| | | |
|---|---|---|
| Safe footwear | 0 | 100% |
| Personal items in reach | 0 | 100% |
| Free from slip or trip hazards | 0 | 100% |

| Falls B Bundle Compliance | Total Charts | Non- Compliant | Compliant % |
|---|---|---|---|
| | 150 | 36 | 76% |
| Cognitive Screen* | | 3 | 98% |
| Bedrails risk assessment | | 1 | 99% |
| Lying and Standing Blood Pressure | | 36 | 76% |

| Pressure Ulcer Bundle Compliance | Total Charts | Non- Compliant | Compliant % |
|---|---|---|---|
| | 113 | 19 | 83% |
| Type of Mattress Recorded | | 4 | 96% |
| Type of Cushion Recorded if applicable | | 3 | 97% |
| Equipment fit for Purpose | | 1 | 99% |
| Risk Assessment Recorded on Admission, Weekly or if condition changes | | 3 | 97% |
| Patient Repositioning Schedule Recorded | | 10 | 91% |
| Skin Inspected at Least Twice Daily | | 4 | 96% |
| Changes Reported and Recorded | | 0 | 100% |
| Toileting Assistance Provided if Required | | 0 | 100% |
| Continence Products Used and Recorded | | 1 | 99% |
| Skin Kept Clean and Dry if Patient Incontinent | | 0 | 100% |
| Nutrition Tool Applied MUST Recorded | | 8 | 93% |
| Fluid Balance Chart Updated if Appropriate | | 3 | 97% |
| Food Chart Updated if Appropriate | | 1 | 99% |
| | | 0 | 100% |

Assistance Provided if Required and Documented

| | Total Charts | Non- Compliant | Compliant % |
|---|---|---|---|
| **MUST Compliance** | 190 | 11 | 94% |

| | Total Charts |
|---|---|
| **Omitted Medicines Compliance** | 190 |
| Total Doses Prescribed within the Previous 24hrs | 3018 |
| Total Number of Blank Doses | 17 |
| Total Number of Omitted Critical Meds | 1 |

| | Total Patients | Non- Compliant | Compliant % |
|---|---|---|---|
| **Line Labelling Compliance** | 97 | 1 | 99% |
| Line labelled with an appropriate label | | 1 | 99% |
| Line label clearly states the following: Time, date, initials, visible | | 1 | 99% |
| Has the label been replaced within timescales of the SHSCT Peripheral Line Guidance | | 1 | 99% |

Southern Health and Social Care Trust

*Quality Care - for you, with you*

# MUSC GOVERNANCE MEETING

Date: Friday 31st August 2018
Time: **2pm**
Venue: Meeting Room, Admin Floor, CAH with videolink to Committee Room 2, DHH

Present: Anne McVey, Dr P Murphy, Paul Smith, Dr S Moan, Catriona McGoldrick, Mary Burke, Louise Devlin, Dr McCaffrey

Apologies: Caroline Beattie, Kay Carroll, Sandra Burns, Trudy Reid, Dr Bradley, Connie Connolly

| Issue | Discussion | Action |
|---|---|---|
| Welcome/Apologies | Anne welcomed all to the meeting and gave apologies from the above | |
| Standards and Guidelines | Anne read form monthly activity report and discussed with group.<br><br>- Mr E McCormick to provide input on Prescribing of Liquid and other Sedative Medications for Children and reducing the risk of over use. Mary Burke to advise Dr McCormick of same.<br><br>Anne read and discussed Key Priorities with the group.<br><br>- Sepsis Meeting taking place on 21st September 2018 to review who needs to attend from MUSC. Query Paul Smith. | Mary Burke<br><br>Paul Smith |

| | | |
|---|---|---|
| | Outstanding Change Leads for MUSC | |
| | - Dr Murphy advised Dr McKnight has declined to be the change lead for Resources to support the safety of girls and women who are being treated with valproate and Dr Forbes is too busy. Dr Murphy to liaise with Dr Campbell regarding same. | Dr Murphy |
| | - Dr Moan to liaise with Dr Harty Immunosuppressive therapy for kidney transplantation in adults. | Dr Moan |
| | - Dr Hillemand has been asked twice to be change lead for Eluxadoline for treating irritable bowel syndrome with diarrhoea however has declined on both occasions. Dr Murphy will try again. | Dr Murphy |
| | Relocation of Change Lead: | |
| | - NCEPOD 'Managing the Flow' was previously Dr M Roberts, Dr C Byrne to take over. Dr Murphy to advise. | Dr Murphy |
| | - Dr Murphy will liaise with Mr Mumtaz regarding Non-alcoholic fatty liver disease | Dr Murphy |
| | Anne read and discussed agenda items with the group. | |
| | - Anne Mc Vey to liaise with Ronan Carroll re NICE NG 39 – Major trauma – assessment and initial management and NICE NG 40 – Major trauma service delivery. | Anne McVey |
| | - Kay Carroll to update at next meeting re NICE CG 161 - The assessment and prevention of falls in older people. Need to liaise with Anita Carroll on how she would like this to be taken forward in Esther's absence. | Kay Carroll<br><br>Paula Fearon has been seconded to |

| | | |
|---|---|---|
| | Mary Burke advised pilot has started in relation to NICE CG 176 – Head Injury and advised good feedback has been received. Trudy Reid to advise when pilot to be fully rolled out. Paul Smith to link with Trudy Reid regarding same and advise at next meeting.<br><br>Quality e Proforma report discussed<br><br>Paul Smith advised group did not meet regarding HSC (SQSD) 53-16 Patient Safety Alert – Restrictive use of injectable medicines over the Summer. The next meeting will take place in September.<br><br>Group discussed RQIA review on the implementation of GAIN Guidelines for Caring For People with a Learning Disability in General Hospital Settings (2011). Learning Disability Case in ED was discussed. | assist with the implementation of falls pathway<br><br>Paul Smith |
| Complaints | Reopened Complaints<br>Anne McVey advised Sandra McLoughlin meets with her weekly regarding reopened complaints.<br>- Personal Information - nearly ready to be sent<br>- Personal Information - minutes have been returned to Sandra McLoughlin<br>- Personal Information – Case discussed. Patient wanted a meeting however cancelled same. Pre meeting has taken place.<br>- Personal Information redacted by the - Returned to SMcL<br>- Personal Information – Kay returned response<br>- Personal Information redacted by the US - response to be returned<br>- Personal Information – Ongoing<br>- Personal Information – Dr Murphy to meet with Patient<br>- Personal Information – Pauls Smith gave an update<br>- Personal Information – Date for meeting to be sought<br><br>Complaints and MLA enquiries from 2011 to date was discussed. Increase in complaints and MLA enquiries. | |

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|---|---|---|
| | 11 current complaints in red need to be addressed. Anne read from the actions for the outstanding complaints.<br><br>Ombudsman complaints discussed.<br><br>Anne discussed [redacted] ombudsman report with group. Anne discussed correspondence received from the ombudsman in relation to a patient that died in Cardiology pre surgery.<br><br>[redacted] was with Ruth Donaldson who has now left the Trust. Flo Fegan to pick up.<br><br>[redacted] case discussed.<br><br>Ombudsman has advised meting needs to take place with [redacted]. Dr Hampton has declined to attend. Mary Burke advised ned to sit down and decide who will be attending this meeting. Anne read from initial complaint.<br><br>Mary Burke gave an update on [redacted] Case. | Flo Fegan |
| Clinical Incidents | Dr Murphy discussed clinical incidents with the group. A lot of incidents being submitted as major when they are not.<br><br>Mary gave an update on discussion at M&M on incident ID 85298. The learning has been discussed and disseminated to patient flow. Catriona McGoldrick advised she has not received this communications. Mary Burke to send same. Dr Hampton to discuss with anaesthetics and agree a way forward. Both ED Staff and patient flow need clear guidance on what they need to do. Mary Burke and Dr Hampton to update at next meeting.<br><br>Incident 85339 discussed. Need to meet with NIAS regarding this as it is not | Dr Hampton<br>Mary Burke |

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|---|---|---|
| | acceptable. Datix's are being completed and shared at NIAS interface meeting however it takes months for feedback from NIAS on cases.<br><br>Incident ID's 85533 and 85966 were discussed.<br><br>Mary Burke gave updates on ED DHH incidents and discussion took place regarding same. | |
| SAI's | Need assurance that recommendations from SAI's have been implemented and address where and what the similar themes are. There is currently no audit tool in place to measure these. Need support from the governance team to review and draw up action plans on how these are implemented and timescales from implementation.<br><br>Dr Moan advised SAI's are presented at M&M for learning and how these mistakes can be avoided.<br><br>Recommendation from SAI's to be shared at MUSC Governance Meetings.<br><br>Mary Burke advised she is currently setting up a governance group in her areas to discuss SAI recommendations and implementation.<br><br>Anne gave an example of an old SAI which has not been closed off and same was discussed.<br><br>Anne discussed case where an SAI was completed and now there is an independent SAI review headed by Mary Hinds PHA. | |
| Recommendations from SAI's | Going forward SAI recommendations and implantations are to be presented at this meeting to be audited. | Trudy Reid |

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|---|---|---|
| Risk Registers | Louise Devlin advised Biologics to be put on risk register.<br><br>Dr Moan advised telemetry has been on the risk register for years and stated that risk registers become irrelevant if nothing is being done about them<br><br>Need to ensure that the 5 levels of risk is being recorded: -<br><br>- Ward<br>- HOS<br>- Division<br>- Directorate<br>- Corporate<br><br>Directorate Risk Register discussed and concerns raised regarding nothing being done about the items on same.<br><br>Anne McVey and Dr Murphy to raise with Director of Acute and Medical Director the level of concern which has been raised regarding how the risk registers are managed.<br><br>Risk registers are discussed at Acute monthly governance meetings which include AMD's and CD's<br><br>Need to have a mechanism put in place for updating risk registers.<br><br>Need governance arrangements tightened to ensure action plans and recommendations for everything are implemented.<br><br>Telemetry to be escalated from low to high priority. Anne read from email regarding funding and will liaise with Kay Carroll regarding same. Kay Carroll to update at next meeting.<br><br>MUSC HOS to review their own risk registers and advised at next meeting what their greatest risks are. | Louise Devlin<br><br>Anne McVey<br>Dr Murphy<br><br>Kay Carroll<br><br>MUSC HOS |

| | | |
|---|---|---|
| A.O.B | SSNAP Audit on both sites is C/ Dr McCaffrey advised it is not cost effective to put suspected stroke patients in the wrong areas.<br><br>Catriona McGoldrick gave an update on the upcoming Hospital Hub workshop. Need to try and formulate a control room that meets the needs of the whole organisation, need to put a plan in place before winter and input is required from all disciplinaries and cross directorates.<br><br>Mary Burke advised she will be working with HOS colleagues in Community and Mental Health regarding Detox in the community. An audit will be completed to identify frequent offenders to see if an action plan can be put in place for these patients.<br><br>Agreement has been given to open a Winter Ward on both sites.<br><br>Mary Burke discussed changes in AMU from 03.09.2018 regarding post take up to 5pm each day.<br><br>Discussion took place regarding locum cover in AMU and DHH and what their job plans should be. | |

**Date and Time of Next Meeting:**

Friday 26th October 2018
Meeting Room, Admin Floor, CAH with videolink to Committee Room 2,DHH
2pm

**DIRECTORATE OF ACUTE SERVICES**
**Weekly Report on Formal Complaints - 24 June 2019**

| Ref | Record name | Div | Loc (Exact) | Date Received | Current Date | Investigation due | Reply due | Current Stage |
|---|---|---|---|---|---|---|---|---|
| [redacted] | Personal information redacted by the USI | MUC | ED | 21/02/2019 | 04/06/2019 | 07/03/2019 | 20/03/2019 | Responses being prepared prior to meeting - Collette to speak to Anne McVey 24-6-19 |
| | | MUC | ED | 22/03/2019 | 04/06/2019 | 05/04/2019 | 19/04/2019 | Meeting to be arranged - Ms Yoong to provide availability but needs scheduling list first 11/6/19 |
| | | MUC | Emergency Department | 29/03/2019 | 04/06/2019 | 12/04/2019 | 30/04/2019 | With Anne McVey for approval 25/6/19 |
| | | MUC | Male Medical Ward DHH | 29/03/2019 | 04/06/2019 | 12/04/2019 | 30/04/2019 | Connie Connolly to discuss with Collette 12.06.19. Responses being prepared in advance of potential meeting. |
| | | MUC | Female Medical | 01/04/2019 | 04/06/2019 | 15/04/2019 | 01/05/2019 | Response being drafted 24-6-19 |
| | | MUC | Emergency Department | 04/04/2019 | 04/06/2019 | 18/04/2019 | 07/05/2019 | Response being drafted 20/6/19 |
| | | MUC | 1 South | 15/04/2019 | 04/06/2019 | 01/05/2019 | 16/05/2019 | With Anne McVey for approval 25/6/19 |
| | | MUC | Emergency Department | 17/04/2019 | 04/06/2019 | 03/05/2019 | 20/05/2019 | Response being drafted 19/6/19 |
| | | MUC | Emergency Department | 18/04/2019 | 04/06/2019 | 07/05/2019 | 21/05/2019 | Draft to A McVey for approval 22/5/19 - given to Mary Burke for review - reminder to Mary 12/6/19, 18/6/19 & 24/6/19 |
| | | MUC | Emergency Department | 19/04/2019 | 04/06/2019 | 08/05/2019 | 22/05/2019 | Awaiting Response from finance 24-6-19 |
| | | MUC | Emergency Department | 24/04/2019 | 04/06/2019 | 09/05/2019 | 23/05/2019 | To Anne McVey for approval 25/6/19 |
| | | MUC | Haematology | 03/05/2019 | | 20/05/2019 | 04/06/2019 | Response being drafted 24-6-19 |
| | | MUC | Neurology | 07/05/2019 | | 21/05/2019 | 05/06/2019 | With Louise Devlin & Mr Forbes for review 25/6/19 |
| | | MUC | Emergency Department | 14/05/2019 | | 29/05/2019 | 12/06/2019 | Awaiting response from Sharon Holmes - reminder sent 24/6/19 |
| | | MUC | AMU | 20/05/2019 | | 04/06/2019 | 18/06/2019 | Awaiting response Sharon Holmes. Reminder sent 13.6.19 |
| | | MUC | Emergency Department | 20/05/2019 | | 04/06/2019 | 18/06/2019 | To Anne McVey for approval 18/6/19 (Anne to review) |
| | | MUC | Stroke/Rehab | 21/05/2019 | | 05/06/2019 | 19/06/2019 | Awaiting response from Fiona Reddick - reminder sent 24/6/19 |
| | | MUC | Emergency Department | 23/05/2019 | | 07/06/2019 | 21/06/2019 | Awaiting response from Sharon Holmes / Paul Smith & DHH ED consultant - reminder sent 25/6/19 |
| | | MUC | Emergency Department | 28/05/2019 | | 11/06/2019 | 25/06/2019 | Florence Fegan (obo Anne) has asked for Nursing ED input - 11/6/19 |
| | | MUC | Outpatients Department | 28/05/2019 | | 11/06/2019 | 25/06/2019 | Awaiting response from Carrie McCann / Kay Carroll. Reminder sent 24.6.19 |
| | | MUC | Emergency Department | 29/05/2019 | | 12/06/2019 | 26/06/2019 | Response provided by Lisa Small - Mary Burke to review 25/6/19 |
| | | MUC | 2 North | 29/05/2019 | | 12/06/2019 | 26/06/2019 | Response being drafted 20/6/19 |
| | | MUC | Rheumatology | 30/05/2019 | | 13/06/2019 | 27/06/2019 | Awaiting response from Belfast Trust. Reminder sent 24.6.19 |
| | | MUC | Emergency Department DHH | 30/05/2019 | | 13/06/2019 | 27/06/2019 | To Director for signature 24.6.19 |
| | | MUC | 2 South Stroke | 31/05/2019 | | 14/06/2019 | 28/06/2019 | Meeting to be arranged between OPPC, Ruth Heatrick, Dr McCaffrey & Brigeen Kelly |
| | | MUC | Male Medical Ward DHH | 31/05/2019 | | 14/06/2019 | 28/06/2019 | Awaiting response from Siobhan Rooney / Connie Connolly. Reminder sent 24-6-19 |
| | | MUC | Female Surgical | 10/06/2019 | | 24/06/2019 | 08/07/2019 | Response being drafted 20/6/19 |
| | | MUC | Emergency Department | 17/06/2019 | | 01/07/2019 | 16/07/2019 | Awaiting response from Sinead Corr & Sharon Holmes |
| | | MUC | Minor Injuries | 17/06/2019 | | 01/07/2019 | 16/07/2019 | Awaiting response for Olive Sloan & Paul Smith |
| | | MUC | Cardiology | 17/06/2019 | | 01/07/2019 | 16/07/2019 | Awaiting response from Mr Flannery & Kay Carroll |
| | | MUC | Emergency Department | 18/06/2019 | | 02/07/2019 | 17/07/2019 | Awaiting response from Dr Doherty (Locum) - notes requested and to be delivered to AMU for Dr Doherty to view |

| Ref | Record name | Div | Loc (Exact) | Date Received | Investigation due | Reply due | Current Stage |
|---|---|---|---|---|---|---|---|
| [redacted] | Personal information redacted by the USI | MUC | Emergency Department | 03/10/2018 | 17/10/2018 | 31/10/2018 | Awaiting response from Dr McGleenon & Jeanette Robinson |
| | | MUC/CCS | ED / Gynae DHH | 30/10/2018 | 13/11/2018 | 27/11/2018 | To Esther for signature 14.05.19 |
| | | MUC/SEC | ED / Fracture Clinic DHH | 26/11/2018 | 10/12/2018 | 24/12/2018 | Paul Smyth has drafted Ronan to approve. Reminder sent 8.5.19 |
| | | MUC | 3 South | 04/01/2019 | 18/01/2019 | 01/02/2019 | With Esther for signature 09.05.19 |
| | | MUC | Lung Function Lab | 24/01/2019 | 07/02/2019 | 21/02/2019 | Response to Esther for signature 09.05.19 |
| | | MUC | General Medicine Clinic | 12/02/2019 | 26/02/2019 | 12/03/2019 | Draft response to Anne McVey for approval 13/5/19 |
| | | MUC | 1 North | 13/02/2019 | 27/02/2019 | 13/03/2019 | Draft response returned to R Weir for further comment 14.05.19 |
| | | MUC | Emergency Department | 21/02/2019 | 07/03/2019 | 20/03/2019 | Meeting notes being processed 09.05.19. KAY CARROLL WANTS TO ORGANISE MEETING |
| | | MUC | Emergency Department DHH | 07/03/2019 | 22/03/2019 | 05/04/2019 | Need input from Kay Carroll, DHH - forwarded 14/5/19 |
| | | MUC | Male Medical Ward DHH | 21/03/2019 | 04/04/2019 | 18/04/2019 | Response being drafted 18/4/19 |
| | | MUC | Emergency Department | 27/03/2019 | 10/04/2019 | 26/04/2019 | Draft forwarded to Anne McVey for amendments 13/5/19 (insuffient ED response) |
| | | MUC | Emergency Department | 29/03/2019 | 12/04/2019 | 30/04/2019 | Awaiting response from Mr Holmes, ED - reminder sent 13/5/19 |
| | | MUC | Male Medical Ward DHH | 29/03/2019 | 12/04/2019 | 30/04/2019 | Awaiting response from Sr Rooney, Connie Connolly & Josie Matthews - reminder sent 13/5/19 |
| | | MUC | Emergency Department | 01/04/2019 | 15/04/2019 | 01/05/2019 | To Esther Gishkori for approval 13/5/19 |
| | | MUC | Female Medical | 01/04/2019 | 15/04/2019 | 01/05/2019 | Awaiting response from Sharon Holmes & Sr Small - reminder sent 13/5/19 |
| | | MUC | Emergency Department | 04/04/2019 | 18/04/2019 | 07/05/2019 | Awaiting response from ED Consultant, DHH - reminder sent to Paul Smyth 13/5/19 |
| | | MUC | Emergency Department | 04/04/2019 | 18/04/2019 | 07/05/2019 | Response being drafted 16/4/19 |
| | | MUC | Emergency Department | 05/04/2019 | 19/04/2019 | 08/05/2019 | To Esther Gishkori for approval 13/5/19 |
| | | MUC | Gastro OPD | 08/04/2019 | 24/04/2019 | 09/05/2019 | To Anne McVey for approval 13/5/19 |
| | | MUC | AMU | 10/04/2019 | 26/04/2019 | 13/05/2019 | Draft to Barry Conway for approval 14/5/19 (Barry to forward to Anne McVey if happy) |
| | | MUC | 1 South | 15/04/2019 | 01/05/2019 | 16/05/2019 | Awaiting response from Laura Richardson, Sandra Burns & Dr A Beshir - reminder sent 13/5/19 |
| | | MUC | Emergency Department | 17/04/2019 | 03/05/2019 | 20/05/2019 | Awaiting response from Dr Hampton & Sharon Holmes / Paul Smyth - reminder sent 13/5/19 |
| | | MUC | Emergency Department | 18/04/2019 | 07/05/2019 | 21/05/2019 | Response being drafted 30/4/19 |
| | | MUC | Emergency Department | 18/04/2019 | 07/05/2019 | 21/05/2019 | Awaiting response from Paul Smyth / Sharon Holmes & Dr Hampton - reminder sent 14/5/19 |
| | | MUC | Emergency Department | 19/04/2019 | 08/05/2019 | 22/05/2019 | Awaiting response from Paul Smyth / Sharon Holmes & Dr Hampton - reminder sent 14/5/19 |
| | | MUC | Emergency Department | 24/04/2019 | 09/05/2019 | 23/05/2019 | Awaiting response from Dr Roger Stewart, Paul Smyth & Mary Burke - reminder sent 13/5/19 |
| | | MUC | Emergency Department | 24/04/2019 | 09/05/2019 | 23/05/2019 | Response to Anne McVey for approval 14.05.19 |
| | | MUC | Emergency Department | 26/04/2019 | 13/05/2019 | 28/05/2019 | Awaiting response from ICU and Surgical Team - reminder sent to Amie & Helena 13/5/19 |
| | | MUC | Emergency Department | 26/04/2019 | 13/05/2019 | 28/05/2019 | Awaiting response from Sharon Holmes / Paul Smyth, Sarah Ward & Joanne Cochrane. - reminder sent 14/5/19 |
| | | MUC | Haematology | 03/05/2019 | 20/05/2019 | 04/06/2019 | Awaiting response from Annette O'Hara & Stephanie Carson / Kay Carroll |
| | | MUC | Neurology | 07/05/2019 | 21/05/2019 | 05/06/2019 | Awaiting response from Louise Devlin |
| | | MUC | 1 South | 09/05/2019 | 23/05/2019 | 07/06/2019 | Awaiting response from Dr D Craig & Caitriona McGoldrick |
| | | MUC | 3 North Winter Ward | 10/05/2019 | 24/05/2019 | 10/06/2019 | Awaiting response from Patricia Loughan & Trudi Kelly (Mary Burke) |

**DIRECTORATE OF ACUTE SERVICES**

**Incident Position, Awaiting and Being Reviewed - as at 18.06.19**

| | Awaiting Review | In Review |
|---|---|---|
| Functional Support Services | 27 | 16 |
| IMWH - Cancer and Clinical Services | 12 | 510 |
| Medicine and Unscheduled Care | 82 | 320 |
| Pharmacy | 58 | 18 |
| Surgery and Elective Care | 19 | 161 |

**Directorate of Acute Services - ATICS**
**Incident Position, Awaiting and Being Reviewed - as at 18.06.19**

| | In review | In holding area awaiting review |
|---|---|---|
| **Cancer Services** | **100** | **12** |
| Booking Centre | 2 | 0 |
| Breast Clinic | 3 | 0 |
| Breast Screening Unit | 4 | 0 |
| Corridor/Stairs | 1 | 0 |
| General OutpatientsTreatment Room | 1 | 0 |
| Haematology Clinic | 4 | 0 |
| Oncology Clinic, Mandeville Unit | 9 | 2 |
| (blank) | 1 | 0 |
| 2 North Respiratory | 1 | 0 |
| CT Scanner | 9 | 0 |
| Day Hospital | 1 | 0 |
| ED X-ray | 1 | 0 |
| EEG Clinic | 3 | 0 |
| Male Surgical/HDU | 1 | 0 |
| MRI Unit | 3 | 0 |
| Paediatric Ward | 1 | 0 |
| Portadown HSSC | 1 | 0 |
| Rathfriland Health Centre | 1 | 0 |
| Rheumatology Clinic | 1 | 0 |
| X-ray Dept (Radiology) | 16 | 0 |
| (blank) | 2 | 0 |
| 1 East Maternity/Gynae | 2 | 0 |
| 2 West Maternity Post Natal | 3 | 0 |
| Bio-chemistry Lab | 3 | 1 |
| Blood Transfusion Lab | 6 | 2 |
| Cellular Pathology Lab | 2 | 1 |
| Day Hospital | 0 | 1 |
| Delivery Suite, CAH | 5 | 0 |
| Delivery Suite, DHH | 4 | 0 |
| Early Pregnancy Problem Clinic | 1 | 0 |
| ED Majors | 0 | 1 |
| Gynae Clinic | 1 | 0 |
| Haematology Lab | 3 | 2 |
| Laboratory | 3 | 0 |
| Mortuary | 1 | 0 |
| Surgical Assement Unit | 0 | 1 |
| Theatre | 0 | 1 |
| | | |
| | | |
| | | |
| | | |

**Directorate of Acute Services - CCS**
**Incident Position, Awaiting and Being Reviewed - as at 18.06.19**

| | In review | Holding area awaiting review |
|---|---|---|
| **Anaesthetics, Theatres and IC Services** | **33** | **3** |
| Coronation Building | 1 | 0 |
| Day Hospital | 0 | 1 |
| Day Procedure Unit DHH | 1 | 0 |
| Day Surgery Unit CAH | 15 | 0 |
| General Outpatients Reception/Waiting / | 0 | 2 |
| Hyperbaric Oxygen Chamber | 1 | 0 |
| Pre-operative Assessment Clinic | 1 | 0 |
| Recovery CAH | 1 | 0 |
| Theatres 1-4 CAH | 6 | 0 |
| Theatres 5-8 CAH | 2 | 0 |
| Theatres DHH | 1 | 0 |
| Theatres/DPU STH | 3 | 0 |
| X-ray Dept (Radiology) | 1 | 0 |
| | | |
| | | |

**Directorate of Acute Services - FSS**
**Incident Position, Awaiting and Being Reviewed - as at 18.06.19.**

| | In review | In Holding Area awaiting review |
|---|---|---|
| **Staff accommodation** | **1** | **0** |
| Functional Support Services | 16 | 27 |
| Booking / Admin | 5 | 1 |
| Booking Centre | 1 | 0 |
| Fracture Clinic | 1 | 0 |
| General Outpatients Reception/Waiting Area | 1 | 0 |
| Health Records | 0 | 1 |
| Scheduling Team | 1 | 0 |
| Trauma Ward | 1 | 0 |
| Decontamination Services | 4 | 2 |
| Biomed Workshop | 0 | 1 |
| Laundry Room | 0 | 1 |
| Sterile Services Dept | 4 | 0 |
| Health Records | 1 | 0 |
| Coronary Care Ward | 1 | 0 |
| Linen Services | 0 | 9 |
| Laundry Room | 0 | 9 |
| Locality Support Services (C&B) | 5 | 8 |
| 4 North | 2 | 0 |
| AMU | 0 | 1 |
| Car Park/Grounds | 1 | 0 |
| Cloughmore Ward | 0 | 1 |
| Corridor/Stairs | 0 | 2 |
| Emergency Department CAH | 0 | 1 |
| Entrance/Exit | 0 | 1 |
| Lift | 1 | 0 |

**Directorate of Acute Services - IMWH**
**Incident Position, Awaiting and Being Reviewed - as at 18.06.19.**

| | In review | ng area awaiting review |
|---|---|---|
| **Midwifery and Gynaecology** | **409** | **0** |
| 1 East Maternity/Gynae | 30 | 0 |
| 2 East Midwifery Led Unit | 15 | 0 |
| 2 West Maternity Post Natal | 46 | 0 |
| Antenatal Clinic | 28 | 0 |
| Bio-chemistry Lab | 1 | 0 |
| Blood Transfusion Lab | 1 | 0 |
| Day Obstetric Unit | 1 | 0 |
| Delivery Suite, CAH | 158 | 0 |
| Delivery Suite, DHH | 44 | 0 |
| Emergency Department CAH | 1 | 0 |
| Female Surgical/Gynae | 16 | 0 |
| General Outpatients Reception/Waiting Area | 2 | 0 |
| Gynae Clinic | 3 | 0 |
| Health Records | 1 | 0 |
| Home of client | 20 | 0 |
| Maternity Admissions/Assessment Unit | 18 | 0 |
| Maternity Ward | 19 | 0 |
| SAUCS (GPOOH) Kilkeel | 1 | 0 |
| SAUCS (GPOOH) Newry | 1 | 0 |
| Theatre | 1 | 0 |
| GUM Clinic | 1 | 0 |
| John Mitchel Place, HSSC | 1 | 0 |

**Directorate of Acute Services - MUC**
**Incident Position, Awaiting and Being Reviewed - as at 18.06.19.**

| | In review | Holding area awaiting review | |
|---|---|---|---|
| **Medicine and Unscheduled Care** | **335** | **105** | **0** |
| 1 East Maternity/Gynae | 1 | 0 | 0 |
| 1 North Cardiology | 9 | 0 | 0 |
| 1 South Medical | 7 | 1 | 0 |
| 1 West Gynae | 0 | 1 | 0 |
| 2 North Medical | 4 | 0 | 0 |
| 2 North Respiratory | 23 | 0 | 0 |
| 2 South Medical | 6 | 2 | 0 |
| 2 South Stroke | 3 | 2 | 0 |
| 3 North Winter Ward | 4 | 0 | 0 |
| 3 South | 6 | 0 | 0 |
| 4 South | 2 | 0 | 0 |
| Admin Floor | 3 | 0 | 0 |
| AMU | 34 | 24 | 0 |
| Ardmaine Nursing Home | 0 | 1 | 0 |
| Banbridge HSSC | 0 | 1 | 0 |
| Bio-chemistry Lab | 2 | 0 | 0 |
| Bluestone Day Hospital | 1 | 0 | 0 |
| Brooklands Nursing Home | 1 | 0 | 0 |
| Canteen/Dining Room | 1 | 0 | 0 |
| Car Park/Grounds | 1 | 1 | 0 |
| Cardiac Catheterisation Lab | 3 | 2 | 0 |
| Cardiology Research | 2 | 0 | 0 |
| CEAW | 1 | 0 | 0 |
| Cellular Pathology Lab | 2 | 0 | 0 |
| Collegelands Nursing Home | 1 | 0 | 0 |
| Coronary Care Ward | 4 | 0 | 0 |
| Corridor/Stairs | 1 | 2 | 0 |
| Daisy Day Clinical Centre | 1 | 0 | 0 |
| Delivery Suite, DHH | 1 | 0 | 0 |
| Dermatology Clinic | 1 | 10 | 0 |
| Direct Assessment Unit | 1 | 0 | 0 |
| Discharge Lounge | 0 | 2 | 0 |
| Drapersfield House Nursing Home | 1 | 0 | 0 |
| ECG Clinic | 1 | 0 | 0 |
| ED Majors | 1 | 0 | 0 |
| Emergency Department CAH | 72 | 8 | 0 |
| Emergency Department DHH | 19 | 5 | 0 |
| Entrance/Exit | 4 | 4 | 0 |
| Female Medical | 30 | 5 | 0 |
| Gastroenterology Clinic | 1 | 0 | 0 |
| General Male Medical, | 12 | 3 | 0 |
| General Medicine Clinic | 1 | 3 | 0 |
| General Outpatients Reception/Waiting Ar | 4 | 3 | 0 |
| General OutpatientsTreatment Room | 2 | 2 | 0 |

| | | | |
|---|---|---|---|
| Haematology | 5 | 0 | 0 |
| Haematology Clinic | 1 | 0 | 0 |
| Hamilton Court PNH | 0 | 1 | 0 |
| Home of client | 3 | 3 | 0 |
| Lift | 0 | 1 | 0 |
| Male Surgical/HDU | 3 | 1 | 0 |
| Maternity Admissions/Assessment Unit | 2 | 0 | 0 |
| MEC | 0 | 1 | 0 |
| Minor Injuries Unit | 2 | 0 | 0 |
| Mountvale Nursing Home | 1 | 0 | 0 |
| MRI Unit | 2 | 0 | 0 |
| Neurology Clinic | 0 | 1 | 0 |
| Non Trust GP premises | 0 | 1 | 0 |
| Non Trust premises | 0 | 3 | 0 |
| Paediatric Ward | 1 | 0 | 0 |
| Patient Flow Team | 14 | 1 | 0 |
| Patient Support Office | 1 | 0 | 0 |
| Pharmacy Dispensary | 1 | 2 | 0 |
| Public Toilets | 1 | 0 | 0 |
| Ramone Day Clinical Centre | 0 | 1 | 0 |
| Reception/Waiting Area | 1 | 2 | 0 |
| Rehabilitation Ward | 4 | 0 | 0 |
| Renal Clinic | 3 | 0 | 0 |
| Renal Unit | 2 | 0 | 0 |
| Rheumatology Clinic | 0 | 2 | 0 |
| Stroke / Rehab | 8 | 0 | 0 |
| Tower Block | 0 | 1 | 0 |
| Urology Clinic | 0 | 1 | 0 |
| Ward 1, Assessment & Rehabilitation | 1 | 0 | 0 |
| Ward 1, Stroke | 2 | 0 | 0 |
| Ward 2, Assessment and Rehabilitation | 1 | 0 | 0 |
| Waste Transfer Station | 0 | 1 | 0 |
| (blank) | 2 | 0 | 0 |

**Directorate of Acute Services - Pharmacy**
**Incident Position, Awaiting and Being Reviewed - as at 18.06.19**

| | Being Reviewed | In Holding Area, awaiting review |
|---|---|---|
| **1 West Gynae** | **0** | **1** |
| 2 North Medical | 4 | 0 |
| 2 North Respiratory | 18 | 0 |
| 2 South Medical | 1 | 0 |
| 2 South Stroke | 1 | 1 |
| 3 North Winter Ward | 4 | 0 |
| 3 South | 6 | 0 |
| 4 South | 2 | 0 |
| Admin Floor | 2 | 0 |
| AMU | 33 | 9 |
| Banbridge HSSC | 0 | 1 |
| Car Park/Grounds | 0 | 1 |
| Cardiac Catheterisation Lab | 0 | 1 |
| CEAW | 1 | 0 |
| Cellular Pathology Lab | 0 | 1 |

**Directorate of Acute Services - SEC**
**Incident Position, Awaiting and Being Reviewed - as at 18.06.19.**

| | In review | In holding area awaiting review |
|---|---|---|
| **General Surgery** | **128** | **16** |
| 3 North Winter Ward | 1 | 0 |
| 3 South | 71 | 1 |
| 4 North | 5 | 0 |
| 4 South | 3 | 0 |
| CEAW | 1 | 0 |
| Day Surgery Unit CAH | 1 | 0 |
| DEAW | 2 | 0 |
| Female Surgical/Gynae | 4 | 5 |
| General Outpatients Reception/Waiting | 0 | 3 |
| Haematology Lab | 1 | 0 |
| Male Surgical/HDU | 9 | 2 |
| Opthamology Clinic | 1 | 0 |
| Oral Surgery Clinic | 0 | 1 |
| Orthopaedic Ward | 3 | 2 |
| Paediatric Ward | 1 | 0 |
| Surgical Assement Unit | 0 | 1 |
| Trauma Ward | 11 | 0 |
| Urology Clinic | 1 | 0 |
| Breast Clinic | 1 | 0 |
| Fracture Clinic | 5 | 0 |
| General Surgery Clinic | 0 | 1 |
| Opthamology Clinic | 1 | 0 |
| Orthopaedic Clinic | 1 | 0 |
| Theatres/DPU STH | 1 | 0 |
| 3 South | 1 | 0 |
| Day Procedure Unit DHH | 1 | 0 |
| Day Surgery Unit CAH | 1 | 0 |
| Theatres/DPU STH | 1 | 0 |

**SAI Update at at 25.06.19 - MUSC**

| Department | Type | Name and H&C | Background | Screening update |
|---|---|---|---|---|
| MUSC | Interface | Personal information redacted by the USI | Missed CVA Belfast Interface SAI | Dr McGleenon to be part of Belfast Trust SAI review panel. |
| MUSC | Screening | | Complaint lodged 13.2.19. Attended ED DHH 3.11.18 with acute confusion and vomiting. Patient is diabetic on insulin. She was admitted to Female Medical DHH and discharged 5.11.18. Readmitted CAH 5.11.18. Patient had a bowel obstruction and died. | Report in draft format. Further meeting organised with review panel for 17 July 2019. |
| SEC/MUSC | Screening | | Issue re availability of inner trachae tube for patient in cardiac arrest | First meeting of review team 26 July 2019. |
| ED MUSC | Complaint/ SAI | | (Complaint.) Personal Information attended ED CAH 16/03/2018 with limb problems. Moderate pain. Fast VE SOB- Nebulizer & GTN & Furosemide. Breathing relieved at triage. Fall on 7/03/2018 ? NOF. Patient's wife and daughter drew attention to staff that he could not weight bear on left leg and that left leg was markedly cold from calf down. The foot was turning in and he was unable to straighten it. Patient was transferred to Older People's assessment Unit where his daughter drew attention to the doctor to the left leg and expressed concern regarding the coldness and lack of mobility in the foot. Family also expressed concern of coldness of left foot to nursing staff. Patient was transferred on 18/03/2018 to RVH Belfast Irrelevant information redacted by [redacted] | Report in draft format. Further meeting organised with review panel for 9 July 2019. |
| ED | M&M complaint now SAI | | ED attendance x3 out of hospital arrest. Coroner's report received 18.6.18 Cause of death: Hypoxic Ischaemic Necrosis of Brain & pneumonia due to Cardiac Arrest. | Report in draft formal. Further meeting organised with review panel for 5 July 2019. |
| MUSC | Screening | | Patient treated for hyperkalemia appropriately as ECG changes. Clear documentation of monitoring required in medical notes and handed over to nurse caring for patient including BM monitoring. Last BM recorded 3am = 4.8. Cardiac arrest at 6.35am with hypoglycaemia 1.9. Lack of BM and physical observations in patient overnight which should have been hourly and 4hourly respectively. | First meeting of review team to be organised. |
| MUSC SEC | Complaint | | Crohns and Colitis treatment (Complaint). Subtotal colectomy May 2018 | Report in draft format. |
| MUSC | screening | | A patient had a decision to commence on Airvo in MSW last night around 1am. The medical notes record that there was no beds in HDU or moves possible Arivo was commenced in MSW single room with staff not trained or competent.An immediate transfer ( direct swap single room for single room) occurred when nursing day staff came on duty . The vent was not recorded in the night report despite MSW nuring staff raising this as a concern | First meeting of review team to be organised. |
| MUSC | SAI LEVEL 2 | | RACPC referral , patient on waiting list for 3 months, patient died. | First meeting of review team to be organised. |
| MUSC | Screening | | Patient X was post eus pancreas procedure. Patient received 100mcg of fentanyl and 1 gram of midazolam during procedure in Xray dept. Patient received from x-ray patient only response to voice but very drowsy.Clinical GCS 3. urgent call for Doctor to review patient and Naloxone given to counteract the medicine. Bloods done and sent. Continue to monitor Clinical | 17/06/2019 For screening |
| MUSC | Screening | | Patient seen at clinic 9/3/19<br>Letter dictated<br>Letter only typed 11/06/19<br>results only put through with letter on 11/06/2019<br>elevated PSA - could be Prostate Carcinoma<br>Referred urgently yo Urology | 17/06/2019 - For Screening |

MUSC/ED Summary and Recommendations approved by ACG in May/June 2019

| Patient Name | Summary of Incident | Conclusions/Learning | List of Recommendations |
|---|---|---|---|
| Personal Information redacted by the USI | Personal Information redacted by the USI was a Personal Information redacted by the USI 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 Information redacted by the USI collapsed in the waiting room and was transferred to Resus for further management. Personal Information redacted by the USI was noted to have a weak pulse and an un-recordable 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 Information redacted by the USI was pronounced dead at 23:50. | 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 redacted by the USI's case and were in agreement that overcrowding was a key factor for the delay in Personal Information redacted by the USI's treatment and care.<br><br>Personal Information redacted by the USI had no prior medical issues, however it was agreed by the review team that Personal Information redacted by the USI 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.<br><br>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 Information redacted by the USI 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.<br><br>Emergency Department overcrowding is one of the greatest hospital challenges to delivering safe, high quality, urgent and emergency care.<br><br>The SHSCT needs to develop an escalation plan to deal with overcrowding in the ED.<br><br>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.<br><br>SHSCT will continue to include recognition of abdominal aortic aneurysm at induction for medical staff. | **Recommendation 1**<br>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.<br><br>**Recommendation 2**<br>The SHSCT should undertake / review the bed modelling exercise and implement any recommendations.<br><br>**Recommendation 3**<br>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.<br><br>**Recommendation 4**<br>Consideration should be given to reviewing the process of obtaining blood investigations following triage. |
| Personal Information redacted by the USI | On Wednesday 28 December 2016 Personal Information redacted by the USI presented to Daisy Hill Hospital (DHH) Emergency Department (ED) at 06:15 having pulled out his percutaneous endoscopic gastrostomy (PEG) tube at 01:00, in the private nursing home (PNH). Personal Information redacted by the USI was reviewed by Dr 1 who could not re-insert the PEG. Personal Information redacted by the USI 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 USI was discharged back to PNH at 12:50.<br><br>Personal Information redacted by the USI re-attended DHH ED on Thursday 29 December 2016 at 15:15 with history of repeated vomiting since change of PEG. His temperature was 37.2º C, Pulse 102, Respirations 26, BP 90/69, SpO2 92% on arrival.<br><br>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.<br><br>Personal Information redacted by the USI passed away on 10 January 2017. | 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.<br><br>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.<br><br>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. | **Recommendation 1**<br>Share this report for learning with the ED, medical and surgical morbidity and mortality meetings.<br><br>**Recommendation 2**<br>Trust guidelines have been developed for the replacement of late displacement of PEG tubes to include correct positioning checks.<br><br>**Recommendation 3**<br>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. |

| Patient Name | Summary of Incident | Conclusions/Learning | List of Recommendations |
|---|---|---|---|
| Personal Information redacted by the USI | Person al Informati was a Perso nal Informa year old male with severe colitis which was diagnosed in 2007. Person al Informati was noted to have mass lesion on a background of colitis upper rectum following colonoscopy and biopsies on 26th April 2016. Seven biopsies were taken and one showed possible dysplasia. The results were discussed at the Lower Gastroenterology (GI) Multidisciplinary meeting (MDM) where the plan was for repeat scope and biopsies. Person al Informati had a follow up flexible sigmoidoscopy carried out on 14th June 2016 which showed no evidence of dysplasia, there was ongoing mild to moderate patchy inflammation in the rectum and some inflammatory polyps in the sigmoid colon.<br><br>Person al Informati had review appointments on 14th November 2016 and 16th May 2017. He had a few episodes of rectal bleeding with loose stools during this time, which was thought to be dietary element to his loose motions. Dietary advice was given. The plan was for a review in 1 year.<br><br>On 16th April 2018 Person al Informati was admitted to Daisy Hill Hospital (DHH) with acute flare up of ulcerative colitis and his bowel motions had increased to 15-20 per day from 5 per day which contained more blood. Person al Informati was started on prednisolone with good effect and was discharged on a reducing dose and planned review at clinic on 22 May 2018.<br><br>On 21st April 2018 Person al Informati attended the Emergency Department (ED DHH) with abdominal pain and was admitted medically initially with query acute colitis / ulcerative colitis flare. A computerised tomography (CT) scan initially reported thickening of a segment of sigmoid colon which may have been due to colitis and the differential diagnosis included malignancy. Repeat scan in the morning after review by the surgical team concluded there was "*evidence of perforation from the distal sigmoid colon. Whilst this may simply be on the basis of an inflammatory process, malignancy has certainly not been excluded*".<br><br>Person al Informati went to theatre and had a laparotomy and subtotal colectomy and end ileostomy for perforation. Pathology confirmed a Dukes C1 pT4a N2b R1 tumour with 12/29 nodes positive.<br><br>Person al Informati was referred to Oncology for adjuvant chemo-radiotherapy on 3rd May 2018. He then developed widespread metastatic disease and died on 25th August 2018. | The review team considered following the colonoscopy on 26th April 2016 given the background inflammation, dysplasia is very difficult to diagnose and interpret. Escalation of histology results was appropriate as was discussion at MDM and plan for repeat flexible sigmoidoscopy in three to four weeks and take extensive repeat biopsies from the rectum and recto sigmoid areas. The review team felt this was an appropriate treatment plan at this stage.<br><br>The review team considered that the inflammation found at endoscopy in April 2016 may have clouded the picture and when treated the changes may have settled down. However the findings at repeat biopsy in June 2016 could have been discussed at the MDM. This may have altered his management plan with the opportunity for more intensive surveillance or surgical intervention.<br><br>The review team considered the appropriateness of surgery following the second CT scan and conclude it was warranted based on the CT report of perforation and Person al Informati's general condition that emergency surgery was required on site. The surgeon involved operated to control sepsis and remove the tumour. At the time of surgery he felt there was sufficient margins to clear the tumour, however histology revealed the tumour was identified within the pericolonic fat at the distal resection margin and twelve lymph nodes showed metastatic adenosquamous carcinoma.<br><br>The review team concluded that there were two opportunities for earlier review of his endoscopic findings. Firstly the repeat biopsies taken in June 2016 could have been discussed at a MDM and secondly based on the original biopsies taken in April 2016 a further surveillance endoscopy in one year was indicated. These steps may have provided an opportunity for earlier intervention. | **Recommendation 1**<br>Where there is a cancer MDM recommendation that a case be re – discussed, this should happen. New processes must be put in place to track these cases. This would ensure that re-discussion occurs within an appropriate timeframe. This should be implemented within 6 months.<br><br>**Recommendation 2**<br>The IBD subspecialty MDM meeting should be strengthened with administrative support to ensure cases are listed and notes available for learning. This should be implemented within 3 months.<br><br>**Recommendation 3**<br>Patients with colitis should have appropriate surveillance as per the BSG guidelines. To ensure this happens, the BSC guidelines should be circulated to the relevant clinical teams. An audit should be carried out (suggested frequency, annually) to ensure that the trust is compliant with surveillance recommendations. This will require appropriate support from the Audit department.<br><br>**Recommendation 4**<br>All patients with inflammatory bowel disease should be assessed by their responsible clinician to ensure surveillance is arranged if indicated.<br><br>**Recommendation 5**<br>Appropriate resources in the form of increased endoscopy capacity need to be put in place to ensure that the trust can meet the surveillance needs in their IBD patients. |

**Acute Services Directorate**
**Directorate Risk Register - JULY 2019**

| ID | Dir | Opened | Principal objectives | Title | Des/Pot for Harm | Controls in place | Progress (Action Plan Summary) | Risk level (current) |
|---|---|---|---|---|---|---|---|---|
| 773 | ACUTE | 29/07/2008 | Safe, High Quality and Effective Care | CAH Theatres Endoscope Decontamination room | The interim Endoscope decontamination facilities at CAH theatres do not meet DHSSNI decontamination strategy.<br>There are no transfer lobbies or staff gowning rooms.<br>The process flow is severely compromised by the size of the extremely cramped unit.<br>There is no room for expansion.<br>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.<br>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).<br>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.<br>The endoscope washer disinfectors were installed in 2009 and have a working life of approximately 8 years.<br>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 | Situation being monitored. | 24.06.19 Risk remains unchanged. 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.<br>5.1.16 Short paper highlighting the risks shared with Planning Dept and Director of Acute Services | HIGH |
| 2594 | PAR | 16/04/2010 | Provide safe, high quality careMake the best use of resources | Insufficient capacity and resources to manage patients waiting for a review appointment in Acute Services | Potential of harm to the patient secondary to not having timely management of condition and/or disease-possible progression of disease/worsening status of condition. Risk of harm to patient by unmanaged progression or monitoring of condition in a timely manner secondary to SHSCT not having sustained capacity to provide review appointments, within the appointed time.<br>Risk of harm to Medical and Nursing staff as addressing the patients needing review are all done as 'extra sessions'. Potential for exhaustion and escalation of sick leave. There has been inadequate Nursing resources recruited to support the increase work load. Risk of escalation of clinical risks as the Trust is under strict financial constraints, and does not have an obvious form of funding for this risk. Potential harm to patient family secondary to anxiety of not having a timely review. Potential of litigation against staff and Trust due to not providing treatment in a timely manner. Potential of harm to reputation of Trust due to potential lack of adequate patient management. | RVBL teams established to 'cleanse' the lists of patients waiting, ensuring no duplication or incorrect recording of activity. This group will also continue to meet and create effective strategy to manage this chronic gap in capacity.<br>Monthly reports monitoring review waiting lists to give current position. Specialist Nurses working in Consultation with relevant Consultants to screen urgent, and patients waiting the longest length of time. Vacant Outpatient sessions have been backfilled with Review Backlog patients, when Consultant available.<br>Heads of Service are meeting with Relevant Consultants and conveying current provision on a monthly basis. | 24.06.19 Clinical risk remains high for review backlog patients. Each division has performance risks on their RR 13.9.16 VK spoke to Lyn Lappin who confirmed on P&R RR<br>27.05.16 - Additional clinics being organised and carried out as additional money becomes available.<br>23.02.16 - SEC working to reduce the number of patients awaiting review from September to end March 2016. Virtual clinics and clinical validation being carried out. Significant progress to date. | HIGH |
| 3663 | ACUTE | 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. | Nov18 Second CT Scanner is now in situ in CAH. 7.3.18 Mobile CT Scan is operational on site. 5.12.16 Mobile CT scanner now on site. Funding up until 31.3.17 to seek further funding to retain on site 17/18. 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 | ACUTE | 13/09/2016 | Safe, High Quality and Effective Care | Absconding patients from all Wards & Department | Patients at risk of leaving the ward or department without investigations, diagnosis and management plan in place. Patient risk - Incomplete treatment for medical or mental health issues leading to physical and/or mental health deterioration<br>Risk of self harm / death<br>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. | 24.06.2019 Absconding policy available - any incidents submitted on Datix, reviewed and staff aware. 23/2/2018 - Additional measures have been introduced to access and egress from ED and AMU. Swipe card is required. Statistics need to be reviewed before consideration can be given to reducing the risk rating.<br>Situation continually monitored. | HIGH |
| 3951 | ACUTE | 10/04/2018 | Provide safe, high quality care | Delays in isolation | Due to lack of side rooms/one to one nursing/lack of bed capacity in the service. Risk of spread of infection. Failure to isolate promptly can lead to outbreaks, close of bays, increased pressure on service. May lead to potential patient harm through the spread of potentially preventable infection or due to a lack of beds. | Trust can emphasise the importance of IPC issues at bed meetings and elsewhere. A recent teaching sessions was arranged to do this amidst the winter pressures. Side rooms are often occupied for reasons other than IPC reasons. IPC reasons for isolation are often of critical importance in that severe harm can be done to other patients and staff by failure to isolate promptly. This is often not the case for other reasons patients are in side rooms and side rooms should be prioritised to maximise patient safety. The Trust should also look to ways to enhance the capacity to isolate a patient when the hospital is full and a patient needs isolated urgently e.g. where a patient could be moved out of a room to facilitate critical IPC isolation. | Risk added to Directorate RR April 2018 | HIGH |

| ID | Dir | Opened | Principal objectives | Title | Des/Pot for Harm | Controls in place | Progress (Action Plan Summary) | Risk level (current) |
|---|---|---|---|---|---|---|---|---|
| 3952 | ACUTE | 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.<br>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.dfficile 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.<br><br>Nursing staff when contacted should inform medical staff immediately. On certain occasions this has not happened as RCAs have reflected.<br><br>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.<br><br>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.<br><br>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 | Risk added to Directorate RR April 2018 | HIGH |
| 3953 | ACUTE | 10/04/2018 | Provide safe, high quality care | Inappropriate antibiotic use (tied to stewardship issues in terms of corporate actions needed) | Inappropriate antibiotic prescribing can lead to a rise in antibiotic resistance which impacts on the safety of the entire public. It can also lead to side effects for individual patients such as Clostridium difficile infection (CDI). The risk of CDI is enhanced where antibiotic treatment is unnecessarily broad spectrum or overly prolonged.<br><br>Inappropriately narrow spectrum or inadequately long courses of antibiotics can also lead to adverse outcomes for patients including recurrences of infection and death.<br><br>Inappropriate prescribing most often occurs:-<br>(a) When patients receive antibiotics when they do not have infections - this often occurs whenever a diagnosis is initially unclear and infection is in an initial differential but antibiotics are not stopped whenever the situation becomes clearer.<br>(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<br>(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<br>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.<br><br>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 | 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.<br><br>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.<br><br>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. | Risk added to RR April 2018 | HIGH |
| 3954 | ACUTE | 10/04/2018 | Provide safe, high quality care | Lack of documentation | Root cause analyses are repeatedly picking up incidences of poor documentation e.g. lack of filling out of Clostridium difficile bundle, lack of documentation that the patient has been informed of a diagnosis of Clostridium difficile, lack of filling out of cannula charts, etc.<br>Lack of documentation can reflect either that something that should have happened has not happened or just that it has not been documented.<br><br>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).<br><br>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.<br><br>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.<br><br>When challenged regarding poor documentation excuses given are usually:-<br>(a) A lack of education/awareness regarding aspect s of care bundles<br>(b) A lack of time to document things due to service pressures<br><br>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.<br><br>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 |

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| 4020 | ACUTE | 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. | 24.06.19 Continue to monitor by HOS and OSL (same as 2594). However, update on inhouse additionality from consultants due to 'pension' issue. Same has been escalated to the Acute Director 28/3/29 - non-recurrent funding received in Q1 of 2019/20 for general surgery and chronic pain. continued monitoring by HOS and OSL<br><br>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<br><br>20/11/18 - Ongoing review backlog clinics in general surgery, chronic pain and urology to the end of March 19. RBL remains high risk<br><br>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 |
| 2979 | ACUTE | 13/05/2011 | Provide safe, high quality care | Multiple records/charts per patient e.g. a patient may have STH, CAH, BPC & DHH medical notes | Patient is at risk due to information in multiple charts (no one chart may contain a full record of patient history and investigations). Trust from risk of litigation. Risk to patient of incomplete information being available at time of consultation, incorrect diagnosis due to incomplete information, delay in diagnosis, risk of injury and/or death. Reputation of Trust at risk. | Patient information is available electronically in Patient Centre, NIPACS, Labs, TOMCAT. Charts for CAH and DHH only now registered. All charts are made available if requested. | 24.06.19 New system - one patient one chart for all new and recent patients. Ongoing update for older files for existing patients. 7.3.18 Risk remains unchanged 28.09.17 Further work is to take place with regard to registration of CAH and DHH charts and a move to 1 patient 1 chart. Initial discussions will take place in October with Health Records managers and the Booking Centre to identify issues relating to registration, and following this a proposal will be taken to Acute SMT for discussion and agreement.<br>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 |
| 3070 | ACUTE | 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.<br>27.05.16 - Yearly audit taking place May/June 2016.<br>23.02.16 - Ongoing NQI audits continue to highlight this problem area.<br>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 | ACUTE | 16/01/2013 | Provide safe, high quality care | Lone Workers in X-Ray after 12 midnight | Risk to the welfare of the lone Radiography staff working out of hours shifts either in CT or when performing Mobile radiography in remote areas of the hospital. On both instance the lone Radiographer is required to come into the x-ray department that is located some distance from ED and the wards. This leaves the lone Radiographer vulnerable and at risk from verbal/physical abuse/theft from visitors and patients . This potentially increases the staff's stress levels. Staff have a right to expect a safe and secure working environment.Risk of patients/visitors having free access to the x-ray department during the period from 8pm-8am as the department is not locked down securely during this period. | Staff Awareness. Restricted access in some areas. MOVA policy and procedures. Personal attack alarms issued to all staff. CCTV. Porters available to escort staff. Porters and Radiographers to lock main doors of x-ray when not in use. Radiographers required to checked that all doors into x-ray are locked before 8pm at night.Lone worker policy. IR1 Reporting. | 14.11.17 Awaiting update from J Robinson<br>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 | ACUTE | 05/02/2014 | Safe, High Quality and Effective Care | Pharmacy Aseptic Suite | The external audit of the pharmacy Aseptic Suite, which prepares all the total parenteral nutrition and the chemotherapy for oncology and haematology patients, has identified The design and fabric of the aseptic building does not meet the modern building standards for pharmacy aseptic dispensing units (critical audit finding).<br>Application of the newly introduced capacity plan has identified the chemotherapy pharmacists' activity is exceeding 100% on a regular basis (Major audit finding)<br>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<br>Expiry dates of all products prepared has been reduced to a maximum of 24 hours.<br>A daily report on the chemotherapy pharmacists activity level in relation to the capacity plan has been developed and implemented<br>Additional activity will not be accepted by the aseptic unit until the staffing issue is resolved<br>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.<br>• 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.<br>• 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.<br>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%<br>Capital was identified to replace both isolators and this work was completed by January 2015. | MOD |

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| 3529 | ACUTE | 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:<br>- 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,<br><br>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.<br><br>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 | Provision of bi monthly assurance responses to the HSCB as part of the Trust's Positive Assurance response.<br>Corporate governance have an Excel database in place for logging and monitoring S&G.<br>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.<br>Standard item for discussion at the monthly Acute Clinical Governance meetings with submission of relevant reports<br>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<br>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<br>A new Acute Services Lead Nurse, Midwifery & Radiology S&G forum - meetings held on a monthly basis<br>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 | 7/3/18 & 5/12/17 Information below remains current<br>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.<br>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.<br>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 | ACUTE | 13/11/2017 | Provide safe, high quality care | Lack of funding to ensure compliance with NICE guidelines that have been regional endorsed by the DHSSPSNI. | In April 2017 a Band 5 Governance Officer commenced work within the Acute S&G team as part of a secondment from the Corporate Governance team. This secondment to the Acute S&G forum ended on 31/12/17. The purpose of this audit was to ensure that an assurance framework is in place to comply with the reporting arrangements to the relevant external agencies (such as the HSCB). The outcomes from this audit are now being operationalised and outstanding actions are presented at the Acute S&G forum and Divisional Governance meeting to ensure progression.<br><br>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.<br><br>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<br>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 | ACUTE | 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 Gastroentrology 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 | ACUTE | 30/04/2018 | Safe, High Quality and Effective Care | The medical team on the Daisy hill hospital site cannot provide daily senior review for all the Medical in patients | Due to medical workforce they are unable to ensure that all in patients receive a senior medical review. Delay in investigations. Delay in review of investigations. Delay in Diagnosis.<br>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 | 24.06.19 No change. Zoning introduce needs evaluated. Review workforce available. | MOD |
| 3958 | ACUTE | 30/04/2018 | Safe, High Quality and Effective Care | EBUS Provision lack of Funding | The risk is that patients requiring cardiac investigations are waiting in access of 13 week Pot for Harm -Delays in patients being diagnosed, commencing treatment and the appropriate way<br>Delays may contribute to patient death. | We have Cardiac investigations teams across both acute Sites<br>Agreed referral process to be used by CI staff at Triage<br>Avail of funding from HSCB for additional clinics. | 24.06.19 Additional EBUS session secured and we will continue to monitor. 19/11/18 Measure access times monthly and highlight to HSCB via performance team. Review of cardiac investigation demand and capacity by HSCB. | MOD |
| 3971 | ACUTE | 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.<br>Angiography within 72 hours improves outcomes for patients. (NICE).<br>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. | 24.06.19 Monitored via MINAP only 50% getting to cath lab despite modula. High volumes of inpatient activity (monitored monthly for each site) Need to secure Funding premanent for modula. Need to reduce elective to facilite inpatient. 13.08.18 Performance team to liaise with HSCB re funding | MOD |

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| 4005 | ACUTE | 28/02/2019 | Provide safe, high quality careMake the best use of resourcesBe a great place to work | Lack of Availability of Core AHP Staff | Increase volume of complex patients requiring intervention. 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 | ACUTE | 28/02/2019 | Provide safe, high quality care | Risk that patients receive inappropriate care due to the misuse of point of care testing | Risks arise from the inherent characteristics of the devices themselves and from the interpretation of the results they provide. They can be prone to user errors arising from unfamiliarity with the devices. Patients are at risk of inappropriate treatment as a consequence of inaccurate results.<br>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 | ACUTE | 28/02/2019 | Provide safe, high quality care | Delay in the treatment of Cancer Patients due to vacant Oncology Consultant | Due to vacant Acute Oncology Consultant post and 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 | ACUTE | 28/02/2019 | Provide safe, high quality care | Delay in the Management and Review of Haematology Patients | Due to pressures within Haematology service patients requiring review at outpatient Haematology clinic may not be reviewed in a timely manner due to review backlog therefore risk that patients may have delay in diagnosis. A senior Consultant is planning to retire at the end of December and due to difficulties in recruiting medical workforce this may further impact the ability to review patients in a timely manner. | Staff have been offered the opportunity to undertake additional sessions to ensure that the waiting time for patients to be seen is reduced and patients are seen in a timely manner. | | MOD |
| 4031 | ACUTE | 28/05/2019 | Provide safe, high quality care | BTS National Audits | Patients are being disadvantaged because we can't take part in good quality national audits.<br>Staff can't show evidence of good quality practice. We are unable to be properly benchmarked against similar organisations. | Ongoing backlog in data provision for national audits | May 2019 Risk placed on Register for monitoring | MOD |
| 2422 | ACUTE | 13/10/2009 | Provide safe, high quality care | Multiple training schedules for staff at Trust Level. Lack of resources to facilitate staff to go to training. | Staff unable to attend training due to multiple training schedules, therefore leaving ward short staff or staff not being updated. Mandatory requirements unable to be facilitated. With staff at training there is a potential risk of not providing safe high quality care to patients. It will deplete staff numbers at ward level therefore failure to meet the expected standards of care. This will apply pressure on colleagues who remain on the ward. | Ward Sister to manage off duty rotas and prioritise training needs/where there are high dependency levels responsibility of nurse in charge to assess situation and take decision on releasing staff for training/more flexible approaches to training eg delivered at ward level,e-learning etc. | 24.06.19 No change, Monitor compliance monthly. Training now available on-line. Review frequency of training. 23.9.17 - CMT remains challenging to achieve over 80% mainly due to 1- staffing challenges and 2 availability of training which is not 'online'.<br>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 |
| 3929 | ACUTE | 12/12/2017 | Provide safe, high quality careMake the best use of resources | Declaratory Orders for patients who lack capacity | Decisions sought from the court in those cases when someone lacks capacity and wherein a deprivation of liberty is likely to exist. The risk is that for those cases not taken to the court for a declaration order, there is a risk that the Trust could be challenged through judicial review for the best interests decisions it makes obo individuals without capacity. | Advice is that in all cases where a DoL is evident for individuals assessed as lacking capacity, the Trust should seek a decision from the court. This is neither achievalbe not affordable. This paper proposes that Multi-disciplinary teams agree only the most difficult cases are taken to the court for a decision. | 7.3.18 Risk remains unchanged | LOW |
| 3956 | ACUTE | 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. | 24.06.19 Group established. Action plan developed. Non-compliance areas due to lack of staffing. Compliant with 12 of 21 KPI | LOW |
| 4009 | ACUTE | 28/02/2019 | Provide safe, high quality care | Delay in the management of oncology patients | Due to significant vacancies in Medical Oncology Consultant workforce 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 |

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| 4006 | ACUTE | 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 | ACUTE | 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.<br>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.<br>The potential risk occurring during the transfer of images outside the trust is the loss of patient data.<br>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<br>Company has DPA obligations in place and have been co-operative in responding to additional requests for clarification<br>-Lack of alternative re processing of records<br>-Consequences of a data breach (CT scan images)<br>-Likelihood of a data breach<br>-Impact on patient if breach occurred<br>-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."<br><br>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 | ACUTE | 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.<br>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.<br>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 |

**Medicine and Unscheduled Care Division**
**Divison, Head of Service and Team Risk Register - July 2019**

| 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.<br>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.<br>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.<br>Protocol to be review by medical, pharmacy and nursing staff.<br>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.<br>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 :-<br>1. Whilst the patient is on the table mid procedure<br>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.<br>2. No controls in place | 24.06.19 Discussed with Medical team still high risk as radiology room only available at times, would impact on elective and inpatient activity if C Arm was broken. High Risk as only one cath lab theatre. 11.03.19- No update.<br>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 | Dermatology Unit | 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.<br>Review clinic templates and increase Red flag slots.<br>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<br>We work closely with Cancer trackers re access times and investigations<br>Escalate accordingly<br>Three patients breeched monthly report. | 11.03.19- No update.<br>Review access times monthly. | MOD | DIV |
| 3991 | 19/11/2018 | Provide safe, high quality care | Dermatology Unit | 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<br>avail of additional funding for clinics. Review performance monthly. Escalate to Performance team. | 11.03.19-no update<br>Review access times monthly. | MOD | DIV |

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|---|---|---|---|---|---|---|---|---|---|
| 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.<br><br>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.<br>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.<br>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 |
| 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 |
| 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<br>01.06.16 - Business case prepared for additional resources. | MOD | DIV |
| 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.<br>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<br>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 |

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| 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.<br>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 wellbeing | 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. | 24.06.19 Team agreed met wit estates. Plan for extension being developed. On capital list as priority No 4 currently. Reviewing accomodation alternatives as interim until extension undertaken. 11.03.19-No update<br>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. | 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.<br>01.06.16 - Diabetic Antenatal Specialist Nurse recruited. Increased number of patients requiring interpreters at clinics which is slowing down appointments.<br>29.02.16 - Additional diabetic nurse specialists have been recruited and a second consultant for the DHH site has been advertised. | MOD | DIV |

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| 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<br>Delay in commencing appropriate pathway<br>Delays in diagnosis for patients who presented with Respiratory Conditions. | Our Respiratory team provide clinic across a number of sites within the Trust<br>Urgent Patient reviewed<br>Clinic Templates set up to address new to review ratio<br>Revalaidtion of clinic<br>Review clinical activity<br>Available of WLI clinics as required. | 24.06.19 No change, Access 97 weeks for non urgent. Monitored monthly via performance team. Escalated to Dir and HSCB 11.03.19- No update.<br>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<br>Delay in commencing appropriate pathway<br>Delays in diagnosis for patients who have potential for cardiac conditions | Our Cardiology team provide clinic across a number of sites within the Trust<br>Urgent patient reviewed<br>Clinic Templates set up to address new to review ratio<br>Revalidation of clinic waiting lists<br>Review clinical activity<br>Available of WLI clinics as . required and when funding is available | 24.06.19 WLI - carried out when funding available. New outpatients 45 weeks currently monitored monthly and escalated to Dir and HSCB. 11.03.19- No update.<br>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<br>Delays in patients starting appropriate Drug Regimes<br>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.<br>Validate waiting times<br>Review clinic templates New and review to assist with increased red Flag referrals from May To October<br>Review Clinic templates new to review<br>avail of additional funding for clinics<br>Avail of additional medical support locum consultant to assist with review backlog<br>Review performance monthly<br>Escalate to Performance team | 24.06.19 4 Consultants in post, access reviewed but demand high as SHSCT have highest incidence of skin cancer. So high demand for new and review apts. 11.03.19- No update<br>Development of IPT to secure finding to support 4th consultant. Review access times monthly and escalate to Assistant Director and Director. | MOD | DIV |
| 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<br>Delay in diagnosis and patients commencing appropriate treatment plan<br>Delays in diagnosis for patients who have potential for cardiac conditions<br>Potential for high risk patients who may require Cardiac surgery/ Valve replacement waiting over 13 weeks<br>Potential of death for patients waiting on cauterisation procedure or stenting. | Our Cardiology team provide 10 theatre sessions in main cath lab<br>Secured Funding for modular cath lab until March 2018.<br>Maximise cardiac cath lab sessions<br>Revalidation of waiting lists<br>Review clinical activity<br>Avail of WLI in Modular cath lab sessions | 11.03.19- No update.<br>1.Identify any risks to HSCB re performance and access Times<br>2.Review NICE guidelines and highlight areas of Non-compliance to AD and Director and Director of performance.<br>3. Validate Waiting lists<br>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.<br>26.02.18 Guidelines developed by Lead Nurses, to be signed off at Acute Nursing and Midwifery meeting 05.03.18 | 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 |
|---|---|---|---|---|---|---|---|---|---|
| 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.<br>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<br>(Consider equipment, staffing, environment, policy/procedure, training, documentation, information - this list is not exhaustive).<br>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<br>01.06.16 - International recruitment ongoing.<br>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.<br>Telephone calls not being returned to patients within 48 hours when they contact the help line.<br>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<br>Non compliant with NICE guidelines re Chest pain diagnosis -- first referral is CT angio.<br>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.<br>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.<br>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 |

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| 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.<br>The risk to patients if call not returned and patient assessed in timely manner.<br>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.<br>Group set up to review other options that could be resourced.<br>Band 5 out of hours period 7 days per week and at weekend and bank holiday being costed by finance. | 24.06.19 Audit carried out. Meeting arranged July re Haematology Service. Currently helpline facilities Haem/Oncology. New clinic lead for haem requested Haem Helpline only. So process being worked through re impact. 1.03.19- No update.<br>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.<br>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.<br><br>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<br>01.06.16 - Still ongoing. Review of processes being taken forward.<br>29.02.16 - Requires directorate focus. | MOD | DIV |
| 1022 | 07/08/2008 | Safe, High Quality and Effective CarePro vide 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.<br>01.06.15 - Disruption continues to be caused due to violent and aggressive patients and/or relatives. | LOW | DIV |

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|---|---|---|---|---|---|---|---|---|---|
| 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.<br>01.06.16 - No update. Work ongoing.<br>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 |
| 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<br>26.02.16 - Health and Safety Risk Assessment completed.<br>26.11.14 - HOS to re look at all storage options including off site, scanning and microfilming. | LOW | DIV |
| 3892 | 24/05/2017 | Make the best use of resources Provide 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.<br>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 |
| 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.<br>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 |
| 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 |

| ID | Opened | Principal objectives | Location (exact) | Title | Des/Pot for Harm | Controls in place | Progress (Action Plan Summary) | Risk level (current) | Register Holding |
|---|---|---|---|---|---|---|---|---|---|
| 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:<br>1. Potential for poor outcome for the patient when they remain in SHSCT ED. 2 Loss of confidence in the organisation.<br>3. Potential for complaints, litigation for the Trust | Escalation plan within ED for patients in the department 4 hours or greater.<br>Plan includes escalation up to ED consultant on call which facilitates dialogue with Consultant in Regional facility. | 11.03.19- No update.<br>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.<br>01.02.13 - Reviewed by Heads of Service on both sites. Trauma group established to address further issues, December 2012.<br>23.01.12 - No delays reported since last review.<br>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<br>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.<br>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 |
| 2250 | 08/09/2009 | Provide safe, high quality careSafe, High Quality and Effective CareImproving Health and Wellbeing Effective 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.<br>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.<br>Thrombolytic team should be paged immediately if patient presents with ischemic cardiac pain. | 11.03.19- No update.<br>01.06.16 - NICE guidelines currently being reviewed.<br>01.02.13 Chest pain pathway to be reviewed by clinicians.<br>25.10.12 - Position remains unchanged from previous report - no adverse incidents reported since.<br>23.01.12 - Cardiology liaison service commenced 9am - 5pm Monday - Friday.<br>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 |

| ID | Opened | Principal objectives | Location (exact) | Title | Des/Pot for Harm | Controls in place | Progress (Action Plan Summary) | Risk level (current) | Register Holding |
|---|---|---|---|---|---|---|---|---|---|
| 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.<br>01.06.16 - Some work carried out during the last refurbishment. Negative Pressure Room in Ward 2 North Respiratory.<br>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.<br>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.<br>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 |
| 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. | 24.06.19 Ongoing walk arounds and meetings with Infection control, estates, ward sisters and management to develop action plan to address.<br>11.03.19- No update.<br>01.06.16 - Storage space still not adequate. Refurbishment has helped but still falls short of appropraite standard.<br>26.11.14 - AD to write to locality team to raise issue of non-clinical use of clinical space on wards.<br>25.09.13 - refurbishment on-going.<br>27.12.12 - Each ward working towards refurbishment programme.<br>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 |
| 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.<br>24.10.13 - 6 monitors will cost £30k - £40k. Further bid for capital submitted. | LOW | HOS |
| 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. | 24.06.19 New Renal extension. Walk around. Action plan developed. 11.03.19- No update.<br>26.02.18 Priority No 7 on capital list. | LOW | HOS |

| ID | Opened | Principal objectives | Location (exact) | Title | Des/Pot for Harm | Controls in place | Progress (Action Plan Summary) | Risk level (current) | Register Holding |
|---|---|---|---|---|---|---|---|---|---|
| 2083 | 21/10/2008 | Improving Health and Wellbeing Effective 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.<br>Two members of staff previoulsy attended Occupational Health in relation to health issues associated with the working environment.<br>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.<br>26.02.16 - Health and Safety risk assessment form completed.<br>2013. New fans provided to allow exchange of air. | LOW | HOS |
| 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.<br>01.06.16 - New process in place for protected beds.<br>25.02.16 - New Risk. | MOD | TEAM |

## Stinson, Emma M

**From:** Gishkori, Esther [redacted]
**Sent:** 01 February 2019 15:25
**To:** Boyce, Tracey; Kingsnorth, Patricia; Walker, Helen; McCloskey, Sharon; OKane, Maria
**Subject:** A/L.

Dear All,
I had arranged to meet you all for various meetings throughout the day on Monday 4th February.
I am however going to take an A/L day [redacted].

We can arrange through Emma another time for you all.
Please send me an e mail for anything urgent and we can perhaps have a conversation over the phone.

Many thanks,
Best
Esther.

## Stinson, Emma M

**From:** Tracey.Boyce [redacted]
**Sent:** 08 February 2019 14:53
**To:** 'esther. gsihkori [redacted]
**Cc:** Kingsnorth, Patricia; Emma M Stinson
**Subject:** Monday governance meeting

Hi Esther
I am on leave on Monday so won't be at the gov briefing with Patricia

The key things I think we need to address are
- the continuing poor hyponatremia audit results- could those results become a standing item on your monthly 1-1 meetings with relevant ADs and AMDs perhaps - as a way of keeping it on their radar
- the governance structure- is there any way we could even go at risk for the medic PAs now and the lessons learned and 5 you mentioned in relation to the sai recommendations this morning?
- ideas for some project around the pressure stores risk.

See you next week.

Have a good weekend.

kind regards

Tracey

## Stinson, Emma M

**From:** Gishkori, Esther [redacted]
**Sent:** 22 February 2019 12:00
**To:** Gishkori, Esther
**Subject:** Patricia Kingsnorth - Needs a chat

**Subject:** Patricia Kingsnorth - Needs a chat
**Location:** your office
**Importance:** Normal
**Start:** 2019-02-22 12:00:00Z
**End:** 2019-02-22 13:00:00Z

## Stinson, Emma M

**From:** Kingsnorth, Patricia Personal Information redacted by the USI
**Sent:** 22 February 2019 14:32
**To:** Gishkori, Esther
**Cc:** Boyce, Tracey
**Subject:** re: today's meeting

Dear Esther
Thank you for meeting with me today.
Just to clarify points as discussed.

1. Keeping Hyponatraemia on the AD and HOS radar as we are required to implement the recommendation 11-30 for acute.
2. Trudy is working on the NEWS 2 which should be easier to complete.
3. SAIs – I have 31 reviews to complete . 5 since taking up post (SAIs). There are 9 that are almost complete (just a few issues) that Trudy has been advised by Dr OKane to ask me to complete. As I am not familiar with the reviews and there are only a few issues to be sorted, can I ask that Dr OKane allows Trudy to complete those reports.
4. I have appointed a new band 6 to cover David Cardwell on a secondment opportunity, who cannot be released for a period of 1 month. Colleen McCaul is the staff member and her manager is Katherine Robinson. I received an email this afternoon from Katherine to advise that Colleen will not be released until 22/3/19. This means that David Cardwell will not be able to take up his band 7 post until the end of March. I am currently struggling with the work load and require assistance sooner than that. You advised that you will speak with Anita to see if she can be released sooner.
5. We discussed the governance structure and the problems with complaints and staff sickness – currently Vivienne is on Personal Information redacted by the USI and we may need to get someone to cover for her. We discussed the possibility of converting some band 3 monies to make up a band 5 for complaints if possible. With the current sick leave we are not able to make our 20 day response times.
6. You said you will look into getting me some band 6 nursing governance officers.

Kind regards
Patricia

Patricia Kingsnorth
Acting Clinical Governance and Social Care Coordinator Acute
Governance Office
Administration Floor
CAH
Tel: Personal Information redacted by the USI

**Stinson, Emma M**

**From:** Stinson, Emma M [redacted]
**Sent:** 25 February 2019 08:21
**To:** Boyce, Tracey; Kingsnorth, Patricia
**Subject:** CANCELLED Governance Update This Morning

Dear both

I can't remember if I did this last week but I need to cancel this morning's meeting as Esther has to attend an urgent meeting in Belfast.

Many Thanks
Emma

Emma Stinson

**PA to Mrs Esther Gishkori, Director of Acute Services**
**SHSCT, Admin Floor, Craigavon Area Hospital**

**Direct Line:** [redacted]

[redacted]

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**Stinson, Emma M**

**From:** Stinson, Emma M [redacted]
**Sent:** 08 March 2019 15:23
**To:** Boyce, Tracey; Kingsnorth, Patricia
**Subject:** CANCELLED Governance Briefing on Monday

Sorry Ladies

Esther has to attend an urgent meeting with consultants at 8.30am on Monday so will have to cancel Monday's meeting with you – let me know if you need it rescheduled

Many Thanks
Emma

Emma Stinson

**PA to Mrs Esther Gishkori, Director of Acute Services**
**SHSCT, Admin Floor, Craigavon Area Hospital**

**Direct Line:** [redacted]

[redacted]

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Southern Health and Social Care Trust

**Acute Governance**
**Urology MDM**
**Thursday 18 February 2021 @ 12.30pm**

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**PRESENT:** **Mr Dr Dermot Hughes (Chair)**
**Mrs Patricia Kingsnorth**
**Mr Michael Young**
**Mr Anthony Glackin**
**Jason Young**
**Jenny McMahon**
**Martina Corrigan**
**Kate O'Neill**
**Mr Mark Haynes**
**Mr Shawgi Omer**
**Roisin Farrell, note taker**

Dr Hughes introduced himself to the meeting. He provided an update to the meeting. He advised he was asked to chair the Urology review in August. The review team have been working on the review from October 2020 and the draft report is expected to be ready for 28.2.2021. He has met with all 9 families once and is meeting with them between today and tomorrow (18 & 19 February 2021) for the second time and will meet with them for a third time to provide them with the draft report.
Cases in question were: 5 prostate cancers, 1 testicle cancer, 1 penile cancer and 2 renal cancers. He asked if anyone had any questions. – None. He advised in the instance of the prostate cancers there was no adherence to MDM and clinical guidelines of March 2016. Other issues of concern are the timeline for diagnosis, some delays and some were lost in the pathway to diagnosis and follow ups. He confirmed 3 patients have since died. Patient 4, Patient 1 and Patient 3 and other patients are not so well. Dr Hughes advised the group that the external urology reviewer is Mr Hugh Gilbert he was nominated by the professional body that gives professional advice.

Dr Hughes explained that the Cancer Nurse Specialist was excluded from these patients care. 9 patients didn't have the supporting link leading to a greater risk of failsafe measures to ensure pathway is adhere to. Dr Hughes said he was not sure why this happened and he doesn't know if all at MDM were aware. He has been told MrO'B didn't refer patients to Cancer Nurse Specialist. He said these patients needed someone to manage their pathway. He advised he believed MDM was not appropriately resourced leading to a resource deficit in the recommendations referring back to the peer review of 2017. He asked if there were any questions.

Mr Glackin advised he was chair of Urology MDM, he took over from MrO'B. He confirmed nurses were excluded from MrO'B's practice. He doesn't believe there is an issue with other doctors.

Dr Hughes confirmed has been speaking to nurses and will be putting recommendations into the report to reflect this. He is not sure why patients didn't have access to Cancer Nurse Specialist which has caused issues in the community.

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Mr Glackin highlighted there are only 5 Cancer Nurse Specialist covering the services over a number of hospitals.

Dr Hughes advised he thought at the start it was geographical but asked why patients were not given contact details. He advised this is one of the questions he has asked MrO'B. He was concerned there was no multi-disciplinary support for these patients.

Mr Glackin advised the issue surrounding resources of nurses has only improved in the last 2 years.

Dr Hughes highlighted that renal patients needed Cancer Nurse Specialist.

Mr Glackin suggested there was an issue with resources at MDM. He recalled his experience in the West Midlands where MDM was better resourced. The follow up and tracking was more robust, more a priority and had admin support. He advised there were weekly trackers who would liaise with consultants enabling them to meet their timelines. Adding here they are never able to meet timely care.

Dr Hughes agreed with Mr Glackins points. He questioned if the issue was systematic and a problem for more than the 9 cases, if so this would need to be addressed. He added the recommendations will be able to review this through the recommended audits.

Mr Glackin referred to the proposed audits and advised at present they would not have the time or resources.

Dr Hughes advised consultants should have been doing audits and agreed there was a need for more resources. He advised other concerns raised were the appropriate onward referral to other professionals, oncology etc from MDM. He feels MDM focused on first diagnosis.

Mr Glackin suggested this was more or less unique to MrO'B. He added that the MDM chair is rotated among colleagues.

Dr Hughes advised he had raised this with Mr Gilbert and was advised this was a common way of working and feels it is beneficial to rotate the chair, they can review cases in advance and identify where there is care deficit. He said when patients progress they are not being taken back to MDM leading to uni-professional care, causing a problem.
He also said there were issues around flutamide.

Mr Glackin advised this was discussed at MDM. He referred to the specific dose of 150mg and suggested the evidence was weak in the criticism in the use of this treatment and said the scientific evidence was not so robust.

Dr Hughes said he was taking advice from Mr Gilbert. He feels in these cases it was inappropriate and said it would have been more appropriate for onward referral to oncology.

Mr Glackin suggested that generally consultants give other treatments and feels if the review is referring to the use of flutamide this needs to be scientific and not opinion.

Dr Hughes referred to the 5 prostate cancers. 1 being coincidental, 1 was potential prostate that didn't get a diagnosis for 15 months.

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Mr Glackin suggested TURP's was not a good diagnosis for prostate cancer.

Dr Hughes asked if there were any issues of concern raised outside MDM.

Mr Glackin advised management were aware of no nurses.

Dr Hughes advised he had spoken to AD in CCS who was not aware of issues.

Mr Glackin advised they did bring issues of concern a number of years ago. Their reaction was a shrug of shoulders and said "what do you want us to do".

Dr Hughes said he noted staff at MDM was generally locums and that oncology were not attending.

Mr Glackin said he had suggested suspending the Trust MDM due to attendance.

Dr Hughes advised one of the recommendations would be to provide resources for MDM.

Mr Haynes – AMD. He believes there is an enormous disconnection between services and feels consultants are blamed when they fail but at the same time CCS will take credit when they succeed. He referred to occasions where at MDM meetings issues were bounced back to urology. He asked what they can do.

Dr Hughes advised he attended a meeting and was stunned to hear staff was aware of the issues. He feels it's hard for staff if they feel isolated. He added when the report is complete staff need to feel supported.

Mr Glackin said there was no input from outside of MDM, no support from CCS.

Dr Hughes agrees staff do need support and feels supported to raise concerns. He suggested these concerns need minuted and actions taken. He advised he was going through the process of meeting families which has been quite upsetting to patients and their families.
Dr Hughes asked the meeting if they wanted to meet again or if they wanted to raise concerns directly they could contact him.
He advised he has struggled a little regarding the governance, he feels staff were told to sort out themselves which is not appropriate especially when people are paid. He questioned if there was the same issues in breast screening.

Mr Haynes advised breast screening was under the same remit; the same team CCS and they meet their targets.

Dr Hughes advised 8 or 9 recommendations from MDM were appropriate.
One of the safety checks to oncology, if had oncology been attending patient could have got referred.

Mr Glackin advised they use Belfast MDM. He suggested he doesn't feel comfortable making referrals to oncology. He added this has all been minuted at a governance meeting.

Dr Hughes advised them they focusing on the 9 patients.

Mr Glackin doesn't feel they are addressing any issues.

Dr Hughes suggested the trust needs a forum to address these issues.

Mr Glackin said their workload is another issue which needs to be recognised. He said they are "carrying more than their peers". Pressures causing risk with under resourcing of urologists and Cancer Nurse Specialist.

Dr Hughes agreed and asked to get data, he suggested if workload an issue causing underlying issues.

Mr Haynes advised here there is 1consultant per 90,000 of population, in England it is a lot lower.

Martina Corrigan advised the Western Trust has taken back their referrals from mid-September.

Mr Young advised the change in volume was only recently due to not being able to cope.

Dr Hughes advised he would share the draft report with MDM.

Kate O'Neill CNS advised she was astounded CNS had not been asked or been met with.

Martina Corrigan advised there was a meeting planned for Monday.

Dr Hughes said she had asked Patricia Thompson to speak with staff.

Kate O'Neill has only been made aware of meeting and thought it would have been formal.

Dr Hughes advised the issues were the absence of Cancer Nurse Specialist which was a deficit to the patients.

Kate O'Neill clarified it was not the fault of the nurses.

Dr Hughes agreed and advised when investigating the issues surrounding the Cancer Nurse Specialist he thought it was due to geographical but this was not the issue.

Martina Corrigan advised it was a fast process and the review team had to arrange to meet all the families involved. She advised both her and Patricia Kingsnorth liaised to arrange a meeting with Cancer Nurse Specialists.

Dr Hughes advised he needed to get the background of the cases before meeting with the Cancer Nurse Specialists. He apologised for the confusion and offered to chat more at the meeting arranged for Monday.

Jenny McMahon CNS said their role was central and provides a failsafe process that is benchmarked with other Trusts. She asked if other Trusts have the same issues as the Southern Trust.

Dr Hughes understands nurses meet patients with consultants or contact details are made available. He said one issue highlighted due to COVID was that patients were

going to their GP or ED because they wouldn't know what to do. He advised where he worked Specialist Nurses would refer patients to MDM this would give patients better access to care.

Jenny McMahon didn't think it was unique to one consultant and suggested it was a resource issue.

Dr Hughes said it may be an issue and suggested it needs investigated to see if this is the issue. He said they need to know if there is a deficit, adding if the Trust is saying best care for everybody they need to have the resources available.

Dr Hughes asked if they would like him to come back to update them on the progress. He advised he has no involvement in the independent enquiry.

Patricia Kingsnorth advised there was no criticism of Cancer Nurse Specialists; it highlights how important their role is.

Mr Glackin believes it is criticism of other consultants.

Patricia Kingsnorth said it's not criticism just an acknowledgment of urology being under resourced.

Dr Hughes advised he was writing the report based in evidence and the only criticism of the Clinical Lead and Associate Medical Director was not being aware. He added 8 of the 9 recommendations by MDM were fine, but added these recommendations were not actioned. Another issue was patients not being referred back to MDM. He doesn't know if MDM were aware.

Martina Corrigan asked Dr Hughes to clarify was the AD and AMD for CCS.

Dr Hughes confirmed it was for CCS. He said there was an issue, CCS didn't seem to know.

Mr Young said he recalled MrO'B appearing very keen to have Nurse Specialists and was very vocal.

Dr Hughes said MrO'B was chair of the group and was aware of the rationale behind the need for Nurse Specialist. He said there was a clear role for these nurses. He said he needed to clarify if the Nurse Specialist were available or if it was a decision to leave them out, adding patients should have been given a phone number.

Mr Glackin asked from the discussions has anything become apparent from the 9 cases.

Dr Hughes said he was reluctant to add anything into the report that is hearsay.

Mr Glackin clarified the question, is there any need for immediate action.

Dr Hughes said there was a need for enhanced tracking, more oncology input with assurance audits. These need to be put in place. He said if staff feels there is anything else needs to be put in place to let him know, he said the public need to have confidence. The review team need to be able to go back to families and show them it's not the way it was. He highlighted the need for resources. He said there is a need

to sort team resources. He apologised the Cancer Nurse Specialist and advised he was happy to share the comments about the Nurse Specialists.

Mr Shawgi Omer advised he was new to the team from July. He advised he was glad it was made very clear the central role of the Nurse Specialist and they were not criticised in any way. He hoped it was very clear the quality and quantity of the work was magnificent which relieved any anxiety he had at joining a new team.

Dr Hughes acknowledged it was a good point made and advised he would take it on board in the report.

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Southern Health and Social Care Trust

**Acute Governance**
**Cancer Nurse Specialists**
**22 February 2021 @ 11am**
**Zoom**

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**PRESENT:** **Dr Hughes (Chair)**
**Patricia Kingsnorth Acute Clinical Governance Co-Ordinator**
**Roisin Farrell, Governance Officer**
**Patricia Thompson**
**Martina Corrigan**
**Kate O'Neill**
**Leanne McCourt**
**Jenny McMahon**
**Jason**

Patricia Kingsnorth thanked all for attending, she explained she tried to arrange the meeting in January but it had to be cancelled due to COVID. She advised the meeting that the CNS care was not brought into question.

Dr Hughes advised he was asked to chair the review. He advised he was previously Medical Director in the NHSCT and Director of NI Cancer Network. He has a pathology background. He explained there was a huge deficit with not having Nurse Specialist's involvement in the patients care.
He gave a background to patients involved in the SAI review.

Patient 1 – Prostate cancer patient. His disease progressed and was not referred back or provided palliative care. The patient has since died. He did not get best care pathway.

Patient 9 – Person at Inform ation year old Biochemical, PSA & potential prostate care. TRP came back negative. Variety of reasons things were missed. He later attended ED with query rectal cancer but was diagnosed with prostate cancer. The disease has progressed.

Patient 5 – Had a large renal cancer, he was treated exemplary. He attended ED no PSA or scan, was missed for 8 months. PSA was over 100 he probable had prostate cancer from start. Never got CNS.
Kate O'Neill believes she had met this man late last summer with Mr Haynes.

Patient 5 – High grade cancer. Should have been referred to oncology, didn't happen. Disease progressed and spread. He wasn't referred back to MDM and no referral to palliative.
Dr Hughes believes issues with lack of onward referrals.

Patient 2 – Very good first time care. He has rheumatoid disease and arthritis. He has been diagnosed with testicular cancer, recommendation referral for treatment, was not referred for treatment and was identified by BHSCT. No CNS assigned.

Patient 6 – elderly with possibility of prostate cancer. MDM suggested active surveillance. No CNS for support. No LRH. Doing reasonably well.

Patient 7 – Renal mass. Multiple consultants involved. No CNS assigned until tissue diagnosis. Did have surgery and doing well. Question is how to support these patients prior to diagnosis. This family are from a Governance background and are very angst.

Dr Hughes advised another family has a legal background.

Jenny McMahon asked if patient should have got laparoscopy surgery.

Dr Hughes advised he was not sure. He believes a pathway should been drawn up. Then locums would be aware. There was no attendance at MDM.

Patient 3 – Penile cancer. He received local treatment, as a rare cancer should have been on regional and super regional pathway. There was a delay of 17 weeks from CT scan to diagnosis. Cancer very progressive and patient has died.

Patient 8 – Had TURP, small chippings. Wasn't referred back to MDM, missed for 8 months, don't feel he has come to any harm. Have issues with TURP and incontinence.

Dr Hughes feels the issues are
8 of 9 recommendations from MDM were perfect but none were put in place.
1 query of penile cancer.

Patient 9 – early diagnosis – Referral
Patient 4 – Referral to oncology
Patient 2 – Oncology – missed
Patient 6 – Oncology
Patient 7 – Super regional network earlier.

All should have had input from Nurse Specialists.

Dr Hughes invited staff to speak.

Kate O'Neill asked if the review was from Jan 2019 to 2020.

Dr Hughes advised one started in 2016.

Kate O'Neill advised during that time staffing team consisted of 2 staff. January 2017 an additional 2 more staff was allocated. At interview job description was changed. Had to re-advertise for staff. This did add to the staff but was a management role.

Leanne McCourt advised she was one of the original clinical sisters. She started in April 2017 and was successful and joined CNS 2019.

Kate O'Neill advised they had established 1 staff clinic and had new clinics Monday to Thursday. She advised at the clinic you might have 1 consultant and 2 reg's with 15 – 21 patient to process along with other work in 3 ½ - 4 hours. There were issues with staffing levels, she advised she would work longer on a Thursday. Kate said if there were 21 patients Monday – Thursday and 6 reviews their first priority was the 21 patients.

Dr Hughes advised these were first review patients. He advised they weren't given phone numbers. He needs to know if MrO'B had an issue working with Nurse Specialists or was it a deficit.

Leanne McCourt doesn't feel he valued the Nurse Specialists. She recalled him asking her in the kitchen what the role of a Nurse Specialists was. He didn't understand the role if a Nurse Specialists.

Dr Hughes advised the Nurse Specialists was signed off in 2016. He advised the reason for Nurse Specialists are for patients. He advised he needs to know if it was a deficit because of work or this particular doctor.

Jenny McMahon said she had a very different experience. She advised she was not sure why MrO'B didn't invite CNS into the room and feels this is a question MrO'B needs to answer. She advised MrO'B spoke very highly of CNS. She recalls MrO'B having review oncology on Friday but she wasn't asked to attend.

Dr Hughes confirmed he had asked MrO'B this question. He asked if it is reasonable to say resources were made available.

Jenny McMahon said yes they would have been made available if support was need on the day but advised nurse specialists were not invited to attend appointments.

Kate O'Neill advised the period during 2019 MrO'B only seen reviews, she asked Martina Corrigan if this was decided.

Martina Corrigan advised no. MrO'B decided to do this himself.

Kate O'Neill advised reviews changed to Tuesdays. She recalled MrO'B contacting her to help with cath etc.

Leanne McCourt agreed MrO'B would approach her to arrange prostate appointments.

Kate O'Neill advised if there was no nurse available other staff was available to assist.

Dr Hughes advised referrals were not made and no numbers given out even though resources were available.

Jenny McMahon felt MrO'B was very supportive of Nurse Specialists.

Dr Hughes advised there are 9 patients in the review and they were not referred to Nurse Specialists and 3 have died. He advised families were not aware of Nurse Specialists. He feels Nurse Specialist should be imbedded.

Jenny McMahon agreed contact details should have been given. She conceded there may not have anyone available on the day but patients should have been given contact details.

Kate O'Neill advised at MDT Nurse Specialists should have been present or available. She advised there was an audit done from March 2019 to March 2020, 88% was given Nurse Specialist contacts.

Dr Hughes asked Kate if she would send the information to him. He advised he wants to be able to say resources were available but patients were not referred. He feels this is a patient's choice whether or not to avail of the support of Nurse Specialists.

Jason advised he worked with MrO'B and his experience was entirely different. He said he may not have been in the room but would have been introduced after but with MrO'B he would not have had as much input. He said MrO'B may have given contact details in the

room he doesn't know. He said MrO'B was supportive in other ways, he made him aware of other patients.

Dr Hughes advised families didn't know this service was available. Patients were unsupported and didn't have an understanding of their care.

Patricia Kingsnorth asked Jason if he followed up on patients results.

Jason said no patients were told to contact if needed.

Dr Hughes asked if they all get the opportunity to attend MDM.

Jenny McMahon advised no she hadn't linked for 1 year.

Dr Hughes asked if they can put patients on for discussion.

All said yes.

Kate O'Neill gave an example of contact from a patient. She was never questioned when she added to MDM.

Dr Hughes suggested they didn't have a seamless pathway.

Kate O'Neill asked if the SAI is to be closed at the end of the wee will be inclusive of MrO'B response.

Dr Hughes advised the draft report is to be completed to see if there is any early learning. He advised draft reports would be sent to the families. He advised families are more interested in how this happened. He added the report will include referrals not made and no contact details made available. He said this can't be done if referrals are not made.

Leanne McCourt advised in the year 19/20 they had 2016 patients. 14 from MrO'B. She advised they may have had a call later and took into process.

Dr Hughes asked staff to share their experiences.

Patricia Kingsnorth asked Leanne to clarify. Were those 14 from MrO'B.

Leanne McCourt advised these may not have been from MrO'B. She agreed to check for Patricia.

Dr Hughes asked if staff had any other questions.

Kate O'Neill advised it would be nice to work in an environment doing one job at a time. Reflected work load.

Dr Hughes acknowledged doctors have a work plan. He asked if they have a job plan.

Kate O'Neill advised it's to do what needs done on the day. If theatres need covered their day would change.

Dr Hughes advised there is no criticism of Nurse Specialists. The issues are with the person not refering patients which is best practice. He advised this review has highlighted the importance of Nurse Specialists. These issues are not of Nurse Specialists doing.

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Kate O'Neill asked if this will be reflected in the report.

Both Dr Hughes and Patricia Kingsnorth said yes.

Jenny McMahon said she feels much better supported now, but back years it took all consultants a while to engage. She added in 2019 all resources were there it is indefensible not to provide contact details.

Dr Hughes advised the report will be written without any criticism of Nurse Specialists but will highlight resource issues.

Jenny McMahon asked if the report could be share with CNS.

Patricia Kingsnorth advised not at this stage it is just shared with staff involved.

Dr Hughes agreed to share the part of the report that refers to Nurse Specialists.

Patricia Kingsnorth suggested Patricia Thompson could share that part of the report.

Dr Hughes read the part referring to CNS from the draft report. He advised he wants to say what happened is against regional guidelines and what the Trust signed up to.

Dr Hughes thanked staff for attending the meeting.