravid deliveries in MLU and transfers to DS		M Dawson	CAH	IMWH	Live audit
Trust	tba	2019-20	Audit of communication between EPPC and ANC in the event of pregnancy loss		O Kelly	CAH	IMWH	Live audit
Trust	tba	2019-20	Accuracy of late trimester scanning for EFW in DOU	SM E Thompson/ M Byrne	A McGeown	CAH	IMWH	Live audit
Trust	tba	2019-20	Failure of Ovarian Screening	Dr Ghazala Khan	Mr R de Courcy-Wheeler	DHH	IMWH	Live audit
Trust	tba	2019-20	Audit of Robson 2A: nullips, CS not in labour in year 2018	Tom Magee, Ciaran McKernan	Mr R de Courcy-Wheeler	DHH	IMWH	Live audit
Trust	tba	2019-20	CS scar ectopic pregnancies		Dr T Hadjieva	CAH	IMWH	Planned audit
Trust	tba	2019-20	Fertility IOU outcomes	Aine	Dr Knox	CAH	IMWH	Planned audit
Trust	tba	2019-20	Length of stay for hyperemesis		Dr Currie	CAH	IMWH	Planned audit
Trust	tba	2019-20	VTE risk assessment and suggested protocol for Gynae inpatients	Dr Rebecca Reid	Dr S Finnegan	CAH	IMWH	Completed
Trust	tba	2018-19	Quality assure follow up of patients at discharge (ad hoc audit)		Katherine Robinson booking centre manager	CAH	MUSC	Completed
Trust	tba	2018-19	DKA note keeping audit	Dr McCarthy	Dr S Budd	CAH	MUSC, ED	Completed
Trust	tba	2018-19	HIV and Post Exposure Prophylaxis PPSE following sexual exposure (PL/2015/006)		tba	tba	MUSC, ED, IMWH, Pharmacy	tba
Trust	tba	2018-19	Acute Cholecystitis management	Dr Lara Armstrong		CAH	SEC	tba
Trust	tba	2018-19	Diverticular Disease	Dr Lara Armstrong		CAH	SEC	tba
Trust	tba	2019-20	Re-Audit on last minute theatre cancellations	Dr D McCrory		CAH	SEC, ENT	Completed
Trust	tba	2018-19	Post Operative Calcium Management Following Thyroid Surgery		Mr N Hope	CAH	SEC, ENT	Completed
Trust	tba	2019-20	Re-audit of OGDs for dysphagia:	Dr G Jones		CAH	SEC, General Surgery	Completed
Trust	tba	2018-19	Ambulatory Care Craigavon Emergency Surgical Service (ACCESS)	Mr R Mayes	Ms S Yoong	CAH	SEC, General Surgery	Live audit
Trust	tba	2018-19	Audit of pre-operative mortality scoring, consultant theatre presence and critical care admission in emergency laparotomies (NELA)	Dr C Aldworth		CAH	SEC, General Surgery	Completed
Trust	tba	2019-20	Pts BMI vs HR of surgeon study	G Finlayson/ D Milligan		CAH	SEC, T&O	live audit
Trust	tba	2019-20	Proximal humeral fractures – time to surgery	Dr R Lloyd/G McCrabbe		CAH	SEC, T&O	live audit
Trust	tba	2019-20	Time to surgery for fractures/cost/numbers	Dr R Lloyd/ Dr M McKee		CAH	SEC, T&O	live audit
Trust	tba	2019-20	Osteocondral darts, follow up	A Bjourson / G McCrabbe		CAH	SEC, T&O	live audit
Trust	tba	2019-20	Removal of Pelvic Binder Protocol Re-audit'	Dr M Arneill		CAH	SEC, T&O	Live audit
Trust	tba	2019-20	TRUS biopsy of prostate service	Sr Kate O'Neill		CAH	SEC, Urology	Completed
Trust	tba	2019-20	Audit of waiting times for surgery of patients with indwelling ureteric stents		Mr Hiew and Mr Young	CAH	SEC, Urology	Live audit

HQIP Quality Accounts list 2019-20 for validation by clinical teams

National Clinical Audit and Clinical Outcome Review Programme	Host Organisation	Will SHSCT be participating?	Audit Lead
Endocrine and Thyroid National Audit	British Association of Endocrine and Thyroid Surgeons (BAETS)	TBA	
National Smoking Cessation Audit	British Thoracic Society (BTS)	TBA	New audit - date collection will be : 1/7/2019 - 31/8/2019
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	IBD Registry Ltd	TBA	Has the Regional IBD registry software been developed?
Surgical Site Infection Surveillance Service	Public Health England (PHE)	TBA	
National Audit of Seizure Management in Hospitals (NASH3)	University of Liverpool	TBA	
Assessing Cognitive Impairment in Older People / Care in Emergency Departments	Royal College of Emergency Medicine (RCEM)	yes	Dr Patton & Dr Mawhinney
Care of Children in Emergency Departments	Royal College of Emergency Medicine (RCEM)	yes	Dr Patton & Dr Mawhinney
Mental Health - Care in Emergency Departments	Royal College of Emergency Medicine (RCEM)	yes	Dr Patton & Dr Mawhinney
Case Mix Programme (CMP)	Intensive Care National Audit and Research Centre (ICNARC)	yes	Dr C Clarke
Child Health Clinical Outcome Review Programme Long-term ventilation in children, young people and young adults	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	yes	Acute & CYP Directorates
Medical and Surgical Clinical Outcome Review Programme 1. Dysphagia in Parkinson's Disease	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	yes	TBA
Medical and Surgical Clinical Outcome Review Programme 2. In-hospital management of out-of-hospital cardiac arrest	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	yes	TBA
National Cardiac Audit Programme (NCAP) Myocardial Ischaemia National Audit Project (MINAP)	Barts Health NHS Trust	yes	Denise Nelson
National Cardiac Audit Programme (NCAP) National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Barts Health NHS Trust	yes	Dr I Menown
National Cardiac Audit Programme (NCAP) National Audit of Cardiac Rhythm Management (CRM)	Barts Health NHS Trust	yes	Natalie Archer
Sentinel Stroke National Audit programme (SSNAP)	King's College London	yes	CAH-Dr P McCaffrey Dr B McGleenon
Maternal, Newborn and Infant Clinical Outcome Review Programme	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK)	yes	Dr Adams Dr McCormick, Joan Boyce
Mental Health Clinical Outcome Review Programme	National Confidential Inquiry into Suicide and Homicide in Mental Health (NCISH)	yes	Mr T Black, Dr P McMahon
National Audit of Intermediate Care (NAIC)	NHS Benchmarking Network	yes	Catherine Sheeran
UK Parkinson's Audit	Parkinson's UK	yes	Dr McCaffrey Audit data collection period: 01/05/19- 30/9/19
National Joint Registry (NJR)	Healthcare Quality Improvement Partnership (HQIP)	yes	Mr M Murnaghan
Prescribing Observatory for Mental Health (POMH-UK)	Royal College of Psychiatrists (RCPsych)	yes	Dr P McMahon; Aaron Coulter
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Serious Hazards of Transfusion (SHOT)	yes	Dr Mark Bridgham

Received from SHSCT 05/05/2023. Annotated by the Urology Services Inquiry.

National Clinical Audit and Clinical Outcome Review Programme	Host Organisation	Will SHSCT be participating?	Audit Lead
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Society for Acute Medicine (SAM)	yes	Dr C Byrne
National Audit of Cardiac Rehabilitation (NACR)	University of York	yes	Sean Cartmill, Siobhan Quinn, Ruth Porter
National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network	yes	**David Calvin Regional audit For NI**
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists (RCOA)	yes	Ms S Yoong -challenge with regard to the legalities of data collection specific to Northern Ireland
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC) / Resuscitation Council UK	GDPR issues	Dr A Cullen
BAUS Urology Audit - Cystectomy	British Association of Urological Surgeons (BAUS)	GDPR issues	Update from Mr Glackin: Due to current advice from DoH in NI we do not submit any date to BAUS audits due to concerns regarding data governance and control
BAUS Urology Audit - Female Stress Urinary Incontinence	British Association of Urological Surgeons (BAUS)	GDPR issues	
BAUS Urology Audit - Nephrectomy	British Association of Urological Surgeons (BAUS)	GDPR issues	
BAUS Urology Audit - Percutaneous Nephrolithotomy	British Association of Urological Surgeons (BAUS)	GDPR issues	
BAUS Urology Audit - Radical Prostatectomy	British Association of Urological Surgeons (BAUS)	GDPR issues	
Perioperative Quality Improvement Programme (PQIP)	Royal College of Anaesthetists	No	Email from Dr Scullion (26/3/19): There is considerable enthusiasm for this but it would require considerable investment and support
National Cardiac Audit Programme (NCAP) National Congenital Heart Disease (CHD)	Barts Health NHS Trust	N/A to SHSCT	Congental heart dsease in under 18s - Belfast Trust
National Cardiac Audit Programme (NCAP) National Adult Cardiac Surgery Audit	Barts Health NHS Trust	N/A to SHSCT	Service not provided by SHSCT
National Bariatric Surgery Registry (NBSR)	British Obesity and Metabolic Surgery Society (BOMSS)	N/A to SHSCT	Service not provided by SHSCT
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	N/A to SHSCT	Service not provided by SHSCT
National Ophthalmology Audit (NOD)	Royal College of Ophthalmologists (RCOphth)	N/A to SHSCT	Service managed by BHSCT
National Vascular Registry	Royal College of Surgeons (RCS)	N/A to SHSCT	Index cases are carried out in Belfast Trust
Neurosurgical National Audit Programme	Society of British Neurological Surgeons	N/A to SHSCT	Service not provided by SHSCT
Paediatric Intensive Care Audit Network (PICANet)	University of Leeds / University of Leicester	N/A to SHSCT	Service provided by BHSCT
Falls and Fragility Fractures Audit programme (FFFAP)	Royal College of Physicians (RCP)	Not eligible	not commissioned in NI hence not currently participating
National Cardiac Audit Programme (NCAP) National Heart Failure Audit	Barts Health NHS Trust	Not eligible	Data Collection England & Wales
National Early Inflammatory Arthritis Audit (NEIAA)	British Society for Rheumatology (BSR)	Not eligible	Data Collection England & Wales
Mental Health Care Pathway - CYP Urgent & Emergency Mental Health Care and Intensive Community Support	National Collaborating Centre for Mental Health (NCCMH)	Not eligible	Data collection England
Elective Surgery - National PROMs Programme	NHS Digital	Not eligible	Data collection England
National Audit of Pulmonary Hypertension (NAPH)	NHS Digital	Not eligible	Data Collection England & Scotland

Received from SHSCT 05/05/2023. Annotated by the Urology Services Inquiry.

National Clinical Audit and Clinical Outcome Review Programme	Host Organisation	Will SHSCT be participating?	Audit Lead
National Diabetes Audit – Adults	NHS Digital	Not eligible	Data Collection England
National Gastro-intestinal Cancer Programme	NHS Digital	Not eligible	Data Collection England & Wales
clostridium difficile infection	Public Health England (PHE)	Not eligible	Data Collection England
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Public Health England (PHE)	Not eligible	Data Collection England
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Royal College of Paediatrics and Child Health (RCPCH)	Not eligible	Data Collection England, Scotland and Wales
National Maternity and Perinatal Audit (NMPA)	Royal College of Paediatrics and Child Health (RCPCH)	Not eligible	Data Collection England, Scotland and Wales
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Royal College of Paediatrics and Child Health (RCPCH)	Not eligible	Data Collection England, Scotland and Wales
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health (RCPCH)	Not eligible	Data Collection England & Wales
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	Royal College of Physicians (RCP)	Not eligible	Data Collection England, Scotland and Wales
National Lung Cancer Audit (NLCA)	Royal College of Physicians (RCP)	Not eligible	Data Collection England & Wales
National Audit of Dementia (Care in general hospitals)	Royal College of Psychiatrists (RCPsych)	Not eligible	Data Collection England & Wales
National Clinical Audit of Anxiety and Depression	Royal College of Psychiatrists (RCPsych)	Not eligible	Data Collection England & Wales
National Clinical Audit of Psychosis	Royal College of Psychiatrists (RCPsych)	Not eligible	Data Collection England & Wales
National Audit of Breast Cancer in Older People (NABCOP)	Royal College of Surgeons (RCS)	Not eligible	Data Collection England & Wales
National Prostate Cancer Audit	Royal College of Surgeons (RCS)	Not eligible	Data Collection England & Wales
Head and Neck Audit (HANA)	Saving Faces	Not eligible	Data Collection England & Wales
Major Trauma Audit	Trauma Audit Research Network (TARN)	Not eligible	Data Collection England & Wales

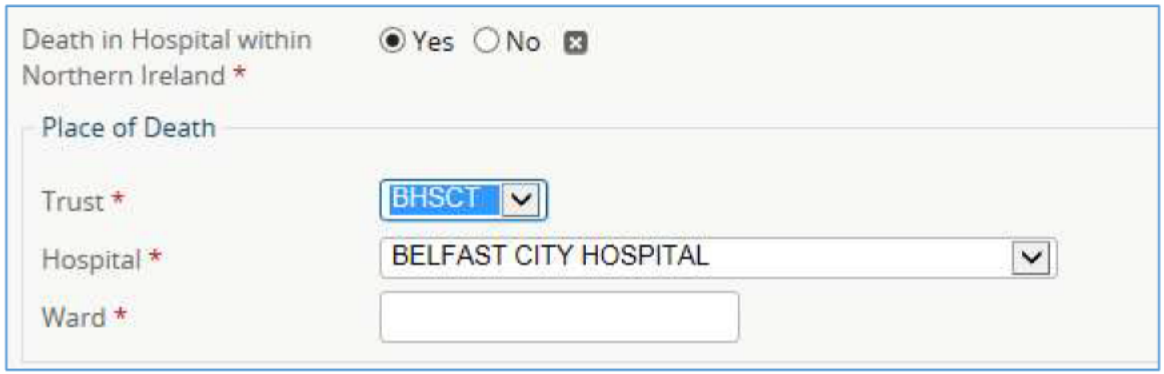
Acute Standards & Guidelines where there is an audit requirement
Report Date: 23/03/2018

Title of Correspondence	Date of Issue from External Agency	Reference	Guidance Type	Full Implementation Date for S&G	Acute Clinical Change Lead	Audit Requirement Y/N	Directorates applicability	Acute Directorate Compliance Rating	Acute Risk Rating	Acute Progress Update
Policy for the Identification of Labelling of Invasive Lines and Tubes - Regional Audit Tool	08/12/2017	Not specified	CMO Letter		Lead Nurse, Midwifery, AHP & Radiography S&G Forum	Yes	Lead Acute, CYPS , OPPC		LOW	05/01/2018 - The Trust have received the newly updated regional policy (version 0.3). This has now been signed by the Medical Director and sent to the Clinical Guidelines team for uploading on the trust intranet. A review of the posters indicate no change from the previous version so no change in posters required at local level. A new regional audit tool has also been developed by RQIA and this has been appendiced within the new policy for use by front line staff (induction and ongoing monitoring). A regional CAG meeting is scheduled for January 2018 to review the contract arrgangments for the labels and Trudy Reid to feedback to the Change Lead forum
Risk of accidental overdose of IV paracetamol	15/11/2017	SQR-SAI-2017-031 (AS & MCH)	Safety and Quality Reminder of Best Practice Guidance	01/03/2018	Acute Standards & Guidelines Forum	Yes	LEAD CYPS, Acute, OPPC		MEDIUM	21/11/2017 Update from Acute S&G Group - Trudy has asked for this to be added to the next Governance Co-ordinators forum for discussion and asked CYP to confirm if they are happy to to support the guidance in the document from the Belfast Trust in relation to prescribing and administration of IV paracetamol for neonates, infants and children. J Redpath will draft an action plan for tabling at Acute S&G forum on the 05/12/2017. 18/01/2018 - Memo highlighting actions to be taken by staff has been forwarded from Acute Directors Office to Clinical Leads for sharing with relevant staff. Update 07/03/2018 - Draft action plan has been completed to indicate the Directorate's compliance position and is awaiting approval at the Acute S&G forum scheduled for 06/03/2018. Audit tool has been developed - Dr Currie has agreed for junior medical staff to complete the data collection in CAH by 31/03/2018; Dr Harty has agreed for junior medical staff to complete on the DHH site.
Departmental Endorsement - Intravenous Fluid Therapy for Children and Young People in Hospital (CR NICE NG 29)	06/09/2017	HSS (MD) 16/2017	CMO Letter	01/09/2017	Acute Representation - Dr Rodgers, Dr O'Connor, Dr McCormick, Sharon Holmes, Dr McCracken, Wendy Clarke	Yes	Acute, CYPS		HIGH	Medical Director will convene a cross directorate meeting on the 26/01/18. Acute Representation to this group: - Dr Rodgers, Dr O'Connor, Dr McCormick, Sharon Holmes, Dr McCracken, Wendy Clarke
Reducing the risk of retained throat packs after surgery	02/06/2017	SQR-SAI-2017-026	Safety Quality Reminder of Best Practice Guidance	31/08/2017	Helena Murray	Yes	Acute			
Central Alerting System: Resources To Support The Care Of Patients With Acute Kidney Injury (AKI)	29/09/2016	HSC (SQSD) 48/16	Patient Safety Alert	29/10/2016	Dr John Harty (Acute Services)	Yes	Acute, CYP, OPPC	Y		
Routine Preoperative Tests for Elective Surgery.	27/05/2016	NG 45	NICE Clinical Guideline	27/05/2017	Dr N Rutherford Jones/Mrs M McGeough	Yes	Acute, CYP	PC [I]		June 2017 - Risk not yet determined.
Policy on the Surgical Management of Endoscopic Tissue Resection **REVISED** **cross ref draft policy**	07/09/2015	HSS(MD)14 /2015	CMO Letter	14/11/2015	IMWH: Dr McCracken, Wendy Clarke SEC: Mr M Young, Martina Corrigan ATICS: Dr C McAllister, Mary McGeough, Brigeen Kelly	Yes	Acute	PC		The 5 POCT machines that have been purchased, calibrated and training is completed. An SOP to be developed to ensure that there is restrictions in place for these users. Standard Operating Procedures for the Management of irrigation fluids for patients undergoing TCRE/TCRF/TURP/TURB/TART continues to be progressed. Equipment trials have now completed and the product evaluation and decision making processes to determine the most suitable medical device to purchase continues. 24/01/208 – met with Helena Murray as part of quarterly HoS meeting schedule. She confirmed that the funding for the purchase of the bipolar equipment had been allocated and this equipment has now been procured for urology theatres. It is anticipated the equipment will arrive in February / March 2018. Once it has been commissioned for use, with the appropriate SoP written and training provided to staff the action plan supporting the implementation of the regional policy will be reviewed and updated to indicate progress and overall compliance For review at the next meeting scheduled for 18/04/2018. Update 06/03/2018 - Funding has been secured for the new urology scopes. Timescales for completion of implementation plan (Commissioning/training) to be determined
HIV and Post Exposure Prophylaxis (PEP) Following Sexual Exposure	12/06/2015	PL/2015/006	PHA Letter	07/08/2015		Yes	Acute, OPPC	C	LOW	April 2016 compliance position: This work will be progressed alongside the following 2 documents HSS (MD) 23/2010 and HSS (MD) 34/2008 Aworking group is currently being set up with representatives from IMWH, ED and GP Out of Hours. The working group will also agree a suitable audit proforma that will allow an audit to be undertaken and therefore fulfill the requirements of recommendation 3. 05/12/2016 - Meeting held on 02/12/16 with Mrs Anne McVey chairing the forum. Trust PEPSE policy to be reviewed and updated and audit processes to support 2015 learning letter to be determined. 23/06/2017 - Meeting held on 02/12/16 with representation from ED, IMWH, GPOoH and Audit. Trust PEPSE policy has been updated and circulated on the 06/12/16 for comment/approval. An audit tool has been developed and will be used for future audit work scheduled for after August 2017. Mr Johnny Fyffe has recently recirculated the draft policy and this was discussed at the IMWH S&G Workshop on the 10 May 2017. Patricia McStay will follow up to ensure implementation. CMcN shared GPOOHs Action plan- Trust compliant Link with other S&G on similar title Trust guidance for PEPSE was discussed at the Acute S&G meeting on the 20/02/2018 - refer to notes for agreed actions.
Bladder Cancer: Diagnosis and Management	17/04/2015	NG 2	NICE Clinical Guideline	17/04/2016	Mr Mark Haynes/Mr Tony Glackin	Yes	Acute , OPPC	PC [I&E]		April 2016 compliance position: Baseline assessment tool has been reviewed and completed by Mr Mark Haynes. A number of areas of non-compliance have been identified and a meeting has been arranged for 28/04/2016 to discuss and ascertain if there are any external barriers impeding implementation. June 2017 - Risk to be determined. 30/10/17: The need to review this E proforma was raised at last ATICS/SEC divisional governance meeting on 9/9/2017. Meeting scheduled with Mrs Martina Corrigan on 25/10/2017 to review and determine way forward Update 06/03/2018 - Meeting has been held with Martina Corrigan 20/02/2018 and the updated baseline assessment tool and E Proforma have been sent to Clinical Change Leads for final approval.
Harm from flushing of nasogastric tubes before confirmation of placement	03/04/2012	HSC (SQSD) 2/2012	NPSA Alert	03/09/2012		Yes	Acute, OPPC	C	LOW	
Better Blood Transfusion 3 Northern Ireland (BBT3 NI)	24/08/2011	HSS (MD) 17-2011	CMO Letter	30/12/2011		Yes	Acute, OPPC	PC		April 2016 compliance position: The Better Blood Transfusion Team reviewed those recommendations relevant to CCS and updated the action plan to provide a February 2016 compliance position. The anaemia in pregnancy guideline was approved and has been on the intranet for a few years. One of the f2 doctors is currently auditing this in DHH. There is a well-established referral pathway to Dr Catherine Boyd, consultant haematologist, for advice relating to antenatal patients. There is a joint haematology antenatal clinic in Belfast for complex cases There are only 3 areas were compliance is not 100% (3.3, 3.8 and 5.5) and this needs to be reviewed by the TTT to monitor progress.
Reducing the risk of retained swabs after vaginal delivery and perineal suturing	10/06/2010	HSC (SQSD) 09/2010 NPSA/201/RRR012	NPSA Alert	10/12/2010		Yes	Acute	C	LOW	
Checking pregnancy Before Surgery	04/06/2010	HSC (SQSD) 07/2010 NPSA/201/RRR011	NPSA Alert	04/12/2010		Yes	Acute, CYP	C	LOW	
Early Detection of complications following gastrostomy	04/06/2010	HSC (SQSD) 06/2010 NPSA/201/RRR010	NPSA Alert	03/12/2010		Yes	Acute, OPPC, CYP	C	LOW	

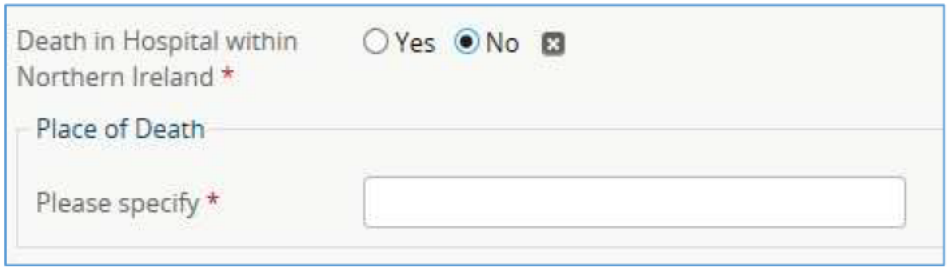
PROPOSED CHANGES TO RM&MRS ON NIECR – JANUARY 2019 RELEASE

Initial Record of Death (IRD)

1. Place of Death
   Checkbox added = *'Death in Hospital within Northern Ireland'*
   If answer "YES" → then select Trust and complete Hospital & Ward.



2. If answer "NO" → then supply full postal address (e.g. home address).

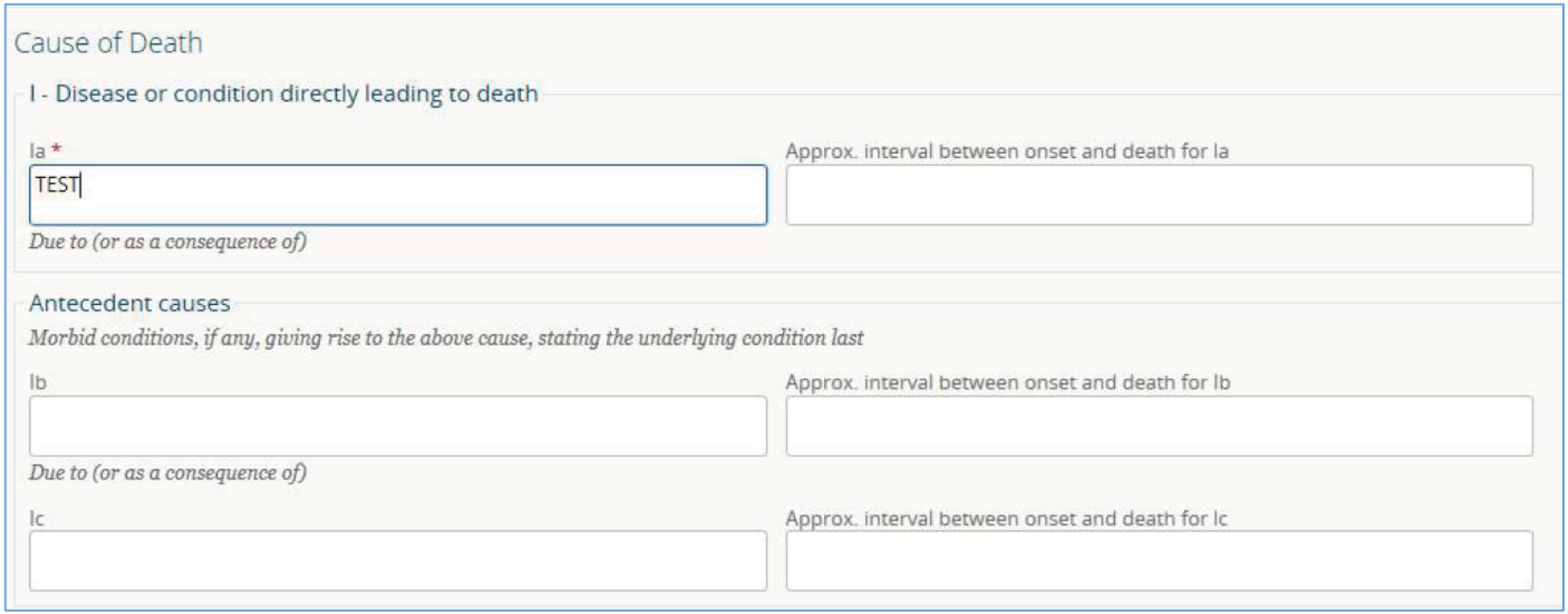


Useful for Acute Care at Home Teams, if death in NI but not in hospital to be recorded and a MCCD is required or Coroner details needed. A free text box will appear to allow the place of death to be recorded (home address). Everything else about certifying and reviewing the case will be the same as for a hospital death.

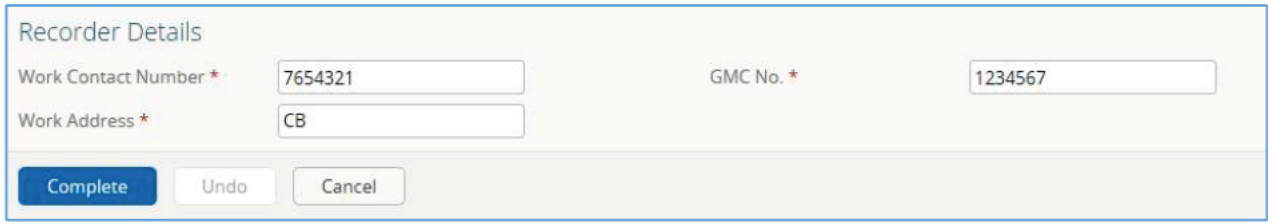
3. There are terminology changes made throughout the system,
   - Initial Review Team has been changed to the Primary Review Team,
   - in the meeting context, the term 'Additional Team' has been changed to 'Joint Team'. This is because 'Additional Team' is used elsewhere to denote another team who have interacted with the deceased during their final episode and who will complete their own M&M review.

4. Additional team search will use the same Hospital dropdown list as the Place of Death (point 1).

5. Update layout of MCCD outcome in IRD to align Cause of Death disease information & approximate interval information.



6. Autofill of the IRD recorder details & date created removed from end of form.
(details for the MCCD/Clinical Summary will be taken from the log-in details of the person 'completing' the form).

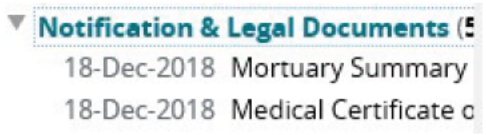


7. Appearance of Medical Certificate of Cause of

GUIDANCE MCCD.pdf

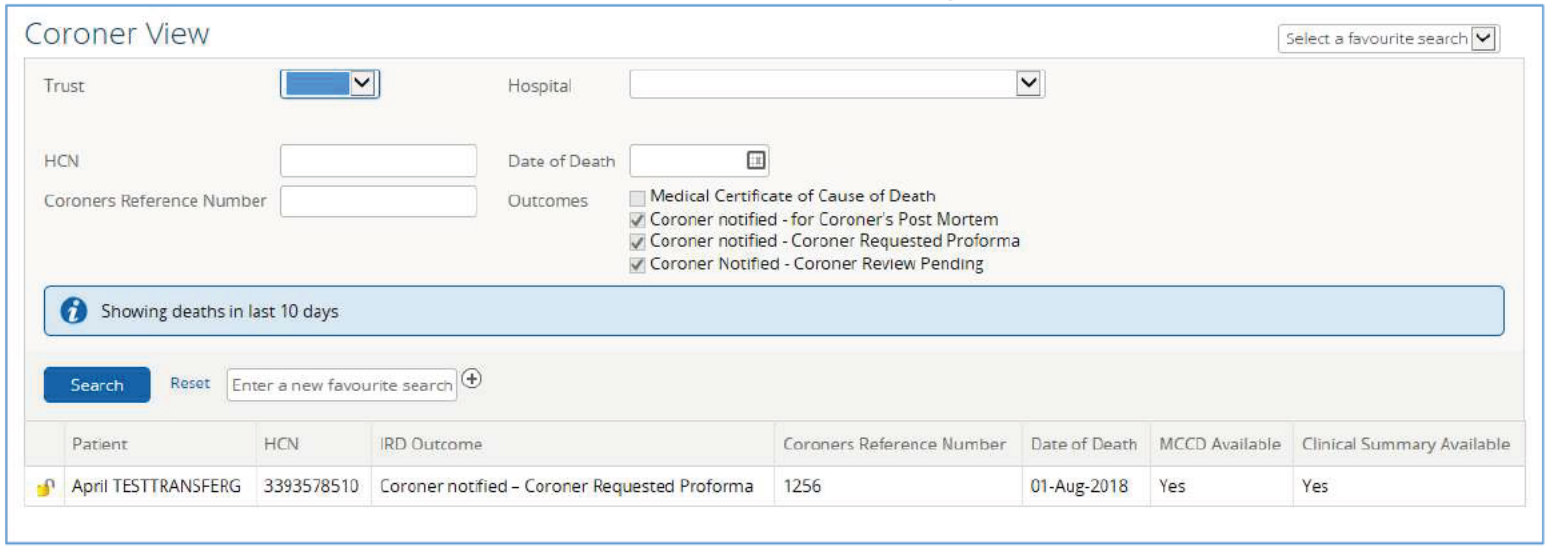
Death much improved - spacing and layout changed.
A text change to the MCCD has also been agreed with the General Registers Office. The wording of the statement under the cause of death section has been amended to a gender neutral term.

8. A Mortuary Summary will appear in the Notification and Legal Documents section of the CDV tree of the deceased when the MCCD outcome is selected on the IRD. This will allow the mortuary to check if there are any communicable diseases or infections they need to be aware of.



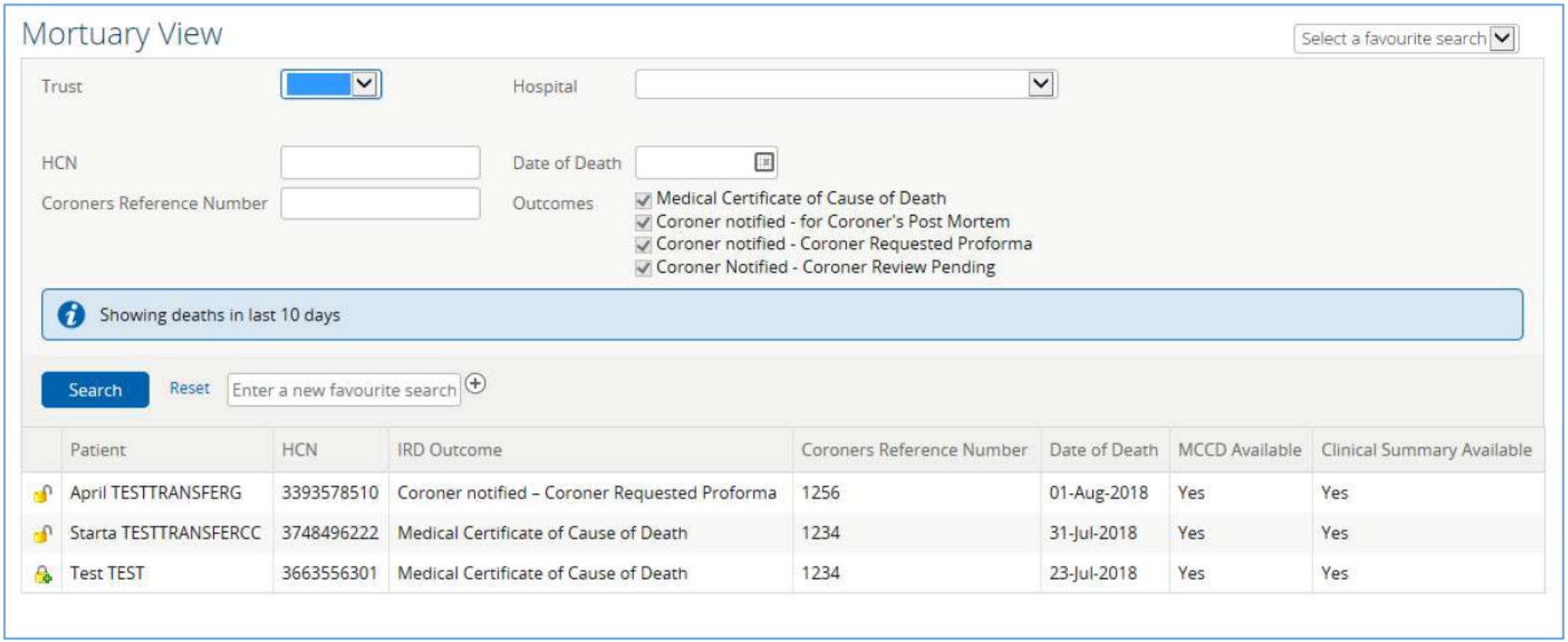
Coroner View & Mortuary View

9. MCCD and Clinical Summary form – for sending to the Coroner's Office.
Mechanism for sending these forms to Coroner's Office has been changed. System will now have a list view created for Coroner's staff containing deaths for which Coroner's outcome selected. They will be able to go online to NIECR, find these forms and download them. Medical Staff should not now have to email, fax or post these forms.



10. Mortuary staff

A similar method for Mortuary Staff has been designed. A list view to be created for all deaths, this will allow them to see all MCCD and Coroner cases and have sight of the implant questions and details of any blood borne diseases.

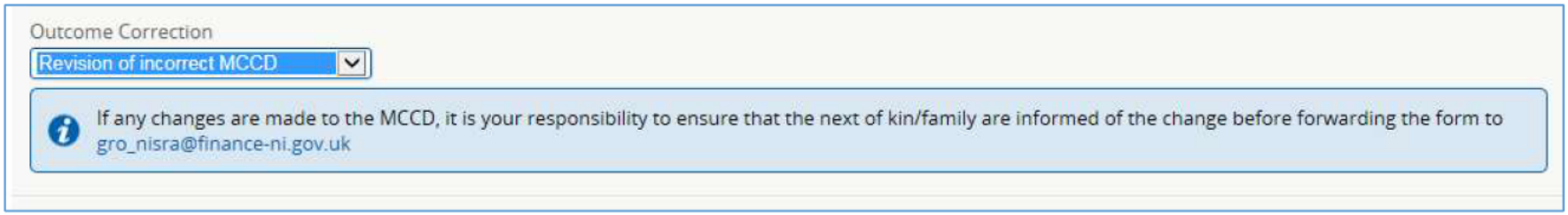


Patient	HCN	IRD Outcome	Coroners Reference Number	Date of Death	MCCD Available	Clinical Summary Available
April TESTTRANSFERG	3393578510	Coroner notified – Coroner Requested Proforma	1256	01-Aug-2018	Yes	Yes
Starta TESTTRANSFERCC	3748496222	Medical Certificate of Cause of Death	1234	31-Jul-2018	Yes	Yes
Test TEST	3663556301	Medical Certificate of Cause of Death	1234	23-Jul-2018	Yes	Yes

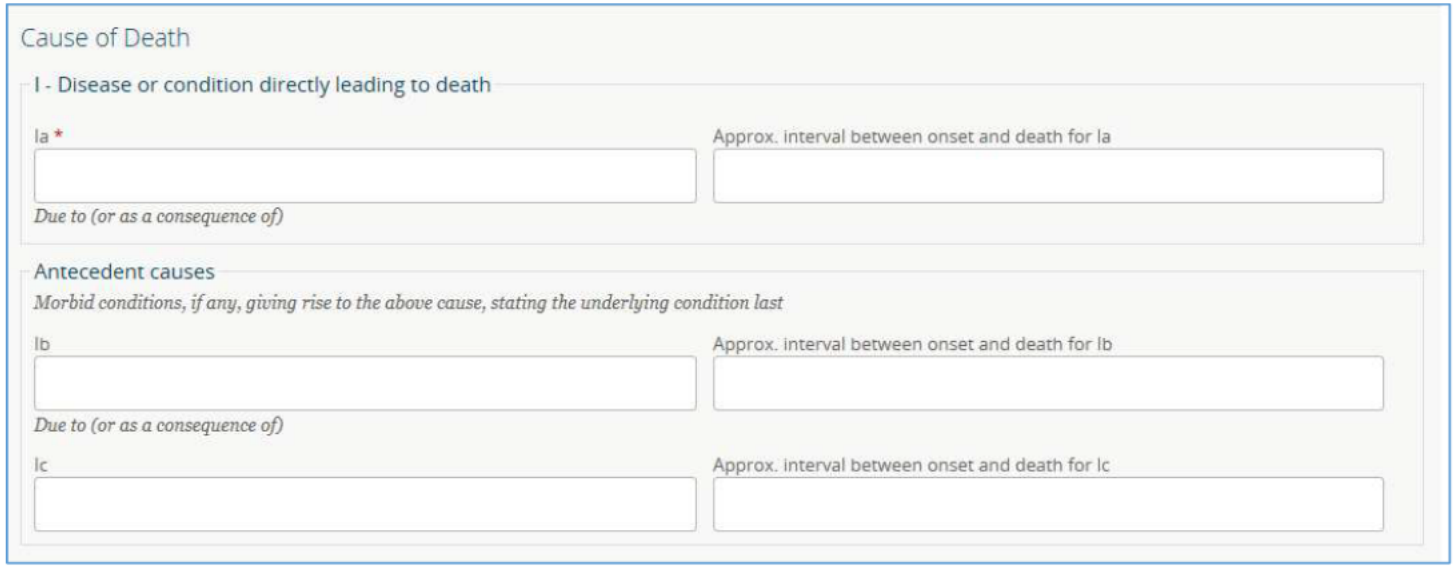
Consultant Review Form

11. On IRD completion, the Consultant Review Form will be hidden from all except for those in the Level 1, M&M Consultant Review Group. All Consultants should be in Level 1 – the highest permission in NIECR.
Some Senior Medical Staff (e.g. SAS doctors etc.) may currently be in Level 2. They will need Trust approval to be added to Level 1 which will enable them to perform a Consultant Review.
This should then stop the practice of some trainees completing Consultant Reviews.

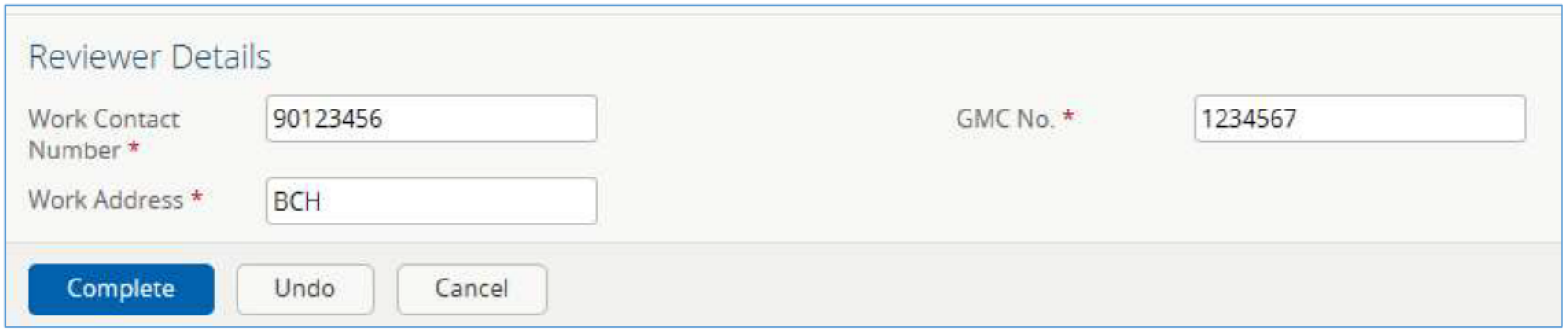
12. If a Consultant, when performing their Consultant Review, decides to correct a MCCD they will need to,
    - Send the MCCD correction from to the GRO;
    - Alert the family or next of kin. A warning to that effect is now included: "*If any changes are made to the MCCD, it is your responsibility to ensure that the next of kin/family are informed of the change before forwarding the form to gro_nisra@finance-ni.gov.uk*"



13. Layout change to align two columns on Cause of Death section if incorrect MCCD option chosen.



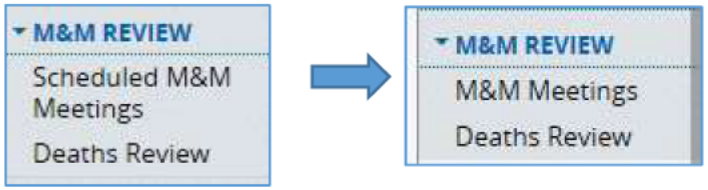
14. Removed autofill of the Consultant recorder details & date created from the form (details will be taken from the log-in details of the person 'completing' the form) and have added work contact and work address details.
This will aid Consultants who finally complete a Review which was started by somebody else.



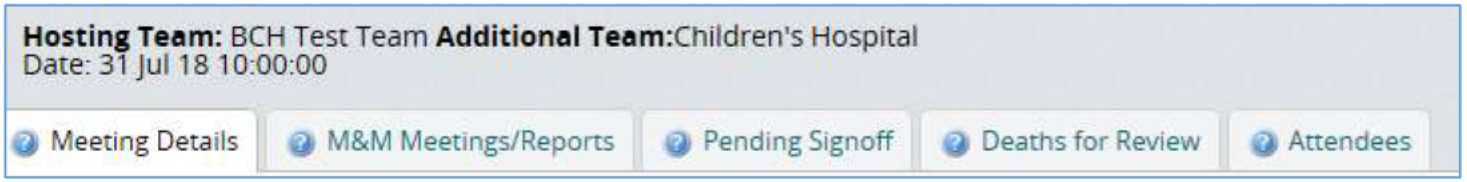
M&M Meeting

M&M Review tab on Home Screen

15. Change "*Scheduled M&M Meetings"* tab on the left hand side of the Home Screen to "*M&M Meetings*".

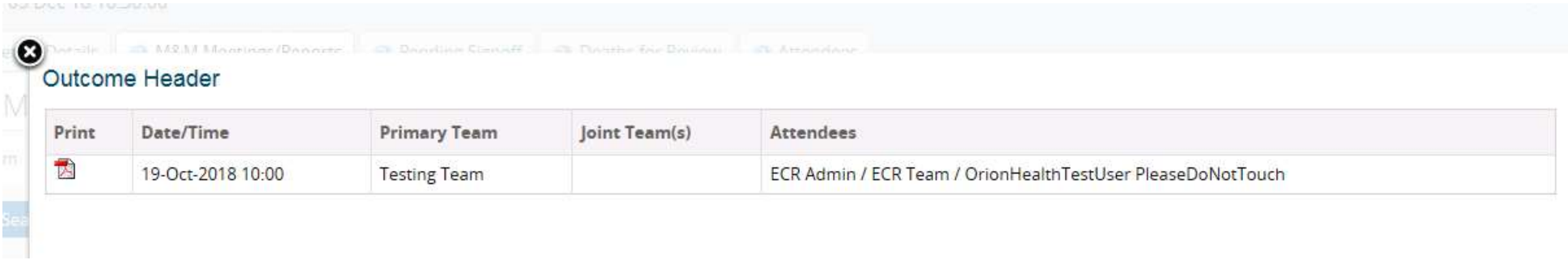


16. The M&M Meetings tabs are now ordered as - Meeting Details, M&M Meetings/Reports, Pending Signoff, Deaths for Review, Attendees.



M&M Meetings/Reports Tab

17. This tab will show the meeting Outcome Report which now includes - date, time and attendance list.

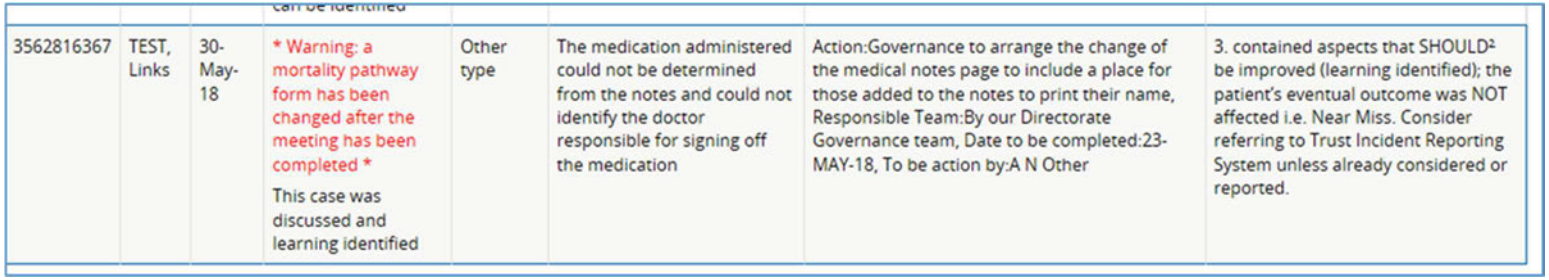


Outcome Header

Print	Date/Time	Primary Team	Joint Team(s)	Attendees
	19-Oct-2018 10:00	Testing Team		ECR Admin / ECR Team / OrionHealthTestUser PleaseDoNotTouch

18. Outcome Report will now include those ad hoc Additional Team Patient M&M Review Forms completed when an Additional team completes their meeting.

19. The Outcome Report will display a warning message if the Primary M&M Patient Review Form or the Ad-hoc Additional Team M&M Review Form is amended following completion of the meeting.



3562816367	TEST, Links	30-May-18	* Warning: a mortality pathway form has been changed after the meeting has been completed * This case was discussed and learning identified	Other type	The medication administered could not be determined from the notes and could not identify the doctor responsible for signing off the medication	Action:Governance to arrange the change of the medical notes page to include a place for those added to the notes to print their name, Responsible Team:By our Directorate Governance team, Date to be completed:23-MAY-18, To be action by:A N Other	3. contained aspects that SHOULD² be improved (learning identified); the patient's eventual outcome was NOT affected i.e. Near Miss. Consider referring to Trust Incident Reporting System unless already considered or reported.

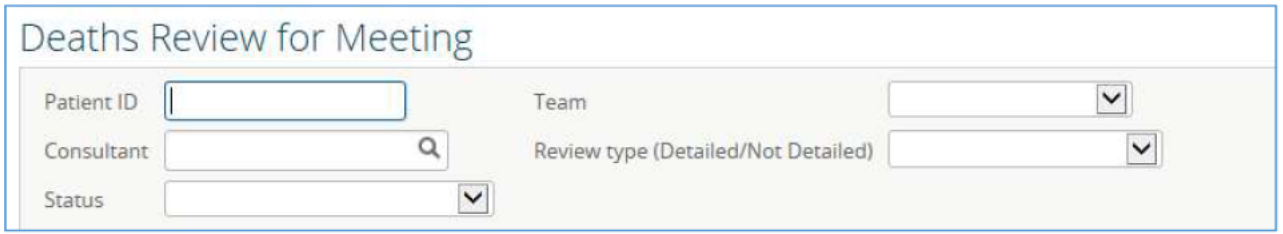
20. To print the output report as a pdf document this must be done using the pdf print icon.

Print	Date/Time	Primary Team	Joint Team(s)	Attendees
	29-Aug-2018 12:00	BCH Test Team		DOH Training / ECR Admin / ECR Team / G O'Prey / RDE Doctor

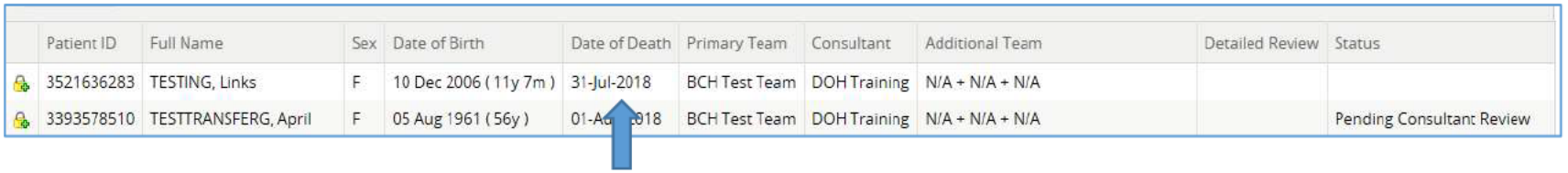
MRN	Full Name	Date of Death	Discussion Details	Lesson Category	Lesson Discussion Details	Action(s)	Outcome
3356547054	TESTTRANSFERM, Dermot	22-Jul-18	Testing	N/A	N/A		1. was Satisfactory. There were no particular Learning Lessons.

Deaths for Review Tab (and also Deaths Review List)

21. Labelling of box *'Death awaiting for Review*' replaced with '*Review Type'* and its dropdown filters changed to 'Detailed Review', 'Not for Detailed Review' and a blank for All.
Also, see point 29.

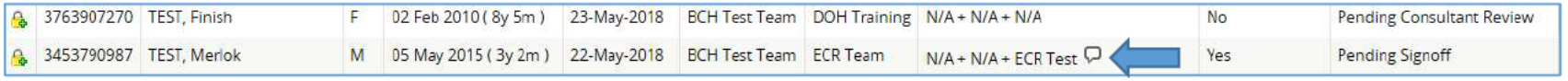


22. Date of Death value previously taken from PAS changed to Date of Death as entered by doctor completing IRD.



	Patient ID	Full Name	Sex	Date of Birth	Date of Death	Primary Team	Consultant	Additional Team	Detailed Review	Status
	3521636283	TESTING, Links	F	10 Dec 2006 (11y 7m)	31-Jul-2018	BCH Test Team	DOH Training	N/A + N/A + N/A		
	3393578510	TESTTRANSFERG, April	F	05 Aug 1961 (56y)	01-Aug-2018	BCH Test Team	DOH Training	N/A + N/A + N/A		Pending Consultant Review

23. Display reason for requesting an Additional team using the icon/hover function beside Additional team name.



	3763907270	TEST, Finish	F	02 Feb 2010 (8y 5m)	23-May-2018	BCH Test Team	DOH Training	N/A + N/A + N/A	No	Pending Consultant Review
	3453790987	TEST, Merlok	M	05 May 2015 (3y 2m)	22-May-2018	BCH Test Team	ECR Team	N/A + N/A + ECR Test	Yes	Pending Signoff

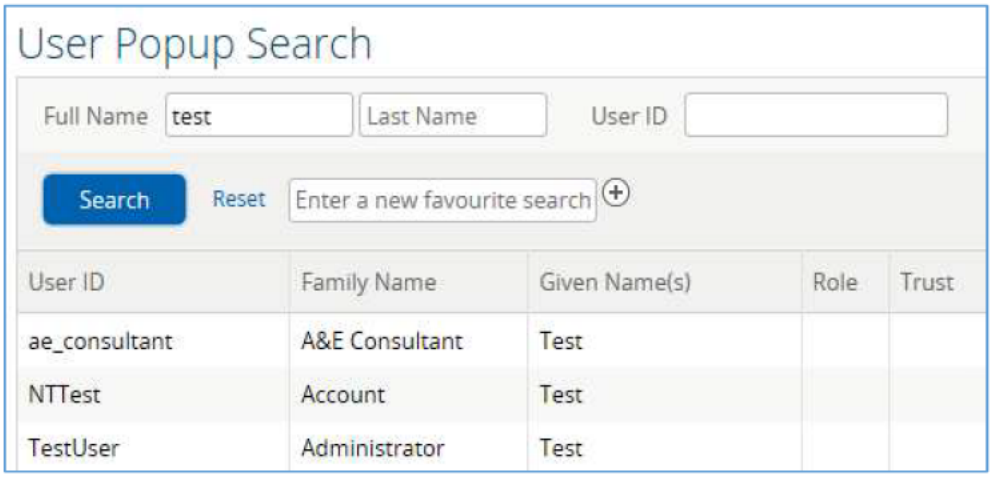
24. An extra column on the Death Review table entitled 'Detailed Review' which would show at a glance if the death was for detailed review or not.

	Patient ID	Full Name	Sex	Date of Birth	Date of Death	Primary Team	Consultant	Additional Team	Detailed Review	Status
	3353054588	TEST, Merlok	M	11 May 1980 (38y)	06-Jun-2018	BCH Test Team	DOH Training	N/A + N/A + N/A	No	Pending Patient M&M Review
	3353054588	TEST, Merlok	M	11 May 1980 (38y)	21-May-2018	BCH Test Team	DOH Training	N/A + N/A + N/A	No	Pending Patient M&M Review

<u>Attendance List Tab</u>

25. Can now add extra meeting attendees using "*User Popup Search*" facility by adding NIECR log-in details or name search.

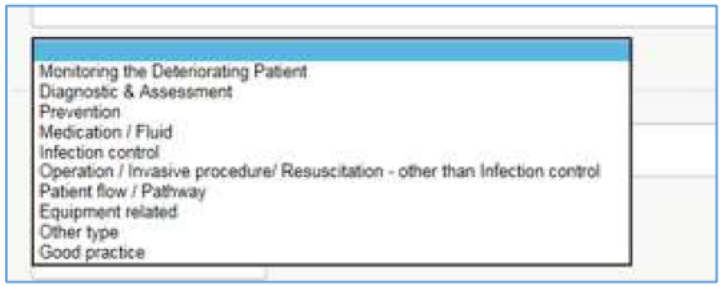
26. Once attendees list is confirmed, the meeting details are <u>locked down</u> by using the '*Complete*' button – this finishes the M&M meeting.

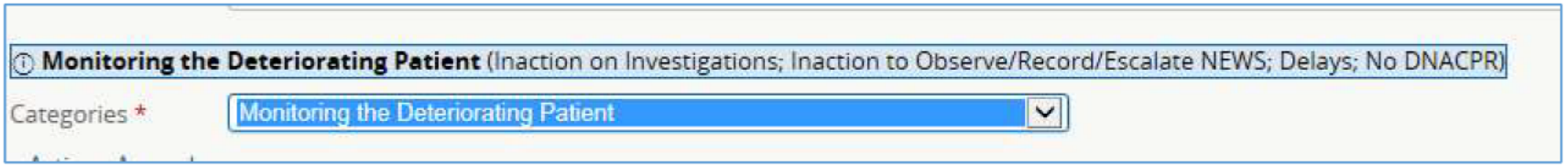


M&M Review Form

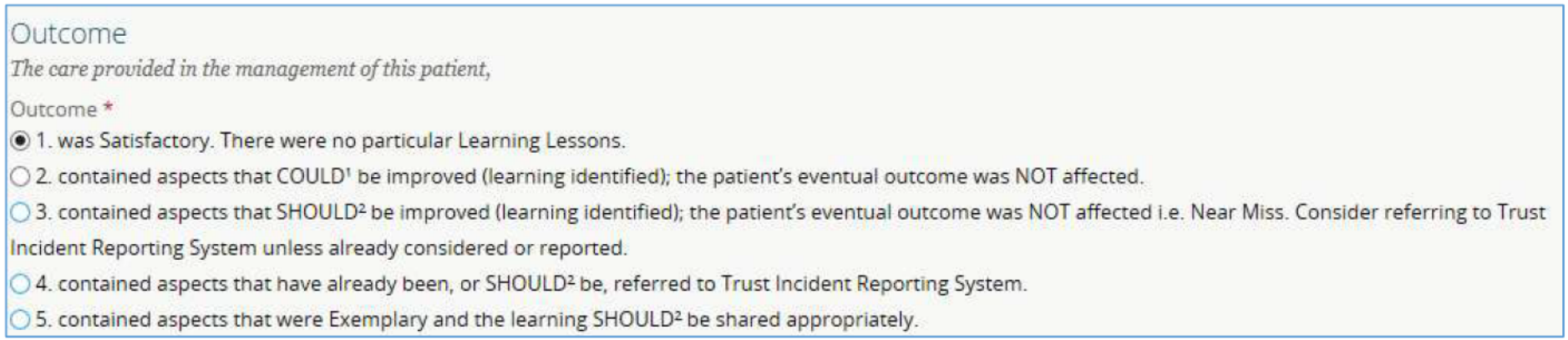
27. Meeting details (Team and Date) will now have to be included at the top of all M&M Review Forms.
If a M&M review is not completed 'in meeting context' i.e. not using a scheduled meeting, from now on the meeting details must be added manually, as both are now mandatory fields. Also, see point 31.

28. Updated the Learning lessons category options to make them more 'positive' and a description of each category is displayed using an information box.

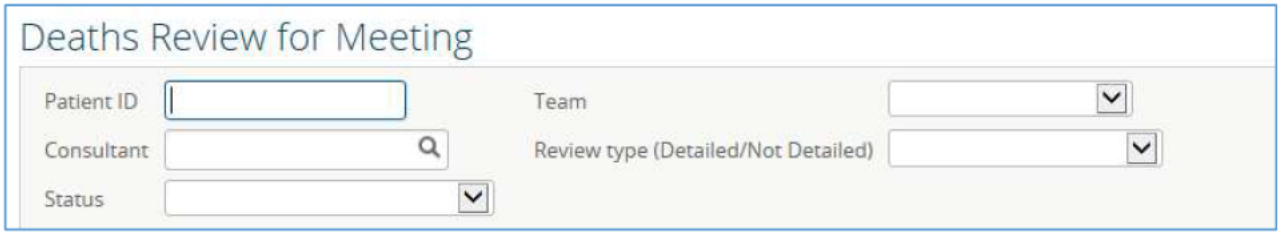




29. Layout of the outcome categories changed from text to radio buttons.

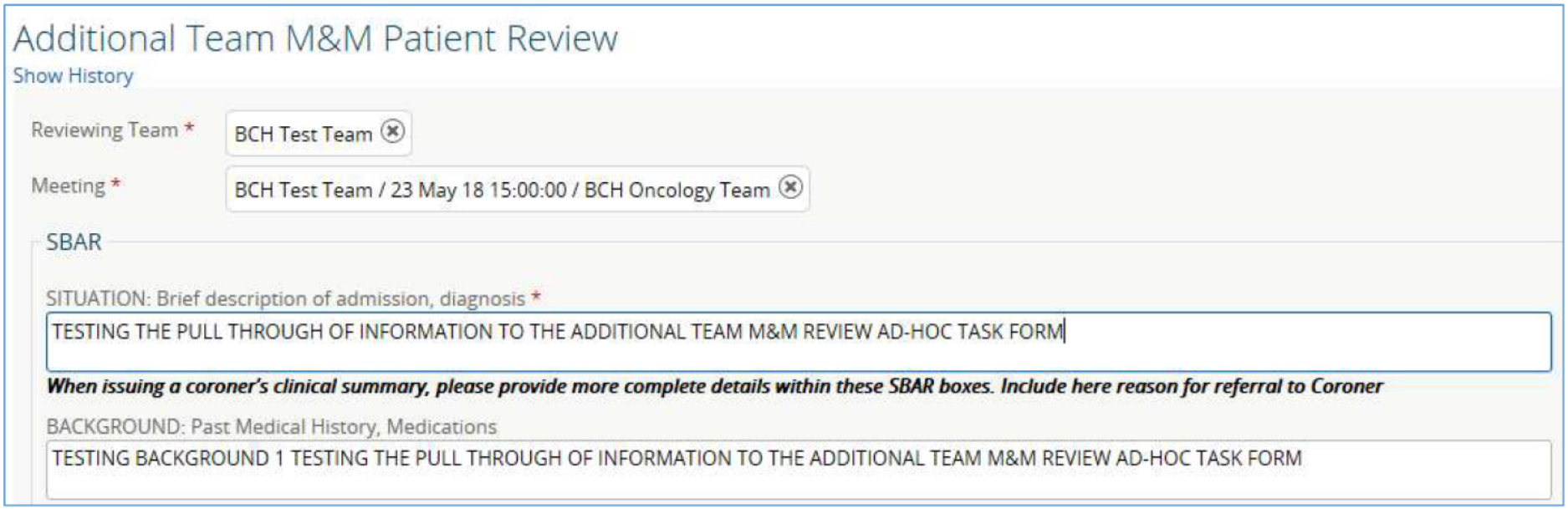


30. To help M&M leads to efficiently progress through their meeting, it is advised that the M&M lead,
    - uses the filters (e.g. for 'detailed' or 'not for detailed review) in the Deaths for Review tab; and then
    - 'cycles' through the cases using the **< ≡≡ >** icons at the top right hand of the page.



Ad hoc Additional Team M&M Patient Review

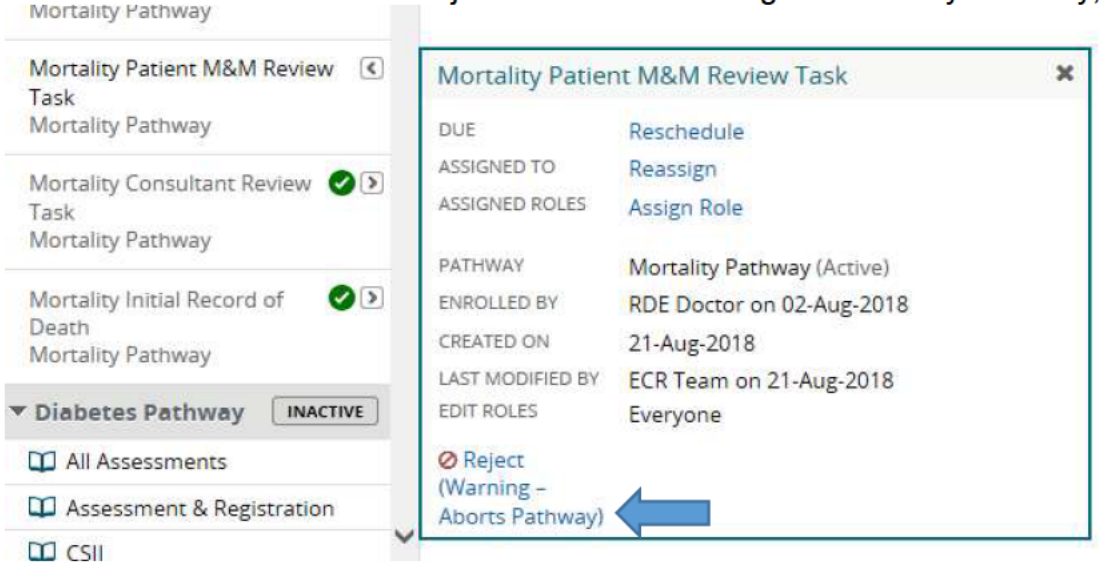
31. SBAR information from the primary Consultant Review form will now be pulled through to SBAR section onto the Additional Team Patient M&M Review form as it already does for the Primary team form.



32. As indicated in point 26, if a M&M review is not completed 'in meeting context' i.e. not using a scheduled meeting, the meeting details must now be added manually, as both are now mandatory fields.
This feature will now also allow an Additional Team, who have <u>not</u> been asked to be an Additional team by the Primary Team, to elect themselves to perform their own review. Done by selecting the patient and, then in meeting context, completing the meeting detail boxes.

General

33. To help deter the use of the 'Reject' button available on every pathway form, which disables the pathway, the button now includes additional text 'Reject (Warning – Aborts Pathway)' highlighting the fact that the 'Reject' button will abort/disable the pathway. There is no need to use the 'Reject' button when using the Mortality Pathway; it is used in other NIECR Pathways.



34. RM&MRS Upgrade – Edit function at the top right hand corner of all forms changed to "Re-open Task"

THIS CERTIFICATE MUST BE DELIVERED WITHIN FIVE DAYS TO A REGISTRAR IN NORTHERN IRELAND

WIT-94348

FOR INSTRUCTIONS TO INFORMANTS SEE OVERLEAF

MEDICAL CERTIFICATE OF CAUSE OF DEATH

Births and Deaths Registration (Northern Ireland) Order 1976, Article 25(2)

FOR USE OF REGISTRAR

ENTRY NO. ……

DISTRICT ……

To be signed by a Registered Medical Practitioner WHO HAS BEEN IN ATTENDANCE during the last illness of the deceased person and given to some person required by Statute to give information of the death to the Registrar. (SEE OVERLEAF)

Name of Deceased: Test TEST

The Health & Care Number of the Deceased: 3663556301

Usual Residence: 13 Test Road BT9 7AB

Place of Death: BELFAST CITY HOSPITAL (18)

Date of Death: 23-July-2018 13:13

Date on which last seen alive and treated by me for the undermentioned conditions: 17-July-2018

Whether seen after death by,

- me — No
- another medical practitioner — No

CAUSE OF DEATH			These particulars not to be entered in Death Register Approximate interval between onset and death (years, months, weeks, days, hours)
I **Disease or condition directly leading to death***	(a)	**I** TEST TEST TEST TEST TEST TEST TEST TEST TEST TEST TEST TEST TEST TEST TEST TEST TEST TEST TEST TEST TEST Due to (or as a consequence of)	12 34 56
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last.	(b)	TEST TEST TEST TEST TEST TEST TEST TEST TEST TEST Due to (or as a consequence of)	12 34 56
	(c)	TEST TEST TEST TEST TEST TEST TEST TEST TEST TEST	12 34 56
II **Other significant conditions** contributing to the death, but not related to the disease or condition causing it		**II** TEST	12 34 56

*This does not mean the mode of dying e.g. heart failure, asthenia, etc. it means the disease, injury or complication which caused death.

Coroner's Reference Number: 1 2 3 4 — 1 8

I hereby certify that the above-named person has died as a result of the natural illness or disease for which he has been treated by me within twenty-eight days prior to the date of death, and that the particulars and cause of death above written are true to the best of my knowledge and belief.

Signature _____ Date _____

Name (Please Print) RDE Doctor Work Contact Number 123

Work Address 123 GMC Registration No. 1234567

PERSONS QUALIFIED AND LIABLE TO ACT AS INFORMANTS

1. Any relative* of the deceased who has knowledge of the particulars required to be registered concerning the death.

2. Person present at the death.

3. Executor or administrator of the deceased's estate.

4. ¥Occupier of the premises in which the death occurred.

5. Person finding the body.

6. Person taking charge of the body.

7. Person procuring the disposal of the body, i.e., the person employing the undertaker.

* The term "Relative" includes a relative by marriage/ civil partnership.

¥ The term "Occupier" in relation to a public building includes the governor, matron, superintendent or other chief officer, and, in relation to a house let in separate apartments or lodgings, includes any person residing in the house who is either the person under whom the lodgings or apartments are immediately held or his agent.

The informant must deliver this Certificate without delay to the Registrar and by personal attendance give the prescribed information concerning the deceased.
Failure to comply with this requirement renders the informant liable to prosecution. The Registrar is an officer of the District Council and the registration may be made in any District Registration Office.
The informant must be prepared to state accurately to the Registrar the following particulars concerning the deceased:-

1. Full name and surname.

2. Date and place of death and the usual residence.

3. Status (single, married/civil partner, widowed/surviving civil partner or divorced/civil partnership dissolved).

4. Date and place of birth.

5. Occupation.

6. Name(s) and surname of spouse or civil partner.

7. Details of any pension (apart from a state pension) that the deceased may have held. (The pension or allowance order book or other pension etc. Document should be produced to the Registrar.)

Mortuary Summary

Patient Name: **Links TEST** **H&C No: 3562816367**

Date of Birth: **10 May 2006 (12 years 0 months)**

Address: **1 Anywhere Street Belfast County Antrim BT9 5FA**

Date of Death: **30-May-2018 10:00**

Place of Death: BELFAST CITY HOSPITAL (ward 3)

SBAR Details

SITUATION: Brief description of admission, diagnosis:

test

BACKGROUND: Past Medical History, Medications

BACKGROUND: Describe clinical course

BACKGROUND: Procedural details, surgery, investigations

Coroners Reference Number: — 1 8

Coroner Contacted By:

Date Coroner Contacted:

Date form completed **31-May-2018 11:56**

Record of discussion with Coroner

Doctor's Name: **DOH Training** **GMC Number:** **1234567**

Work Address: **cb**

Work Contact: **123**

Implants

Does the deceased have any implanted cardiac device which is still implanted e.g. cardiac pacemaker, cardioverter-defibrillator (ICD), ventricular assist device? Yes/No

Does the deceased have a Radio-active implant which is still implanted? Yes/No

Does the deceased have any other hazardous device which is still implanted or not made safe e.g. Expandable Intramedullary nail - FIXION(™) nail; battery powered implant? Yes/No

RM&MRS – MAIN CHANGES TO BENEFIT USERS

Place of Death

The change to the recording of the Place of Death will allow:

- Mental Health Teams to record their deaths on to the system, which should result in all hospital deaths now being recorded on to NIECR (RM&MRS).

- Acute Care at Home Teams to record their deaths in the community on to the system and produce a MCCD.

Coroner View

This new feature will allow the Coroner's Office to access the deaths where a Coroner's outcome has been assigned on the system.

In these cases the Coroner's Office staff will now retrieve the documents (unsigned MCCD and/or Clinical Summary) themselves, directly from NIECR. Effectively this means that doctors will no longer need to print or send these documents to the Coroner's Office.

Mortuary View

The Mortuary View gives the Mortuary staff access to view all the deaths occurring within their Trust which will allow the release of bodies as appropriate. They will also have sight of the implant questions and details of any blood borne diseases. This should make what can be a difficult and time consuming process much simpler.

M&M Review Form

All M&M case reviews will now have to be included as an integral part of a meeting. You cannot complete the M&M Review Form until the meeting details have been included on the form. This will ensure that every death reviewed will be included on a M&M meeting report.

This feature will now also allow an Additional Team, who have not been asked to be an Additional Team by the Primary Team, to elect themselves to perform their own review.

To help produce actual Learning where there is learning and to encourage its identification and categorisation, significant changes have been made to how details are recorded for Learning Lessons and their resultant Actions.

Acute SMT Report on Patient Experience and Adverse Incidents

Introduction

The attached report looks at complaints, compliments and adverse incidents for the month of April 2019 in Acute Services.

Key Messages

Complaints

- There has been a increase in the number of formal complaints received in April 2019.
- There are a number of overdue current complaints which require response. Assistant Directors are asked to expedite these through their systems.
- There are also a number of re-opened complaints which need to be expedited.
- Staff shortages within the Acute Governance Team are having an impact on the ability to process complaints as quickly as the team would like to. This is currently being rectified and hopefully May figures will reflect this.

Compliments

- A discussion needs to take place in relation to the recording of compliments and the revised Trust process.

Incidents

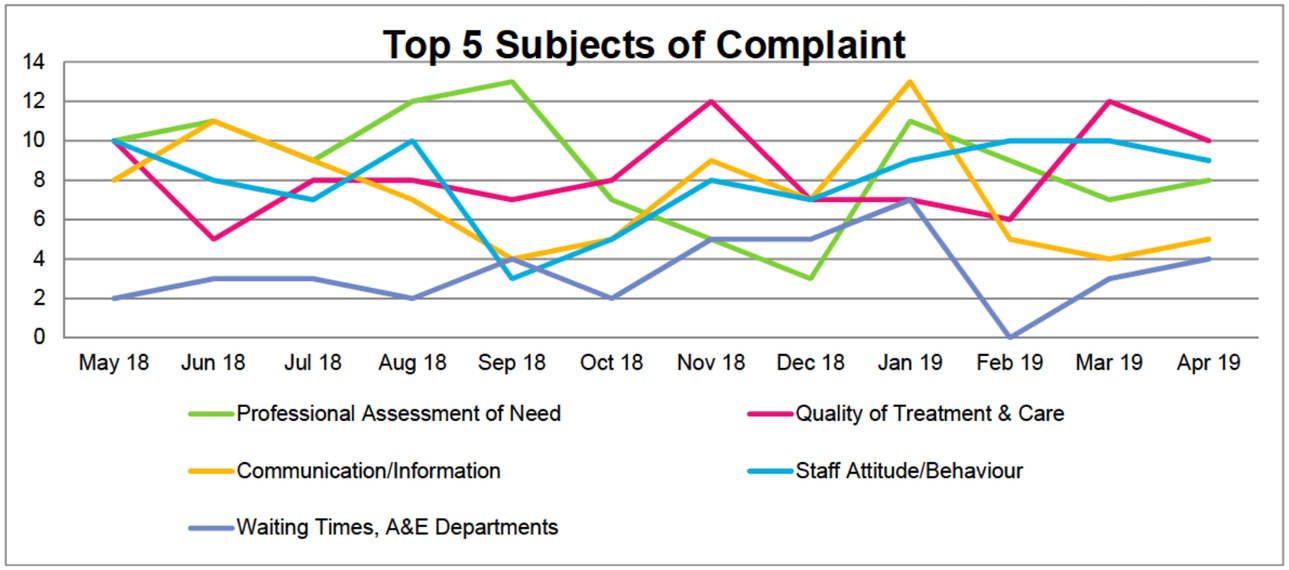
- There has been an increase in the number of incidents reported in March compared with the previous month (up 66).
- There was a decrease in the number of incidents relation to violence and aggression with the figure decreasing to 21 from 57.

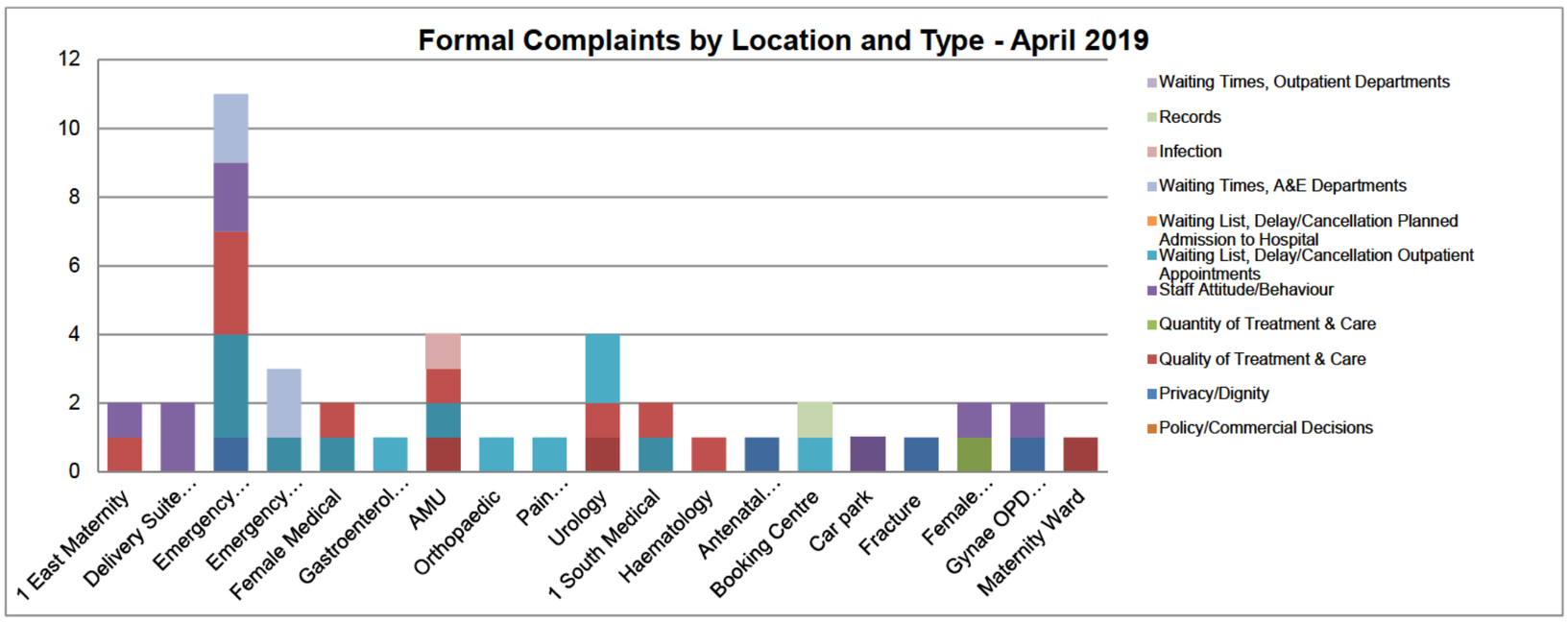
PATIENT EXPERIENCE (Complaints and Compliments)

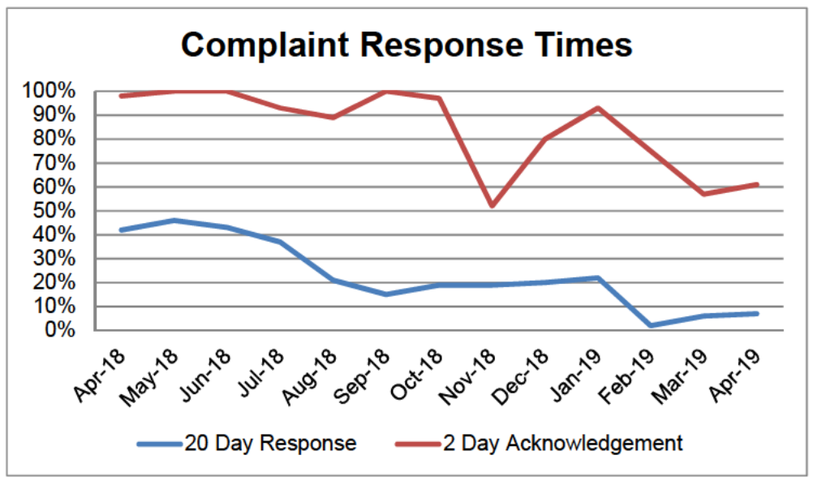
Complaint Statistics

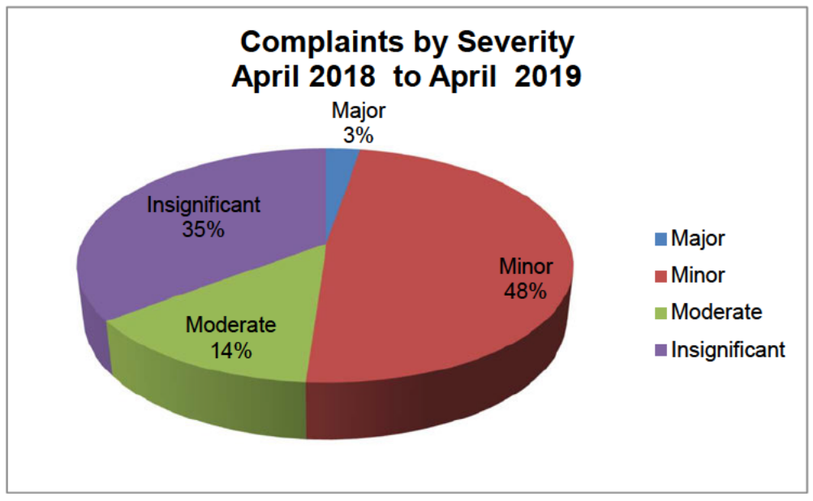
	Formal Complaints	Informal Complaints	MLA Enquiries	Re-Opened Complaints	Awaiting Consent	Ombudsman*
May	47	1	15	8	4	1
Jun	40	10	12	2	1	1
Jul	46	7	8	7	1	0
Aug	52	8	10	7	2	0
Sep	38	9	15	4	2	1
Oct	38	3	9	6	3	0
Nov	58	14	7	9	5	1
Dec	30	8	11	3	2	1
an	72	12	11	3	4	1
Feb	45	7	21	3	0	0
Mar	31	5	14	8	0	1
Apr	53	3	15	6	0	0
Total	**550**	**87**	**148**	**66**	**24**	**7**

* There are currently 7 cases in total under investigation by NIPSO.









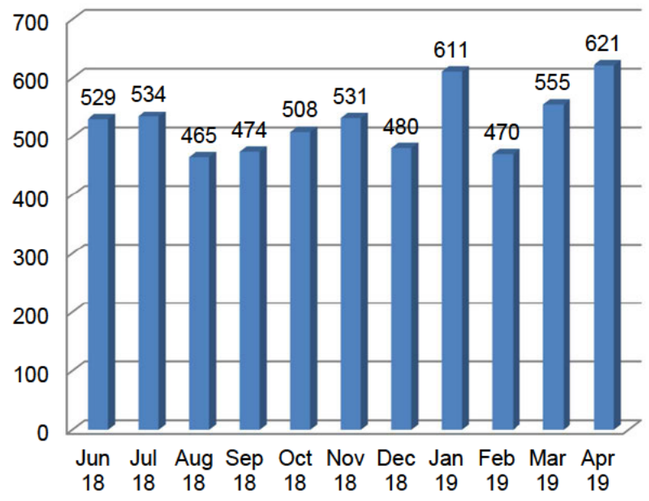
April 2019 117 Compliments

Complaints by Division and Date Received

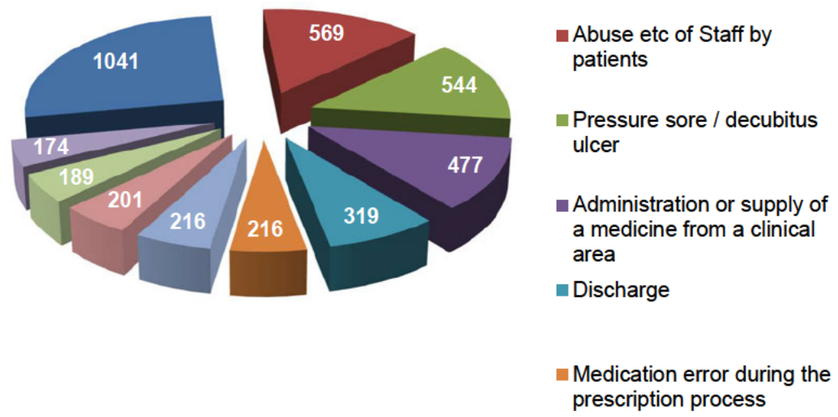
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Total
IMWH / CCS	3	13	5	16	12	7	10	11	6	20	8	9	11	131
FSS	0	2	2	4	7	1	2	8	1	3	6	1	4	41
MUC	12	18	19	21	19	26	19	26	17	31	21	23	25	277
PHARMACY	1	1	0	0	0	0	0	0	0	0	0	1	0	3
SEC	17	18	17	7	10	4	11	14	6	18	10	16	10	158

ADVERSE INCIDENTS

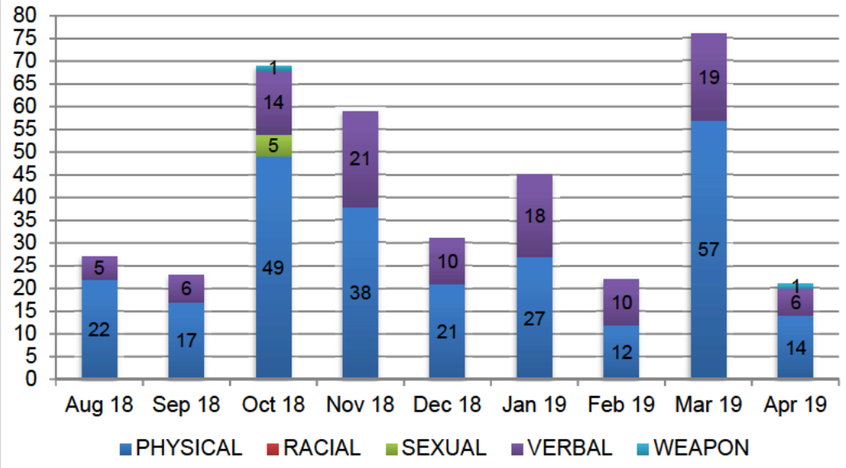
Adverse Incidents



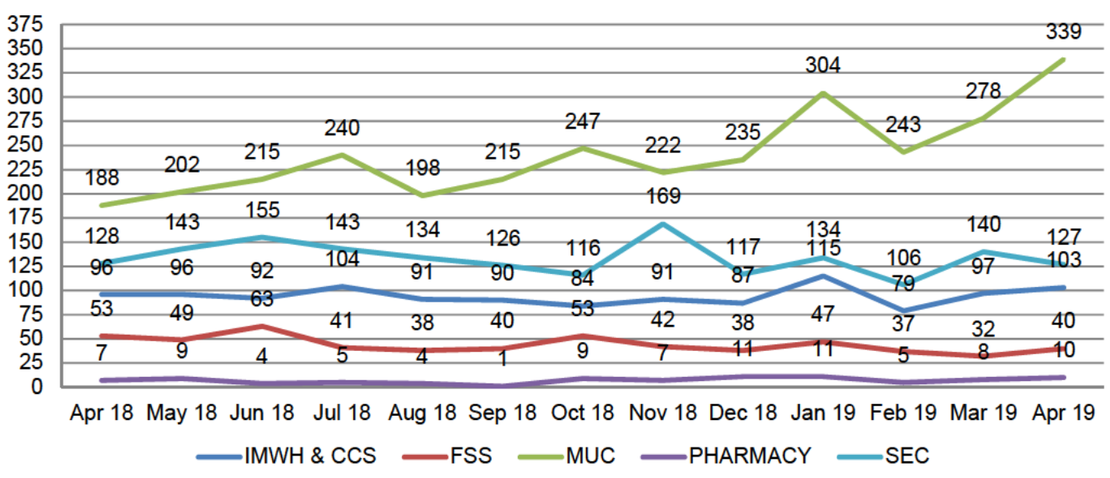
Top 10 Incidents - Year to Date



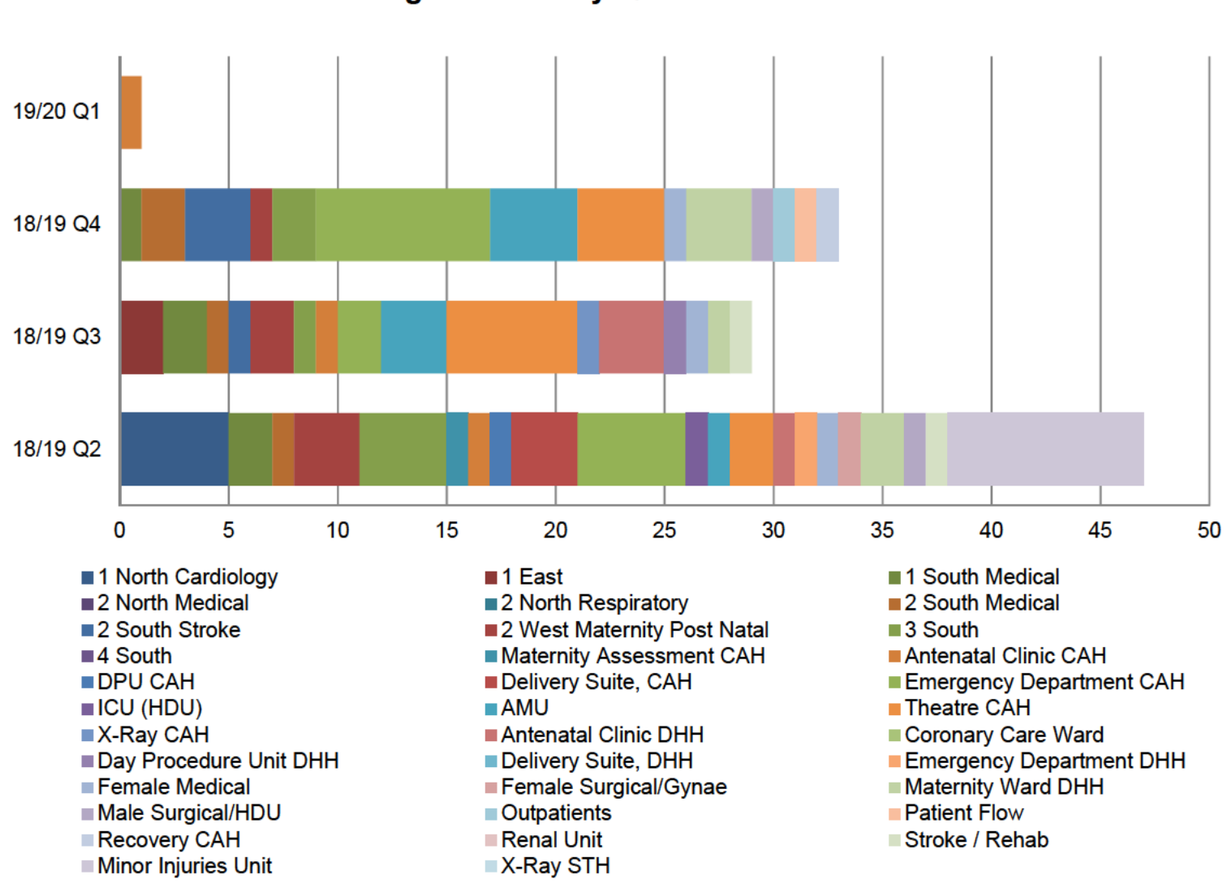
Violence and Aggression Incidents by Month and Type - Acute Services



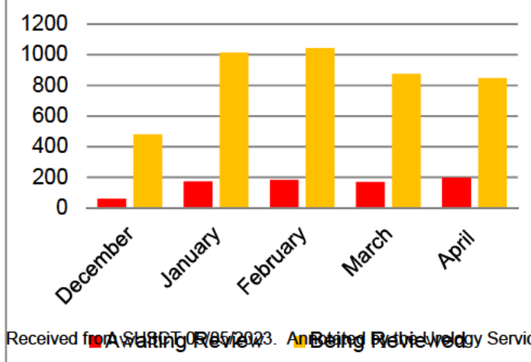
Adverse Incidents by Division



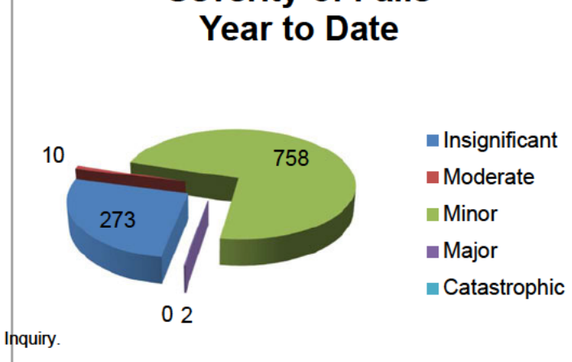
Staffing Incidents by Quarter and Location

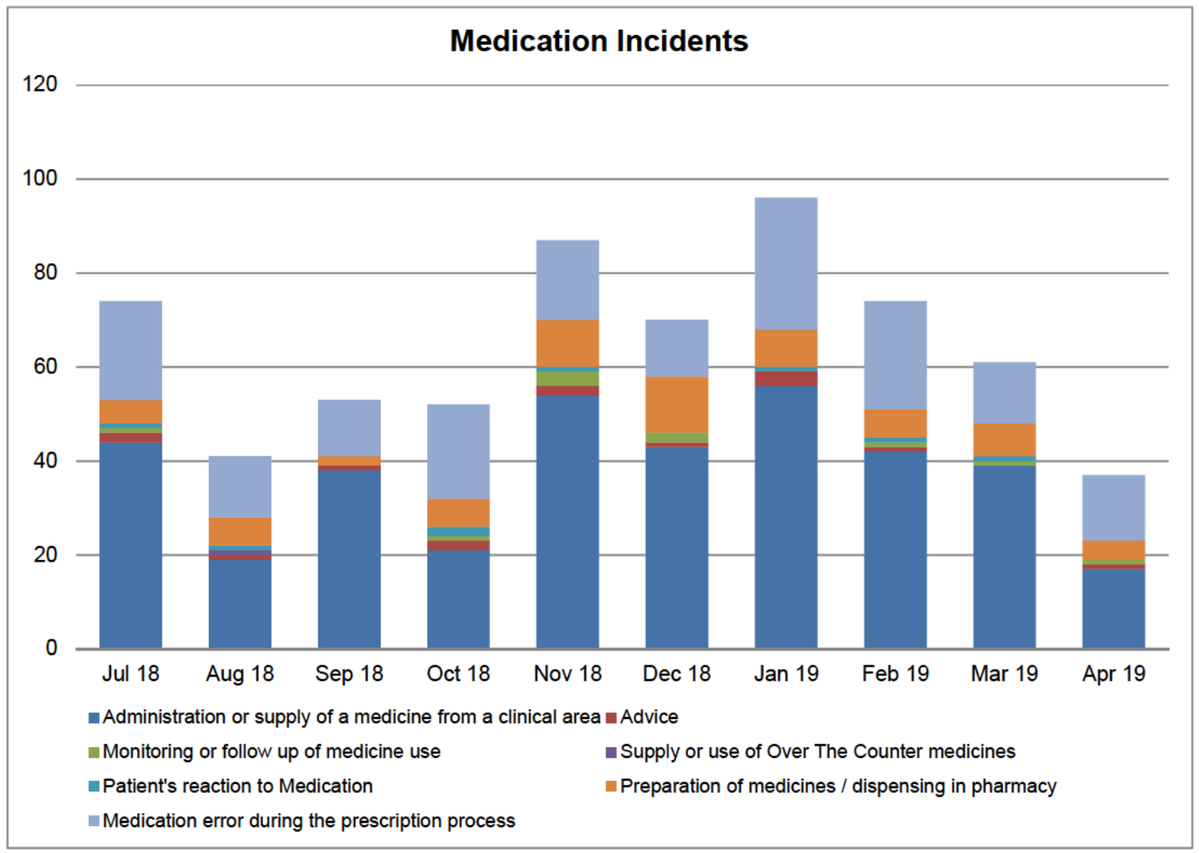


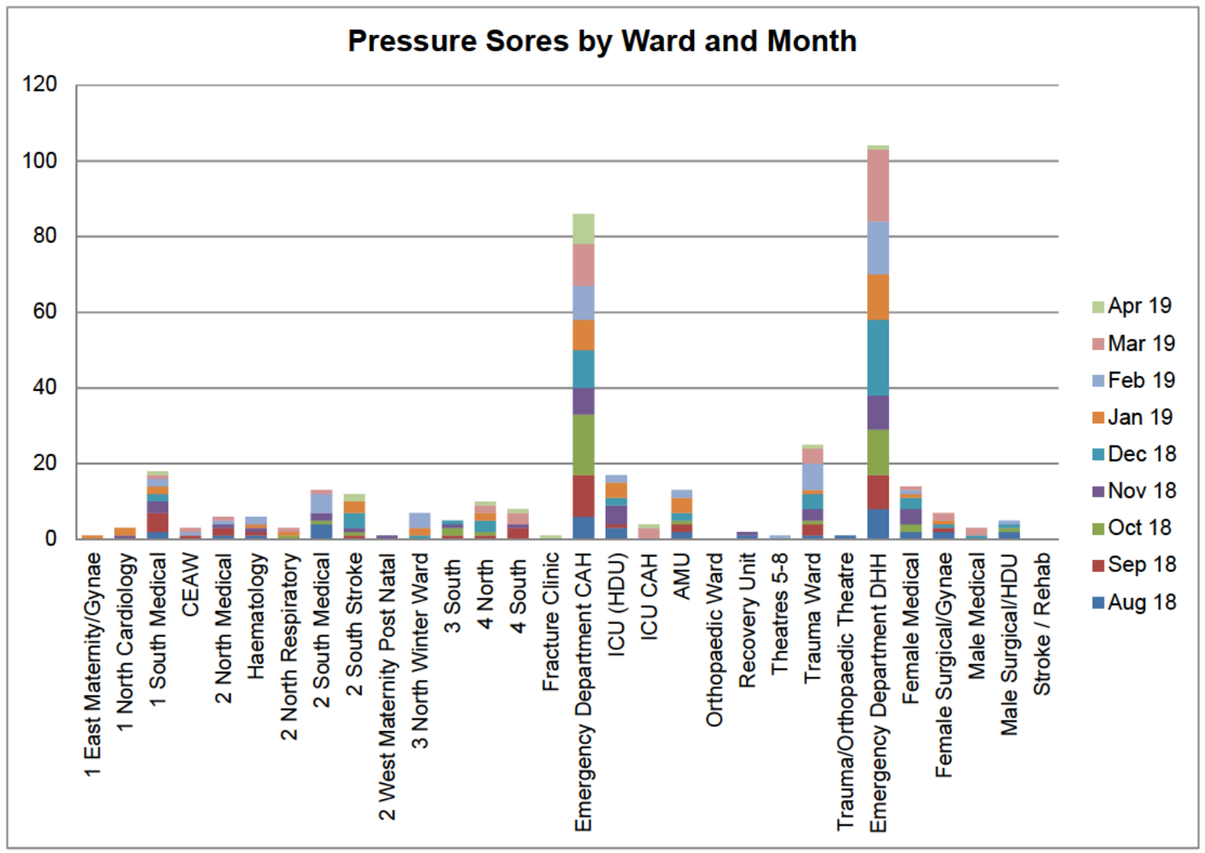
Stages of Investigation

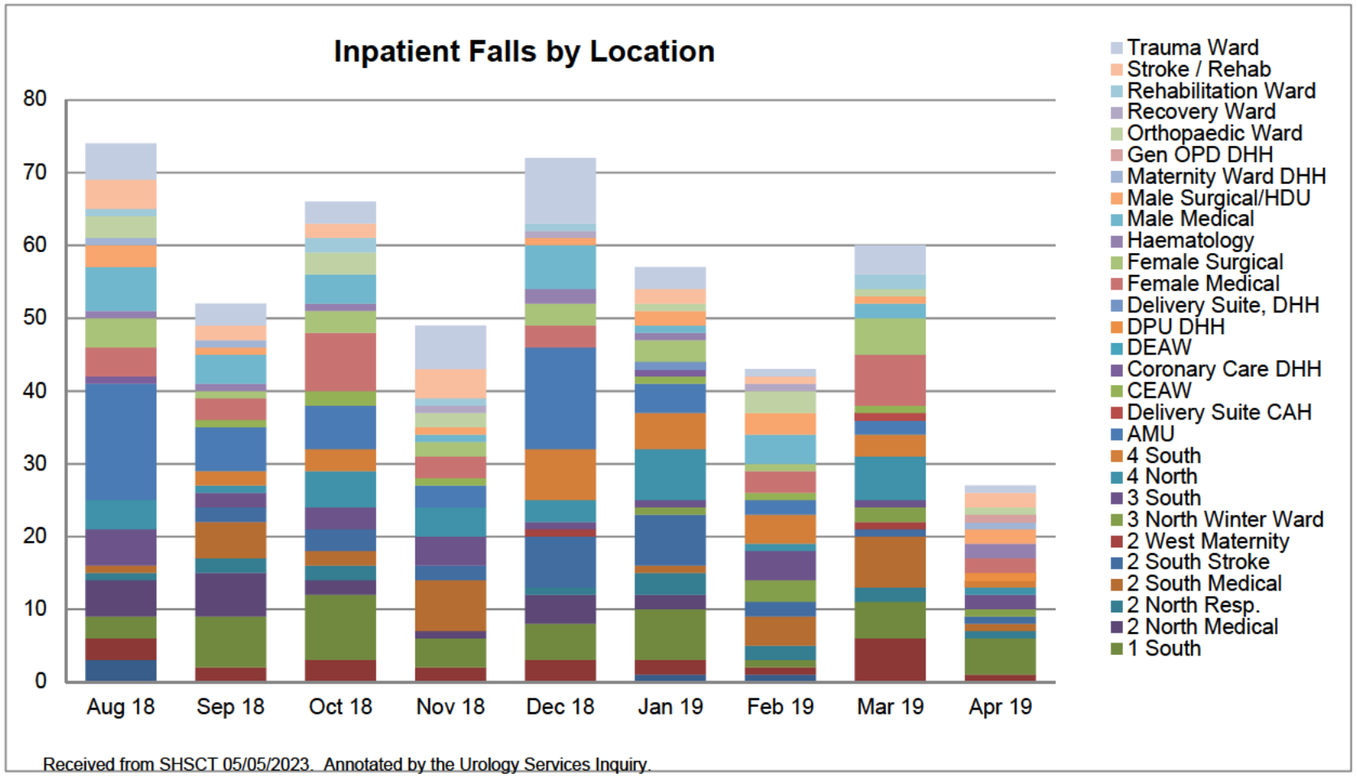


Severity of Falls Year to Date









Received from SHSCT 05/05/2023. Annotated by the Urology Services Inquiry.

Absconding Patients

	18/19 Q2	18/19 Q3	18/19 Q4	19/20 Q1	Total
ED DHH	26	16	27	4	73
ED CAH	18	18	28	5	69
AMU	4	6	5	3	18
4 North	0	4	1	1	6
Discharge Lounge CAH	1	0	0	0	1
Stroke / Rehab	0	0	0	0	0
1 South	0	0	1	0	1
2 South Stroke	0	0	0	0	0
3 South	0	0	1	0	1
4 South	0	0	0	0	0
Car Park/Grounds CAH	0	1	0	0	1
Car Park/Grounds DHH	0	1	0	0	1
Female Medical	0	0	0	0	0
Female Surgical	0	1	0	0	1
Male Medical	1	0	0	0	1
Trauma Ward	0	1	0	0	1
ICU (HDU)	1	0	0	0	1
Totals:	51	48	63	13	162

Acute Services Directorate
Directorate Risk Register - 1 MAY 2019

ID	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
773	29/07/2008	Safe, High Quality and Effective Care	CAH Theatres Endoscope Decontamination room	The interim Endoscope decontamination facilities at CAH theatres do not meet DHSSNI decontamination strategy. There are no transfer lobbies or staff gowning rooms. The process flow is severely compromised by the size of the extremely cramped unit. There is no room for expansion. The workload in the endoscope decontamination facility has increased considerably over the last number of years due to additional theatre and radiology sessions as well as additional ENT OPD clinics. There is inadequate space for holding the contaminated endoscopes for manual washing prior to the automated process in the endoscope washer disinfectors. This frequently creates a bottleneck and slows down the process flow and turnaround time. The endoscopes and transport trolleys have to be stored in the hospital corridor outside the endoscope decontamination room due to lack of space - increased risk of theft (trolley plus endoscopes). In the event of any prolonged endoscope washer disinfector downtime there would be significant disruption to endoscopic procedures in Theatres, Radiology, ICU or in ENT OPD as there would be insufficient capacity to decontaminate the endoscopes on the Craigavon site. There would also be logistical issues and delays in turnaround times if the endoscopes had to be transported to another Trust site for decontamination ie Daisy Hill or South Tyrone. The endoscope washer disinfectors were installed in 2009 and have a working life of approximately 8 years. The Lancer endoscope washer disinfectors do not have the ability to perform channel patency tests to current DHSS guidance i.e. inability to perform partial blockage of the duodenal channel which is part of the quarterly channel patency testing regime.	Situation being monitored.	8.8.18, 12.6.18, 7.3.18 This risk remains unchanged 1.12.16 No further change 13.9.16 Head of Decontamination Services will work with Acute Planner to explore options for a modular unit adjacent to CAH CSSD to replace the existing the interim arrangement. Given that CSSD will form part of Phase 1 for the CAH Redevelopment, a modular solution will be considered as a further interim arrangement although it will need to address existing concerns. Indicative costs to be detailed in the paper and logged for consideration under capital allocations for 17/18. 23.2.16 Following discussion at Acute senior management team with Head of Acute Planning, the risk will be addressed in the first phase of the redevelopment of the Craigavon site. On this basis it was agreed that nothing further would be done at this stage. 5.1.16 Short paper highlighting the risks shared with Planning Dept and Director of Acute Services	HIGH
3663	29/04/2015	Provide safe, high quality care	Single CT Scanner available on both DHH	No CT service available to patients when the CT is down due to essential maintenance/breakdown. Delay in diagnosis, delay in discharge. CAH major trauma will be diverted to other hospitals.	All essential maintenance is carried out at weekend or evening periods. Trauma patients are diverted. Global communication e-mail is circulated when CT is down. Transfer of urgent inpatients between CAH/DHH sites.	7.3.18 Mobile CT Scan is operational on site. 5.12.16 Mobile CT scanner now on site. Funding up until 31.3.17 to seek further funding to retain on site 17/18. 13.9.16 No further update provided 28.6.16 Awaiting funding to replace mobile CT scanner to place 2 permanent scanners on CAH site. 1/3/16 Retaining mobile CT to July 16. 5/1/16 - Jeanette is meeting with Sandra Waddell re completing a IPT to request funding to retain the mobile CT following the 1/4/16.	HIGH
3829	13/09/2016	Safe, High Quality and Effective Care	Absconding patients from all Wards & Department	Patients at risk of leaving the ward or department without investigations, diagnosis and management plan in place. Patient risk - Incomplete treatment for medical or mental health issues leading to physical and/or mental health deterioration Risk of self harm / death Staff risk- unable to deliver care to patients, risk of violence and aggression when trying to persuade patients to avail of assessment, treatment and care for their illness.	Level of absconding rates identified. Absconding patient protocol in place. Staff awareness raised. Datix reporting in place. Short life working group established to review access to wards and departs promoting pts and staff safety.	23/2/2018 - Additional measures have been introduced to access and egress from ED and AMU. Swipe card is required. Statistics need to be reviewed before consideration can be given to reducing the risk rating. Situation continually monitored.	HIGH
3951	10/04/2018	Provide safe, high quality care	Delays in isolation	Due to lack of side rooms/one to one nursing/lack of bed capacity in the service. Risk of spread of infection. Failure to isolate promptly can lead to outbreaks, close of bays, increased pressure on service. May lead to potential patient harm through the spread of potentially preventable infection or due to a lack of beds.	Trust can emphasise the importance of IPC issues at bed meetings and elsewhere. A recent teaching sessions was arranged to do this amidst the winter pressures. Side rooms are often occupied for reasons other than IPC reasons. IPC reasons for isolation are often of critical importance in that severe harm can be done to other patients and staff by failure to isolate promptly. This is often not the case for other reasons patients are in side rooms and side rooms should be prioritised to maximise patient safety. The Trust should also look to ways to enhance the capacity to isolate a patient when the hospital is full and a patient needs isolated urgently e.g. where a patient could be moved out of a room to facilitate critical IPC isolation.	Risk added to Directorate RR April 2018	HIGH
3952	10/04/2018	Provide safe, high quality care	Delays in prescribing treatment for CDI	Delay in treatment of infection can be associated with increased morbidity and mortality. The enquiry into the Northern Trust Clostridium difficile outbreak said that treatment should be given to any patient with Clostridium difficile within 2 hours of diagnosis. Where such a patient is septic they should receive treatment within 1 hour as per the Sepsis 6 criteria. Failure to treat a patient promptly carries of risk of adverse consequences to the patient (e.g. pseudomembranous colitis, toxic megacolon, the need for laparotomy and subsequent stoma a formation, death) as well as a risk of subsequent litigation to the Trust and the potential for disciplinary procedures to doctors and nurses from their governing bodies.	The microbiology laboratory calls out positive C.difficile results as soon as they are known and informs the consultant microbiologist on duty and the Infection Prevention and Control Nurses (during working hours). The microbiology laboratory is fully complaint with the Royal College of Pathology's Key Performance Indicators with regards to this matter as audits would reflect. Nursing staff when contacted should inform medical staff immediately. On certain occasions this has not happened as RCAs have reflected. On other occasions medical staff have given excuses that they have been too busy to attend within 2 hours. This more often occurs depends the out of hours periods whenever there is a relative lack of medical cover and there is a particular issue in the non-acute sites where there is no resident medical cover. A lack of awareness of the urgency of treatment has also been given as a reason for not treating promptly. There would be significant concern that this could reflect general medical busyness out of hours and that other treatments could be being delayed as doctors are overwhelmed by the volume of work out of hours. The delay in administration of treatment for Clostridium difficile is is being picked up because of the root cause analysis process but many other things are not picked up. The antimicrobial stewardship team proposed a PGD to allow nursing staff to give a single dose of metronidazole in instances when doctors could not see patients quickly enough however this has yet to be approved. Opposition was raised by clinicians who were concerned that if nursing staff gave this it would potentially delay medical review of such patients even further. This concern is not unreasonable but if accepted it reflects concerns regarding system pressure on medical staff out of hours that need addressed by the Trust to maintain patient safety. The failure of nursing staff to inform medical staff regarding the diagnosis of CDI is rare and can be addressed by Lead Nurses and Ward Sisters by education. Similarly the lack of awareness about the urgency of treatment is rare as the need for prompt treatment is regularly reinforced by microbiologists when calling such results. Clinical Directors could address deficits of education in their areas. The Trust simply needs to decide whether to support the proposed PGD or not. Difficulties regarding a lack of medical staff on duty out of hours if the Trust believes that this is a legitimate concern are far more difficult and could only be resolved by employing more medical staff out of hours. Doing so would be in line with the Secretary of State for Health's vision of a 24/7 NHS. This however would undoubtedly require significant extra resource in terms of capital as well as significantly more junior medical staff which there is currently a shortage of. It may be worth the Trust auditing the speed at which other procedures e.g. treatment for other conditions, writing up of fluids, analgesia, etc occur in hours and out of hours to ascertain the extent of the problem.	Risk added to Directorate RR April 2018	HIGH
3953	10/04/2018	Provide safe, high quality care	Inappropriate ant biotic use (tied to stewardship issues in terms of corporate actions needed)	Inappropriate antibiotic prescr bing can lead to a rise in antibiotic resistance which impacts on the safety of the entire public. It can also lead to side effects for individual patients such as Clostridium difficile infection (CDI). The risk of CDI is enhanced where antibiotic treatment is unnecessarily broad spectrum or overly prolonged. Inappropriately narrow spectrum or inadequately long courses of antibiotics can also lead to adverse outcomes for patients including recurrences of infection and death. Inappropriate prescr bing most often occurs:- (a) When patients receive ant biotics when they do not have infections - this often occurs whenever a diagnosis is initially unclear and infection is in an initial differential but antibiotics are not stopped whenever the situation becomes clearer. (b) A clear diagnosis is not made e.g. a patient is designated ?LRTI ?UTI - often even when a diagnosis is subsequently made broad spectrum antibiotics are not narrowed as they should be (c) When patients receive prolonged antibiotic courses instead of getting proper source control - all guidelines advise that abscesses or infected collections should be drained promptly if at all possible The patient is at side effects from antibiotics, at risk of acquisition of multi-drug resistant organisms, at risk of Clostridium difficile and potentially death. Other patients and staff are put at risk as bacteria in the hospital environment develop greater resistance, meaning that the number of antibiotics available for future treatments become more restricted. Ultimately bacteria can become panresistant and untreatable. This in turn places greater pressure on side ward capacity in the Trust and risks targets e.g. MRSA target. The Trust has will not be able to meet the upcoming targets for the reduction of broad-spectrum antimicrobial use unless the situation is improved. Staff and the Trust are at risk of litigation and censure from the Coroner and the GMC.	The Trust conducts antimicrobial stewardship rounds to reduce inappropriate antibiotic use. This service however is limited by the inadequate number of microbiologists and antimicrobial pharmacists. The Trust has far fewer microbiologists than neighbouring trusts and the number it is funded for (2) is far short of what the Royal College of Pathologists standards says it requires. The Trust only employs 1 antimicrobial parmacist in comparison to the standard 2 in other Trusts. This means that the stewardship round service is exceptionally vulnerable to leave or illness and at best only is staffed to function two thirds of the year. The service has been severely impacted by the current staffing situation in the Trust. The Trust has only had a single microbiology consultant for over a year and a half. At times there has been no locum cover and there is not capacity to do stewardship rounds when a microbiology is single-handed. Since the Trust's antimicrobial pharmacist was promoted several months ago the Trust has had only had a pharmacist effectively 1 day a week which again had a severe further impact on the antimicrobial stewardship service. Membership of the Trust's Antimicrobial Team Meeting (the main forum for communication for stewardship issues) had waned however the DIPC recently reviewed the membership of the meeting and medical leaders are now expected to attend. This has significantly improved the platform at which stewardship is discussed however the situation of the service as a whole remains critical. The Trust has offered positions to a new antimicrobial pharmacist and a second microbiologist however they have yet to take up posts. A business case is being submitted for expansion of the microbiology and antimicrobial pharmacist services which is critical to address these issues. Medical leads need to be encouraged to take more actions in their areas to emphasise the importance of stewardship. This will be discussed at the next AMT meeting on Tuesday the 27th of March. Lead Nurses and Ward Sisters should be empowered also to encourage nursing staff to challenge prescriptions.	Risk added to RR April 2018	HIGH
3954	10/04/2018	Provide safe, high quality care	Lack of documentation	Root cause analyses are repeatedly picking up incidences of poor documentation e.g. lack of filling out of Clostridium difficile bundle, lack of documentation that the patient has been informed of a diagnosis of Clostridium difficile, lack of filling out of cannula charts, etc. Lack of documentation can reflect either that something that should have happened has not happened or just that it has not been documented. In the former there is a direct risk to patient safety (e.g. death from Staphylococcus aureus bacteraemia from a cannula that was not inspected properly and removed when it should have been, death from Clostridium difficile due to deterioration not being picked up due to lack of due diligence in the application of the bundle). In the latter there is still danger to the patient as staff subsequently on duty will not be able to see what was done as it is not documented. There is also significant risk to litigation to individual staff and the Trust as without documentation to say that good practice has been carried out there is no proof that it has been done.	Medical and nursing training would emphasise the importance of good documentation. Root cause analyses would emphasise the importance of this. The recurrence of this problem as demonstrated by repeat root cause analyses however would suggest that current control measures are not sufficient. When challenged regarding poor documentation excuses given are usually:- (a) A lack of education/awareness regarding aspect s of care bundles (b) A lack of time to document things due to service pressures Problem (a) could re resolved through additional education to staff through Lead Nurses, Ward Sisters and Clinical Directors to their teams where this is needed. Problem (b) can only be resolved by easing the pressure on nursing and medical staff in general. In general the experience of the IPCT is that nursing documentation is better than medical documentation, especially with regards to documenting when a patient has been informed of their diagnosis.	Risk added to Directorate RR April 2018	HIGH
2979	13/05/2011	Provide safe, high quality care	Multiple records/charts per patient e.g. a patient may have STH, CAH, BPC & DHH medical notes	Patient is at risk due to information in multiple charts (no one chart may contain a full record of patient history and investigations). Trust from risk of litigation. Risk to patient of incomplete information being available at time of consultation, incorrect diagnosis due to incomplete information, delay in diagnosis, risk of injury and/or death. Reputation of Trust at risk.	Patient information is available electronically in Patient Centre, NIPACS, Labs, TOMCAT. Charts for CAH and DHH only now registered. All charts are made available if requested.	7.3.18 Risk remains unchanged 28.09.17 Further work is to take place with regard to registration of CAH and DHH charts and a move to 1 patient 1 chart. Initial discussions will take place in October with Health Records managers and the Booking Centre to identify issues relating to registration, and following this a proposal will be taken to Acute SMT for discussion and agreement. 28.12.16 - work ongoing with continuing to reduce number of charts per patient in circulation - robust weed and destruction of charts takes place every year and registration reduced. Risk reducing each year. 12.9.16 work still continuing on reducing the number of charts per patient - this is an ongoing exercise. A trial of going "paperlight" was conducted in June - Aug 16 which would reduce the amount of paperwork generated per patient however, until such time as a "write on" information system is available we cannot progress with paperlight / paperless clinics as information still needs to be recorded on the patient visit.	MOD

ID	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3070	23/01/2012	Safe, High Quality and Effective Care	Omitted and delayed medications within Acute Directorate Wards	Wards and departments not administering medications in a timely manner. Patients are receiving an inadequate quality of service with the potential risk for harm.	Staff nurse or ward based pharmacist where possible highlights all incidents via datix. Proforma is to be completed in conjunction with the Band 6 and the staff nurse responsible for the omission or delay to reinforce learning and improve standards. Staff nurse to escalate to Ward Sister if any delays or omissions at ward level.	06.09.17 Jilly and Trudy to discuss 1.12.16 No further update. 13.9.16 Audit completed. Report circulated for learning. Showing some improvement but NQI monitoring continuing. 27.05.16 - Yearly audit taking place May/June 2016. 23.02.16 - Ongoing NQI audits continue to highlight this problem area. 24.09.15 - Focus on the number of omitted and delayed medications in SEC continues supported by lead nurses, HoS and the NEAT project. Regular audits to monitor performance in this area and learning from medicines incidents group shared across the directorate.	MOD
3304	16/01/2013	Provide safe, high quality care	Lone Workers in X-Ray after 12 midnight	Risk to the welfare of the lone Radiography staff working out of hours shifts either in CT or when performing Mobile radiography in remote areas of the hospital. On both instance the lone Radiographer is required to come into the x-ray department that is located some distance from ED and the wards. This leaves the lone Radiographer vulnerable and at risk from verbal/physical abuse/theft from visitors and patients . This potentially increases the staff's stress levels. Staff have a right to expect a safe and secure working environment.Risk of patients/visitors having free access to the x-ray department during the period from 8pm-8am as the department is not locked down securely during this period.	Staff Awareness. Restricted access in some areas. MOVA policy and procedures. Personal attack alarms issued to all staff. CCTV. Porters available to escort staff. Porters and Radiographers to lock main doors of x-ray when not in use. Radiographers required to checked that all doors into x-ray are locked before 8pm at night.Lone worker policy. IR1 Reporting.	14.11.17 Awaiting update from J Robinson 5.12.16 The lock down system is being installed W/C 12 Dec 16. 13.9.16 Situation continues to be monitored	MOD
3528	05/02/2014	Safe, High Quality and Effective Care	Pharmacy Aseptic Suite	The external audit of the pharmacy Aseptic Suite, which prepares all the total parenteral nutrition and the chemotherapy for oncology and haematology patients, has identified The design and fabric of the aseptic building does not meet the modern building standards for pharmacy aseptic dispensing units (critical audit finding). Application of the newly introduced capacity plan has identified the chemotherapy pharmacists' activity is exceeding 100% on a regular basis (Major audit finding) The two isolators used in the cytotoxic reconstitution section of the aseptic suite both require urgent replacement.(Major audit finding)	Increased environmental monitoring to check for failures of sterility in the unit Expiry dates of all products prepared has been reduced to a maximum of 24 hours. A daily report on the chemotherapy pharmacists activity level in relation to the capacity plan has been developed and implemented Additional activity will not be accepted by the aseptic unit until the staffing issue is resolved Additional environmental and function testing is being performed on both isolators to identify any sterility failures.	16.10.17 Unchanged 1.12.16 No further update. 13.9.16 Development Work ongoing 1/3/16 Work commenced for new suite. • Confirmation of the funding for the business case for a new build aseptic suite co-located with the Mandeville Unit was received at the end of July 2017. The design team have met throughout August with the aim of commencing the build in March/April 2017. • Recent deterioration in the fabric of the building has been addressed through an interim plan involving urgent minor works to the aseptic suite which was completed by mid-May 2016. • The external auditor revisited the suite on 26th July 2016. Their report is awaited. From discussions with the lead auditor on the day, it is expected that their report will still class the unit as high risk, but will recognise the work that has been done to manage this risk whilst the new unit is awaited. two additional pharmacist posts were funded by HSCB to address the staffing deficit that was leading to the capacity plan model showing that the pharmacists are working between 130 and 150% capacity. Both pharmacists took up post in Jan 2017 and the capacity score has been reduced to 94% Capital was identified to replace both isolators and this work was completed by January 2015.	MOD
3529	05/02/2014	Provide safe, high quality care	Non compliance to Standards and Guidelines issued to Southern Trust	There is often a time lag between when the external agencies require the Trust to achieve full compliance against the recommendations outlined within standards and guidelines and when this is actually achieved. Such non-compliance poses the following risks for the patient and the organisation: - Reduced ability to deliver quality patient care; Compromised patient safety and wellbeing; Poor patient outcomes - mortality/morbity, delayed discharge, increased secondary complications; Staff members are non-compliant with evidence based working practices, lack of standardised practice, vulnerable wrt registration; Organisational risk - complaints, incidents, litigation, As of April 2018 there are 1609 standards and guidelines identified on the Trust's register. 74% (1193) of these are applicable to Acute Services Directorate. Of these, 34% (405) remain at a partial or non determined level of compliance with many identifying significant external barriers impeding the Trust's ability to comply. 689 are indicated as 'Compliant ' and 99 indicated as either N/A or Superseded. It is noteworthy to state some of this data is pending QA as part of Phase 1 and 2 review work which has not been fully completed due to service capacity. Due to volume and complexity of these guidelines it is a challenge for the Trust to monitor and review the compliance status of all the standards and guidelines that have been received. There is a corporate need to invest in a more fit for purpose information system . Regionally the WHSCT is currently piloting a new system that is being developed by Microsoft - it is a modified system within Sharepoint. Funding has been allocated by BSO to take this work forward with a view of developing a regional system for use by all HSC organisations. A planned demonstration by WHSCT was planned in February 2018 but had to be deferred due to some difficulties in getting the system operationalised S&G backlog continues since the number of newly issued S&G demands the capacity of the Acute S&G team to ensure timely implemenation. Consequently there continues to be a need to review the register, identify the backlog and prioritise those standards and guidelines that need to be implemented by nominated change leads. Since 7 January 2017 the corporate S&G forum has been stood down. Whilst new processes for managing S&G have been developed, one key challenge is the timely implementation of those S&G that have a cross directorate applicability. This includes a delay in identifying the lead directorate and who will lead these pieces of work. This has resulted in some S&G circulars not meeting the required deadline to submit an assurance response to the required external agency. It also has the risk of creating 'siloed' implementation processes within each applicable directorate which in turn has the potential to produce inconsistency in any new processes that are being developed, especially across the different care boundaries. This is a risk.	Provision of bi monthly assurance responses to the HSCB as part of the Trust's Positive Assurance response. Corporate governance have an Excel database in place for logging and monitoring S&G. Within Acute Services a directorate S&G forum has been established - Inaugral meeting was held 19 January 2017. Terms of reference are in place and the forum is chaired by the Director and attended by the SMT. The forum meets twice a month to review all newly issued S&G so to ensure appointment of a clinical change lead is confirmed in a timely manner, thereby ensuring implemenation processes are put in place as early as possible. It also reviews and approves implementation plans requiring submission to the the relevant external agency. It approves any policy/procedures/guidance that has been developed as part of these implemenation plans. Standard item for discussion at the monthly Acute Clinical Governance meetings with submission of relevant reports Patients Safety & Quality Manager (Acute Services) attends all divisional governance meetings on a monthly basis and presents tailored activity reports to determine progress at an operational level Meeting schedule is in place to ensure meetings are held with the Heads of Service to review compliance against all S&G within their areas of responsibility A new Acute Services Lead Nurse, Midwifery & Radiology S&G forum - meetings held on a monthly basis Monthly summary report is issued out to Acute SMT to communicate to all staff what new regionally endorsed S&G have been issued. A copy is also shared with the M&M chairs so that they can review and share within their committee meetings Service KPIs are in place and presented to the Acute S&G forum on a quarterly basis Acute S&G procedures manual has been developed and has been operationalised since 1/4/2017. This is subject to ongoing review and updating Acute S&G administation processe maps have been developed and are to be presented at Acute S&G forum on 01/05/2018 Standard item for discussion at SMT (monthly) and Governance Committee with submission of relevant reports / assurance statements. Meetings held 6 monthly with the Head of development & Planning to ascertain if any business cases can be supported with relevant S&G Patient Safety & Quality Manager (Acute Services) attends the regional NICE Managers meeting which provides a valuable network with the other 4 HSCTs, DHSSPSNI and HSCB Patient Safety & Quality Manager has completed a one year scholarship programme. A project was undertaken to determine what evidence based processes are required to ensure effective implementation of S&G. The controls outlined above provide evidence of the quality improvement work that has been achieved. In April 2017 a Band 5 Governance Officer has commenced work within the Acute S&G team as part of a secondment from the Corporate team. This completed on 31/12/17. An audit was undertaken to determine the level of assurance against all NICE guidelines that are applicable to Acute Services. The outcomes from this audit have been operationalised in an action plan and this work is progressing. Outstanding actions are escalated to the Acute S&G forum / Divisional Governance forum to ensure progresssion.	7/3/18 & 5/12/17 Information below remains current 19.7.16 - Decision needs to be made regarding the viability of re-appointing an AMD for Standards and Guidelines (Acute Services) - forms part of the current review of Acute Services structures. Administrative support for the Patient Safety & Quality Manager needs to be reviewed - there is currently no administrative support. Patient Safety & Quality Manager (Acute Services) has successfully achieved a one year NICE scholarship - project is to undertake a review of the directorate's process for implementing standards and guidelines - to be completed by 31/03/2017. Regionally the WHSCT is to undertake a pilot of Sharepoint to ascertain if this system would be fit for purpose for the development of a regional information system for the management of standards and guidelines. HSCB are involved in this process and funding to support this initiative is currently being sought. There continues to be an urgent need to put in place a more effective information system for the logging, dissemination and monitoring of standards and guidelines. Corporate governance is currently designing an inhouse system until an appropriate regional solution is agreed.	MOD
3922	13/11/2017	Provide safe, high quality care	Lack of funding to ensure compliance with NICE guidelines that have been regional endorsed by the DHSSPSNI.	In April 2017 a Band 5 Governance Officer commenced work within the Acute S&G team as part of a secondment from the Corporate Governance team. This secondment to the Acute S&G forum ended on 31/12/17. The purpose of this audit was to ensure that an assurance framework is in place to comply with the reporting arrangements to the relevant external agencies (such as the HSCB). The outcomes from this audit are now being operationalised and outstanding actions are presented at the Acute S&G forum and Divisional Governance meeting to ensure progression. As part of this work a significant number of NICE guidelines have been identified as having an external barrier impeding implemention. This audit identified 53 NICE guidelines where an E proforma is required. 34 E proformas have been submittted to the HSCB and a further 8 are pending submission once the baseline assessment has been completed and approved by Acute SMT. 11 E proformas are now due for review and work is progressing to undertake this process. A copy of the updated May 2018 E proforma report will provide evidence of this work. The work also provides a timely trigger for the compliance position to be reviewed in accordance with stipulated review timescales. In the past the HSCB would have reviewed 'red' status guidelines for all Trusts and for guidelines were all Trust's identified significant barriers these would have been prioritised as part of their annual work plan and there was the possibility of funding being allocated to support implementation at a local level. With effect from 01/04/2017 this is no longer the process, with all Trust' needing to manage all funding requests within existing financial resources. Given the number of competing demands this makes it very difficult to ensure that the S&G constraints are overcome and presenting a risk for the Directorate.	Provision of bi monthly assurance responses to the HSCB as part of the Trust's Positive Assurance response. The content of this report is approved by the Director of Acute Services and Director of Performance prior to submission The accountability arrangements for the management of S&G within Acute Services are well defined to ensure the risk of not complying with a guideline due to identification of an external barrier is communicated to the SMT in a timely way. There are robust processes in place to ensure timely review of E proformas to ensure any change in compliance is identified and should the compliance status be downgraded from red to green the HSCB can then be notified	June18 On-going monitoring and review within Acute S&G forum agenda Discussion with Trust SMT since this risk issue will be the same within the other operational directorates, albeit the number of guidelines are less	MOD
3940	26/02/2018	Provide safe, high quality care	Provision of a on-call bleeding rota	Inability to provide consultant cover every on-call night with the skills to manage patients admitted with haematemesis. Patients admitted with large haematemesis unable to be managed in a time critical manner.	Registrar manages the patient with haematemesis in the first instance. If Registrar requires support they would phone round the Gastroenterology Team if available to come in to assist.	10.4.18 Escalated to Directorate RR 26.02.18 Risk added to Divisional Register	MOD
3957	30/04/2018	Safe, High Quality and Effective Care	The medical team on the Daisy hill hospital site cannot provide daily senior review for all the Medical in patients	Due to medical workforce they are unable to ensure that all in patients receive a senior medical review. Delay in investigations. Delay in review of investigations. Delay in Diagnosis. Impact on the patient treatment plan. Potential to contribute to overcrowding in ED as some of in patients could be potentially discharged.	Each Ward Sister to identify at the bed meetings if patient has not had senior review. Ensure that outlyers are seen and escalate accordingly to Lead Nurse/ HOS		MOD
3958	30/04/2018	Safe, High Quality and Effective Care	EBUS Provision lack of Funding	The risk is that patients requiring cardiac investigations are waiting in access of 13 week Pot for Harm -Delays in patients being diagnosed, commencing treatment and the appropriate way Delays may contr bute to patient death.	We have Cardiac Investigations teams across both acute Sites Agreed referral process to be used by CI staff at Triage Avail of funding from HSCB for additional clinics.	19/11/18 Measure access times monthly and highlight to HSCB via performance team. Review of cardiac investigation demand and capacity by HSCB.	MOD
3971	28/08/2018	Provide safe, high quality care	Access to cath lab for NSTEMI patients	Standard 18d of Cardio vascular framework that eligible NSTEMI / ACS pts should have Cor Angio +/- PCI within 72 hrs of admission. Angiography within 72 hours improves outcomes for patients. (NICE). MINAP state: The performance of angiography and coronary intervention soon is an important facet of treatment for the majority of patients.	Monitored weekly. Access elective patients. Escalate number of patients waiting for in patient cath procedures daily to AD and Director.	13.08.18 Performance team to liaise with HSCB re funding	MOD
4005	28/02/2019	Provide safe, high quality careMake the best use of resourcesBe a great place to work	Lack of Availability of Core AHP Staff	Increase volume of complex patients requiring intervention. Gaps in core services with inability ot recruit. Lack of backfill for maternity leave hence Patients not receiving timely assessment and appropriate level of rehabilitation to maintain patient flow. Patients under nourished, remain nil by mouth for increased length of time, unable to facilitate mobilisation with resulting deterioration in muscle bulk and increased morbidity, lack of facilitation of activities of daily living hence increased dependency and requirement for larger package of care on discharge which will be delayed. Patients being discharged prior to assessment. Poor SSNAP results and trust may not receive hyperacute unit.	Regular contact with BSO re recruitment. Requests to contract and non contract agencies for AHP staff, core staff offered additional hours,		MOD
4007	28/02/2019	Provide safe, high quality care	Risk that patients receive Inappropriate care due to the misuse of point of care testing	Risks arise from the inherent characteristics of the devices themselves and from the interpretation of the results they provide. They can be prone to user errors arising from unfamiliarity with the devices. Patients are at risk of inappropriate treatment as a consequence of inaccurate results. Individuals are sharing passwords in contravention of Trust procedures and good governance. Equipment is not being properly maintained which puts equipment at risk of malfunction leaving patients vulnerable. Internal Quality Control review and regular audits have stopped due to a lack of resources. There is a lack of Assurance around temperature control of reagents etc. which has the potential to influence the results. Patients are at risk of receiving an inaccurate test result and receiving inappropriate treatment or not receiving treatment when it is actually required. Patients could come to serious harm / death. Staff are at risk to Trust sanction or Professional body sanction, litigation, dismissal. Trust is at risk of litigation due to Improper use of devices. Trust is at risk of litigation due to improper treatment based on inaccurate results or misinterpretation of results.	Training is available on all devices. Quality controls are available. DATIX web is available to report and monitor any incidents. Staff are given unique barcodes to operate Trust equipment where they are deemed competent to do so. It is the responsibility of all staff issuing a POCT device to end users to ensure that the user is adequately trained and competent to use the device.		MOD
4010	28/02/2019	Provide safe, high quality care	Delay in the treatment of Cancer Patients due to vacant Oncology Consultant	Due to vacant Acute Oncology Consultant post and long term sickness with Specialty Doctor in Oncology there may be times when unwell patients attending mandeville unit will have to be directed to Emergency Department for further assessment and management. Service reliant on Clinical Nurse Specialist support at present	Trust currently trying actively to recruit into vacant Acute Oncology Consultant post and working closely with colleagues in Belfast Trust to support the oncology service.		MOD
4011	28/02/2019	Provide safe, high quality care	Delay in the Management and Review of Haematology Patients	Due to pressures within Haematology service patients requiring review at outpatient Haematology clinic may not be reviewed in a timely manner due to review backlog therefore risk that patients may have delay in diagnosis. A senior Consultant is planning to retire at the end of December and due to difficulties in recruiting medical workforce this may further impact the ability to review patients in a timely manner.	Staff have been offered the opportunity to undertake additional sessions to ensure that the waiting time for patients to be seen is reduced and patients are seen in a timely manner.		MOD
2422	13/10/2009	Provide safe, high quality care	Multiple training schedules for staff at Trust Level. Lack of resources to facilitate staff to go to training.	Staff unable to attend training due to multiple training schedules, therefore leaving ward short staff or staff not being updated. Mandatory requirements unable to be facilitated. With staff at training there is a potential risk of not providing safe high quality care to patients. It will deplete staff numbers at ward level therefore failure to meet the expected standards of care. This will apply pressure on colleagues who remain on the ward.	Ward Sister to manage off duty rotas and prioritise training needs/where there are high dependency levels respons bility of nurse in charge to assess situation and take decision on releasing staff for training/more flexible approaches to training eg delivered at ward level,e-learning etc.	23.9.17 - CMT remains challenging to achieve over 80% mainly due to 1- staffing challenges and 2 availability of training which is not 'online'. 1.12.16 No further update. 13.9.16 Awaiting update 27/5/16 - No change. 7/5/15 Ongoing issues remain with the number of training sessions being provided and the ability of ward Sisters to release staff to attend training due to workload and staffing pressures. The NEAT lead nurse team have commenced supporting nursing staff in medical and surgical wards providing essential written and verbal information and training to ensure patient care standards remain at a high level. With nurse revalidation commencing 15/16 it will become even more important to ensure that training is completed for all qualified nursing staff.	LOW

ID	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3515	14/11/2013	Provide safe, high quality care	Ineffective Cardiac Monitoring System in certain Wards/Departments in CAH and DHH	The current cardiac monitoring system is old and unable to monitor patients in various wards/departments in the hospital site given their physical location. Monitoring is not available for certain patients and patients then may be required to move to 1 North for monitoring unnecessarily.	Appropriate selection of patients for monitoring.	14.11.17 Waiting on decision to start work with the potential of relocating coronary care beds to the HDU in DHH. 1.12.16 No further update. 13.9.16 In relation to CAH telemetry, this has now been fully implemented in the main acute wards, cathlab, and delivery suite.DHHJs awaiting funding allocation. 27.05.16 - Work in CAH will be completed with 3 months time. Costing obtained in respect of DHH work and added to Capital Estates list for consideration. 1/3/16 Now in place residual witing being carried out. 14.07.15 - Replacement system purchased and installed. Estates undertaking wiring to ensure all acute areas are covered.	LOW
3929	12/12/2017	Provide safe, high quality careMake the best use of resources	Declaratory Orders for patients who lack capacity	Decisions sought from the court in those cases when someone lacks capacity and wherein a deprivation of l berty is likely to exist. The risk is that for those cases not taken to the court for a declaration order, there is a risk that the Trust could be challenged through judicial review for the best interests decisions it makes pho individuals without capacity.	Advice is that in all cases where a DoL is evident for individuals assessed as lacking capacity, the Trust should seek a decision from the court. This is neither achievalbe not affordable. This paper proposes that Multi-disciplinary teams agree only the most difficult cases are taken to the court for a decision.	7.3.18 Risk remains unchanged	LOW
3956	30/04/2018	Safe, High Quality and Effective Care	Non-compliance with NCEPOD inspiration for the future	There are 21 recommendations for this NCEPOD Currently only fully compliant with 1 KPI. Patients who require Non Invasive ventilation have the potential to receive inadequate care as we are non compliant with 21 KPI	Established MuLti Disciplinary working group for the Trust. Established Sub groups to take forward key indicators. Establish baseline and review in 6 months.		LOW
4009	28/02/2019	Provide safe, high quality care	Delay in the management of oncology patients	Due to significant vacancies in Medical Oncology Consultant workforce Southern Trust have increased reliance on locum Consultant cover both in Lung and Breast Oncology clinic. In Breast clinic it was highlighted that some patients did not have scans ordered as agreed and there was no documentation recorded on Regional Information System for Oncology/Haematology RISOH.	Trust currently working closely with colleagues in Belfast Trust to complete a look back exercise to ensure patients have all got a management plan. ongoing review of weekly clinic and outcomes from these.		LOW
4006	28/02/2019	Provide safe, high quality care	Lack of robus arrangements and sufficient resources for the management of equipment and medical devices.	The Trust does not currently have in place suitable and robust arrangements to support the management of medical devices and equipment in accordance with the DHSSPS Controls Assurance Standards and MHRA guidance. Stringent management throughout the lifecycle of medical devices (from procurements to disposal) is essential in minimising the associated risks to both patients and staff. The Trust has a duty of care towards its employees and patients to ensure that they are not put at risk from medical devices which are not managed properly, may be unsafe or unsuitable, are not maintained or whose operation is not understood by the user. There is also a risk that the Trust could be subject to litigation if it can be proved that there were not adequate management systems and resources in place to deal with equipment management			LOW
3875	21/02/2017	Provide safe, high quality careSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of resources	The transfer of patient data outside the EEA.	Due to insufficient availability of Radiology Registrars within the Southern Trust the Radiology Department is unable to provide the service of reporting emergency CT scans for patients between 10.00pm and 9.00am daily. This problem has presented itself in the Northern and Western trusts where they also have insufficient staffing. They have addressed this issue by contracting an Independent Sector company. The Southern Trust has procured an Independent Sector company which will be contracted to report on the CT scans during the above hours. The images need to be performed within the Southern Trust and then transferred outside the EEA for viewing and reporting. Reports will then be transferred to the Southern Trust PACS where they will be available to the referring clinician. It is during this process that there is a risk of data loss. The potential risk occurring during the transfer of images outside the trust is the loss of patient data. The risks have been assessed by BSO Legal Services, Trust Information Governance and IT. Due to the following mitigating factors it is believed this risk is of an acceptable level:-Reputable company with contracts ongoing in NHS England Company has DPA obligations in place and have been co-operative in responding to additional requests for clarification -Lack of alternative re processing of records -Consequences of a data breach (CT scan images) -L kelihood of a data breach -Impact on patient if breach occurred -Reputational damage to Trust if breach occurred - may be low - depending on number of records involved	Within the specification the following has been recorded: "3.11 Confidentiality / Intellectual Property Rights. Assurances must be provided to the Trust that data and digital images are secure at all times." Ongoing monitoring of images being sent and reports being returned will also be used to ensure there has been no loss of data.	21.02.17 Risk added to Acute Risk Register	VLOW
3981	05/11/2018	Provide safe, high quality care	Administrating Contrast Media within Radiology	The current framework for prescribing, supply and administration of medicines (primarily the prescription of contrast media) within Radiology across the region does not meet current legislative requirements. It is the agreed approach of the Regional Modernising Radiology Clinical Network that this current practice poses a low risk to patients and has developed as normal practice over the past number of decades to meet the ever increasing demand for contrast enhanced examination. All decisions regarding the administration of medicines in Radiology is done under the direction of senior clinical staff following local procedures, protocols and guidelines as delegated by their Clinical Director. Issues with the management of medicines within Radiology has been recognised as a national issue, which has been escalated to NHS England as a risk to Radiology services. As a long term administration of contrast media. Low Risk PGD's are being put in place within the Southern Trust to provide a degree of cover for Radiographers administering contrast media.	Currently radiographers operate under written protocols agreed by the clinical director of Radiology.	Training of radiographers required to undertake prescribing	VLOW

Cancer and Clinical Services Division
Divisional, Head of Service and Team Risk Register - 1 May 2019

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
4008	28/02/2019	Provide safe, high quality care	MRI Craigavon Area Hospital	SyngoVia imaging software is not covered by service contract.	This software is essential in the reporting of Breast MRI as it is used to produce contrast uptake curves that cannot be produced on the PACS reporting stations. Server breakdown - costly repair as not under contract Software versions not being updated - missing out on new benefits and uses for example in Prostate diffusion analysis. (Information from Siemens support:From our records, I can see you have Syngo.via (Serial Number 130005, Tech ID: N2360) operating on software version VA30A. On VB10 software it is possible to retrospectively interrogate the acquired data set and generate calculated b-Values up to 5000 (see attached). I know this is not immediately helpful to you as it requires an upgrade, but I just wanted to make you aware of your options should you wish to achieve a higher calculated b-Value.) Data security risk - software out of date - updates not carried out Info from IT - There is a security flaw with the SQL database server, which is out of support by Microsoft and I will need to approach Siemens. The other problem is that the current Syngo Via application version only supports this outdated SQL version. There is a higher software version, which supports a higher build version of SQL,. Security risk to patient data if not protected by software and security updates Risk of software becoming obsolete and no longer usable if versions no longer supported Risk then of being unable to provide breast MRI service.	None.		HIGH	DIV
3847	24/10/2016	Provide safe, high quality care	Trustwide	AHP Capacity Deficit for Acute Oncology Staff	Lack of timely response to Oncology referrals by specialist staff and limited rehabilitation input.	Patients rehabilitation may be compromised.	22.1.18 Still ongoing risk 14.11.17 -Capacity and demand paper being revised, This need remains largely unmet 6.6.17 Regional work still ongoing Dec 16 Working with region to establish any regional developments.	LOW	DIV
3936	03/01/2018	Be a great place to work	Laboratory	Lone Worker in Laboratory	Risk of harm to laboratory staff who may be working on their own to provide a critical service on the Daisy Hill site. There is risk to staff form adverse incidents including potential for sudden illness, accident or intruder with no immediate help at hand.	Out of hours entrances and exits are locked. Staff have access to phones and two-way radios that give the laboratory staff access to portering staff in case of an emergency. Single Pane windows upgraded. Personal Panic alarm system installed. Inner doors replaced / thumb turn removed.	7.3.18 Risk continues to be monitored	LOW	DIV
3984	19/11/2018	Provide safe, high quality care		Second CT Scanner is now in situ in CAH				LOW	DIV
3191	03/09/2012	Safe, High Quality and Effective Care		62 Day Cancer Performance	Trust fails to meet performance standard due to increase in red flag, capacity issues, inability to downgrade and Regional issues.	Daily monitoring of referrals of patients on the 62 day pathway. Escalations to HoS/AD when patients do not meet milestone on pathway. Continuous communication with Regional with regard to patients who require PET and ITT patients for Thoracic Surgery, 1st oncology appointment. Monthly performance meetings with AD/HoS and escalations of all late triaging	14.11.17 Cancer work plan under development, Cancer trajectories in place, Weekly monitoring continues 6.6.17 Difficulty achieving 62 day performance due to delay in 1st apt, investigation and external pressures including PET scan lung/cru oncology 28/06/2016-achievement of the 62 day pathway continues to be a risk due to external factors and internal factors such as delay in first appointments, increase in red flag referrals from GPs, Reporting of diagnostics . May performance 76%. • Breast screening and assessment, Breast 2ww - currently unable to achieve this target due to increase in demand and reduction in Radiologists and Surgeons to cover this service. Routine symptomatic breast service.	MOD	DIV
3728	01/09/2015	Provide safe, high quality care	Trustwide	Serious concerns following June 2015 Cancer Peer Review	Serious concerns for skin, urology and H&N following assessment against the cancer peer review standards. Potential for Harm; The highlighted serious concerns may result in risk to patients who are/should be on the cancer pathway.	Recognised capacity gaps exist, consultation with HSCB ongoing with IPTs submitted where appropriate and participate and await the outcome of the Regional outpatient reform exercise. With regards to CNS's await outcome of the Regional CNS prioritisation project.	22.1.18 No longer serious concerns. Awaiting new Risk Assessment with accurate update. There are now action plans in place for each cancer MDT. 14.11.17 Ongoing process. Working closely with cancer MDT's to ensure compliance against standards 6/6/17 Clinical Nurse Spec workforce expansion on a 5 year period agreed by HSCB. Skin & other CNS under recruitment. 24/10/16 Fiona Reddick to provide an update 6/1/16 - The Urology & skin task/finish groups continue to meet to address peer review issues.	MOD	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3869	23/01/2017	Safe, High Quality and Effective Care	Trustwide	Limited Speech and Language Therapist Provision	Inability to provide adequate Speech and Language Therapy to acute based patients due to increased volume of referrals of complex patients over previous 10 years - situation escalated by inability to backfill 2 senior staff on maternity leave and complexity of patients requiring SLT assessment. Capacity to provide Dysphagia treatment significantly reduced. Delayed assessment of patients designated nil by mouth so rehabilitation potential reduced. Delayed review of patients on modified diet Delay in discharge as SLT unable to respond to request for assessment and intervention re: swallow management including information re: food/fluid textures to carers. Potential for SAIs. Patients discharged prior to assessment Limited rehabilitation to patients, hence longer length of stay in hospital. Complaints received re: service provision Inability to consistently meet professional standards Health and wellbeing of staff compromised Staff working outside levels of competency and under significant pressure. Inability to achieve regional PTL waiting time targets	Several requisitions for recruitment of suitably trained staff - unsuccessful Junior locum staff employed but not skilled enough to fully meet caseload demands All core staff offered additional hours Telephone referral system manned by administration staff Triage and prioritisation of referrals Waiting list for in patients Timetable constantly reviewed with staff managed & moved between the 2 sites to attend to priority demands Cancellation of VFS clinics which leads to distress of patients and families.	21.11.18 New post appointed Apr 18. However, capacity v demand compared with NHS benchmarking identifies approximately 50% deficit re staff required. Also Band 6 gap as member of staff left post. 22.1.18 Situation has deteriorated and continues to be monitored. 14.11.17 Secured SLT for AMU - recruitment in process, Capacity / Demand paper being revised, Prioritisation of demand continues. 6.6.17 Remains limited due to low investment in this service.	MOD	DIV
3999	04/12/2018	Provide safe, high quality care		Vacant Oncology post impact on service	Due to vacant Acute Oncology Consultant post and long term sickness with Specialty Doctor in Oncology there may be times when unwell patients attending mandeville unit will have to be directed to Emergency Department for further assessment and management. Service reliant on Clinical Nurse Specialist support at present. Patients may not be seen in Mandeville unit. Delay in treatment when presenting unwell	Trust currently actively trying to recruit into vacant Acute Oncology Consultant post and working closely with colleagues in Belfast Trust to support Oncology service.		MOD	DIV
3998	04/12/2018	Provide safe, high quality care		Review Backlog in Haemotology Service	Due to pressures within Haematology service patients requiring review at outpatient Haematology clinic may not be reviewed in a timely manner due to review backlog therefore risk that patients may have delay in diagnosis. A senior Consultant is planning to retire at the end of December and due to difficulties in recruiting medical workforce this may further impact the ability to review patients in a timely manner. Patients may not be seen within appropriate review. Delay in diagnosis	staff have been offered the opportunity to undertake additional sessions to ensure that the waiting time for patients to be seen is reduced and patients are seen in a timely manner.		MOD	DIV

Functional Support Services Division
Divisional, Head of Service and Team Risk Register - 1 March 2019

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
1220	18/08/2008	Provide safe, high quality careBe a great place to workMake the best use of resources	Laundry	Essential laundry equipment needs to be replaced to avoid breakdown and disruption	Essential laundry equipment needs to be replaced to avoid breakdown and disruption to this fundamental service requirement; equipment breakdowns not only affect the service which is provided to Southern Trust facilities but also to Belfast City and Musgrave Park hospitals. Risk to the supply of clean bed linen to wards and departments. Risk of infection. Impact on service delivery by nursing staff delay in making up beds.	Regular maintenance of ageing equipment as replacement parts are becoming obsolete.	5.4.18 Business case was recosted Nov 17 and was approved by SMT March 18. 16.8.17 Business case is still with Finance for re-costing. 12.12.16 No further update. 21.11.16 An additional option has been included and is with Finance for re-costing. 17.8.16 Business case for replacement of calanders presented to SMT - not approved. SMT has asked for an additional option to be included in the case i.e. to outsource the laundry service from another provider. 23.02.16 Business case forwarded to Finance for costing	MOD	DIV
3799	23/05/2016	Provide safe, high quality care		Falls from height DHH	Condition of Buildings, possible effects from drugs and alcohol, inadequate door access, poor lighting, machinery, equipment, spills, violence. Potential for injury, harm or death.	See action plan attached to Risk	27.02.18 Minor works request submitted for outstanding controls. 12/12/2016 A separate risk assessment is being completed by Acute Governance in relation to falls from heights. Erection or raising of anti-climb fencing in several areas. Secure 3 external doors at exterior of ED Dept,. Enclose plant and equipment.	MOD	DIV
3978	25/09/2018	Provide safe, high quality care		Ineffective monitoring and reduced IT security of CCTV System on network	The CCTV system at DHH is digital and has been put on the Trust Network and this is causing issues from an IT security perspective. The CCTV surveillance coverage does not extend to all of the areas required. Cyber attack and the hacking of data Loss of patient information Breach of Data Protection Act 2018 Compromised safety of all personnel on site Compromised security of both Trust and personal property Inability to detect crime and footage unable to be used in prosecutions Inability to investigate incidents	Precautionary measures by Estates / IT	Business Case to be prepared to secure funding to have all CCTV transferred onto a Single Trust Digital Platform. Identify areas that require cameras on a risk basis and complete Minor Works Form for additional cameras	MOD	DIV
3985	19/11/2018	Provide safe, high quality care	Trustwide	Typing backlogs for secretarial areas	Typing backlogs due to not enough staff plus maternity leaves covered at only 50% and 0.5 WTE allocated for new consultants/services. This is never enough. This can result in late follow up of patients to other clinics, patients being added to inpatient waiting lists etc Areas with continuous backlogs are Gastro, Rheum, Respiratory, T & O, ENT, Diabetic/Endo, RACP, Derm	If Consultants use the Clinic Outcome sheet then follow up will be documented on this and then this should not be an issue, however, this is not used everywhere. Overtime is granted occasionally to try and keep backlogs down. Service Administrators monitor this information fortnightly and continually move resources around and across all sites to try and equalise backlog typing.		MOD	DIV
3911	15/08/2017	Provide safe, high quality careMake the best use of resources		Backlog of filing in Obs and Gynae	Filing in Obs/Gynae area constantly backlogged, results are not in patients charts at time of appointments. These are held on NIECR but directorate has to make a decision. Also non signing of results by doctors is a problem, Hand held charts not being returned timely from community so filing cannot take place. Results filing then sitting on wards, in box for midwifes etc but not in chart		17.10.17 Risk remains unchanged	MOD	DIV
3941	27/02/2018	Provide safe, high quality care		Use of 2 Work neutral detergent which is classified as 'Corrosive' without eye protection	This product is extensively used throughout the Trust in the main production kitchens, ward kitchens, staff tea rooms, for dishwashing, general cleaning and cleaning of floors etc. The use of eye protection when using this product is unrealistic and something that would be extremely difficult to enforce given its extensive use in the Trust.	Induction training, on the job training and BIC's training for Support Services staff. • COSHH awareness training (all staff) • Observation of user completing task/using chemical • Spot checks • Safe Systems of Work (Support Services staff only) • Protective aprons and gloves • Eye Protection for dilution of chemicals (Support Services staff only) • Staff reminded to continue to report incidents to their supervisor/manager • Pre-Employment Medical Advice – skin care etc • Ill Health Referrals to Occupational Health • COSHH Risk Assessment and Data Safety Sheet • SHSCT Policies and Procedures	Feb 2018 A Customer Complaints Form was submitted to BSO and a request made to have this product replaced with a non-classified, 1 litre detergent, which is safe to use. BSO unable to take action as this is a regional contract and the Southern Trust was the only Trust in the region to raise concerns. This matter cannot be resolved until action is taken by BSO.	MOD	DIV
3973	28/08/2018	Provide safe, high quality care		Risk of injury when cleaning fixed beds in Bluestone	There are 68 beds of these beds in the Bluestone Unit. Hazard - manual handling (risk of musculosketal injury) and Infection Prevention and Control - areas of the bed not accessible for cleaning and no programme for cleaning underneath the bed which is fixed to the floor. Mattress type is an issue - no grips on the side of the mattress to aid moving and handling, mattress cannot be folded in half to clean. Low fixed height of the bed is an issue for manual handling.Musculosketal injury, infection control	Induction training, on the job training and BIC's training for Support Services staff. o Infection Control training o Waste management training o Manual Handling training core/refresher o Observation of user completing task/using chemical o Spot checks o Safe Systems of Work - task specific (Support Services staff only) o Protective aprons and gloves o Staff advised to wear enclosed and low footwear o Faults reporting o Staff reminded to continue to report incidents to their supervisor/manager o Staff advised to check if the load is within their capabilities before lifting it. o Staff advised to seek assistance if a load is beyond their capabilities i.e. a colleague. o Pre-Employment Medical Advice o Ill Health Referrals to Occupational Health o SHSCT Policies and Procedures		MOD	DIV
3974	28/08/2018	Provide safe, high quality careBe a great place to work		Working in extremely warm kitchens in Bluestone	Unit opened 2008 - poor ventillation/air quality/extraction in the production kitchens. Risk of injury/harm from working in hot conditions in 6 production kitchens in Bluestone. Staff working in extreme heat up to 30oC resulting in staff feeling unwell including headaches, tiredness and feeling faint/weak.	Consulted with staff and Health and Safety. Health and Safety Risk Assessment reviewed. Portable fans. Cold drinks/additional breaks for staff to avoid dehydration. Lighter uniforms - blouses available for staff. Working practices reviewed (including ovens switched off between services. Air vents in kitchens checked to ensure working and cleaned. Monitored heat in the kitchens daily. Contingency arrangements made for regen of the meals in Ferns kitchens / meals to be transported from the main hospital.	Develop business case for air conditioning units for Bronte, Willows, Cloughmore and Silverwood. Bronte Ward priority.	MOD	DIV
3812	20/07/2016	Safe, High Quality and Effective Care	Switchboard	Lack of Emergency Major Incident Planning Software	Switchboard follows a Major Incident protocol, individually calling a list of key contacts, with a Major Incident Alert, Major Incident Declared and Major Incident Stood Down. In the event of a Major Incident declared up to 50 people may be contacted. This is time consuming, resulting in delays in key staff being notified. On site staff are individually bleeped. Switchboard staffing levels are reduced in the Out of Hours period, which will create further delays as additional staff will be required to come in. Switchboard manually record on paper as each person is contacted. Reports are available showing time of alert and numeric message. Voices over messages are not recorded.	Continue to monitor the situation. Paper completed to identify the risks shared with Acute SMT.	5.4.18 Imessage Appear App (Emergency Planning Software) has been purchased. Trial is ongoing with the Northern Trust. SHSCT awaiting feedback from Northern trial before implementing. IT/Telecoms currently rolling out new smart phones to all blackberry holders as the Appear App will not work on the current blackberry phone. Full implementation scheduled for April/May 2018. All Emergency calls to ext 6666 & 6000 are now being recorded. 16.8.17 New iMessage system delivered March 2017. Problem with the servers discovered during implementation. Estates has advised that "go live" will be September 2017.	MOD	DIV
3813	20/07/2016	Provide safe, high quality care	Switchboard	No facility for Emergency Bleep if Switchboard is evacuated	Emergency Team alerts and a fast bleep facility can only be activated via the multitone console in Switchboard. Unable to transfer to DHH Switchboard.	Unable to implement controls. Continue to monitor. Paper completed to identify the risk.	5.4.18 iMessage system fully functional. If crisis in either CAH or DHH bleeps can be diverted to alternative Acute Hospital. External numbers now in place so that bleep system can be activated from any phone to set off Emergency teams or one-off paging. Full Comprehensive testing of the system is required before Risk could be stood down. 16.8.17 New iMessage system delivered March 2017. Problem with the servers discovered during implementation. Estates has advised that "go live" will be September 2017	MOD	DIV
3814	20/07/2016	Provide safe, high quality care	Switchboard	Possible breakdown of aging Multitone paging console	The Current Multitone paging console used to alert teams and fast bleep is obsolete. New consoles cannot be purchased. Switchboard currently have 2 consoles in use and 2 spare which can be used in the event of a console failing. Switchboard alert teams by pressing a sequence of keys and entering a Team Code. Emergency Teams are alerted to the location of an emergency via a voiceover. In noisy areas the voiceover may be difficult to hear, the bleep holder then will ring Switchboard to find out the location of the emergency, causing a delay. Current system allows only numeric messages and voiceovers. Bleep holder will ring then extension number on the bleep to receive the message. If more than one team is required Switchboard will follow a protocol alerting each team individually, creating a slight delay. Emergency alerts only go to Multitone bleeps.	Unable to implement controls. Continue to monitor. Paper completed to identify the risk.	5.4.18 New Multitone iMessage paging system in operation. System is now running of multiple transmitters to ensure that if there are any outages that another server provides resilience. All Telephonists now have a console (SCU) between each station to ensure there is back-up. Each SCU can be put into different modes to change between CAH & DHH therefore if there is an issue with the CAH server, the SCU can page CAH via DHH. 16.8.17 New iMessage system delivered March 2017. Problem with the servers discovered during implementation. Estates has advised that "go live" will be September 2017	MOD	DIV
3815	20/07/2016	Provide safe, high quality care	Switchboard	Inability for cross site bleeping	Currently staff working in different sites cannot bleep a member of staff in a different site for e.g. Staff in Daisyhill ring Switchboard in Daisyhill to be connected to Craigavon Switchboard who will then bleep the person needed. Estimated fix cost £20K This is becoming an increasing problem as Services are shared throughout the Trust.	Unable to implement controls. Continue to monitor. Paper completed to identify the risk.	5.4.18 New iMessage system implemented to allow cross-site bleeping. 16.8.17 New iMessage system delivered March 2017. Problem with the servers discovered during implementation. Estates has advised that "go live" will be September 2017	MOD	DIV
3834	04/10/2016	Provide safe, high quality care		Falls from height STH	Risk from condition of buildings, possible effects from drugs/alcohol, inadequate door access, poor lighting, machinery, equipment, spills, violence. Potential for injury, harm, death.	See attached action plan.	27.02.18 Minor Works request submitted for outstanding controls. A separate risk assessment is being completed by Acute Governance in relation to falls from heights.	MOD	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3861	13/12/2016	Make the best use of resources	Grounds	Traffic Management Problems DHH	Risk of injury to patients having to park distance from hospital entrance. Patients missing appointments as unable to find parking space - disabled and able bodied. Staff, patients and others unable to use foot paths due to cars parked on them - risk of injury from collision with vehicles. Inappropriate parking compromising access for emergency vehicles and pedestrian access to hospital. Risk of collision due to disregard by drivers of one way system. Risk of injury to pedestrians entering Car Park. Fas no safe footway.	Security porters, cones and sticker patrols to prevent inappropriate parking. As part of Major Incident Review the Director of HR / Estates clarified Estates are responsible for traffic flow on site and FSS are responsible for car parking.	27.02.18 Parking enforcement has been introduced at protect drop off zones, red hatched areas, emergency routes, ambulance bays and disabled spaces.	MOD	DIV
3753	04/01/2016	Provide safe, high quality care		Falls from height CAH	Condition of Buildings, possible effects from drugs and alcohol, inadequate door access, poor lighting, machinery, equipment, spills, violence. Potential for injury, harm or death. 21.11.16 The new retaining wall beside the footpath up the main drive has created additional potential for harm.	None - Action Plan Attached.	23.02.18 Minor Works request submitted for outstanding controls.	MOD	DIV
3754	04/01/2016		Office(s)	Dermatology Office Risks due to file storage issues	Electric shock from electrical equipment in the office. Faulty equipment could lead to a fire which would spread rapidly due to the amount of combustible material in the office which is stored on walkways. Fire would subsequently result in damage to property. Staff may suffer smoke inhalation and/or burns. Musculoskeletal injury while moving/retrieving charts. Personal injury to members of staff due to the storage of patients charts on the floor and underneath desks. Walkways cannot be kept clear due to the volume of files processed in this office and the limited availability of shelving which also has an impact on the safe evacuation of staff from this area in the event of a fire. See Hazard no. 9 & 10. Risk of musculoskeletal injury from incorrect workstation set up.	Fire Safety training for staff. Fire Safety Policy. Fire evacuation plan. Electrical equipment is subject to Portable Appliance Testing (PAT). Manual Handling Policy is available on the intranet. Manual handling training (3 yearly for low risk staff). Limited shelving is available. DSE Procedure is available on the intranet.	12.12.16 No further update 22.02.16 Ongoing. Urgent fire risk assessment required. Please contact Vincent Burke to request this.Remind staff to complete fire safety training on an annual basis. Remind staff to report any faults with electrical equipment, mark it faulty and remove from use. Manual handling risk assessment to be completed for inanimate loads e.g. patients charts, stationery items etc and shared with staff. Request should be made for additional accommodation to facilitate the storage the storage of charts by as the current accommodation is unsafe and a high fire risk.Request to be made to Estates to measure the office to determine if it meets the requirements of Regulation 10 of the Workplace, Health, Safety & Welfare Regulations. DSE self-assessment and 12 point plan to be issued to staff. Staff to be made aware of their entitlement to eye and eyesight testing in accordance with the Trust's DSE Procedure. Staff should complete the DSE awareness via e-learning. Access should be requested via earning.support@southerntrust.hscni.net	MOD	DIV
3792	13/04/2016	Provide safe, high quality careBe a great place to work		Waste Storage and Handling CAH	Lack of space for waste dispersal rooms on 1, 3 and 4 North leading inappropriate storage / segration of waste and risk of leaks from contaminated clinical waste if not stored safely. Waste storage area on 1 East / 1 West and 2 East / 2 West are too small for ward requirements.	3 North waste is stored in the Sluice Room; 4 North waste is stored in a store room and 1 North waste is stored in the Domestic Store. Housekeeping arrangements are in place to ensure waste is stored as safely as possible. Staff are aware to report incidents, which are subsequently recorded on Datix. Spills are cleaned immediately. PPE is provided for staff handling waste and staff are trained in the use of PPE. Staff receive waste management training.	23/2/2018 - 4N have black and yellow bins in their dispersal now. 1N, 3N, 1W/1E, 2W/2E no progress.	MOD	DIV
3291	28/11/2012	Safe, High Quality and Effective Care	Grounds	Traffic Management problems CAH	Contractors taking up spaoe. Limited entranoe and exit access causing grid lock of site in the event of an emergency / major incident. Limited parking spaces around the site. Risk of injury to patients having to park distance from hospital entrance. Patients missing appointments as unable to find parking space - disabled and able bodied. Staff, patinets and others unable to use foot paths due to cars parked on them - risk of injury from collision with vehicles. Inappropriate parking compromising access for emergency vehicles and pedestrian access to hospital. Risk of injury to pedestrians as no safe footway in parts of the site.	Security porters, cones and sticker patrols to prevent inappropriate parking. As part of Major Incident Review the Director of HR / Estates clarified Estates are responsible for traffic flow on site and FSS are responsible for car parking.	23/2/2018 - Parking enforcement has been introduced at protect drop off zones, red hatched areas, emergency routes, ambulance bays and disabled spaces. Additional spaces at Craigavon Area Hospital. Traffic calming measures including ramps at pedestrian crossings and speed control signage at Craigavon Area Hospital. Renewed markings on disabled spaces to ensure they are visible.	MOD	DIV
3977	25/09/2018	Provide safe, high quality care		Ineffective monitoring by current CCTV System	The current CCTV system uses outdated technology (analogue) and surveillance coverage does not extend to all of the areas required. This can result in no CCTV footage available or poor quality images. 1. Compromised safety of all personnel on site 2. Compromised security of both Trust and personal property 3. Inability to detect crime and footage unable to be used in prosecutions 4. Inability to investigate incidents 5. The Trust is not fully compliance with the Data Protection Act 2018 - GDPR Compliance Assessment attached	Health and Safety Risk completed and is attached. Regular checks are carried out on the CCTV system and faults are reported to Estates. Maintenance Contract with Radio Contact. Some faults in the system are unable to be repaired as the technology is outdated and require a longer-term solution - a list of outstanding faults is attached. A list of areas requiring CCTV cameras have been identified on a risk assessed basis and is attached.	£50k has been allocated to address local issues with CCTV Develop Business Case to upgrade and extend the system on a risk basis	LOW	DIV
3355	16/05/2012	Safe, High Quality and Effective Care		Actichlor plus	Risks highlighted: Ingestion of product, Skin damage due to contact, Eye damage due to contact, Unauthorised access to product, Unsafe systems of work by staff, Inhalation	All staff are trained in the safe use of this chemical i.e. induction, BICS, COSHH, food safety and on the job training and in compliance with regional guidance on colour coding. Staff are advised to wear correct PPE when using this product and during the disposal of large quantities and in the event of a large spillage. PPE includes eye protection, apron, & gloves. Safe storage of the product - product stored upright in a closed labeled container - in a cool, dry, well ventilated area. Store away from incompatible materials and sources of direct heat. Store in locked cupboard in Domestic Services store - locked if available. Staff are trained not to mix chemicals. COSHH risk assessments and safety data sheets are located in the managers/supervisors office and in sister's office in A&E. Colour coding for area. Ongoing monitoring & reviewing of COSHH risk assessments. Trust policies & procedures e.g. Health & safety at work, COSHH, Manual handling etc. Cleaning work schedules. Kitchen hygiene audits - monthly audits and spot checks. Uniform audits e.g. low and closed in shoes. Staff referral to occupational health where neoessary	12.12.16 As good control measures are in place the risk rating is being reduced from Moderate to Low.	LOW	DIV
3453	26/06/2013	Safe, High Quality and Effective Care	Switchboard	Internal Bleep System Failure	Risk to patients, staff, service users in the form of: Potentially unable to activate Emergency Teams e.g. Cardiac, Stroke, Paeds, Obstetrics, ILS, etc. Unable to reach individuals in an emergency e.g. Cardiac Nurse, Stroke, Security, etc.	Daily tests carried out on all teams. Maintenance contracts in place with Multitone (bleep providers) and Estates responsible, protocols in place for activating bleeps.	5.4.18 New Multitone iMessage paging system in operation. System is now running of multiple transmitters to ensure that if there are any outages that another server provides resilience. 16.8.17 New iMessage system delivered March 2017. Problem with the servers discovered during implementation. Estates has advised that "go live" will be September 2017.	LOW	DIV
3777	08/03/2016			Waste Management South Tyrone Hospital	Risk of Infection from waste contaminated with blood/bodily fluids. Injury due to sharps being disposed of incorrectly into waste bags, laundry etc and coming into contact with member of staff. Risk of musculoskeletal injury from handling waste which involves carrying on the same level and also between stairwell levels, bags being overfilled. There is excessive handling of waste bags due to lack of storage facilities in wards and departments to allow waste to be placed in the bins by the users. Waste is a as result handled 3 to 4 time by staff thus increasing the risk of injury/ exposure. Risk of injury from slips, trips, falls due to the lack of storage. Lack space to provide suitable waste management arrangements leading to excessive handling result in injury to staff, leaks from contaminated clinical waste if not stored correctly. Portering staff have to go out in all-weather to move waste, from the vehicle and as all the bin storage is open to the elements.	Sharps boxes are provided for disposal of sharps. Segregation of waste. Safe Management of Healthcare Waste- 2013 (information available on the intranet). Waste management training. PPE provided for staff handling waste. Staff trained in use of PPE. Corporate Risk Assessment on Blood Borne Viruses (available on intranet). Staff aware to report incidents, which are subsequently reported on Datix. Manual handling training. Waste management training (advised not to overfill bags). Manual Handling policy. Manual handling risk assessment. Safe systems of work. Staff aware to report incidents, which are subsequently reported on Datix. Cleaning of spillages immediately. Housekeeping arrangements are in place to ensure waste is stored correctly. Staff aware to report incidents, which are subsequently reported on Datix. Cages are provided to store waste. Spills are cleaned immediately. Staff aware to report incidents, which are subsequently reported on Datix. PPE aprons are provided	12.12.16 As all the recommendations made following the HSENI Clinical Waste Inspection visit on the 1 December 2015 have now been actioned the risk rating is being reduced from Moderate to Low. 8/3/16 Domestic Services staff to be advised not to overfill bags and waste receptacles. Communication to be forwarded to ward/department managers advising their staff not to overfill bags. Manual handling risk assessment shared with staff.	LOW	DIV
3281	26/11/2012	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of resources	Kitchen/Dining Room	Risk of vulnerable patients contracting E coli 0157 from very low levels of contamination of ready to eat foods	E. coli O157 is a particularly dangerous type of bacteria because it can cause serious, untreatable, illness and even death from very low-levels of contamination of ready-to-eat food. Because E. coli O157 survives at freezer, chill and ambient temperatures, measures to control cross-contamination apply to all of these environments. Although E. coli O157 is the key focus of this guidance, the measures outlined will also help in the control of other food poisoning bacteria, such as campylobacter and salmonella. The risk of E. coli O157 cross-contamination should be considered wherever raw foods such as raw meat and unwashed vegetables are handled and where ready-to-eat foods are also handled. Without strict controls, E. coli O157 can be spread throughout any food processing environment. It is therefore essential that ready-to-eat foods are at all times handled and stored in clean areas where controls ensure the environment is free from E. coli O157 contamination.	1. External inspection by Environmental Health Officers and CDCC. 2. All food handlers are trained in food safety and HACCP. 3. There is a HACCP in each facility. HACCP plans are reviewed by the Catering Manager and the Locality Support Services Manager as required. 4. Hand washing and Food Safety Audits are completed. 5. There is complete physical separation of raw and ready to eat food during delivery, handling and storage in fridges. 6. The Trust has a dress code policy which covers uniforms, the wearing of jewellery etc. and audits are conducted to measure this compliance. 7. All staff are trained on cleaning disinfection and hand washing.	121.12.16 No further update 26.02.16 Controls have been improved in all food production . At CAH this has been completed by the building of a partition and in DHH a separate area is used , in other units measure are in place to keep these function to sepetate area/times and handling to a minimum. Additional training on all aspect of e-coli has been delivered F ood handling and staff practices continue to be monitored, and audit arrangements have been updated. Additional checks are in place at meal times. Supervision has been reviewed at CAH and there is now a lead cook on shifts. Contingency plans have been reviewed and the learning from Incident in June 2015 has been taken on board. a new contract is in place fo microbiological testing and locally ATP machines are purchased to allow more frequent sampling of surfaces and handwashing.	LOW	DIV
3454	26/06/2013	Safe, High Quality and Effective Care	Switchboard	Risk of Telecoms Failure Across CAH, SLH, STH, and LH	Potential for telephone lines to go down: a)Internally b)Cross-site c)Internally/cross-site/externally d)External lines only Risk 1: If lines go down internally - risk to patients and staff Risk 2: If lines go down externally - risk to members of the public	- Contracts are in place with Telecoms providers. - Protocols are in place with Estates services in relation to re-establishing telecoms links. - Mobile telephones are also available for use within A&D, and C&B localities.	5.4.18 New telephony system "Equinox" to be installed from April 2108. Significant increase in amount of VOIP handsets within the Trust. 16.8.17 Partial roll out of VOIP handsets - Estates awaiting approval of revenue funding to enable full roll out of VOIP handsets. 22.02.16 Capital funding approved to enable Estates to purchase additional hardware. Estates awaiting approval of revenue business case for roll out of VOIP handsets.	LOW	HOS
3807	13/06/2016		Office(s)	Falls from height on Admin Floor CAH	Fall from height. Potential for someone to climb up and fall over the balcony from the admin floor to the atrium. Unauthorised persons in restricted areas which could lead to a breach of confidentiality, risk of theft or physical attack	There is wall approx. 102m high with a stainless steel guard rail. The main door is locked at night and weekends as are Individual room	12.12.16 The window panels have been installed thus reducing the risk to Very Low. The installation of access control system has no impact on falls from heights and a separate risk assessment on access to restricted areas is required to measure this risk. Window panels to be inserted to the openings on the full length of the area of the corridors open to the atrium. Install access control system to the corridor doors and back stairwell on admin floor	VLOW	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3994	19/11/2018	Provide safe, high quality care		Change in the concertation of phenylephrine from a 10ml ampule containing (10mg in 1 ml)to (1mg in 10mls) November 2017	The change of strength to 1mg/10 ml vials of phenylephrine is fine for short term use ie., a few hours waiting for a central line to be placed. The difficulty is the delivery of phenylephrine for longer than a few hours this tends to arise when patients are not deemed stable for a central line or where a decision has been made not to go down a more invasive route.	Discussion with pharmacy/anaesthetic staff & medical staff re-introducing high dose phenylephrine. The plan is to hold in pharmacy in a segregated area; it will only be issued to HDU and it will be the only strength that HDU stock. The remainder of the hospital will use the low strength and follow the Trust protocols, and once transferred to HDU, staff will use an HDU protocol. Protocol to be review by medical, pharmacy and nursing staff. Pharmacy staff to liaise with procurement about getting the high strength product back in and appropriately set up within the pharmacy system.	11.03.19- No update. 12/10/18 MD. A McC & JH to discuss protocol and disseminate to staff nursing and medical staff regarding change over date when established AMcC to discuss with procurement	HIGH	DIV
2382	19/10/2009	Provide safe, high quality careMake the best use of resources	Cath Lab CAH	No contingiency plan in place in event of cardiac catheterisation lab failing.	Risk to health and safety of patients is compromised if cardiac catheterisation lab equipment fails :- 1. Whilst the patient is on the table mid procedure 2. Loss of capacity due to failure causing impact on waiting time standards	1. Should failure occur whilst the patient is on the table mid procedure - a n arrange ment with radiology permits the short term loan of the portable image intensifier to complete the case and maintain the patients safety. 2. No controls in place	11.03.19- No update. 13.08.18 discussed with cardiology and radiology team dependent on when equipment fails the clinician will liaise with radiology and room 1 and 2 in radiology will be used. 26.02.18 Awaiting update, risk remains unchanged. 1.09.16 IPT developed, Working Group Established. Awaiting confirmation of funding and equipment on NHS supply chain. 01.06.16 - business case for replacement and upgrade of equipment. Use of radiology equipment in the interim when required.	HIGH	DIV
3990	19/11/2018	Provide safe, high quality care		Delays in seeing Dermatology Red Flag Referrals at Outpatients	Unable to see new Red Flag patients within the access target time. Delays in diagnosis for patients who have potential for skin Cancer. Delays in patients staring 31 and 62 day pathway. Delays in Patients being seen at Clinic and therefore increases risk of skin cancers developing or spreading.	We provide medical and nurse led clinics across all trust sites. Review clinic templates and increase Red flag slots. Review Clinic templates. Avail of additional funding for clinics. Review performance monthly. Escalate to Performance team. We have medical and nursing clinics across all sites We work closely with Cancer trackers re access times and investigations Escalate accordingly Three patients breeched monthly report.	11.03.19- No update. Review access times monthly.	MOD	DIV
3991	19/11/2018	Provide safe, high quality care		Dermatology delays in patients having day case procedures	Unable to carry out day case procedures on patients within the access target time. Delays in diagnosis for patients who have potential for skin Cancer. Delays in patients starting 31 and 62 day pathway. Delays in Patients being seen at Clinic and therefore increases risk of skin cancers developing or spreading.	We provide medical and nurse led clinics across all trust sites. Review Clinic templates avail of additional funding for clinics. Review performance monthly. Escalate to Performance team.	11.03.19-no update Review access times monthly.	MOD	DIV
3969	31/07/2018	Provide safe, high quality careBe a great place to workMake the best use of resources	Medical Admissions Unit	Risk to Staff of Assault on Acute Medical Ward	Staff at high risk of being harmed. Staff have sustained personal injury and have alleged they have been sexually assaulted in this ward.	Ongoing support for staff. Identying patients at high risk and requestion one to one. Requesting security 1 /1 for violent/aggressive patients. Review of GMAS - AD pharmacy for approval. Refurishment of nurses station - further risk assessment being carried out on same. Ongoing monitoring of same. Ongoing MAPA training for staff		MOD	DIV
3970	31/07/2018	Provide safe, high quality care		Telemetry Systems, Cardiac Monitoring Unable to purchase spare parts	Lack of Cardiac Monitoring at Daisy Hill Site. Currently 6 cardiac monitors operational but only 2 of the 10 telemetries working. The replacement of the cardiac monitoring system was raised in 2016 with the aim that we would roll out the same system installed on the CAH site. When the scoping exercise was carried out as the current system was 15 year old it was agreed that estates work was required. Concerns raised October 2017, March 2018 and again June 2018. Concerns for patient safety due to lack of cardia monitoring on DHH site. Cardiac patient are nmot being monitored as per guidelines therefore a huge risk to patients, the Trust and our service. Unable to undertake DC Conversions and inpatient TOE's on the DHH site as we have no cardiac monitoring facilities for the 3 hour period post operatively. This has resulted in having to book ambulances and transferring three patients last week to give an example to CAH for TOEs	Contingency plans that we have is to 1.Utilise HDU beds for Sick Cardiac patients, 2.Transfer our coronary patients to 1 North.	11.03.19- No update. Escalated 4 times in the past 9 months. Estates staff and HOS have met with Rep and developing time line and costing for 6 cardiac monitors and 16 telemetries. Continue to utilise transfer to 1 North for sick patients. Oct 17 as only 6 telemetries functioning. June 2018. July 18 only 2 working.	MOD	DIV
3831	28/09/2016	Provide safe, high quality care	Day Clinical Centre	Sluice not fit for purpose	Sluice not fit for purpose due to size and location of flush on sluice and lack of space for commodes.To operationalise the sluice poses an element of risk to staff from an infection control and health and safety stance. Due to the size of the sluice the staff can not manoeuvre around to dispose of wastage. It poses also with the location of the flush lever a stretching motion to carryout task . The Sluice also has lack of storage for the commodes	The environment is very compact for the sluice poses an element of risk to staff from an infection control and health and safety stance. To date we have had a stool to avoid the stretching.		MOD	HOS
3832	28/09/2016	Provide safe, high quality care	Day Clinical Centre	Lack of storage within the DCC in DHH	Capacity for storage will impinge on staff workflow .The Lack of Storage within the units lends itself to overcrowding of stock items essential for the treatment of patients within the DCC.	he environment is very compact for the amount of storage needed in the treatment of the DCC patients. Due to the diversity of the type of patient a lot of different stock has to be stored		MOD	HOS
3626	05/12/2014	Safe, High Quality and Effective Care	Accident & Emergency	Reliance of Medical Locums in ED	Sub-optimal care.	Clinical review of work by consultant in charge.		MOD	DIV
2383	22/10/2009	Provide safe, high quality careMake the best use of resources	Accident & Emergency	Transfer of patients with unstable neck injuries to the Regional Centre in Belfast	Delays in transfer of patients with unstable neck injuries to the Regional Centre in Belfast resulting in: 1. Potential for poor outcome for the patient when they remain in SHSCT ED. 2 Loss of confidence in the organisation. 3. Potential for complaints, litigation for the Trust	Escalation plan within ED for patients in the department 4 hours or greater. Plan includes escalation up to ED consultant on call which facilitates dialogue with Consultant in Regional facility.	11.03.19- No update. 22.10.13 - No datix reports of any such incidents within the past year. Discussed with AMD who would like to keep risk on register for a further period of monitoring. 01.02.13 - Reviewed by Heads of Service on both sites. Trauma group established to address further issues, December 2012. 23.01.12 - No delays reported since last review. 01.10.11 Reviewed by P Smyth & M Burke on 27.09.11 on going monitoring of this risk by Nurse Manager & HOS	MOD	HOS
3508	24/10/2013	Safe, High Quality and Effective Care	Accident & Emergency	Overcrowding in ED may result in patients coming to harm by delay in assessment and treatment.	Delay in assessment of NIAS patients as no space to off load. Delay in ECG as no space for patient. Delay in resuscitation treatment as Resus overcrowded. Delay in treatment as Majors area overcrowded. Patient may deteriorate in waiting area as no space and delays in getting them to cubicle and doctor. Patients may deteriorate while waiting for admission bed on ward medication errors will increase as nursing staff unable to cope with delayed admissions. Patients basic nursing care may delayed as not enough nursing staff to deliver it in overcrowded ED. Patients may loose confidence in the Trust. Staff may become burnt out and stressed.	Triage (second nurse in triage in intermittent periods when staffing allows. Department escalation plan in place. See and treat pilot with band 6 and ED consultant (pilot finished). Patient flow meetings. 4pm meetings with patient flow.	11.03.19- No update. 24.10.13 - There are systems in place to monitor this daily. The problem can fluctuate on certain days and become worse from November to March. Swing ward to be set up by November 2013.	MOD	HOS
3685	08/06/2015	Provide safe, high quality care		Lack of pharmacy cover.	Patients being admitted may wait 3-4 days for Medicine Reconciliation and this can lead to Medication prescribing errors.	Managed on a day to day basis.	11.03.19- No update 01.06.16 - Business case prepared for additional resources.	MOD	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3686	08/06/2015	Provide safe, high quality care		Lack of junior medical cover	High demand for cardiology admissions. Due to cover for night duty, annual leave, reduced number of cardiology staff available at ward level. Delays in Treatments, Discharges.	Continues to be managed	11.03.19- No update. 26.02.18 Still gaps in junior medical staff provision from NIMDTA and trust are sourcing this via agency contracts.	MOD	DIV
3687	08/06/2015	Provide safe, high quality care		Medical equipment in Cardiac investigations are old and some parts unable to be replaced	Due To the high demand for cardiac investigations across the trust if these equipment break or become obsolete this is risk to cardiology service	No replacement programme in place yet but replacement programme should be in place soon.	11.03.19- no update 13.08.18 Rolling programme developed and equipment priority placed on the capital list. 01.06.16 - New equipment ordered. Will be delivered June 2016.	MOD	DIV
3688	08/06/2015	Provide safe, high quality care		Decontamination of TOE probe	The current process for decomtamination does not meet Best Practice Guidelines	Sourcing the use of a further probe from ICU as a temporary measure. Requisitioning additional probe.	11.03.19- No update. 13.08.18 further ECHO machine funding confirmed for DHH. ICU also giving probe to cardiac investigation team in CAH. When new ECHO delivered there will be 4 on CAH site and 1 DHH site. 26.02.18 Another ECHO and TOE probe purchased delivery date expected by 31.01.18.	MOD	DIV
3863	21/12/2016	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and	Renal Unit Daisy Hill Hospital	Lack of consultation rooms in Renal OPD	Nephrology outpatients are at risk. There is risk to patients from lack of education regarding drugs and diet.	Education is frequently carried out in a totally unsuitable environment which is not conducive to patients health and well being (Fire escape corridor). In addition other staff are displaced from offices to accommodate patient consultation/education including Dr McKeveney Consultant Nephrologist who is displaced fom his offie during clinics.	11.03.19-No update 13.08.18 Renal team and HOS worked with Estates staff regarding proposed new plan for renal services, This requires costing and to be brought forward to SMT. 26.02.18 Priority No 7 on capital list.	MOD	DIV
3759	26/01/2016	Safe, High Quality and Effective Care	Diabetic Clinic, Surgical Outpatients	Diabetic Antenatal Clinic Risk	Increase in patients attending, significantly since change in threshold for Gestational Diabetes (IAD and PSG 2010). Difficulties arising due to the increase in numbers of patients who need to be seen at these clinics.. Poor pregnancy and neonatal outcomes.	The old early pregnancy room is vacated request submitted to create an additional clinic room. The clinic is commissioned for 1 Doctor; however, effort to ensure that 2 additional doctors attend. (Currently unfunded and can impact of other duties)A GP with specialist interest covers ad hoc. A Locum Physician with specialist interest covers to provide a second doctor. The Consultant from DHH has provided cover however this requires backfill in DHH. The number of CTG's at clinic has been reduced. Patients requiring steroids - Dr Sidhu assesses patients on a Thursday afternoon and if they require and admission the Diabetes Consultants try to ensure that this admission occurs on a Monday as there is no cover available over the weekend to advise on insulin doses. However it is problematic when the situation arises where it is essential for the patient to be admitted on the Thursday night (eg because of a problem on the scan). If this is the case - they are inpatient over the weekend and the midwives usually ring Dr McConnell over the weekend to sort insulin doses as they struggle to get medical reg's to answer bleeps. Unfortunately the medical reg's aren't trained in managing antenatal patients and how to increase insulin doses in relation to steroids in pregnancy. Postnatal GTT are managed virtually and are not called back to clinic. Patients requiring insulin starts and education have been given appointments with the DSN on Friday mornings rather than being started at the Thursday afternoon clinic as they are more time consuming.The number of New patients per clinic has been reduced to 8 to facilitate reviews.Increased the number of virtual contact by DSN to help.	11.3.19- An Additional Diabetic Antenatal Clinic was set up on a Thursday morning where 24 new patients are seen per week. No funding was received for this clinic however due to the high risk it was agreed to try to reconfigure Consultant job plans to enable the clinic to be set up. Funding will have to be secured. With Transformation funding a Diabetic Antenatal Specialty Doctor (Locum) has been appointed who undertakes virtual clinics. Group education Sessions are done on a Monday with A Diabetic Specialsit Nurse + Diabetic specialist Dietician to see the new patients in advance of their consultant appointment to reduce the length of wait at clinic. 01.06.16 - Diabetic Antenatal Specialist Nurse recruited. Increased number of patients requiring interpreters at clinics which is slowing down appointments. 29.02.16 - Additional diabetic nurse specialists have been recruited and a second consultant for the DHH site has been advertised.	MOD	DIV
3768	25/02/2016	Safe, High Quality and Effective Care	2 South Medical	Inappropriate use of the designated Lysis treatment space in Ward 2 South Stroke.	The designated lysis treatment space in 2 South Stroke is regularly used for patients to relieve bed pressures through out the hospital. If this bed is occupied when a patient requiring lysed is admitted this emergency procedure is either delayed or requiring to be carried out in the Emergency department. Both scenarios are not appropriate. The patient's condition can deteriorate or the post lysis outcome is not optimum if the procedure is not carried out in required the timeframe the procedure is carried out in ED the nurse from 2 South Stroke is off the ward for 4-5 hours thereby leaving the ward short and increasing risk for the other patients on the ward.	Produce a guideline for the appropriate use of the Lysis bed and share across the division for clarity of all staff on the ward, working in Patient flow or on call. Work closely with patient flow to ensure this bed is not used unless there are extenuating circumstances and after discussion with the HoS on site or on call.	11.03.19- No update. 01.06.16 - New process in place for protected beds. 25.02.16 - New Risk.	MOD	TEAM
3986	19/11/2018	Provide safe, high quality care	Respiratory Dept	Unable to see new and Review Respirtaory patients at out patient clinics in a timely manner	Delay in patientsd being assessed, Diagnosed and commenced treatment Delay in commencing appropriate pathway Delays in diagnosis for patients who presented with Respiratory Conditions.	Our Respiratory team provide clinic across a number of sites within the Trust Urgent Patient reviewed Clinic Templates set up to address new to review ratio Revalaidtion of clinic Review clinical activity Available of WLI clinics as required.	11.03.19- No update. Development of IPT as part of respiratory services framework. Review compliance with KPIs	MOD	DIV
3987	19/11/2018	Provide safe, high quality care	Cardiology Clinic	Unable to see Cardiology new and review patients in a timely manner	Delay in patients being assessed, Diagnosed and commenced treatment Delay in commencing appropriate pathway Delays in diagnosis for patients who have potential for cardiac conditions	Our Cardiology team provide clinic across a number of sites within the Trust Urgent patient reviewed Clinic Templates set up to address new to review ratio Revalidation of clinic waiting lists Review clinical activity Available of WLI clinics as . required and when funding is available	11.03.19- No update. Identify any risks to HSCB re performance and access Times. Review NICE guidelines and highlight areas of non-compliance to Assistant Director and Director.	MOD	DIV
3988	19/11/2018	Provide safe, high quality care	Dermatology Clinic	Unable to see new and review Dermatology patients within the access target time of 9 weeks	Unable to see new and review patients within the access target time of 9 weeks. Delays in diagnosis for patients who have potential for skin Cancer Delays in patients starting appropriate Drug Regimes Delays in Patients being reviewed at out patients and skin cancers developing or spreading	we provide mediacl and nurse led clinics across all trust sites. Validate waiting times Review clinic templates New and review to assist with increased red Flag referrals from May To October Review Clinic templates new to review avail of additional funding for clinics Avail of additional medical support locum consultant to assist with review backlog Review performance monthly Escalate to Performance team	11.03.19- No update Development of IPT to secure finding to support 4th consultant. Review access times monthly and escalate to Assistant Director and Director.	MOD	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3989	19/11/2018	Provide safe, high quality care		Unable to carry out Acrdiac Catherisation procedures in a timely manner	Delay in patients having their Cardiac Cauterisation procedure carried out Delay in diagnosis and patients commencing appropriate treatment plan Delays in diagnosis for patients who have potential for cardiac conditions Potential for high risk patients who may require Cardiac surgery/ Valve replacement waiting over 13 weeks Potential of death for patients waiting on cauterisation procedure or stenting.	Our Cardiology team provide 10 theatre sessions in main cath lab Secured Funding for modular cath lab until March 2018. Maximise cardiac cath lab sessions Revalidation of waiting lists Review clinical activity Avail of WLI in Modular cath lab sessions	11.03.19- No update. 1.Identify any risks to HSCB re performance and access Times 2.Review NICE guidelines and highlight areas of Non-compliance to AD and Director and Director of performance. 3. Validate Waiting lists 4. Pre-assessemnt of patients by Cath lab nurses	MOD	DIV
3769	25/02/2016	Safe, High Quality and Effective Care		1:1 special staffing not available when required	Patients that are confused, agitated, aggressive or have a lack of awareness of their ability to mobilise are at a greater risk to themselves or others if 1:1 care is not available. Patients at risk of harm to self or others. Loss of dignity of patient. Ward disruption and distress to other vulnerable patients.	1:1 care is not always available to care for patients that are confused, agitated, aggressive or unaware of their inability to mobilise. This results in a greater risk to their safety, the safety of others increasing disruption on the ward and upsetting other vulnerable patients in the vicinity.	11.03.19- No update. 26.02.18 Guidelines developed by Lead Nurses, to be signed off at Acute Nursing and Midwifery meeting 05.03.18	MOD	DIV
3857	29/11/2016	Safe, High Quality and Effective Care		Increased patient confusion when moved continually around wards	There is a risk that elderly patients could have an increase of confusion or develop a delirium if they are moved from one ward environment to another. This would increase with the more moves that occur.	Increased confusion which could lead to patient distress, falls, increased requirement of medication to reduce agitation. Family's distress at relative being more confused than usual , or experiencing confusional state for the first time. In the event the hospital is under bed capacity pressures and outlying is required all Ward staff must ensure that they identify patients that are medically stable, do not have a known confusion or at risk of delirium, or have a learning disability.	11.03.19-No update (Consider equipment, staffing, environment, policy/procedure, training, documentation, information - this list is not exhaustive). It is within the outlying guidelines that patients that are confused should not be moved between wards unless for a clinical reason. This can be a challenge due to the ongoing bed capacity pressures experienced within the acute setting.	MOD	DIV
3627	05/12/2014	Provide safe, high quality care		Increasing patient dependency impacting upon ward staffing.	Dependency levels and health and safety of patients and staff due to sustained high level of dependency, a rapid throughput and reduced length of stay.		11.03.19- No update 01.06.16 - International recruitment ongoing. 26.11.14 - Normative staffing level submitted and allocation of £1.5 million made to SHSCT. ADs and HOS to raise with Director to prioritise allocation of this funding to wards under most pressure.	MOD	DIV
3914	19/09/2017	Provide safe, high quality care		Gastoenterology/IBD Nurse Cover	As a lone worker there is no cover for her annual/sick leave which leaves a gap in the service. Unable to fill as no-one trained to undertake. The Nurse Specialist does not have sufficient capacity to see ward patients due to clinic, biologic, patient telephone helpline commitments. Telephone calls not being returned to patients within 48 hours when they contact the help line. If the IBD Nurse Specialist is not available to take the patient telephone call on the helpline then they will not receive advice on how to manage the 'flare up' of their condition. This will result them them potentially having to present to the Emergency Department and being admitted to hospital if their condition worsens and requires inpatient treatment.	As this is a single handed service with no cover there is no measure which can be put in place. There is a requirement for additional Gastroenterology/IBD Specialist Nurse. the only alternative to the Specialist Nurse not being available is for patients to attend the Emergency Department.	13/3/19 In order to reduce risk for this service a 1 wte IBD Nurse Specialist was appointed at risk in August 2018. a further 0.5wte IBD nurse is being recruited using saving from switching biologics. Due to Start 1/6/19	MOD	DIV
3923	13/11/2017	Safe, High Quality and Effective Care		Cardiac CT angio, high demand	Currently have high demand of Cardiac CT angio. Waiting Time is 55 weeks Non compliant with NICE guidelines re Chest pain diagnosis -- first referral is CT angio. Patients are waiting 55 weeks for this diagnosis which can delay diagnosis and mangement plan.	Only Two sessions per week. Have requested additional funding for a further 3 sessions of CT angio. to address waiting times.	11.03.19- No update. 13.08.18 Two additional sessions have ceased due to availability of room in CT scanner and funding, regional meeting to review CT provision across NI. 26.02.18 Two additional sessions per week provided by review of jobs plans. The access to cardiac MRI and CT angio has been raised regionally and HSCB setting up meeting to discuss	MOD	DIV
3924	13/11/2017	Safe, High Quality and Effective Care	2 North Haematology	Haemtology/Oncology Helpine provision in the out of hours period	The service has been provided for Oncology/ Haematology patients within the Southern Trust without any additional Funding. Non compliance with the oncology/ Haematology Triage. 1.1 unable to ensure that patients receive timely and appropriate responses to their calls. 1.2 patients right to be treated with a professional standard of care. 3.3 no clearly identified triage practitioner for each span of duty the process should allow for allocation of responsibility to a nominated triage practitioner for a period of duty. on completion of this period the responsibility for advice line management and follow up of patients is clearly passed to the next member of suitably qualified staff. this should provide a consistent , high quality service. 3.4.1 no dedicated time in suitable area for consultation will enable the clinician to pay appropriate attention to the caller, without being interrupted. The risk to patients if call not returned and patient assessed in timely manner. Risk of Neutropenic sepsis	Hourly checks in place in the haematology ward regarding phone messages patients advised to ring back if not contacted within 15 mins to ring back to ward or if emergency to ring 999 or go to ED. Group set up to review other options that could be resourced. Band 5 out of hours period 7 days per week and at weekend and bank holiday being costed by finance.	11.03.19- No update. 26.02.18 Raised regionally by HOS Oncology. Pilot re Band 3 taking phone calls in place Monday-Friday 9am-5pm, awaiting results of this.	MOD	DIV
3702	21/07/2015	Provide safe, high quality care		Patients that are being outlied from medical wards are regularly not transferred under the correct physician/geriatrician.	There is a risk that patients will not be seen on a daily basis by their doctor. There is a risk that if the patient's condition deteriorates it is not managed properly. This is a delay in treatment and discharge planning.	Person in charge of the receiving ward will check at the end of their shift that the FLOW board is accurate. Person in charge of looking after the patient that has been outlied on the receiving ward must ensure patients are reviewed on a daily basis and escalate when this does not take place to the correct medical team.	11.03.19- No update. 01.06.16 - Guidelines sent to patient flow team advising that each evening the patient flow must check and ensure all patients outlied are placed under the correct consultant. Daily check to be carried out for 8.45am bed meeting.	MOD	DIV
3624	05/12/2014	Safe, High Quality and Effective Care		Lack of a Biologic Suite	Treatment of patients in facilities which are not designed for this purpose.	Use of isolation ward.	11/3/19 Day Clinical Centre - Where Biologics are administered continues to be located in the 6 Bedded Isolation ward as alternative accommodation has not been secured. The DCC is extremely small however treatments are carried out to ensure they meet appropriate standards and reduce risks. 29.02.16 - Plans in place to upgrade Ramone Ward to improve the accommodation when administering biologics.	MOD	DIV
3625	05/12/2014	Safe, High Quality and Effective Care		Clinical mangement of Medical Outliers.	Potential for patients not to be identified correctly and therefore missed by the clinical teams.	Correct use of IMMIX and updating as per protocols by all staff.	11.03.19-No update 01.06.16 - Still ongoing. Review of processes being taken forward. 29.02.16 - Requires directorate focus.	MOD	DIV

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2250	08/09/2009	Provide safe, high quality careSafe, High Quality and Effective CareImproving Health and WellbeingEffecti ve organisational governance		Risk to health and safety of patients presenting to the trust with chest pain.	Risk of missed diagnosis in wrongly interpreting a patients ECG by junior medical staff. Patients may not receive timely and effective treatment appropriate to their diagnosis.	Where possible a senior member of medical staff will review ECG and give an opinion. Thrombolytic team should be paged immediately if patient presents with ischemic cardiac pain.	11.03.19- No update. 01.06.16 - NICE guidelines currently being reviewed. 01.02.13 Chest pain pathway to be reviewed by clinicians. 25.10.12 - Position remains unchanged from previous report - no adverse incidents reported since. 23.01.12 - Cardiology liaison service commenced 9am - 5pm Monday - Friday. 07.09.09 - a training package has been developed but no dedicated funded personnel to deliver training package to junior medical staff on an ongoing basis has been identified.	LOW	HOS
1022	07/08/2008	Safe, High Quality and Effective CareProvide safe, high quality careBe a great place to work		Disruption caused due to violent/aggressive patients or relatives	Disruption caused due to violent/aggressive patients or relatives - big demand on nursing time causing time spent away from other patients; health and safety and wellbeing of visitors, patients and staff when dealing with/managing violent/aggressing patients; all wards, CAH and DHH.	Staff awareness of proactive approach; availability of security guidelines for alcohol withdrawal for inpatients; review staffing levels; medical review of patients by doctor; consultation with Consultant and Bed Manager; liaison RMN in post; personal safety in the workplace training available for all staff; violent and aggressive behaviour towards staff post incident procedure in place; policy and procedure on the management of aggression and use of restraint; transfer to suitable environment/appropriate unit when medical condition stabilised.	11.03.19- no update. 01.06.15 - Disruption continues to be caused due to violent and aggressive patients and/or relatives.	LOW	DIV
3515	14/11/2013	Provide safe, high quality care		Ineffective Cardiac Monitoring System in certain Wards/Departments in CAH and DHH	The current cardiac monitoring system is old and unable to monitor patients in various wards/departments in the hospital site given their physical location. Monitoring is not available for certain patients and patients then may be required to move to 1 North for monitoring unnecessarily.	Appropriate selection of patients for monitoring.	14.11.17 Waiting on decision to start work with the potential of relocating coronary care beds to the HDU in DHH. 1.12.16 No further update. 13.9.16 In relation to CAH telemetry, this has now been fully implemented in the main acute wards, cathlab, and delivery suite.DHH,is awaiting funding allocation. 27.05.16 - Work in CAH will be completed with 3 months time. Costing obtained in respect of DHH work and added to Capital Estates list for consideration. 1/3/16 Now in place residual witing being carried out. 14.07.15 - Replacement system purchased and installed. Estates undertaking wiring to ensure all acute areas are covered.	LOW	DIREC
1025	07/08/2008	Safe, High Quality and Effective Care		Dependency levels and high bed occupancy	Dependency levels and high bed occupancy; health and safety of patients and staff due to a sustained high level of dependency and high bed occupancy, rapid throughput and reduced length of stay; all wards, CAH and DHH.	Adequate use of equipment; redeployment of staff between wards; staff rotation; risk assessment; consultation with consultant medical staff and bed management/CSM; review staffing levels; monitor dependency levels vs skill mix and stafing levels; monitor accidents and incidents; montior sickness absence; monitor clinical incidents; monitor complaints; annual manpower planning; monitor complaints; monitor patient's stay in hospital 3 times daily - PT flow meetings.	11.03.19- No update. 01.06.16 - No update. Work ongoing. 26.11.14 - New Medical model now in place in CAH. Discussions commenced with regard to medical model in DHH. Opening of additional winter beds in both CAH and DHH. Work commencing on creating a business case for additional medical beds on the CAH site.	LOW	DIV
1027	07/08/2008	Safe, High Quality and Effective Care		Risk of spread of infection due to inadequate facilities	Risk of spread of infection due to inadequate facilities, e.g. lack of sidewards, bed space near sinks and sharing of equipment; all wards, CAH.	Endeavor to adhere to current infection control policy; new visiting policy guidance; use of alcohol gel Trust wide; infection control link nurses in each ward; daily monitoring by Infection Control Team; equipment controlling.	11.03.19- No update. 01.06.16 - Some work carried out during the last refurbishment. Negative Pressure Room in Ward 2 North Respiratory. 25.09.13 - further development of en suite side rooms planned for CAH 2 South along with work highlighted below in 1 South due to commence October 2013 negative pressure isolation rooms being installed in main block for ill patients who cannot transfer to ramone ward. 27.11.12 - Ramone Ward now operational. Work to commence on Ward 1 South in March 2013. Clear guidance and risk assessments in place. Daily review of all patients in side rooms with input from infection prevention and control team. 01.10.11 Risk reviewed by MB,KC, SB on 27.09.11. Isolation ward opened in June 2011 plans to undertake further work in 1 South to create a new isolation unit in the main Upgrading of 2 North Haem/Resp completed in August 2011. Plan to upgrade all wards in MUSC to create additional ensuite facilities and piped oxygen and airblock due being taken forward by HOs.	LOW	HOS
3050	29/11/2011	Make the best use of resources	Corridor/Landing	File Management Issues- Hospital Social Work Department, CAH.	Accomodation issue. Not enough room to store patient records in line with the Trust Retention Policy.	Records reviewed annually. Use of closed storage. Accomodation request previously submitted. AD and Corporate Records aware of issue. Review 9.12.14 discussed with Line Manager and HOS for Corporate Records. Continue to use closed records. Trial using electronic solutions in the community to be audited and then for further consideration by hospital social work.	11.03.19- No update 26.02.16 - Health and Safety Risk Assessment completed. 26.11.14 - HOS to re look at all storage options including off site, scanning and microfilming.	LOW	DIV
1044	08/08/2008	Safe, High Quality and Effective Care	Wards	Safety and wellbeing of patients and staff due to lack of storage space	Space; health, safety and wellbeing of patients and staff due to lack of storage space, lack of bed space, not meeting department guidelines, sanitary facilities, counselling facilities, toilets and showers; lack of space for equipment; all wards, CAH and DHH.	Utilise all available space effectively.	11.03.19- No update. 01.06.16 - Storage space still not adequate. Refurbishment has helped but still falls short of appropraite standard. 26.11.14 - AD to write to locality team to raise issue of non-clinical use of clinical space on wards. 25.09.13 - refurbishment on-going. 27.12.12 - Each ward working towards refurbishment programme. 01.10.11 Reviewed 27.09.11 no change in risk. Minor works being identified at ward level to be undertaken to create more storage space.	LOW	HOS

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3509	24/10/2013	Safe, High Quality and Effective Care	Accident & Emergency	Lack of Monitoring Equipment threatens patients safety in Majors in ED	Patients that are placed in the Cubicles in Majors that will require physiological monitoring. Patients may deteriorate in cubicle without warning alarm from monitor. CNS observations delayed due to lack of equipment. Inability to assess and monitor patients that present with illness. Delays in treatments and assessments of patients Failure to recognise patient deteriorating	Four new monitors replaced condemned monitors in 2012. This leaves 6 cubicles without monitoring equipment. These measures are effective but require further action. Bids for Capital have been attempted for 6 monitors but have been unsuccessful	11.03.19- No update. 24.10.13 - 6 monitors will cost £30k - £40k. Further bid for capital submitted.	LOW	HOS
3956	30/04/2018	Safe, High Quality and Effective Care		Non-compliance with NCEPOD inspiration for the future	There are 21 recommendations for this NCEPOD Currently only fully compliant with 1 KPI. Patients who require Non Invasive ventilation have the potential to receive inadequate care as we are non compliant with 21 KPI	Established MuLti Disciplinary working group for the Trust. Established Sub groups to take forward key Indicators. Establish baseline and review in 6 months.		LOW	DIREC
3864	21/12/2016	Provide safe, high quality careMake the best use of resources	Renal Unit Daisy Hill Hospital	Lack of isolation facilities for haemodialysis	Augmented care area. Dialysis patients ar risk of acquiring hospital associated infection. Infection Risk.	Training in place. Cohorting of pattients where possible. Juggling of patient slots.	11.03.19- No update. 26.02.18 Priority No 7 on capital list.	LOW	HOS
3892	24/05/2017	Make the best use of resourcesProvid e safe, high quality care		Unable to achieve Training Objectives	Training room being down sized resulting in reduced capacity and cancellation of ALS/ILS/BLS Impacts on training for staff throughout the trust, potential impact on patient safety. Potential for patients to be placed at risk secondary to lack of training provision.	No alternative control measure available.	11.03.19- No update. 13.08.18 Review training requirements and develop IPT re funding for additional staff and accomodation.	LOW	DIV
4023	18/04/2019	Provide safe, high quality care	Day Clinical Centre	Discharge letters not completed for patients who attended the Day Clinical Centre for treatment.	As discharge letters have not been completed for patients who attended the Day Clinical Centre for treatment it means that this has not been communicated to the patient's GP. GP's will be unaware of treatment which their patient has received which may affect their decision making with regard to further treatment plans for their patient.	This has been highlighted to the medical team who advise that "asking the F1's to attend to outstanding/historical tasks is 1. ineffective, 2 unrealistic given their current pressures. There remains no current resolution for dealing with this issue however we will endeavour to seek a solution	18.04.19 - await appointment of clinical director in Daisy Hill Hospital who will address this issue with medical staff.	LOW	DIV
2083	21/10/2008	Improving Health and WellbeingEffecti ve organisational governance		Risk of staff ill health due to environmental factors and unsuitability of office accommodation for purpose in Clanrye House DHH	Staff complain of eye irritation, throat irritation, respiratory problems, residual hearing symptoms related to background noise. Two members of staff previoulsy attended Occupational Health in relation to health issues associated with the working environment. Seven members of staff occupy office. Alternative accommodation on site was considered large cost implication e.g relocating to medical records store first floor level - approx cost £28,000. Accommodation request submitted previously	2013 - Ventilation and lighting monitored by estates services. Working environment actively monitored by Acting Senior Social Worker. Staff had been offered prospect of room dividers.	11.03.19- No update. 26.02.16 - Health and Safety risk assessment form completed. 2013. New fans provided to allow exchange of air.	LOW	HOS
4024	30/04/2019	Provide safe, high quality careMake the best use of resources	2 South Medical	RPC Guideline for TIA Management not achievable	RPC guideline indicates that all TIA / ?TIA patients must be reviewed within 24 hours. The service provision in SHSCT is inadequate to meet this requirement. There is a risk that patients will have further TIA / Stroke before they can be reviewed and commenced on appropriate care pathway. This could have a catastrophic outcome for the patient.	There are TIA clinics held Tuesday - Friday for urgent cases and a Neurovascular clinic on Mondays for less urgent cases. The patients attending the Tues - Fri clinics can be waiting 4 days.	30/04/19 Risk added to Register	VLOW	DIV

Surgery and Elective Care Division
Division, HOS and Team Risk Register - Updated May 2019

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3765	24/02/2016	Safe, High Quality and Effective Care		Reduced NIMDTA supply and inability to recruit middle grade doctors in all surgical specialties. HAN service also under pressure	Potential risk to patient safety in the OOH period. Reduced elective activity Potential for increased admissions if surgical review unable to take place in ED. Potential gaps in surgical OOH rotas leaving poor medical cover. Potential for delays in medical administration and discharge.	Offer additional locum shifts to core medical staff. Day rotas adjusted to prioritise OOH cover. Outpatient clinics reduced to release staff for core emergency cover. Agency locum approved. International recruitment commenced. NIMDTA lobbied to provide more FY1's same successful with 4 more FY1 doctors starting August 2016. Working with PHA re planning for medical workforce.	28/3/19 - Continue to use Locum registrars to ensure adquate on-call cover in registrar and SHOs on both sites 6/2/19 - Risk remains. Locums Regs in DHH continue to cover 1:6 on-call and under NIMDTA SHO allocations from Feb 19 20/11/18 - Risk remains, in DHH 4 SHO locum out of 6 due to no NIMDTA allocation. Locum Regs in DHH required to cover 1:6 on-call rota 1/10/18 Risk remains the same as below-Locums in post. 8.8.18 No change with new intake Aug 18. Locums required in DHH for General Surgery SHO and Reg to cover on-call and shifts. 12/6/18 No change, continue to struggle to cover on call-shifts, locum shifts being offered. 10.4.18 no change, struggling in particular within urology. Offering locum shifts to cover on-call. 27/2/18 - situation remains the same. Continue to offer locum shifts to cover on-call. 30.5.17 No improvement, national issue. 7.3.17 No improvement or change 2.12.16 No further update. 24.10.16 - CAH retained a GS Middle Grade for an extra 3 months, however will go to 2 vacant middle grade positions at 01/01/17. DHH vacant middle grade positions are still being filled by locums.	HIGH	DIV
3767	24/02/2016	Organisational and workforce development		Delays / inability to recruit to all vacant posts and the flexing up of surgical beds for winter pressures is causing staffing p	Patients may experience delays in their care provision and outcomes may be affected. Staff morale is reduced due to additional hours and perceived working pressure. This can lead to sickness absence which compounds the problem.	Proactive recruitment and over recruitment at permanent level to attract staff. Use of all bank and agency - outside of contracted agencies. Additional hours / overtime offered. Closely monitored by Heads of Service and and staff reallocated across wards to manage the risk.	28/3/19 - Continued high nursing vacancies throughout the Trust. Ongoing overspend in agency/bank nursing costs. 6/2/19 - Vacancies remain at high level. Winter ward opened from December 18, challenging to staff. Unsuccessful recruitment drives. 20/11/18 - Vacancies remain at high level. To mitigate the risk OPD and RN agency workers recruited on 3-6 monthly contracts to ensure service provision is maintained. 1/10/18 Risk remains the same as below; Unsuccessful recruitment drive. Very high risk remains within ATICs nursing. 8.8.18 Risk can be split into 2 categories Perm Vacancies and Temp posts due to flexing of beds and ML. Unable to staff wards to agreed normative levels and AFPP standards (theatres). Within theatres continued use of agency and ODP's. Beds continue to be flexed and pressures remain. Ongoing discussions at SMT. 12/6/18 RC emailed Directors again re Risk, awaiting feedback. 10/4/18 - ongoing risk and significant pressure on wards due to high volume of vacancy. RC has emailed Directors to escalate risk, highlighting options. Awaiting feedback. 28/2/18 Ongoing international recruitment. Beds are still flexed. Risk ongoing 7.11.17 Monthly workforce international recruitment meetings ongoing 30/5/17 - unchanged, beds still at flexed status. International	HIGH	DIV

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3826	19/08/2016	Safe, High Quality and Effective Care		Demand of fracture referrals outweighs fracture capacity.	Fracture patients at risk of late diagnosis and treatment.	The Trust has given permission for "at risk" fracture clinics, however, this still does not meet demand.	28/3/19 - current fracture patient outweighs capacity. 11th T&O consultant part funded which include 1 fracture clinic per week. Q1 2019/20 additionality approved by SMT for fractures new and review 6/2/19 - as below, no change 20/11/18 - Continuing to use additionality, working towards commencement of MSK hub once accommodation has been allocated. 1/10/18 As below using HSCB additionallity funding to meet demand. 8.8.18 Q2-4 additional received to meet ongoing fracture demand. 12/6/18 Require more non-recurrent funding to meet fracture demand, waiting confirmation of same. 10/4/18 - non-recurrent funding requested for fracture new and review. waiting time approx 4-5 weeks due to Easter leave 28/2/18 fracture waiting time currently 2-3 weeks, ongoing additionality for fracture reviews. 30/5/17 - fracture demand continues to increase and waiting time extended to 5wks for fracture clinics. 'At risk' clinics to continue to meet demand 7.3.17 Unchanged.	HIGH	DIV
3827	19/08/2016	Safe, High Quality and Effective Care		Due to the move down from level 6 to outpatient department to the current OPD accommodation is not suitable to sustain numbers.	Risk of late diagnosis and treatment. Health and Safety and fire risk to patients and staff.	Reduction in the number of fracture patients that can attend each clinic to be reduced.	28/3/19 - fracture clinic in DHH continues to be located on level 3 DHH (SAU room), therefore numbers remain reduced. Remains on the capital allocation list 6/2/19 - as below no change to risk 20/11/18 - new fracture clinic on DHH site has moved to no. 5 on capital allocation. we continue to have significant over crowding issues and the only way address is for new purpose built accommodation as the site has been reviewed and nothing suitable after pathfinder. 1/10/18 Risk remains unchanged 8.8.18 No change - DHH fracture clinics remain in DHH ASU unit all day Monday and Tuesday PM. 10.4.18 No change 28/2/18 requesting for fund still outstanding. New fracture accommodation is essential. Awaiting outcome. 30/5/17 - requested funding for new fracture accommodation, awaiting outcome	HIGH	DIV
3920	13/11/2017	Provide safe, high quality care	Intensive Care Unit	ICU Consultant Workforce	Potential for inability to cover the department with appropriate staff for ICU	Advertisement to replace 2 ICU consultants and also 2 general anaesthetic consultants.	28/3/19 - no change, still waiting start date and vacancies out for re-advertisement. 6/2/19 - 1 consultant anaesthetist recruited awaiting start date. Other vacancies out for re-advertisement. 20/11/18 - Out to advertisement, awaiting outcome of interviews1.10.18 - With medical staffing for recruitment. 8.8.18 Still awaiting start date. 12/6/18 Consultant anaesthetists has been appointed awaiting start date. 10/4/18 - 1 further consultant anaesthetists retirement. Going out for advertisement again closing date Tuesday 17/4/18. 28/2/18 - 4 consultant anaesthetists have been appointment, waiting checks and commencement date. 7/11/17 - in progress, interviewing in the next few weeks and backfilling with Locums at present.	HIGH	DIV
3972	28/08/2018	Provide safe, high quality care	Anaesthetics, Theatres & Intensive Care Services	Inexperience of CT1 for General Anaesthetics in Theatres/OOH/Weekends	ATICS cannot guarantee access for c sections due to CT1 inexperience. Potential for harm to women and babies	On-call Consultants will come into the Trust when c sections is required.	28/3/19 - continued risk. To remain on risk register. 6/2/19 - discussed with Dr Scullion and ATICS Business meeting and remains on Directorate RR 20/11/18 - Dr Scullion to review, keep on Directorate risk 1.10.18 Unchanged, review in November 2018. 7.8.18 Dr Scullion, AMD e-mailed all anaesthetists re CT1 inexperience issue and controls. Competencies of CT1's to be completed in 3 months, revalidate.	HIGH	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3992	19/11/2018	Provide safe, high quality care	High Dependency Unit DHH	Rostering of 3 level 2 skilled/competent staff per shift not achieved	Reduction of beds available for level 2 patients due to reduced availability of competent staff during induction period. Risk of inappropriate placement of level 2 patients in HDU and risk to staff members in undertaking duties pre completion of induction period due to current to training of pre reg nurses to provide care to 2 level 2 patients	Discussed with HOS/AD and Director of Acute Services and SMT plan to recruit trained staff from agency as block booking to fill gaps in roster with suitable skills in level 2 care	28/3/19 - recruitment challenges continue for DHH HDU, to remain under general surgery. Pathfinder group continue to meet regularly to work through possible solutions. 6/2/19 - discussions ongoing re HDU in DHH recruitment. Pathfinder meetings continue regularly. Recruitment challenges continue. 20/11/18 - pathfinder recruitment for DPU DHH ongoing. Risk assessment being completed	HIGH	DIV
3993	19/11/2018	Provide safe, high quality care	High Dependency Unit DHH	Agency nursing staff not trained to SHSCT protocols	Agency staff from block booking with appropriate qualifications in level 2 may not complete procedures as per SHSCT processes's. Potential for risk to patient safety and potential for staff who may not follow procedures as per SHSCT process which could influence results potential for low performance reports. Agency staff fulling gaps in roster without skills for level and may not complete procedures as per SHSCT processw.with appropriate qualifications in level 2 may not complete procedures as per SHSCT processess Potential for risk to patient safety and potential for staff who may not follow procedures as per SHSCT process which could influence results potential for low performance reports.	Discussed with HOS/AD agency staff can be issued with codes for e-learning gap until completed and time to roster to complete need to have suitable trained staff with level 2 care priority to manage deteriorating patients. Roster reviewed to have suitable trained staff with level 2 care on roster /priority to manage deteriotating patients.	28/3/19 - BB agency to complete e-learning and practice audit, ongoing review required. 6/2/19 as below, no further update 28/11/18 ongoing BB agency completing ANTT e learning and practice audited/ Rostering maximising 3 HDU staff on duty. 12/10/18 Block booked staff will be provided with e-learning log ons staff will be provided with induction folder and will be rostered with at least two permanent HDU staff. 12/10/18 every effort will be made to roster with at least three permanent HDU staff with level 2 skills.	HIGH	DIV
4018	15/10/2016	Provide safe, high quality care		Inpatient / Daycase Planned Backlog	Delay in review of patients planned for screening/repeat procedures presenting adverse clinical risk.	INDC planned backlog in the following surgical specialties: urology, general surgery, ortho and chronic pain.	28/3/19 - continue to monitor IPDC planned backlog by HOS and OSL. Validation of strugglers to ensure they are true waiters or appoint. No routine planned capacity currently on the CAH site 6/2/19 - Continue monitoring and discussed at HOS meetings 20/11/18 - IPDC planned backlog continues to be high risk to the Trust. Monthly monitoring continues and discussed at HOS performance meeting and monthly Director performance meeting 15/10/18 - Risk assessment paper written and submitted to Director for discussion at SMT. Validation of long waiters being undertaken in Gen Surgery and Ortho	HIGH	DIV
4019	15/10/2016	Provide safe, high quality care		Inpatient / Daycase Planned Backlog for Endoscopy	Delay in review of patients for planned screening/repeat procedures presenting adverse clinical risk.	Encdoscopy planned backlog. Papers written and submitted to Director re risk. Requested HSCB funding for planned backlog clearance.	28/3/19 - IS contract with medinet ends 29/3/19, they were able to complete approx[redacted] pts out of the contracted[redacted] planned. Continued risk for colonography routine planned backlog. 6/2/19 - Ongoing validation. IS contract with medinet for[redacted] routine planned scope patients, however, only[redacted] colons. Routine planned continues high risk. 20/11/18 - Endoscopy planned validation continues by the NE. Funding secured to transfer routine planned patients to SET mobile for Q4 of 2018/19. 15/10/18 - Risk assessment paper written and submitted to Director for discussion at SMT. Validation to be undertaken of planned long waiters by Nurse Endoscopists	HIGH	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
4020	12/04/2019	Provide safe, high quality care		OP reviews beyond clinically indicated timescales	Delay in review of patients for planned screening/repeat procedures presenting adverse clinical risk	Delays in review of patient presenting adverse clinical risk.	28/3/29 - non-recurrent funding received in Q1 of 2019/20 for general surgery and chronic pain. continued monitoring by HOS and OSL 6/2/19 - non-recurrent funding received to end of March 19 for Gen Surgery and chronic pain. To request funding from April 19 to continue with additionality on RBL. RBL discussed at HOS 20/11/18 - Ongoing review backlog clinics in general surgery, chronic pain and urology to the end of March 19. RBL remains high risk 15/10/2018 - HSCB funding requested for review backlog clinics in general surgery, chronic pain and urology. Clinical validation being undertaken in general surgery	HIGH	DIV
4021	12/04/2019	Provide safe, high quality care		Access Times (Outpatients) - General (not inclusive of visiting specialties)	Increase in access times associated with capacity gaps and emergent demand - Capacity gapin RF, urgent and routine.	ATICs/SEC specialties with New Outpatients >52 weeks; urology, general surgery, Orthopaedics, Chronic Pain	28/3/19 - continued capacity gap in all surgical specialties. regional discussions in ongoing re urology. Q1 2019/20 in house additionality received for breast symptomatic, chronic pain and general surgery additionality for both in house and IS 6/2/19 - Waiting times are monitored by OSL and HOS, and discussed at HOS weekly meetings. Risks highlighted at monthly performance meetings 20/11/18 - new outpatient waits continue to grow on a monthly basis. Additionality secured for general surgery and chronic pain. high risk of incidental cancers from long new waiters 15/10/18 - Clear capacity gap. Request for HSCB funding when IHA capacity available to do additional sessions. Ongoing RF capacity issues discussed at monthly cancer performance meeting	HIGH	DIV
4022	12/04/2019	Provide safe, high quality care		Access Times (In-patient/Day Case) - General	Increase in access times associated with capacity gaps and emergent demand.	ATICs/SEC specialties with New Outpatients >52 weeks; urology, general surgery, Orthopaedics, Chronic Pain	28/3/19 - 30% reduced theatre capacity to continue into April 2019. Access times continue to grow for routine and urgent waits. HOS and OSL continues to monitor and validate long waiters 6/2/19 - IPDC waiting times continue to grow. Winter plan in place from Dec 18 to March 19 with 30% reduced theatre capacity. No routines to be scheduled on CAH site, capacity for RF and urgent only 20/11/18 - IPDC waiting times continue to grow. Winter plan in place from Dec 18 to March 19 with 30% reduced theatre capacity. No routines to be scheduled on CAH site, capacity for RF and urgent only 15/10/18 - Clear capacity gap. Request for HSCB funding when IHA capacity available to do additional sessions. Ongoing RF capacity issues discussed at monthly cancer performance meeting	HIGH	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3801	27/05/2016	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	JAG Accreditation	Due to the waiting times for patients having endoscopy procedures, we cannot achieve timeliness of appointments, and therefore, cannot achieve JAG accreditation. This is a regional issue and JAG are aware of same.	JAG is working with HSCB and the Trusts with regard to the revised JAG standards and the potential for 2 levels of accreditation.	28/3/19 - next ATICS Business meeting Fri 19/4/19, to discuss taking JAG off the RR. 6/2/19 - Consider taking off Directorate RR to be discussed at next ATICS Business meeting. 28/11/18 - Can this be removed if we are not working towards JAG accreditation at this present time?? 1/10/18 IS funding received for 206 urgent scopes and 194 routine elective. Ongoing risk to routine planned endoscopy patients. Escalated to Director and SMT. 8.8.18 Endoscopy backlog clearance bid submitted to HSCB May 2018. Funding received for elective backlog only. Planned backlog (routine and urgent) remain high risk. Briefing paper being submitted to SMT to raise risk again. Currently no capacity in house for routine endoscopy patients. Discussed routinely at EUG, HOS and specialty meetings. 12/6/18 ongoing discussions with HSCB re endoscopy backlog clearance, waiting on confirmation of funding. 2nd endoscopy procedure in DHH ongoing at risk. 10/4/18 - The Trust have a plan to improve endoscopy waiting times, however, still struggling to achieve. 28/2/18 - No change in waiting times, capacity currently for RF and urgent only. Standing agenda at EUG meetings. 30.5.17 No change 7.3.17 Unchanged	MOD	DIV
3802	27/05/2016	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	Nurse Recruitment for Adult and Paed theatres	Risk of being unable to cover all required theatre sessions with appropriately skilled theatre staff, therefore, there is a risk of sessions not being scheduled or being cancelled if insufficient skilled Theatre staff are not available.	We continue to use the Nursing Team in ATICs across all theatre departments. This includes cross site working, to ensure that we make the best use of our resources to cover the core confirmed sessions.	28/3/19 - Continued high level of vacancies in theatres and risk to staffing main theatre sessions. Continue to run at 30% less theatre sessions for April 2019. theatre sisters continue to redeploy skill across hospital sites. Risk remains high. 6/2/19 - Unsuccessful recruitment in Dec 18, continue to work with BSO to fill vacant posts. Weekly nursing rota meeting ongoing to redeploy skill across hospital sites. 30% reduction on CAH and DHH main theatre sites. Draft ATICS theatre nursing staffing risk briefing paper with AD. 28/11/18 - Interviews taking place on the 7/12/18 for Band 5, await outcome 1.10.18 Risk remains the same. Unsuccessful recruitment drive. Continue with agency and bank. 8.8.18 Risk remains the same and the paediatric service unable to assist with 2nd stage recovery due to vacancies and maternity leave. 12/6/18 Still only 2 paed nurses trained for new paed theatre. Paediatric nursing ward team are unable to provide 2nd stage recovery in DHH paed recovery. 10/4/18 - Trained 4 and now down to 2 paeds nurses. Ongoing risk 28/2/18 - Paeds theatre operational from Mon 5/3/18. Ongoing risk to paed theatre nurses, lost 3 dual trained, to go back out to recruitment. 7.11.17 Authorisation just given from Director to progress with recruitment for the new paeds theatre in DHH. Scrutiny form has been forwarded to Dean Faloon, awaiting response before	MOD	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3803	27/05/2016	Safe, High Quality and Effective Care	Recovery Ward	Post op Surgical Pts in the Recovery Ward	Regularly there are patients kept over night in the recovery ward due to ongoing bed pressures within the Trust. However, this increases the risk within the recovery area due to having post op surgical pts, HDU patients (med or surg), adults male, female and children are all mixed within the area. There are post op pts being fed while pts are still being brought out from theatre intubated and pts that come round from anaesthetic can also be nauseated. Unable to get patients out in a timely manner to the wards the following day which impacts on patients being able to get out of theatres to recovery, which in turn impacts on the operating time available if patients have to be recovered in the Theatre.	ATICs try to ensure as far as possible that a limited number of patients are kept post op in the recovery ward. This is not always adhered to.	28/3/19 - due to continued bed pressures, recovery cstsaff with 3rd nurse Tue, Wed and Thursday nights, increasing to 4th nurse when required. Some patients continue to be kept in recovery post op which limts their enhanced recovery on the wards. 6/2/19 - continue to staff with 3rd nurse on Tue, Wed, and Thursday on night duty to cope with capacity. increased to 4th nurse dependent on bed pressures. 28/11/18 - Can this be removed as escalation embedded 1/10/18 As below no change. As discussed at bed meetings, if more capacity required 4th nurse is facilitated if possible. 8.8.18 As below no change. As discussed at bed meeting, if more capacity required 4th nurse is facilitated if possible. 12/6/18 - 3 nurses Tues, Wed, Thur on night duty to cope with capacity. Will remain ongoing throughout the year at risk. 10/4/18 - Continues due to bed pressures. 28/2/18 - As below continues over winter period. 7.11.17 Due to winter pressures Tue-Thurs continue to be 3 staff nurses over night for HDU abd post op patients. Post op patients to stay over night in recovery is agreed at the 2 hours bed meetings. 30/5/17 - Currently Tue, Wed and Thur 3 staff nurses for over night HDU post op patients required. Still waiting on draft protocol comments from ADs 7.3.17 Draft protocol has been sent to AD for MUSC and Director for comment.	MOD	DIV
3804	27/05/2016	Safe, High Quality and Effective Care	Outpatients Dept	Pre Op Assessment	Pre-op assessment is currently under resourced to provide the number of assessments required and deal with the increase in demand to the service	Staffing has been structured within pre-op to cover the key areas ensuring the best use of the limited resources. We are currently proactively working to change the existing pre-op processes to ensure that patients are pre-assessed and passed fit before ever being scheduled for surgery. This impacts on the need for additional staffing as we are working to change the processes while having to continue with existing processes.	28/3/19 - Risks continue as below and additionality continues. Agency band 2 part time to start end of April 19 to support the B5/6 nursing staff. 6/2/19 - High sickness rate in pre-assessment at present. Additional hours offered to keep up with demand. Discuss additional admin B2 to be recruited as risk to support the B5/6 28/11/18 - Risk remains the staff. Additional hours offered to try and keep up with the demand. 1/10/18 - pre-op is an unfunded service and continues at risk to the Trust and ATICs. Demand outweighs current workforce and capacity. Non-recurrent additionality for 800 pts has been requested, awaiting outcome. 8.8.18 Pre-op have recruited to 1 post X Band 6. 1 post now not required. 1 person to be interviewed 17.8.18. Keep risk on due to increase in demand. 12/6/18 - demand continues to exceed capacity. Currently recruiting to 3 postsx Band 6. 10/4/18 - Briefing Paper needs to be reviewed. EJK is meeting with Pre-op. 28/2/18 - Demand still exceeds capacity. Additionality ongoing to end of March 18. 7.11.17 Demand for pre-op continues to exceed capacity, leading to delay in getting patients fit for surgery. Risk continues 30/5/17 - POA suspension protocol discussed at THUGs and declined due to current review backlog at clinics. Continue with Ortho fit pool	MOD	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3930	12/12/2017	Provide safe, high quality careMake the best use of resources	Anaesthetics, Theatres & Intensive Care Services	Discontinuation of guaranteed Service for Drager Oxylog Ventilators	Maintenance Company can no longer guarantee support the Drager Oxylog Ventilator for items that may be required for repair/service. There are no spare machines available to STH.	None in place	28/3/19 - 3 machines arrived, training and implementation plan ongoing. anaesthetic machines programme to remain. 6/2/19 - 3 machines procured for CAH. Will be delivered pre-31/3/19. Rolling replacement programme in place to procure remaining 9 machines 28/11/18- anaesthetic machines are being procured, will still not address the overall standardisation throughout the Trust 1/10/18 Remains on capital list. Trial for 3 anaesthetic machines commencing Oct18. 8.8.18 Remains on capital list. Trial to commence. 12/6/18 -currently on capital list and money has been agreed for 3 ventilators in a rolling programme. 10/4/18 - awaiting information from IMWH. With staffing issues in ATICs, hold off progressing. 28/2/18 - Oxylog Ventilator is on the capital list, awaiting 18/19 allocation	MOD	DIV
3800	27/05/2016	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	Anaesthetic cover for maternity services	We currently fail to meet the standards regard to anaesthetic cover for maternity theatres. There is a risk to the Maternity patients from having inadequate cover. The staff is approximately 2.0wte. The nursing levels do not meet the national guidelines. Risk of failing anaesthetic accreditation, currently do not meet the standards.	A paper is being completed with regard to sorting the deficit in both anaesthetic and nursing cover.	28/3/19 - Next ATICS business meeting arranged for 19/4/19, await update from Dr Scullion. 6/2/19 - discussed at ATICS business meeting. Dr Scullion investigating the transfer of IMWH maternity theatres 28/11/18 - no change as funding is still not handed over from IMWH 1.10.18, 8.8.18, 12.6.18 no change 10/4/18 - awaiting information from IMWH. With staffing issues in ATICs, hold off progressing. 28/2/18 - Draft paper to be submitted re ATICS taking over maternity theatre, led by Dr Scullion. 7.11.17 Mr Carroll to discuss with H Trouton IMWH 30.5.17 No change 7/3/17 - Recruited however 1 is for Pain & Anaesthetists, still no nursing to support	MOD	DIV
3727	01/09/2015	Make the best use of resources	Anaesthetics, Theatres & Intensive Care Services	No equipment store available in Day Surgery Unit CAH	Currently there is a 2 bedded side room unable to be used for patients as it stores the equipment for this unit. This can impact on the availability of beds for the daycase list, particularly when lists are occurring simultaneously. Potential for harm; Potential delay of access to day surgery beds. Limited availability of segregation for patients for IPC reasons and also male/female.	Try to maximise the use of the existing 12 bed spaces. Continues to use the 2-bedded side room for equipment as this reduces the risk to patients and staff of equipment being stored in corridors, this would also be a fire hazard.	28/3/19 - as below, risk remains as no capital funding identified. 6/2/19 - no capital funding, therefore risk remains the same. 28/11/18 - 2 bedded side room continues to be used as a store, storage remains a risk but have been advised it is capital works (Helena to follow up) 1.10.18, 8.8.18,12.6.18, 10.4.18 , 28.02.18, 7.11.17, 4.7.17 Unchanged 30/5/17 - unchanged. Store is still required. On the minor works list and requires to be prioritised by the Acute Directorate. 7.3.17 Unchanged 2.12.16 On the minor works list and requires to be prioritised by the Acute Directorate	MOD	DIV
3746	30/11/2015	Safe, High Quality and Effective Care	3 South ENT	Paediatric Patients treated in 3 South ENT treatment room - cannot guarantee nurses with upo to date paediatric training.	Limited paediatric trained staff includes - paediatric trained nurse may not be with patient in the treatment room - clinical outcomes if patient needs specific paediatric nursing care including resuscitation - poor patient experience and safeguarding issues.	Meeting held with Paediatric Head of Service to discuss issues on 27 November to scope the problem. Data has been requested. Further meetings planned with the aim to have a paediatric nurse with paediatric patients or inform paediatric ward of admissions.	28/3/19 - no change. 06/02/2019 No change. 1.10.18, 8.8.18, 12/6/18, 10.4.18, 28/2/18 - No change - further discussions required. 30.5.17 No change 7/3/17 - Paed nurse is required in room when child is getting a procedure, need to resolve. Ronan to discuss with Geraldine Maguire. Approx. 6 pts per week. ENT ward attender report to be run for under 16's to establish volume of occasions Paed nurse is required.	LOW	DIV
750	28/07/2008	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	STH Theatres and Day Procedure Unit requires UPS/IPS syste,	Theatres and Day Procedure Unit at STH currently does not have any form of backup electrical supply other than the emergency generator; in the event of a power failure all power supplies to socket outlets will drop out for approx. 15 seconds until the generator comes on line.	Battery backup exists on the anaesthetic machine only.	28/3/19 - no change. 06/02/2019 - No change. 1.10.18, 8.8.18, 12.6.18, 10.4.18, 28.02.18 Risk remains unchanged 6.11.17 remains unchanged, no UPS on anaesthetic machines or any other monitoring equipment in STH Theatres/DPU. 30.5.17 Risk remains unchanged	HIGH	HOS

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3880	07/03/2017	Provide safe, high quality care	Trustwide	Patients requiring review at Breast Family History Clinic	Patients requiring review at Breast Family History Clinic not being seen in a timely manner due to review backlog therefore risk that patients may have delay in diagnosis. Patients may not be seen within appropriate review.	Staff have been offered the opportunity to undertake additional sessions to ensure that the waiting time for patients to be seen is reduced and patients are seen in a timely manner . Plan to recruit and additional admin person to book yearly mammograms as a rolling programme.	28/3/19 - no update. 6/2/19 - downgrade to departmental risk 20/11/18 - Downgrade to Departmental risk. 1/10/18 As below RBL risk reduced due to stratification of patients. BFH fail safe admin Band 4 in post. 8.8.18 BFH sub-group near completion of modernisation and stratification of BFH review patients. Review backlog remains however, all patients have been risk assessed. 12/6/18 - WC met with the BFH, working group has been set up with Breast team to modernise service to cope with capacity. ongoing risk to review patients. 10/4/18 - RC and WC meeting the team Wed 17/3/18 to discuss BFH. 28/2/18 - Recruitment successful and successful applicants commence beginning of April 18. 7.11.17 Recruitment for Breast fail safe with BSO at present, however on hold due to possible redeployment. 6.6.17 Transferred to SEC Risk Register following meeting with HT. Requires update.	MOD	HOS
1205	15/08/2008	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	Trust facilities for the cleaning, decontamination and storage of endoscopes do not comply with standards	Trust facilities for the cleaning, decontamination and storage of endoscopes do not comply with standards recommended in the Hine Review, increasing the risk of infection transmission.	STH have new fully compliant decontamination facility which is JAG accredited. DHH same opened Jan 2014. CAH day surgery has been refurbished with AERS and drying cabinets and is awaiting the installation of new sinks.Interim decontamination facilities for main theatres, Xray and ENT services are in place. Management of this service has been taken over by CSSD staff. Minor works upgrade to the endoscopy theatre and storage facilities is taking place to comply with JAG	28/3/19 - No change. 06/02/2019 - No change. 1.10.18, 8.8.18, 12.06.18, 10.4.18, 28/02/2018, 6.11.17 & 30.05.17 Remains unchanged. All areas compliant with Hine recommendations now. To remain on Risk Register as not achieving JAG accreditation.	LOW	HOS

Absconding Patients

	18/19 Q2	18/19 Q3	18/19 Q4	19/20 Q1	Total
ED DHH	26	16	27	4	73
ED CAH	18	18	28	5	69
AMU	4	6	5	3	18
4 North	0	4	1	1	6
Discharge Lounge CAH	1	0	0	0	1
Stroke / Rehab	0	0	0	0	0
1 South	0	0	1	0	1
2 South Stroke	0	0	0	0	0
3 South	0	0	1	0	1
4 South	0	0	0	0	0
Car Park/Grounds CAH	0	1	0	0	1
Car Park/Grounds DHH	0	1	0	0	1
Female Medical	0	0	0	0	0
Female Surgical	0	1	0	0	1
Male Medical	1	0	0	0	1
Trauma Ward	0	1	0	0	1
ICU (HDU)	1	0	0	0	1
Totals:	51	48	63	13	162

APPENDIX 4
Revised November 2016 (Version 1.1)

LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1

1. ORGANISATION: **SHSCT**	**2.** UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE: Personal Information redacted by the
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE: S11480	**4.** DATE OF INCIDENT/EVENT: **28/12/2016**
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: NO *Please select as appropriate*	**6.** IF 'YES' TO 5. PLEASE PROVDE DETAILS:
7. DATE OF SEA MEETING / INCIDENT DEBRIEF: **05/04/2017**	

8. SUMMARY OF EVENT:

On Wednesday 28 December 2016 Personal Information redacted by the presented to Daisy Hill Hospital (DHH) Emergency Department (ED) at 06:15 having pulled out his percutaneous endoscopic gastrostomy (PEG) tube at 01:00 hrs, in the private nursing home (PNH). Personal Information redacted by the was reviewed by Dr 1 who could not re-insert the PEG. Personal Information redacted by the was seen by Dr 2 at 10:00 and a size 14ch PEG was re-inserted. There is no documentation of any difficulty with the insertion. Personal Information redacted by the was discharged back to PNH at 12:50 hrs.

Personal Information redacted by the re-attended DHH ED on Thursday 29 December 2016 at 15:15 hrs with history of repeated vomiting since change of PEG. The temperature was 37.2º C, Pulse 102, Respirations 26, BP 90/69, SpO2 92% on arrival.

At 19:40 a computed tomography (CT) scan of abdomen and pelvis with contrast was performed. The report (21:29) stated "Misplaced PEG tube within the peritoneal cavity (not within the stomach), with consequence free fluid (likely introduced via PEG) and pneumoperitoneum".
After discussion with the family a do not actively resuscitate (DNAR) was implemented from 20:30

Personal Information redacted by the passed away on 10 January 2017.
Dr 6 met with the family 13 March 2017 to discuss the patient care with them. A Datix was submitted in relation to PEG re-insertion and promised an internal investigation.

SECTION 2

9. SEA FACILITATOR / LEAD OFFICER:	10. TEAM MEMBERS PRESENT:
Dr C Braniff – Consultant Physician	Dr C Braniff – Consultant Physician Mr Gilpin – Consultant Surgeon Mrs A Nelson - Home Enteral Tube Feeding Coordinator Mrs R Wright - Home Enteral Tube Feeding Coordinator Mrs T Reid Acute Clinical and Social Care Governance coordinator (Facilitator)

11. SERVICE USER DETAILS:

Male DOB Personal Information redacted by the USI ***aged*** Personal Information redacted by the USI ***at time of incident.***

12. WHAT HAPPENED?

On Wednesday 28 December 2016 Personal Information redacted by the USI presented to DHH ED at 06:15 with having pulled out his PEG tube at 01:00, the private nursing home (PNH) staff were unable to reinsert it. The patient's past medical history included haemorrhagic cerebral vascular accident (CVA), neurofibromatosis T2, tracheostomy, depression and epilepsy. Personal Information redacted by the USI was deaf and partially sighted. The PNH sent a size 12 PEG tube for re-insertion. Personal Information redacted by the USI was reviewed by Dr 1 who could not re-insert the PEG. He was seen by Dr 2 at 10:00 the notes document that the PEG was re-inserted, after the gastrostomy was dilated with a size 14ch bougie (tube to assist with placing tube). Personal Information redacted by the USI was discharged back to the PNH at 12:50.

Personal Information redacted by the USI re-attended DHH ED on Thursday 29 December 2016 at 15:15 with a history of repeated vomiting since change of the PEG. Personal Information redacted by the USI's wife had observed medication administration via PEG and had noticed this was painful. Temp 37.2 Pulse 102 Respirations 26 BP 90/69 SpO2 92% on arrival.

At 19:40 a computed tomography scan (CT) of abdomen and pelvis with contrast was performed. The CT scan was reported at 21:29 and showed a misplaced PEG tube within the peritoneal cavity (abdominal cavity), free fluid (likely introduced via PEG) and a pneumoperitoneum (air in the abdominal cavity).
After discussion with the family a DNAR was implemented from 20:30 and comfort care was implemented. Personal Information redacted by the USI passed away on 10 January 2017.

Death certification documents sepsis secondary to peritonitis due to gastric perforation. Other significant conditions type 2 diabetes mellitus.

Following discussion between Dr 6 and the family of Personal Information redacted by the USI to discuss his care on 13th March 2017, a Datix was submitted in relation to PEG re-insertion.

13. WHY DID IT HAPPEN?

The review team reviewed the clinical notes and available evidence. Personal Information redacted by the had cognitive impairment and was unable to clearly articulate signs of PEG tube displacement

The misplaced PEG was likely caused by disruption of the mature PEG tube tract, which may have been caused either by initial removal of the PEG, or at reinsertion. The PEG tube had been re-inserted into the peritoneal cavity (abdominal cavity) not within the stomach leading to a leak of gastric contents and free peritoneal air resulting in peritonitis and sepsis.

The review team concluded that disruption of the tract could have happened by; 'forcible' removal of the PEG tube by the patient, or, during the attempted reinsertion at the nursing home, or, at the time the tract was dilated by Doctor 2 in the ED. The review team concluded it was impossible to ascertain which of the event or events, noted above, contributed to disruption to the tract.

The review team noted that the correct positioning of the PEG tube was not confirmed by Xray contrast studies, after the balloon was inflated or prior to discharge from ED.

Personal Information redacted by the was noted to have repeated vomiting since change of the PEG and his wife noted pain while medications were being administered via the PEG, following which Personal Information redacted by the re-attended DHH ED.

Personal Information redacted by the was unfit for emergency surgery and following discussion with Personal Information's wife, it was decided to DNAR and comfort care was implemented.

SECTION 3 - LEARNING SUMMARY

14.WHAT HAS BEEN LEARNED:

The PEG tube was misplaced during re-insertion due to disruption of the mature PEG tube tract. The review team concluded it was impossible to ascertain which of the event or events, discussed previously, contributed to disruption to the tract.

The review team noted that the correct positioning of the PEG tube was not confirmed by after the balloon was inflated or prior to discharge from ED, either by aspirate or X-ray studies.

The review team recommend that whenever a PEG tube is replaced, correct positioning must be confirmed by pH monitoring or radiological investigation. This is particularly important when; PEG tubes that have been insitu for a prolonged duration, if there was 'forcible' removal of the PEG, the tract has been dilated or a patient has a cognitive impairment. The contrast studies should occur after the balloon is inflated, but before administering water, enteral feed or medications through the tube.

15.WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

The Emergency Department staff have been reminded of the importance of post insertion checks following re-insertion of displaced PEG tubes, particularly PEG tubes that have been insitu for a prolonged duration. These checks should include the use of pH and X-ray contrast studies.

Trust guidelines are being developed to assist staff and prevent this situation occurring again.

16.RECOMMENDATIONS

Recommendation 1
Share this report for learning with the ED, medical and surgical morbidity and mortality meetings

Recommendation 2
Trust guidelines have been developed for the replacement of late displacement of PEG tubes to include correct positioning checks.

Recommendation 3
Emergency boxes enteral feeding tubes should be designed and made available on both ED sites. This should include guidance for staff and a variety of tubes with ordering codes.

16.INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

17.FURTHER REVIEW REQUIRED? **NO**
Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)

18.PLEASE INDICATE LEVEL OF REVIEW:
LEVEL 2 / LEVEL 3
Please select as appropriate

19.PROPOSED TIMESCALE FOR COMPLETION:
DD / MM / YYYY

20.REVIEW TEAM MEMBERSHIP *(If known or submit asap)*:

21.TERMS OF REFERENCE *(If known or submit asap)*:

SECTION 5

APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR	
22.NAME:	**23.**DATE APPROVED:
24.DESIGANTION:	

SECTION 6

25.DISTRIBUTION LIST:

Personal Information redacted by the USI wife
HSCB
SHSCT Litigation Department
Director of Acute Services
Associate Medical Director Medicine and Unscheduled Care
Clinical Director Emergency Department
Assistant Director of Medicine and Unscheduled Care
Review Panel
Chairs of Morbidity and Mortality meetings

Time Line

First Attendance			
Date/Time	**Source**	**Time Line**	**Comments**
Wednesday 28/12/16 01:00	ED Flimsy		Patient dislodged PEG tube. Unable to be replaced by nursing home staff
06:15	ED Flimsy	Patient transferred by ambulance from NH to ED Triaged at 06:20	Family in attendance
07:30	ED Flimsy	PMHx: haemorrhagic CVA, Neurofibrometosis T2, Tracheostomy, Deaf, partially sighted, Depression Epilepsy. o/e: stoma closed over: unable to replace. Abdomen soft. Plan: d/w surgeons	12ch Replacement tube with patient. Patient non-communicative Referred to surgery at 7:30 (tube replaced by Dr 2 in ED) C-RP/U&E/FBP/LFT done
10:00	ED Flimsy	Seen by Dr 2. _____ 14ch inserted-air entry_____ for home now	NIAS booked for return to NH. NH informed. Wound cleaned and dressed. Left ED at 12:50
Second Attendance			
15:28	ED Flimsy	c/o vomiting since PEG reinserted yesterday	Triaged at 15:34 as priority 2.- very low SpO2 Temp 37.2 Pulse 102 Resps 26 BP 90/69 SpO2 92%
16:24	ED Flimsy	Seen by Dr 3. Personal Inform year old attended yesterday. Repeated vomiting. Wife noticed that the insertion of medication via PEG tube was painful. Imp: dislodged PEG	Plan: CXR/AXR i/v fluids ? IAB Surgical review
Date/Time	**Source**	**Time Line**	**Comments**

Thursday 29/12/16 16:50	NIECR		CXR: Lungs are clear, VP shunt seen on the left side. Free air seen under the domes of diaphragm. AXR: Gaseous distention and faecal loading of the large bowel.
17:15	ED Flimsy		i/v fluids commenced.
17:20			
17:30	Surgical Admission Proforma	Seen by Drs 4 and 5. History noted, CXR noted- free air. Fully aware that there is perforation- and will require CT to check peg tube site.	Wife informed that Personal information redacted by the will not be a candidate for surgery and agreed with same. Plan: urgent CT, review.
19:40	NIECR		Attended CT of abdomen and pelvis with contrast Reported at 21:29. Misplace PEG tube within the peritoneal cavity but not within the stomach, with consequence free fluid (likely introduced via PEG) and pneumoperitoneum.
20:00	ED Flimsey		Pts family highlighted episode of unresponsiveness to PS. SpO2 <60 with 15l, increased to 100%. BP 97/67. Seen immediately by Dr 3.
23:00	Note by Dr 5	CT- peg misplaced, not fit for surgery. DNAR comfort measures only, not for antibiotics	

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

Reporting Organisation SAI Ref Number:	Personal Information redacted by USI	**HSCB Ref Number:**	Personal Informa

SECTION 1					
INFORMING THE SERVICE USER[1] / FAMILY / CARER					
1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**	✓	**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**	✓	**NO**		
	If **YES**, insert **date informed**: 9.11.17				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**	✓	
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**)					
Content with rationale?	**YES**		**NO**		

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

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

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	✓
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			✓
	c) Report not shared but contents discussed ***(if you select this option please also complete 'l' below)***			
	d) No contact or Next of Kin or Unable to contact			
	e) No response to correspondence			
	f) Withdrew fully from the SAI process			
	g) Participated in SAI process but declined review report			
	(if you select any of the options below please also complete 'l' below)			
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer			
	i) case involved suspected or actual abuse by family			
	j) identified as a result of review exercise			
	k) other rationale			
	l) If you have selected **c), h), i), j), or k)** above please provide further details:			

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

SECTION 2

INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) *(complete this section for all death related SAIs)*

1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date report shared**:			
	If **NO**, please provide details:			
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**	**NO**	**N/A**	**Not Known**
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			

DATE CHECKLIST COMPLETED	**21.2.2019**

[1] *Service User or their nominated representative*

1. Action Plan : [redacted] [redacted]

Reference number	Recommendations	Designated responsible person	Action required	Date for completion/ timescale	Date recommendation completed with evidence
1	**Recommendation 1** Share this report for learning with the ED, medical and surgical morbidity and mortality meetings.	Paul McGarry	Presented at M+M	Completed	
2	**Recommendation 2** Trust guidelines to be developed for the replacement of late displacement of PEG tubes to include correct positioning checks.	Rachel Wright and Ashleigh Nelson	Dissemination to clinical teams.	Completed	29/5/19 Guidelines on replacement of dislod Guidelines on replacement of PEG t
3	**Recommendation 3** Emergency boxes enteral feeding tubes should be designed and made available on both ED sites. This should include guidance for staff and a variety of tubes with ordering codes.	Mary Burke	Emergency Boxes are in place in Both EDs	Completed	29/5/19

Southern Health and Social Care Trust
Quality Care - for you, with you

For Emergency Department Use Only

Guidelines on the replacement of dislodged Jejunal (JEJ) feeding tubes

JEJ tubes are inserted in patients for temporary feeding following complex abdominal and upper GI surgery. There are several appearances of these tubes.

1. **DO NOT attempt to replace the JEJ tube if it was initially inserted less than 6 weeks ago**. These patients should be referred surgically for urgent advice.

2. The stoma tract is usually well established 6 weeks after insertion of the initial JEJ tube. This may take longer in patients who are immunosuppressed or malnourished.

3. JEJ sites can stenose fairly quickly after displacement of a tube and every effort should be made to replace a displaced tube *as quickly as possible and within the first 4 hours*.

4. Replace the tube with a foley catheter of the same size or one size smaller.
    a. **DO NOT** attempt to insert a larger catheter.
    b. **DO NOT** attempt to dilate the tract or use an introducer.
    c. **DO NOT** use force.
    d. **DO NOT** inflate the balloon of the catheter.
    e. **DO NOT** use multiple attempts (more than 2-3)*. If the tube cannot be inserted, contact the senior ED Doctor. Try a replacement catheter one size smaller , if the smallest size 10 French paediatric catheter cannot be inserted try an 8 French nasogastric tube(with guidewire removed). If unable to insert any tube seek urgent advice from the surgical team.*

5. The tube should be secured to the skin with an IV 3000/Tegaderm dressing to prevent tube movement.

6. Contrast imaging (CT or gastrograffin tubogram) **MUST** be obtained after tube replacement. Once position is confirmed flush the tube with 50mls sterile water to ensure no resistance. Feeding can recommence.

7. Signs of a misplaced jejunal tube may include abdominal pain and /or fresh bleeding.

8. Following reinsertion of the tube please inform the Home Enteral Tube Feeding Coordinator at the number below.

Ashleigh Nelson/Rachel Wright
Home Enteral Tube Feeding Coordinator
Telephone: Personal Information redacted by the USI
Mobile Personal Information redacted by the USI

November 2018

Review November 2020

Southern Health and Social Care Trust
Quality Care - for you, with you

Guidelines on the replacement of dislodged Percutaneous Endoscopic Gastrostomy (PEG) tubes

1. Replacement of an established PEG tube is usually a safe and simple procedure.

2. **DO NOT attempt to replace the PEG tube if it was initially inserted less than 4 weeks ago**. These patients should be referred surgically to rule out intraperitoneal leakage from the gastrostomy site and may require replacement under fluoroscopic or endoscopic guidance.

3. The stoma tract is usually well established 4 weeks after insertion of the initial PEG tube. This may take longer in patients who are immunosuppressed or malnourished.

4. PEG sites can stenose fairly quickly after displacement of a tube and every effort should be made to replace a displaced tube *as quickly as possible and within the first 4 hours*.

5. Replace the tube with a balloon Gastrostomy (G) tube of the same size or one size smaller. A range of sizes of these tubes are kept in Emergency Department(ED). The patient should also bring a spare tube of the same size with them from home.
    a. **DO NOT** attempt to insert a larger G tube.
    b. **DO NOT** attempt to dilate the tract or use an introducer.
    c. **DO NOT** use force.
    d. **DO NOT use** multiple attempts (more than 2-3 attempts). *Inform the senior ED doctor for assistance. If the ED senior doctor is unsuccessful, refer surgically.*
6. If a suitable replacement G tube cannot be located then the patency of the tract should be maintained by insertion of an appropriately sized foley catheter.

7. Signs of **intraperitoneal** placement of a G tube may include abdominal pain on flushing or commencement of feed, fresh bleeding, leakage of gastric contents or abnormal resistance to flushing of the tube as outlined in NPSA (2010) RRR010 Early detection of complications after gastrostomy.

8. Correct placement of the PEG tube within the stomach **MUST** be confirmed by:
    a. Aspiration and testing of gastric fluid (confirmed by pH of 5.5 or less using pH indicator paper) **AND**
    b. Flushing the tube with 50ml of sterile water to ensure no resistance and no patient discomfort.

9. Contrast imaging (CT or gastrografin tubogram) **MUST** be obtained after tube replacement if:
    a. There has been forcible removal of the tube
    b. There has been any failed attempt at replacement in the community
    c. There is failure to aspirate gastric fluid
    d. There is any concern about patient discomfort or resistance when flushing
    e. If the tube was not replaced easily without force or resistance on the ***first*** attempt
    f. The patient has cognitive impairment
    g. If there are any other concerns about misplacement of the tube.

10. Re-attendance at ED after first PEG reinsertion must be treated as a misplaced tube until proven otherwise with contrast study.

11. **NOTE** that patients with PEG tubes often have neurological dysfunction or cognitive impairment making interpretation of symptoms challenging.

April 2018

Review April 2020

APPENDIX 7

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

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

Date of Incident/Event: 6 February 2019

HSCB Unique Case Identifier:

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

June 2015

Responsible Lead Officer: Dr David Patton

Designation: Consultant ED

Report Author: The review team

Date report signed off:

Date submitted to HSCB:

1.0 EXECUTIVE SUMMARY

Personal Inform was a Personal Inform year old man who attended the Emergency Department (ED) in CAH on 6th February 2019 at 19:10 complaining of right sided lower abdominal pain with no bowel or urinary symptoms. He was triaged within 21 minutes of arrival and was prioritised as a category 3 (Manchester Triage Tool recommending medical review within 60 minutes).

Whilst waiting to be reviewed by the medical staff, Personal Inform collapsed in the waiting room and was transferred to Resus for further management. Personal Inform was noted to have a weak pulse and an unrecordable blood pressure, an ultrasound scan revealed a ruptured abdominal aortic aneurysm. Cardio pulmonary resuscitation (CPR) was commenced and resuscitation was carried out for a period of 40 minutes. Personal Inform was pronounced dead at 23:50.

2.0 THE REVIEW TEAM

Dr Patton – Consultant Emergency Medicine
Mrs Mary Burke – Head of Services
Mrs Patricia Kingsnorth – Acting Clinical Governance Coordinator Acute
Mrs Carly Connolly – Clinical Governance Manager

3.0 SAI REVIEW TERMS OF REFERENCE

- To carry out a review in the care provided to Personal Inform using a Root Cause Analysis (RCA) Methodology.
- To use a multidisciplinary team approach to the review.
- To provide an agreed chronology based on documented evidence and staff accounts of events.
- To identify the key contributory factors which may have had an influence or contributed to Personal Inform's treatment and care on 6th February 2019.

3.0 SAI REVIEW TERMS OF REFERENCE

- To ensure that recommendations are made in line with evidence based practice.
- To set out the findings, recommendations, actions and lessons learnt in an anonymous report.
- To take into account the family concerns.
- To report the findings and the recommendations of the review through the Director of Acute Services SHSCT and disseminate to the staff associated with Personal Inform's care and with Personal Inform's family.

4.0 REVIEW METHODOLOGY

Review of the Datix report

Emergency Department Notes

Staff Statements

Staff rotas

Work load within the Department

5.0 DESCRIPTION OF INCIDENT/CASE

Personal Inform was a Personal Inform year old man who attended the Emergency Department in CAH on 6th February 2019 at 19:10. Personal Inform was triaged at 19:31 by S/N 1. Observations were recorded as T 36.5^{O}C; pulse 68; blood pressure (BP) 152/81: respirations 16; oxygen saturations (SpO_2) 97%. Personal Inform's pain score was recorded as 4 /10. Personal Inform was noted to have had a history of lower right sided abdominal pain from the afternoon. It was noted Personal Inform had no urinary or bowel symptoms and no analgesia had been taken. Personal Inform was prioritised as a category 3 as per the Manchester Triage Tool [(1)]. A Category 3 would recommend medical review within 60 minutes. Blood tests were ordered and were obtained and sent to the laboratory at 20:40.

At 23:10 Personal Inform was noted to have collapsed in the waiting area and was taken immediately to Resus. He was noted to have agonal breathing, a weak pulse and an unrecordable blood pressure. An electrocardiograph (ECG) was carried out and showed an inferior posterior infarction. An abdominal ultrasound scan showed a

5.0 DESCRIPTION OF INCIDENT/CASE

5.5cm x 9cms aortic aneurysm. An anaesthetic crash call was made at 23:25 and the arrest team were called. CPR was commenced and Personal Inform was intubated for airway protection and blood products were administered. It was noted Personal Inform had pulseless electrical activity (PEA) and 4 rounds of adrenaline were administered. There was no shockable rhythm from 23:26 until 23:50. The decision to cease resuscitation was made with the team in agreement. Personal Inform's time of death was 23:50.

6.0 FINDINGS

Contributory Factors

Environmental Factors

The review team have established that the CAH ED was in 'Code black' on the day of the 6th February 2019. Code Black is a term used to describe the state of the ED based on the Southern Trust's Hospital Early Warning Score. A code black would denote an unsafe department. In CAH ED there are a total of 33 cubicles, 6 in resus area, 11 in yellow area, 12 in green area, 3 in clinical decision unit (CDU), and 3 in paediatrics. The actual patient numbers in the CAH ED on the 6th February 2019 at 7pm was 111 patients. The number attending between 5pm - 8pm were 70 attendances. At the time of Personal Inform's presentation there were 12 category 2 patients and 14 category 3 patients waiting to be assessed, and there were 26 bed waits. In the 24 hour period there were in total 272 attendances.

Staffing records confirm that there was a normal complement of medical and nursing staff working in the ED on 6th February, however the department was vastly overcrowded. The main issues being the lack of available space to assess new patients. This resulted in a delay in Personal Inform being reviewed as the standard would state that a category 3 should be seen within 60 minutes. This was not possible in view of overcrowding.

Patient Factors

Personal Inform was a Personal Inform year old man who attended ED on the 6th February 2019. Personal Inform was noted to have had a history of lower right sided abdominal pain from the afternoon. It was noted Personal Inform had no urinary or bowel symptoms and no analgesia had been taken. Personal Inform was prioritised as a category 3 as per the Manchester Triage Tool (1). The review team agreed Personal Inform was appropriately triaged using the Manchester triage system and that he did not meet the criteria for an ECG. Personal Inform had no prior medical issues. It was agreed by the review team that Personal Inform was a male patient over the age of 65 years complaining of abdominal pain and therefore an abdominal aortic aneurism would be a differential diagnosis for a patient of this age. Personal Inform deteriorated whilst in the waiting room and this

6.0 FINDINGS

was highlighted when he was in acute pain and was very unwell.

Clinical assessment

Personal Information was triaged within 21 minutes of arriving to ED. Observations were recorded as T 36.5^{O}C; pulse 68; blood pressure (BP) 152/81: respirations 16; oxygen saturations (SpO_2) 97%. Personal Information's pain score was recorded as 4 /10. Personal Information was noted to have had a history of lower right sided abdominal pain from the afternoon. It was noted Personal Information had no urinary or bowel symptoms and no analgesia had been taken. Personal Information was prioritised as a category 3 as per the Manchester Triage Tool (1). A category 3 would recommend medical review within 60 minutes. Blood tests were ordered and were obtained and sent to the laboratory at 20:40. The review team have established in the department the normal process would be that Personal Information would have been handed over to a HCA for bloods in order to frontload investigation. This means ensuring bloods were available for the assessing clinician. Due to the volume of patients requiring investigation this resulted in a delay of Personal Information's bloods being taken.

The review team concluded that there was no clear suggestion at triage that Personal Information had an aortic aneurysm. However, had he been reviewed by a doctor and had a detailed history taken, examination and investigation carried out; there would have been an opportunity to make this diagnosis.

National AAA screening.

The Northern Ireland AAA Screening Programme commenced in July 2012. The Northern Ireland AAA Screening Programme invites men in their 65th year to screening. Men over the age of 65 were not invited for screening but could have requested a screening appointment through their General Practitioner. Personal Information would have been over 65 years old when this service was first introduced in July 2012 and therefore would not have received a programmed invite.

7.0 CONCLUSIONS

The risk of a serious incident occurring increases with every patient that arrives at the ED when the ED is in code black, as such the ED department has more patients that it can potentially safely care for. The review team discussed Personal Information's case and were in agreement that overcrowding was a key factor for the delay in Personal Information's treatment and care.

Personal Information had no prior medical issues, however it was agreed by the review team that Personal Information was a male patient over the age of 65 years complaining of abdominal pain and therefore a differential diagnosis of an abdominal aortic aneurysm would have been considered.

A leaking abdominal aorta aneurysm is a time critical emergency. The longer it takes to diagnosis, the higher the mortality. It carries a mortality rate of 42% if surgical

intervention ([2]). The review team concluded that Personal Inform waited for 4 hours and collapsed in the waiting room before being seen by a doctor. The overcrowding in the ED department contributed to the delay in diagnosis.

8.0 LESSONS LEARNED

Emergency Department overcrowding is one of the greatest hospital challenges to delivering safe, high quality, urgent and emergency care.

The SHSCT needs to develop an escalation plan to deal with overcrowding in the ED.

The ED would also need to develop a system to address the patient flow in the department where there are back logs in triage and front loading investigations.

SHSCT will continue to include recognition of abdominal aortic aneurysm at induction for medical staff.

9.0 RECOMMENDATIONS AND ACTION PLANNING

Recommendation 1

The learning from this case will be shared with staff involved and at ED and medical Morbidity and Mortality meetings and reported in the ED newsletter.

Recommendation 2

The SHSCT should undertake / review the bed modelling exercise and implement any recommendations.

Recommendation 3

The SHSCT to develop and agree an escalation plan for the hospital. The escalation plan will provide clear direction to operationally manage the flow pressures.

Recommendation 4.

Consideration should be given to reviewing the process of obtaining blood investigations following triage.

10.0 DISTRIBUTION LIST

Reference Lancet (March 2014) – Mortality from ruptured aortic aneurysms : clinical lessons

from a comparison of outcomes in England and the USA

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

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

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

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

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

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

Content with rationale?	**YES**		**NO**	

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

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

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

[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**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
2) Following or during the review of the SAI was there a Statutory Duty to notify the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
3) If you have selected 'YES' to any of the above **'1' or '2'** has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date report shared**:			
	If **NO**, please provide details:			

DATE CHECKLIST COMPLETED	

[1]*Service User or their nominated representative*

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

Southern Health and Social Care Trust

APPENDIX 4

Revised November 2016 (Version 1.1)

LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1

1. ORGANISATION: **SHSCT**	**2.** UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE: Commercially Sens
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:	**4.** DATE OF INCIDENT/EVENT **20/02/2018**
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: **NO** ***Please select as appropriate***	**6.** IF 'YES' TO 5. PLEASE PROVDE DETAILS:
7. DATE OF SEA MEETING / INCIDENT DEBRIEF **23 May 2018**	

8. SUMMARY OF EVENT:

Personal Information redacted by attended Craigavon Area Hospital (CAH) Emergency Department (ED) on 19th February 2018 with chest pain, low oxygen saturations, shortness of breath and pyrexia. Personal Info had a cardiac history. Initial electrocardiograph (ECG) was unremarkable; however repeat ECG showed ST elevation at 23:06, which was not actioned. Personal Information redacted by condition deteriorated at approximately 02:15 Personal Information redacted by had a cardiac arrest, cardiopulmonary resuscitation was commenced, and Personal Information redacted by intubated and transferred to theatres for stabilisation. Do not actively cardiopulmonary resuscitation (DNA CPR) was decided, Personal Information redacted by had a further period of cardiac arrest and died at 05:21.

SECTION 2

9. SEA FACILITATOR / LEAD OFFICER:	10. TEAM MEMBERS PRESENT:
Dr Michael Moore - Chair	Dr Michael Moore – Consultant Physician Dr Gareth Hampton Mrs Mary Burke Mrs Trudy Reid (Clinical Governance Coordinator

11. SERVICE USER DETAILS:
Complete where applicable
Personal Information redacted by was a Personal Information year old male.

12. What Happened

Personal Information redacted by attended Craigavon Area Hospital (CAH) Emergency Department (ED) on via ambulance at 20:21 on 19th February 2018. Personal Information redacted by was triaged at 20:22 presenting condition was shortness of breath, presentation was chest pain, the discriminator 'very low oxygen saturations. The triage note stated onset of "*central chest pain last night at 22:00 increase in pain and shortness of breath, temperature with Northern Ireland Ambulance Service*" (NIAS).
Clinical observations were recorded as:

Date and Time	Temperature	Pulse	Blood Pressure	Respirations	SaO_2	NEWS
19/2/18 @ 20:22	36.6°C	123	122/76	32	88%	10

He was noted to be alert with a pain score 6/10. Personal Information redacted by was triaged a priority 2 (Manchester triage tool – should be seen within 10 minutes) and placed in the resuscitation area of ED.

Personal Information redacted by was seen and examined by Doctor 1 (ED consultant) at 21:10, who noted Personal Information redacted by had been unwell from the previous day with a cough, fever and shortness of breath. He was noted to have a severe cardiac history and was short of breath over the previous few days which was worse with lying down. Doctor 1 documented Personal Information redacted by was feverish, hypoxic (low oxygen levels) and was tachycardic (fast heart rate). Chest crepes were noted and he had mild oedema, the plain chest X-ray was showed pulmonary oedema. Blood results noted an elevated troponin of 407pg/mL which was reported at 22:02, (this is a blood test that measures troponin proteins, which are released when the heart muscle has been damaged, e.g. a heart attack). White cell count was 27.3 (blood test which is an indicator of infection). The diagnosis was myocardial infarction (MI) (heart attack) with congestive cardiac failure (CCF) and superficial lower respiratory chest infection (LRTI). A history of coronary artery bypass grafts and epilepsy was noted. Medical management was to increase oxygen to 15 litres, administer antibiotics (amoxicillin was administered t 21:45), other medications administered at 21:45 included frusemide 50mg IV (to reduce fluid), aspirin 300mg orally, ticagrelor 180mg orally (for the treatment of acute coronary syndromes) and enoxaparin 80mg subcutaneously (helps prevent clots). It was recorded that Personal Information redacted by most likely had an MI over the weekend with pulmonary oedema.

The plan was for chest x-ray, commence antibiotics and to admit to Coronary Care Unit. If Personal Information redacted by became hypoxic, AIRVO was to be commenced. It is documented that Doctor 1 made Doctor 5 (ED registrar) aware of the plan.

At 22:40 Doctor 2 (medical registrar) reviewed Personal Information redacted by and noted a two day history of dyspnoea of sudden onset at rest, associated chest tightness which was initially severe, which improved at time of review. He was noted to have had poor sleep due to orthopnoea (orthopnoea is shortness of breath that occurs when lying flat). Personal Information redacted by had lower limb swelling and decreased exercise