SEC	Complaint	Personal Information redacted by the USI	On 19 January 2017 at 13:15 Personal Information redacted by the USI presented to CAH ED with RUQ Abdominal & Epigastric Pain/vomiting C/O SOB ongoing 1/52 Pallor poor at triage/clammy. ECG done at 13:52 Troponin 105 @13:45. Referred to Surgical team query cholecystitis, query Malignancy. Troponin repeated @ 22:00 122 and ECG repeated at 22:37 Transferred to 4S @ 00:45 on 20/01/17. At approx. 17:21 Persona l appeared to have seizure. Loss of consciousness- arrest team called. Persona l did not respond to resuscitation efforts. Most likely cause of death- massive cardiac event. Coroner contacted on Saturday 21/01/17- patient for post mortem. Clinical summary sent	11/09/2018- Meeting took place. Questions answered. Report to be amended. Notes of meeting to be approved. 25/09/2018- as above
SEC Radiology	SAI	Personal Information redacted by the USI	Missed diagnosis of Gallbladder CA	11/09/2018- Report was presented at ACG 7/9/18. AMD's/AD's suggest an Additional recommendation. Recommendation 2 The SHSCT should ensure that the WHO check list includes a question regarding all relevant results being signed off . Email to Mr Gudyma and Dr I Yousif for approval. 18/09/2018. Trudy Reid contacted Personal Information to discuss his requirements of SAI. 25/09/2018- Amendments made to report and sent back to Mr Gudyma and Dr I Yousif for approval 12/11/2018- Email on 22/10/18 to Dr Gudyma to check if he had a chance to share this report for factual accuracy with the staff involved. Mr Gudyma will discuss at Patient Safety meeting 16/11/18. 13/11/2018 Email to Mr Gudyma as a reminder report need to be shared with those involved.
SEC Paeds	SAI	Personal Information redacted by the USI	Child with fractured tibia admitted to Paeds ward (3N) against Trust policy for observation. Child given Oramorph overnight. T&O team not contacted. Child given breakfast against T&O admission policy. Child found to have compartment syndrome on ward round the following morning	11/09/2018- Meeting 12/09/2018 to finalise report 25/09/2018- Report in draft 09/10/2018- Report finalised and for Acute Governance Meeting this Friday. 22 10 2018 emailed Belfast for rep, reconsider recommendations following meeting and presentation to Acute Clinical Goverance Email to Dr V Roberts to advise re outcome of ACG meeting. 13/11/2018 reminder email to BHSCT for nomination for review team
SEC	SAI	Personal Information redacted by the USI	Person al was admitted with possible bowel obstruction on 30 April 2017, investigations included CT scan, IV access failed on route to the CT scanner. Person al aspirated in the CT scanner and developed respiratory failure, requiring intubation and ventilation. Person al had a subtotal colectomy and ileostomy, she was transferred to ICU post operatively but despite maximal treatment she continued to deteriorate and died on the Personal information redacted by USI Cause of death a) Multi-organ failure b) Small bowel obstruction. Datix reflected CT scan without IV access, NG tube or fluid resuscitation	11/09/2018- report approved by review team. 18/09/2018- Report to be finalised before sending to family 25/09/2018- Report being amended 22.10.18 To Mr Gilpin for sharing with the staff involved before I circulate to the family, HSCB and the coroner. I always like to ensure those in the SAI have had a chance to review prior to wider circulation. This was passed via acute clinical governance. 30/10/2018- Report out for sharing, still some team members to review. 13/11/2018 Checking re factural accuracy reminders sent. (W Clayton and Dr Gilpin, Dr Campbell)
SEC	SAI Urology	Patient 13 Patient 16 Patient 12 Patient 14 Patient 11	Delay in diagnosis and treatment of prostate cancer - Review commenced	14/3/18 – Not discussed Acknowledgement letter sent. 25/09/2018- Report sent to Julian Johnston (Chair) for approval.
SEC	SAI	Patient 15 Urology	GP routine referral to Urology 30/08/2015. Raised PSA. Seen bty Urology 8/2/2016. Appears a 6 month delay in diagnosis. Referral wasn't upgraded through triage process.	K R to – double check falls in urology SAI – Dr Wright and Dr Johnston have agreed to it can be included in original SAI 14/3/18 – Added to Urology Time Line Acknowledgement letter not sent yet. HSCB Notification to be completed. 25/09/2018- Report sent to Julian Johnston (Chair) for approval.

SEC ED	SAI	Personal Information redacted by the USI PEG tube	PEG tube insertion - perforation	11/09/2018- Report being final 25/09/218- Amendments of report with Dr R Thompson. Mr Gilpin feels case should be presented to the Coroner 01/10/2018 Report to be amended as per Mr Thompson 22 10 2018 Update sent to Dr Thompson 6.11.18 Trudy emailed Mr Thompson with report for final approval 13/11/2018 Approved by Mr Thompson. Trudy to discuss at screening re Coroner.
SEC ED	SAI	Personal Information redacted by the USI PEG tube	PEG tube insertion - perforation	11/09/2018- Report being finalised 25/09/2018- report finalised and being prepared for sending to HSCB. Mr Gilpin feels case should be presented to the Coroner. 01/09/2018 Report finalised
ED/Anaest	SAI	Personal Information redacted by the USI	Patient transferred to theatre from resus for insertion of lines and stabilization prior to transfer to ICU. Patient arrested and time of death was called at 05:21 Patient had a DNR in place. Personal Informatio attended Craigavon Area Hospital (CAH) Emergency Department (ED) on 19th February 2018 with chest pain, low oxygen saturations, shortness of breath and pyrexia. Personal Informatio had a cardiac history. Initial ECG was unremarkable; however repeat ECG showed ST elevation, at 23:06. Personal Informati condition deteriorated at approximately 02:15 Personal Informatio had a cardiac arrest, Cardiopulmonary Resuscitation was commenced, and Personal Informatio intubated and transferred to theatres for stabilisation. Do Not Attempt Cardiopulmonary Resuscitation was decided, Personal Informatio had a further period of cardiac arrest and died at 0Personal informati.	31.7.18 Report with Dr Moore 21/08/2018 Email Dr Moore re finalising report- on leave until 28 August 11/09/2018 18/09/2018- Meeting with Dr Moore. Letters to be sent to the 2 doctors to invite to a meeting. 24/10/2018 email to Dr Moore 30/10/2018- reminder to Dr Moore- On leave until 5/11/18 12/11/2018 Meeting to be arranged with Dr Moore. Names of doctors received and contact details being sought as they no longer work in SHSCT.
SEC ATICs	SAI	Patient 90 [redacted]	Patient admitted to ICU in extremis. Unexpected death after elective surgery. Preadmitted 03/05/2018 for 09/05/2018 care of Mr A O'Brien Urology. Patient transferred to ICU CAH and died. Post Mortem to be carried out. Case with Litigation.	31.7.18 Report being drafted 11/09/2018- as above 5.11.18 Report being drafted
SEC ATICs	SAI	Personal Information redacted by the USI [redacted]	Personal Information redacted by the USI who attended theatre in DHH for insertion of PEG tube on 15/05/2018. There are no traceability print outs for the scope and the scope used was potentially dirty. Possibly used on previous patient who had a flexible sigmoidoscopy? It was cleaned and rinsed with water but no detoxified.	31.7.18 With Dr Brown for final approval 21/08/2018 Further request to Dr Brown for approval 11/09/2018- email to Dr Brown 07/09/2018 for approval 25/09/2018- Further amendments to report sent to review team. 5.11.18 - For rediscussion
SEC ATICs	Internal	Patient 91 [redacted]	Patient admitted for ureterostomy on 18/05/18. Pyrexic and hypotensive following procedure. Transferred to ICU due to escalating inotropic support. Myocardial infarction. Despite aggressive intensive care management, patient's condition continued to deteriorate and death was confirmed on Personal information	31.7.18 Mr Carroll & Dr Scullion agree internal review. Meeting on 21.8.18- Initial meeting held. Report to be drafted 11/09/2018- report to be drafted 25/09/2018- 5.11.18 Report to be drafted
SEC	SAI	Personal Information redacted by the USI	Perso nal was admitted via ED on 6/11/2017 to the Trauma Ward at CAH following a fall at home. Perso nal was diagnosed with a fracture to her left neck of femur. Person al had a number of Co-morbidities which included COPD, Congestive cardiac failure, aortic stenosis, left bundle branch block, hypothyroidism and chronic kidney disease stage 4. Perso nal acutely deteriorated at 05:30hrs on 08/11/2017 with a reduced level of consciousness low blood pressure and had acute kidney injury. She was felt to be opioid toxic and was given reversal 3 times with naloxone which made some improvement. Perso nal was transferred to theatre for intubation and transfer to ICU. Person al died Personal information redacted by USI at 00:50hrs.	2.8.18 – Notification approved by R Carroll 21/08/2018 Meeting scheduled for 29th August. 11/09/2018- Report to be drafted 5.11.18 - Report being finalised

SEC	SAI	Personal Information redacted by the USI	Admitted perforated diverticular disease and small bowel obstruction. Delay to surgery needs reviewed and discussion. Subsequently never recovered and died. I believe there is a coroners inquest. Requesting urgent case review meeting and SAI will need to take place Died - 27/05/2018	Notes requested (with Litigation) 3.7.18 Timeline to be complete and notification to be completed. 13/07/018 – Discussed at screening Mr McKay to be contacted to review what the exact issue is- email sent to Mr McKay 17/07/2018 Reviewed by Mr McKay delay in getting to theatre in 1st 24 to 72 hours email to Mr Carroll & Mr Haynes 30.7.18 – Discuss with Ronan - Delay to surgery needs reviewed and discussion. Damian has confirmed our thoughts that the patient should have had early surgical intervention based on his original CT scan or review and surgery with 72 hours as per the NASBO report with recommendations are attached. There were also issues with the level of staff review etc. 31.7.18 Mr Carroll & Dr Scullion asked for incident to be referred to Surgical M&M, Paula to follow up 31.7.18 Paula referred incident to Dr Thompson for Surgical M&M 14.8.18 Confirm if SAI and if so nominations of review team 21/08/2018 Reviewed by Mr Haynes- SAI to be completed – Mr McIlvenna to chair. 11/09/2018- Timeline completed. Need review team for meeting. 26/09/2018- Email to screening team for nomination 09/10/2018- Discussed with Mr Carroll who suggested Mr MrArdle DHH for review team. Email to Mr Haynes to confirm he is in agreement. 23/10/2018 Meeting to be scheduled. 5.11.18 Meeting confirmed for 8.11.18 @ 9am 12/11/2018 Mr McArdle and Mr McElvanna to interview medical staff and further meeting to be scheduled in 3 weeks.
SEC	SAI	Personal Information redacted by the USI	Delay in investigation / management of a red flag cancer patient. For SAI. Protocols review	21/08/2018 Reviewed by Mr Haynes- SAI to be completed – Mr Epanomeritakis to chair. 11/09/2018- Need review team to arrange meeting 26/09/2018- Email to screening team for nomination. 09/10/2018- Discussed with Mr Carroll who suggested Mr M Yousaf for review team. Email to Mr Haynes to confirm he is in agreement. 23/10/2018 Meeting to be scheduled after timeline is done. 5.11.18 Sharon Glenny completing timeline

SEC	M&M	Personal Information redacted by the USI [redacted]	Clozpine levels and bowel obstruction Patient died from multiple organ failure on ICU on the Personal information as a result of chronic constipation and acute-on-chronic renal failure. The chronic constipation was contributed to by long-standing clozapine use, prescribed for schizophrenia. This is a known side effect and the patient had had previous hospital admissions with same. While still a patient on the medical ward (admitted with recurrent falls), clozapine levels were taken on the 23rd May following a review by psychiatry. As clozapine is a named medication, prescribed only by psychiatry, levels are monitored commercially by a lab in England and results communicated (as I understand it) directly to psychiatry. Following a second psychiatry review on 1/6, these levels were noted to be high indicating a possible 'clozapine toxicity'. Said levels were not communicated to medicine or ICU. We currently have no method of obtaining these ourselves – and I've checked with Richard, the ICU pharmacist and he is unaware of a current mechanism by which we can do this. I don't know if they were ever phoned through to psychiatry or whether checking the results requires contact to the company. Not knowing the clozapine levels did not affect this patient's care - clozapine continued to be with-held on ICU. There is no specific therapy for clozapine toxicity. Clozapine toxicity did not cause death.	Email from Jilly Clozapine has been associated with varying degrees of impairment of intestinal peristalsis, ranging from constipation to intestinal obstruction, faecal impaction and paralytic ileus. On rare occasions these cases have been fatal. Particular care is necessary in patients who are receiving concomitant medications known to cause constipation (especially those with anticholinergic properties such as some antipsychotics, antidepressants and antiparkinsonian treatments), have a history of colonic disease or a history of lower abdominal surgery as these may exacerbate the situation. It is vital that constipation is recognised and actively treated. Should this incident be screened as a SAI to determine if all appropriate action had been taken regarding the risk of constipation and gastrointestinal obstruction both with patient prior to attendance and with management while in hospital. Should it be shared with MHD? 26/06/2018 reviewed with Mr Carroll and Dr Scullion NOT SAI from and anaesthetics perspective- has been forwarded to MHD for review 3.7.18 Timeline to be completed 17/08/2018 Discussed 13/07/2018 SEC screening, suggested surgeon reviews. Mr McKay is reviewing and will discuss radiology finding with Radiology and respond with outcome 24/07/2018- awaiting feedback from Mr McKay, Mr Carroll updated re Mr McKays discussion and possible radiology findings 31.7.18 Email to Dr McKay on 27.7.18 request to review CT result. 21/08/2018. CT reviewed and medical notes left with Mr McKay today 11/09/2018- 25/09/2018- Dr D McKay has referred to Surgical M&M. 23/10/2018 Discussed at screening. For referral to Medical M&M. ? Round table discussion between Mental Health and Surgeons.
SEC	Internal	Personal Information redacted by the USI [redacted]	Complaint letter from patient and husband regarding her diagnosis, treatment and care. Patient treated for colitis subsequently had subtotal colectomy 14.5.18. (27.4.18 – 16.5.18)	26/06/2018 reviewed with Mr Carroll and Dr Scullion Probably not SAI as being taken through medical director process- email to be sent 26/6/2018 01/08/2018- Dr Murphy advises SEC to approve acknowledgement. Timeline to commence from 1st admission. 6.8.18 Acknowledgment approved by RC – Approved. 7.8.18 – Meeting confirmed for 3.9.18 10/09/2018- 2nd meeting being organised 11/09/2018- timeline complete. Internal review. Report to be drafted. 18/09/2018- Meeting with Dr Bhatt and Governance Team 19/09/2018. 25/09/2018- report to be drafted 5.11.18 report being drafted

SEC ED	Internal	Personal Information redacted by the USI	Personal Information redacted by the USI admitted to ED with catastrophic intracerebral bleed. GCS 3 on presentation. Anaesthetic SHO known to be on transfer so ED kindly intubated patient and transferred for scan. Once bleed confirmed, ICU contacted. ICU SHO (non airway competent attended) and contacted ICU consultant (myself). Patient accepted for ICU care but no beds in hospital so instructions given to search for regional bed and to arrange NICCATS transfer. ICU SHO remained with patient to provide care. Anaesthetic team - registrar, SHO, consultant failed to attend ED for five hours to care for ventilated patient despite knowing presence of patient in department and aware they were ventilated. No anaesthetic nurse involvement despite request from ED. Patient not transferred to theatres for ongoing care. Patient remained in ED (on portable ventilator) under care of ED/ICU SHO. Full monitoring according to AAGBI standards of a ventilated patient did not occur - potential harm with regard to cerebral perfusion in a head injured patient. Non-airway competent trainee left unsupervised. Patient was unprepared for transfer when NICCATS team arrived. Substantial additional burden placed on ED nursing and medical staff.	24/07/2018- screening Discussed with Mr Carrol and Dr Scullion, the patient outcome was likely not compromised; however there appear to initially be some internal process issues. Round table internal SEA to be arranged for next week. Time line re patient clinical documentation to be started, Dr Scullion and Dr Hampton to interview or get statements from medical staff in preparation for the meeting. 30.7.18 Meeting arranged for 31.7.18 with Dr Hampton & Dr Scullion. 31.7.18 Mr Carroll updated re meeting earlier today 31.7.18 - Agreed internal SEA at present. Has been discussed at ED M&M. For discussion at ICU M&M in September. Meeting of MDT to take place. To include ED, ICU Anaesthetics, Nursing, Bed management and medical team. 7.8.18 – Meeting took place on 31.7.18 7.8.18 - Mary Burke Advised at ED screening on 6.8.18 – No need for meeting she will discuss directly with Patient flow team. Presented at ED M&M on 25.7.18 for discussion and learning shared. Discussed at ED Screening on 1.8.18 - Mary Burke to advise head of patient flow that anaesthetic nurse is on call. Close from ED perspective. 21/08/2018- For discussion at ICU M&M in September 11/09/2018- Dr Scullion advises ICU M&M meeting will be 20/09/18 25/09/2018- Update from Dr Scullion- Further discussions to take place within Anaesthetic team. 09/10/2018- Dr Scullion advises a meeting is scheduled 15/10/18 to discuss the case. 23/10/2018 SAI. Meetings to be arranged. Dr G Hampton, Nidhi Gupta and Dr Tariq to be asked to chair. Email sent to Dr Tariq 24/10/18. 13/11/2108 Dates circulated for meeting
SEC MUSC	SAI	Personal Information redacted by the USI	Datix re missed bowel tumour	11/09/2018- Meeting scheduled 17/09/2018 with Mr S Bhatt and Mr K McElvanna 18/09/2018- Meeting held yesterday. Dr Bhatt to speak with Dr S Murphy and Dr C Hillemand. Dr McElvanna to speak with Mr G McArdle 09/10/2018- Meeting scheduled with Mr Bhatt and Dr Hillemand.Dr McElvanna has met Dr McArdle. 30/10/2018- Report in draft
SEC		Personal Information redacted by the USI	Patient Personal had ERCP in January 2016 for CBD stones but they could not be removed, a stent was inserted and he was referred for surgery. Lap chole and CBD exploration was performed in April 2016. Over past two months he has had 3 admissions with severe sepsis due to cholangitis. MRCP showed large stones in CBD. Personal attended for ERCP to clear these stones and at the time of the procedure it was noted he still had a stent in his CBD. This was why he developed the recurrent stones and episodes of cholangitis. It should have been taken out at the time of surgery in 2016.	23/10/2018- Timeline in progress. Medical notes received. 30/10/2018 - Timeline completed. For screening.
SEC/Urology		Patient 138	Patient had TURBT 22/12/17 was listed for MDM 28.12.17 (virtual MDM) patient was closed on cancer tracker system and not followed up until GP phoned to enquire 25/10/18. Histology report 28/12/17 showed Transitional cell carcinoma.	For screening. Red Flag team investigating for timeline

SEC	Interface	Personal Information redacted by the USI	Personal Information redacted by the USI attended the glaucoma service at the Wellbeing and Treatment Centre on 4 October 2018 and was seen at an additional clinic that had been set up to see long waiting new glaucoma referrals from the Southern Trust. At the appointment the patient stated that his vision had rediced in the left eye over the past year, vision was recorded as 6/48 on the Snellen Chart in the left eye. His left optic nerve showed early cupping with an early visual field defect. The patient was diagnosed with advanced glaucoma in the left eye and early glaucoma in the right eye. Personal Information redacted by the USI [redacted] The patient had been referred to ophthalmology outpatients in the Southern Trust in March 2017 by his community optometrist who queried glaucoma in his left eye. The referral letter stated that he had been previously referred in April 2015 but he had not been provided with an appointment. The delay in this patient being seen and treated has impacted on his overall outcome.	6.11.18 Email from Ronan Carroll "We need to follow our processes ie screen and a determination made as to the level of investigation required".

O&G Radiology Labs Screening

Department	Type	Name and H&C	Background	Screening update
Radiology	SAI	Personal Information redacted by the USI [redacted]	Patient seen in ED following RTC and CT carried out. CT report stated fractures of cervical spine but omitted to report multiple rib fractures and flail segment of chest. Patient referred to and transferred to RVH fracture clinic for admission. Patient later returned to CAH ED with no communication from RVH to advise of this. Multiple fractures only picked up on return from RVH as nursing staff were concerned regarding patient condition and asked ED consultant to review. As a result there was a significant delay in the appropriate management of this lady. Patient assessed by anaesthetics and transferred to theatre.	Timeline to be done. For screening 9/5/18- discharged home –discussed at ED screening - for screening by RADIOLOGY 07/06/2018 Flail chest is a clinical diagnosis not just radiological. The report was amended by outsourced company. The radiology report was incorrect and the medical director of the out sourced company has been informed. The clinical picture of significant bruising was not highlighted. When the patient returned to CAH further examination identified bruising and radiology were contacted and the report reviewed an amended. The radiology report was then amended. The patient outcome was not affected by the radiology discrepancy. Recommendation is that the case to be reviewed by Emergency Department again 11.10.18 Email from HSCB *I refer to the attached Interface Incident reported by the Southern Trust. This incident was recently discussed by the Acute SAI Review Team where it was agreed this should be reported as a SAI by Southern Trust, who will take the lead, with input from Belfast Trust. We would therefore expect to receive this by 24 October 2018.* Sent to Trudy to action
MUSC Radiology		Personal Information	Patient presented with headache and neck pain. Seen by neurology team who advised MRA. Attended for MR Angio at 1505 on 07/08/18. Noted at time of scan to be abnormal however medical staff told in MR that no one on to report scans that afternoon. Consultant escalated MRA report to be outsourced through bed management for report as if normal patient potentially for discharge. Informed turn around time would be 4hours. 25minutes post MRA patient developed left sided facial droop, slurred speech and left sided weakness. Thrombolysis call initiated and stroke team arrived. Felt not for lysis however concern about possible dissection. No consultant radiologist onsite available/ able to report MRA which was needed to guide management of patient. Stroke consultant present on ward. Significant effort expended by junior medical team seeking to obtain report of MRA. Consultant re-contacted bed management to escalate outsourced report. Ability to do this not widely known by junior staff and no available published protocols regarding its usage in or out of hours. Patient dropped GCS, anaesethetic team called and patient required intubation. MRA report back from Nighthawk showed multifocal ischaemic areas, lack of visualization of both vertebral arteries inc basilar artery. ?dissection ?thrombosis. Report time stamped 1650 however not visually available on PACS until 1730. Patient discussed with RVH Stroke and ICU, intubated and ventilated and transferred for out of hours clot retrieval. Significant difficulty in getting report of neuroimaging in emergency. No established protocols for accessing urgent or emergency report of otherwise unreported neuroimaging if necessary- would likely have been even greater issue if this had occurred during night shift.	Close from MUSC perspective – escalated to Radiology – (patient well) feedback requested to MUSC 19/09/2018- In review 24/09/2018- Dr McCaffrey advises she spoke with Dr Paul McGarry. Discussed at screening. Get formal feedback from Dr I Yousif. 01/10/2018- email to Radiology re review and ward re patient details

MUSC/Gynae		Personal Information	an you advise me if this lady's death was discussed at a gynae M+M given that she first presented to gynae and had problems identified on a CT scan that were not acted on and then referred to GI in Nov 17 but not seen by them either until admitted in Jan 18 terminal malignancy – so that I know whether she should be put down for discussion elsewhere. Was it recorded as an SAI?	Happy this lady is discussed at M+M but agree with David that the main learning will be through the radiology discrepancy process as the root cause problem was the initial CT report. She was referred to GI by gynae for management of her cirrhosis and ascites with a comment 'CT has shown no evidence of GI malignancy'. We get significant numbers of patients who are referred to initially to gynae with ascites who turn out to have cirrhosis. Patients with cirrhosis lose weight. The tumour markers inpatients with ascites can be elevated. She would have been urgent, not RF 5.11.18 Waiting on Radiology M&M
AHP		Personal Information redacted by the USI	Sight loss	Report in draft - Emailed Belfast re Dr George meeting to be arranged with Grandfather.
ATICS		Personal Information redacted by the USI	30/09/2018 Personal Information redacted by the USI was an acutely unwell child who presented to ED DHH. Anaesthetist was Fast bleeped on 4 occasions. Delay in reply and arrival to Resus for at least 40 minutes.	24/10/2018 Discussed at ED screening. For referral to Anaesthetics. Datix sent to Mr R Carroll and Dr D Scullion
Cancer team		Personal Information redacted by the USI	Staff member of Red Flag team emailed me, attaching the OC referral that had been upgraded at triage and advised that this was a late upgrade. I opened referral (06.11.18 due to annual leave) and could see that it was a referral from Respiratory to Gastroenterology. The date dictated on referral was 06.09.18. Date Typed was 22.10.18. The referral was date stamped with 30.10.18 - Date received in RBC. It appears that referral was triaged on 31.10.18 and was marked as RF. This referral was then received into the Red Flag booking office on 02.11.18. Appointment was booked on 02.11.18 for 06.11.18. (61 Day wait from date of registration on PAS) The delay on this occasion appears to be with the typing of clinic.	
ATICS	NIPCAS	Personal Information redacted by the USI	So far we have identified about 200 exams that need an official report - until these have been reported we will not know if any harm has come to the patients	For screening.

Update on M&M						
Patient name	Hospital number/HCN	Datix number	Date of incident	Division	Date to M&M	UPDATE
Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Information	3.4.15	SEC		HSCB was notified of incident. To be presented at M&M Surgical Specialty specific M&M May 2017
Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Information	22.6.16	MUC		Presented to ED M&M on 31.8.16
	Personal Information redacted by the USI	Personal informatio Complaint	19.1.17	MUC		4.9.18 Meeting held with sister and PCC.
Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Information	21/12/2016	MUC		
Personal Information redacted by the USI	Personal Information redacted by the USI					No record to date case has been discussed at M&M
Personal Information redacted by the USI	Personal Information redacted by the USI		7.1.17	MUC	Feb 17 Cardiology M&M	There were areas of concern which may have contributed to this patients death SOM 4 – Just recently signed off by Dr McNeilly on IMMIX following receipt of Cardiology Sub-Speciality M&M minutes
Personal Information redacted by the USI	Personal Information redacted by the USI			MUC		This has been recorded as SOM 4 on IMMIX but is awaiting sign-off by ICU who completed IMMIX
Personal Information redacted by the USI	Personal Information redacted by the USI		6.4.17	MUC		Patient presented to ED DHH on 6/04/2017 with spontaneous pneumothorax – a Right sided chest tube in situ introduced via seventh intercostal space in anterior axillary line. From the insertion site the tube is directed cranially mildly compressing the base of the right lower lobe and impinging on the diaphragm. Personal was admitted to hospital and discharged on the 10/04/2017 with a referral to thoracic surgery given that he had 2 spontaneous pneumothoraces on the same side
Personal Information redacted by the USI	Personal Information redacted by the USI					Discussion Case was screened for SAI however was considered not an SAI. Case IRI. If there is uncertainty around reversing Warfarin then discuss with Haematology or senior colleagues. Octaplex was available however was not refilled from previous use. It is essential that this is restocked as soon as possible after use. Training and availability issues with the Point Of Care INR machine in Daisy Hill were raised. Point Of Care INR is a useful tool to have. This should be available to the Emergency Department on a 24 hour basis. Actions Point of care INR machine to be kept in the Emergency Department. When Octaplex has been used then this should be restocked. If there is uncertainty around reversing Warfarin then discuss with Haematology or senior colleagues. ACTIONS Mary to put on ED Newsletter emails sent last on 22 10 2018
Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Information	8.6.18	CCS		28/06/2018-timeline complete. Response from Radiology "I was on the Saturday and ran all requests via Aaron who said confusion shouldn't be scanned at per guidelines. Ward never contacted me or him about it and covering Drs never mentioned – I always ask anything else for me! Not sure why wasn't scanned Sunday or the Friday" 01/08/2018- Screened. For Medical M&M to review examination process/System. Email sent to Connie Connolly. Wait outcome from Medical M&M. 6.8.18 Paula to Email Dr J Hardy re DHH M&M- email sent 7/08/18 03/09/2018 – Awaiting feedback –Dr Harty on leave until 10/9/18 10/09/2018- reminder email sent to Dr Harty 12/09/2018- Dr Harty advises "We have not presented this case at the m+m. My feeling is that this will lead to a blame culture around named junior and senior doctors. It will be discussed within the department and with our radiology colleagues"
Personal Information redacted by the USI	Personal Information redacted by the USI					SAH discuss at surgical M&M re anticoagulation

Personal Information redacted by the USI	Personal Information redacted by the USI			MUC		Kay to review as per AmcV 2/7/2018- Reminder to Kay Carroll- Medical notes requested (notes received) 23/07/2018- Email reminder to Kay Carroll 01/08/2018- wait update 03/09/2018 email reminder to Kay 12/09/2018- Medical notes receivedOut of hospital arrest – Coroners case- M&M (ICU). This Personal Information redacted by the USI was brought to hospital following a PEA cardiac arrest at home. Her family commenced bystander CPR and ROSC was achieved after 35 minutes with NIAS. This cardiac arrest occurred on the same day she was discharged from Craigavon Area Hospital where she had been an inpatient for 4 days receiving treatment for a Lower Respiratory Tract Infection, Acute kidney injury and electrolyte derangement. During this admission she had been on oxygen via nasal cannula- 3L SaO2 95% until the morning of her discharge. Her clinical observations as per the Nursing notes were SaO2 96% on room air immediately prior to discharge.
Personal Information redacted by the USI	Personal Information redacted by the USI			ED		Presented to ED with PV bleeding, pt had scheduled gynae appointment. Not checked in ED for PV loss. Large bleed. Etopic pregnancy.
Personal Information redacted by the USI	Personal Information redacted by the USI			ED		29/07/2018 - Pt attended ED after falling down flight of stairs, on initial assessment multiple spinal #S missed. Not picked up until reviewed by medical team in ED and CT 11 hrs later.
Personal Information redacted by the USI	Personal Information redacted by the USI	M&M referral		MUSC SEC		MUSC M&M SOM 1 SEC M&M waiting response from Mr Thompson
Personal Information redacted by the USI	Personal Information redacted by the USI			MUSC SEC		Presented to Surgical PSM 17/5/2017 outcome 2 recorded. Presented to ED PSM 25/1/2017 outcome 3. contained aspects that SHOULD² be improved (learning identified); the patient's eventual outcome was NOT affected i.e. Near Miss. Consider referring to Trust Incident Reporting System unless already considered or reported.
Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Information	4.6.18	MUSC SEC MHD		26/06/2018 – Discussed with Mr Carroll and Dr Scullion – no SEC/ATICS issues referred to MHD 27/06/2018 Discussed with Dr Murphy and Dr Hampton – no ED issues referred to MHD 17/08/2018 Discussed 13/07/2018 SEC screening, suggested surgeon reviews. Mr McKay is reviewing and will discuss radiology finding with Radiology and respond with outcome 24/07/2018- awaiting feedback from Mr McKay, Mr Carroll updated re Mr McKays discussion and possible radiology findings 31.7.18 Email to Dr McKay on 27.7.18 request to review CT result. 21/08/2018 Mr McKay reviewing notes 03/09/2018 Mr McKay has reviewed chart- to go to Surgical M&M – screening meeting updated
Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Information	8.7.19	MUSC SEC ICU		9.10.18 This case has been presented and discussed at the Anaesthetic Patient Safety Meeting on the 20/9/2018. Minutes with lessons learnt will be added when available. As pewr Laurie Martin ICU Has been discussed at ED M&M. For discussion at ICU M&M in September. Meeting of MDT to take place. To include ED, ICU Anaesthetics, Nursing, Bed management and medical team. 7.8.18 – Meeting took place on 31.7.18 7.8.18 - Mary Burke Advised at ED screening on 6.8.18 – No need for meeting she will discuss directly with Patient flow team. Presented at ED M&M on 25.7.18 for discussion and learning shared. Discussed at ED Screening on 1.8.18 - Mary Burke to advise head of patient flow that anaesthetic nurse is on call. Close from ED perspective. 21/08/2018- For discussion at ICU M&M in September 11/09/2018- Dr Scullion advises ICU M&M meeting will be 20/09/18

Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Information	31.12.17	MUC		30.07.18 Meeting to be arranged with family, Dr Hampton attending need name of medical Dr to attend. 1/08/2018- Dr Murphy to confirm his nomination for meeting. ? need for ED rep.6.8.18 – Dr P Murphy agreed to meet with family & Trudy. Dr Murphy said no need for ED rep. 03/09/2018 Meeting to be organised 21/05/2018- email to litigation re PM report 2/05/2018 – Awaiting approval of report 6/4/18 – Report drafted by T Reid and share with MUSC 24.1.18 ED M&M findings sent to Dr Moan for review 10.1.18 Letter from family. For presentation at ED M&M.
Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Information	2.10.18	MUC		Discussion at ED screening, it was requested that this incident is discussed at ED M&M Fall New Neurological deficit. Pt attended ED DHH head injury alcohol on board. CT head and neck NAD. Patient transferred to ward before surgical clerk in. CT spine ordered showed fracture T9 T10 T11
Personal Information redacted by the USI	Personal Information redacted by the USI			SEC		M&M referral DC conversions at ward level 18/12/2017 - DC conversion at ward level. Review -29/01/2018 – Discussed incident – also M&M findings – which state Complex co-morbidity – RCA undertaken – no change in outcome – SOM 1 was satisfactory. There were no particular Learning Lessons. Does not meet the criteria for SAI. 07/02/2018 - Review again following M&M M&M Issues: □ Interface between specialities □ DC cardioversion was carried out despite advice of medical SpR and Cardiology consultant against. □ Not appropriate to ask Junior Doctors to leave the wards to complete DC cardioversion □ Action: Forward to Surgical/ICU M&M with feedback to Medical M&M 30/04/2018 –being discussed at M&M – await formal sign off 18/06/2018- Close. (Keep on SEC) 31.7.18 – Wait formal signoff of surgical M&M. 21/08/2018-wait response from Dr Thompson re Surgical M&M 11/09/2018-as above 25/09/2018- No Surgical M&M report available
Personal Information redacted by the USI	Personal Information redacted by the USI			ED		09/02/2018 – Notes reviewed by Dr Hampton and Dr Murphy (no time line) no obvious lapse in care – surgery to review 12/04/2018 provisional M&M on ICU - ECR SOM1 was satisfactory there were no particular learning lesions .21/08/2018- as before. PM report sent to Dr R Thompson Mr Haynes aware 11/09/2018- wait surgical M&M 25/09/2018 No surgical M&M report available

Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Information		SEC		Email from Jilly Clozapine has been associated with varying degrees of impairment of intestinal peristalsis, ranging from constipation to intestinal obstruction, faecal impaction and paralytic ileus. On rare occasions these cases have been fatal. Particular care is necessary in patients who are receiving concomitant medications known to cause constipation (especially those with anticholinergic properties such as some antipsychotics, antidepressants and antiparkinsonian treatments), have a history of colonic disease or a history of lower abdominal surgery as these may exacerbate the situation. It is vital that constipation is recognised and actively treated. Should this incident be screened as a SAI to determine if all appropriate action had been taken regarding the risk of constipation and gastrointestinal obstruction both with patient prior to attendance and with management while in hospital. Should it be shared with MHD? 26/06/2018 reviewed with Mr Carroll and Dr Scullion NOT SAI from and anaesthetics perspective- has been forwarded to MHD for review 3.7.18 Timeline to be completed 17/08/2018 Discussed 13/07/2018 SEC screening, suggested surgeon reviews. Mr McKay is reviewing and will discuss radiology finding with Radiology and respond with outcome 24/07/2018- awaiting feedback from Mr McKay, Mr Carroll updated re Mr McKays discussion and possible radiology findings 31.7.18 Email to Dr McKay on 27.7.18 request to review CT result. 21/08/2018. CT reviewed and medical notes left with Mr McKay today 11/09/2018- 25/09/2018- Dr D McKay has referred to Surgical M&M. 05/11/2018- Email to Dr Convery who advises for presentation at Medicine M&M November.
Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Information		ED		
Personal Information redacted by the USI	Personal Information redacted by the USI	NONE	23.7.18	MUC		03/09/2018 Emailed Dr Murphy regarding presentation at M&M

Received from Trudy Reid on 16/05/2023. Annotated by the Urology Services Inquiry.

Public Health Agency

Via Email

Mr Shane Devlin
Chief Executive
SHSCT

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13 November 2018

Dear Mr Devlin

I am writing to you in my capacity as Chair of an Independent Serious Adverse Incident (SAI) Review Panel which has been established following concerns raised regarding the scope and independence of the SHSCT SAI review into the homicide by Mr McEntee of Michael and Marjorie Cawdery on the 26th May 2017.

The SAI Review is a Level 3 Review which will examine the events leading up to the homicides and the subsequent care and support provided to the families and will adhere to the guidance produced by the HSCB, Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016).

As Mr McEntee received care and treatment from SHSCT I am requesting access to Mr McEntee's medical notes for members of the review panel and also to inform you that during the course of the review, panel members may need to speak with some staff from SHSC. I would appreciate your advice on how we can best co-ordinate the practical arrangements required in respect of these requests.

If you have any queries please do not hesitate to contact me.

Looking forward to hearing from you

Yours sincerely

Personal Information redacted by the USI

Miss Patricia Gordon
(Chair of Independent Review Panel)

Improving Your Health and Wellbeing

HSC Business Services Organisation

Southern Health & Social Care Trust

Management of Standards & Guidelines – 2018/19

nqa ISO 9001 Registered Quality Management

Contents

Acknowledgement

Internal Audit wishes to thank management and staff at the Southern Trust for their assistance and co-operation during the course of the audit engagement.

Control Log

Working Draft Issued On:	31 October 2018
Exit Meeting Held On:	02 October 2018
Management Meeting Held On:	26 November 2018
First Draft Issued On:	
Management Actions Due By:	**Add Date – 4 weeks following draft report issue**
Management Actions Received:	
Final Report Issued On:	

Distribution List

Shane Devlin	Chief Executive (final report only)
Dr Ahmed Khan	Acting Medical Director
Margaret Marshall	Assistant Director Clinical and Social Care Governance
Helen O'Neill	Acting Director of Finance
Alison Rutherford	Assistant Director of Finance

Introduction

In accordance with the 2017/18 Annual Internal Audit Plan, BSO Internal Audit carried out an audit of Management of Standards and Guidelines during September 2018. The last Internal Audit of this topic was performed during May 2015 when Satisfactory assurance was provided.

This audit reviewed corporate and directorate processes for the dissemination, prioritisation/risk assessment (where appropriate) and implementation of standards and guidelines.

Standards and Guidelines (S&G) are initially received by the Corporate Standards and Guidelines Team who will log the S&G on the central corporate register. On a weekly basis the Corporate Team forward the Standards and Guidelines received to Directorate Governance Officers, Pharmacy Governance and Medical Directors Office. In addition S&Gs received are available on the Trust Sharepoint site. Responsibility for identifying applicability, risk assessment and subsequent implementation of Standards and Guidelines within the Trust resides within the operational directorates. Each of the operational directorates has developed their own processes as to how Standards and Guidelines will be managed through Directorate Governance structures. As the majority of Standards and Guidelines fall within the remit of Acute Services, the directorate has established a Standards and Guidelines Review Group which meets on a bi-weekly basis. The role of this committee is to undertake a risk review of each clinical standard and guideline received and the identification of a change lead to take forward the required actions. The group is also responsible for the ongoing monitoring of those clinical standards and guidelines where full compliance has not yet been met.

Standards and Guidelines come from a variety of sources and are received by a number of regional bodies for regional endorsement. Such external agencies include the HSC Board, Public Health Agency (PHA) and Safety & Quality Unit at the DoH. These agencies disseminate the Standards and Guidelines to the HSC Trusts for action and in some instances, there is a requirement that an assurance will be provided to confirm that the required recommendations have been embedded within local practice. Standards and Guidelines are increasingly challenging for providers and commissioners to manage due to their increasing numbers and variety of sources involved.

There were 360 Standards and Guidelines received from January 2017 to August 2018 and of these 156 (43%) had been received from NICE and a further 76 (21%) from the Chief Medical Officer. In line with NICE Circular HSC (SQSD) 2/13 and Circular HSC (SQSD) 3/13, the HSCB seeks a positive assurance report on NICE Guidance issued from September 2011 on a bi monthly basis. This assurance includes confirmation the Trust has completed the initial actions of targeted dissemination, identification of a clinical/management lead and implementation planning within 3 months of issue and that the Trust has fully implemented all guidance within the required timescale. Where NICE Clinical Guidelines are not implemented or not on track for implementation within 12 months of issue, the Trust is required to complete a Section E template which sets out the major barrier/s to implementation, any specific requirements to address the major barriers and any immediate patient safety concerns if the clinical guideline is not implemented within the 12 month timescale. The HSCB requires the Trust to monitor and keep under review the Section E documents which are in place and provide updates on implementation. The Trust currently has 55 NICE guidelines within Acute Services where a Section E template is in place and notified to the HSCB.

The breakdown of Standards and Guidelines received are as follows:-

Issuing Organisation	Number of Standards and Guidelines (Issued January 2017 to August 2018)
NICE Technology Appraisal	93
CMO Letter	76
NICE Clinical Guideline	27
NICE Clinical Guideline Update	23
Safety & Quality Reminder of Best Practice Guidance	20
HSCB/PHA Letter	17
Medical Device Alert	17
HSCB Letter	16

Issuing Organisation	Number of Standards and Guidelines (Issued January 2017 to August 2018)
PHA Letter	15
DOH Letter	10
NICE Public Health Guidance	8
Drug Safety Update	5
NICE Interventional Procedures	5
Public Health Guideline	5
Various Others	23
TOTAL	**360**

Scope of Assignment

This assignment reviewed the processes in place for receipt, dissemination, implementation and corporate oversight for standards and guidelines received. It also reviewed processes in place for ensuring that systems were in place for reporting compliance to issuing organisations.

The audit was based on the risk that guidance and circulars may not be adhered to and required actions implemented in the absence of a robust process for dissemination of documents.

The objectives of this audit were:

- To ensure that there is an appropriate system in place for coordinating, disseminating and overseeing standards and guidelines.
- To ensure that Standards and Guidelines are appropriately disseminated and implemented in the Trust.
- To ensure that changes to practice/procedure following receipt of Standards and Guidelines is effectively communicated and implemented.
- To ensure that there are reporting arrangements in place in respect of guidance and circulars.

This audit did not include NIAIC or Drug Alerts received directly into Estates and Pharmacy

Note: We report by exception only, and where no issues and recommendations are made, the result of our work indicates that the key objectives and risks are being managed and that procedures are being adequately adhered to.

Level of Assurance

Limited

There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.

Executive Summary

Internal Audit can provide Limited assurance in relation to the Management of Standards and Guidelines within the Trust. While the Trust has in place good controls to record corporately the receipt and subsequent dissemination of all Standards and Guidelines to directorates, there is no corporate overview and reporting of the Trust's overall compliance against standards and guidelines. Weaknesses were also found in relation to completeness of data held on the Corporate Standards and Guidelines register and there is limited ongoing audit / follow up of compliance. There was evidence within the operational directorates of ongoing review, implementation and management of standards and guidelines, through Directorate Governance processes.

A satisfactory assurance was given in our previous audit of Standards and Guidelines in 2015/16. Since then there has been a reduction in the extent of corporate reporting e.g. previously the accountability report on compliance and implementation of Standards and Guidelines went to Governance Committee twice a year – currently there is no reporting through Governance committee.

There are two significant findings in this report that impacts on the assurance provided.

1. During the period September 2017 to September 2018, there had been no reporting of compliance with Standards and Guidelines presented to the Board Governance Committee. Consequently the Trust Board has not received assurance that all Standards and Guidelines are implemented on a timely basis and are subsequently being complied with.
   Previously the Trust prepared an Accountability Report for Standards and Guidelines which was presented to the Trust Governance Committee on a six monthly basis which detailed the Trust's compliance against each standard and guideline received. This Accountability Report is no longer compiled.
2. Review of the corporate register (spreadsheet) found that there are significant gaps in the information held. Data was incomplete to enable compliance progress against individual standards and guidelines to be tracked and reported corporately. There is no mechanism to issue reminders to prompt staff when actions are due, and there are no updates on actions taken by directorates. Both the corporate and operational governance teams raised concerns in relation to the completeness and usefulness of the corporate register for managing and monitoring status of Standards and Guidelines.

The other key findings of the audit are:-

3. When a Standard or Guideline is viewed as fully implemented, there is no formal audit or follow-up process in place to ensure ongoing compliance. Where a Standard and Guideline is for dissemination only, the operational directorates governance teams do not have a process in place to ensure that this has been disseminated to all relevant staff.
4. In review of the corporate process map, Internal Audit noted that whilst the process for dissemination and review of the Standards and Guidelines is outlined, it does not refer to how responses should be managed and collated centrally via the corporate team. Responses to the issuing organisation are agreed at Directorate level but there is no corporate overview or monitoring of these responses.
5. 24 of the 40 Standards and Guidelines reviewed had a response timeframe:
   - The Positive Assurance report for July 2018 had not been submitted to the HSCB at the date of audit fieldwork in September 2018.
   - In 3 out of 24 cases, the response date as per the Standard & Guideline had not been achieved, the Trust submitted responses 2, 4 and 7 weeks after the required submission date.
   - In 2 cases, the response was for a nomination from the Trust to attend a regional group – in these 2 cases the nomination had not been made through the corporate team as per procedures.
6. Standards & Guidelines are issued every week by the Corporate team to Governance Teams in the Operational Directorates. In review of 40 Standards and Guidelines the following exceptions were noted:-
   - 3 had not been issued to 8-9 working days after receipt from issuing organisation.
   - 1 had not been issued to 13 working days after receipt from issuing organisation.
   - 1 case where the S&G had been issued from the source organisation on 24 May 2018 but was not emailed to operational governance leads until 20 July 2018, a delay of 42 working days. 1 had been issued by the source organisation on 25 September 2017 but was only issued on 9 March 2018 by the corporate team – this S&G had not been received by the corporate team and had been issued directly to the Medical Directors office. The Corporate team picked this up as part of a compliance audit completed in March 2018. There was a delay of 120 days between receipt and dissemination to Governance Leads.

There are no other observations in this report.

Summary of Findings and Recommendations

Finding		Number of Recommendations		
		Priority 1	Priority 2	Priority 3
1.	Corporate Oversight and Reporting	1	-	-
2.	Register of Standards and Guidelines	-	1	-
3.	Follow-Up and Audit of Implemented Actions	-	1	1
4.	Corporate Process Map for Standards and Guidelines	-	1	-
5.	Performance Management – Meeting Target Responses Dates	-	1	-
6.	Compliance with Processes	-	2	-

Detailed Findings and Recommendations

1 Corporate Oversight and Reporting

Finding

There was evidence within the operational directorates of ongoing review, implementation and management of standards and guidelines, through Directorate Governance processes.

However, during the period September 2017 to September 2018 there had been no reporting of compliance with Standards and Guidelines received to the Board Governance Committee, either as a stand-alone item or as part of a broader Clinical Governance report or quality improvement report. Trust Board are not receiving assurances that Standards and Guidelines are being appropriately managed.

Previously the Trust prepared an Accountability Report for Standards and Guidelines which was presented to the Trust Governance Committee on a six monthly basis which detailed the Trust's compliance against each standard and guideline received. This Accountability Report is no longer compiled.

Implications

There is a lack of robust and formal oversight at a corporate level of the overall Trust compliance with Standards and Guidelines issued. Trust Board may not receive the necessary assurances that actions required in relation to Standards and Guidelines are being progressed and implemented.

Recommendation 1.1	Management should strengthen the governance and corporate oversight arrangements in respect of compliance with Standards and Guidelines. A regular report should be presented to Governance Committee in relation to compliance with Standards and Guidelines.
Priority	1
Management Action	**ACCEPTED / REJECTED**
Responsible Manager	
Implementation Date	

2 Register of Standards and Guidelines (Data Quality and Completeness)

Findings

Currently the Corporate Standards and Guidelines Register is held as an excel spreadsheet by the Medical Directorate. The purpose of the register is to provide a central record of all standards and guidelines received by the Trust, who they were disseminated to, risk rating and to monitor progress re implementation within designated timescales where applicable. Review of the corporate register found that there are gaps in the information completed e.g. Lead Directorate not always completed, applicable directorates not always completed. Additionally there is no mechanism or reminders to prompt staff when actions are required / overdue and there are no updates on actions being taken to ensure compliance.

Both the corporate and operational governance teams raised concerns in relation to the completeness of assurance data and usefulness of the corporate register for managing and monitoring the status of Standards and Guidelines.

There is currently no reporting mechanism to allow real time information on the Trust's actual compliance and progress against actions.

Implication

The current register may not be fit for purpose as it is incomplete.
Trust is unable to use the register to report corporately on the implementation status of standards and guidelines.

Recommendation 2.1	The corporate spreadsheet should be fully adopted across all directorates and processes introduced to ensure it is properly managed and timely updated. The corporate spreadsheet should be reviewed to ensure all fields are accurately completed and up-to-date and that all directorate data regarding progress and actions taken to comply with standards is recorded on a timely basis, and to allow accurate reporting of data.
Priority	2
Management Action	**ACCEPTED / REJECTED**
Responsible Manager	
Implementation Date	

3 Follow-Up and Audit of Implemented Actions

Finding

Each Directorate manages standards and guidelines through their directorate governance processes this includes ensuring dissemination to appropriate staff, were applicable identifying change leads. Where responses are required to issuing organisations these must be agreed by the Director in advance of submission to the corporate team who are responsible for forwarding these responses to the issuing organisation, including where applicable any barriers to implementation within the agreed timeframes etc.
However when a Standard or Guideline is deemed to be fully implemented, there is no formal audit process in place to ensure ongoing compliance. In addition where a Standard and Guideline is for dissemination only, the operational directorates governance teams do not have a process in place to ensure that this has been disseminated to all relevant staff.

Implications

On an on-going basis the Trust does not have assurance that they continue to be compliant with Standards and Guidelines received.
Not all relevant staff may receive the standards and guidelines.

Recommendation 3.1	Internal Audit acknowledges that due to the volume of standards and guidelines received it would not be feasible to audit compliance for all. However based on the overall risk rating or profile of the standard or guideline, management should include audits of compliance with Standards and Guidelines within directorate audit plans.
Priority	2
Management Action	**ACCEPTED / REJECTED**
Responsible Manager	
Implementation Date	

Recommendation 3.2	Where a Standard and Guideline only requires dissemination, governance teams in operational directorates should build into their initial email a request from Heads of Service to confirm dissemination of the Standard and Guideline to relevant staff in operational teams.
Priority	3
Management Action	**ACCEPTED / REJECTED**
Responsible Manager	
Implementation Date	

4 Corporate Process Map for Standards and Guidelines

Finding

There is a process map in place which details the dissemination of Standards and Guidelines from the corporate team to the operational directorates. However, whilst this corporate process map outlines the process for dissemination and review of the S&Gs, it does not refer to how responses should be returned centrally via the corporate team. Each directorate compiles their own response and agree this through their Governance processes before forwarding to the corporate team who are responsible for forwarding this to the issuing organisation. There is no corporate overview or monitoring of these responses.

Implication(s)

The process map does not reflect all processes which are undertaken by the Corporate Standards and Guidelines team.

Recommendation 4.1	The corporate process map should be reviewed, amended, updated and approved to reflect the complete process for the management of Standards and Guidelines within the Trust. • This should include the process in relation to NICE positive assurance. • The corporate co-ordination or submission of responses to the issuing organisation.
Priority	2
Management Action	**ACCEPTED/REJECTED**
Responsible Manager	
Implementation Date	

5 Performance Management Meeting Target Responses Dates

Finding

24 of the 40 Standards and Guidelines reviewed had a specific response timeframe stated.

15 of the 24 were in relation to NICE guidelines or technology appraisals. On a bi-monthly basis the Trust are asked to provide a Positive Assurance to the HSCB in relation to NICE guidelines and Technology appraisals at the date of audit fieldwork the Positive Assurance report for July 2018 had not been submitted to the HSCB.

In the remaining 9 cases which had designated response dates, Internal Audit noted the following exceptions:-

- In 3 cases the response date as per the Standard & Guideline had not been achieved, the Trust submitted responses 2, 4 and 7 weeks after the required submission date.
- In 2 cases the response was for a nomination from the Trust to attend a regional group – in these 2 cases the nomination was not through the corporate team as per procedure and had been submitted directly in one case by the Executive Director of Nursing (this was recorded as overdue on the central register) and in one case by the Medical Director.

A similar finding was previously reported in the 2015/16 Standards and Guidelines report.

Implication(s)

Failure to comply with issuing organisation response timeframes.

Recommendation 5.1	As previously recommended, the Trust should ensure that response to standards and guidelines are made by the designated response date. Where response timeframes are not achieved this should be included in the report to Governance Committee and reasons for none compliance or barriers to implementation.
Priority	2 *(Priority 2 under previous audit classifications)*
Management Action	**ACCEPTED** **Responsible Officer: -** Assistant Director of Clinical and Social Care Governance **Original Implementation Date: -** 28 February 2016
Responsible Manager	
Revised Implementation Date	

6 Compliance with Processes

Finding

Standards & Guidelines as per the corporate process map should be issued every week by the Corporate Team to Governance Teams in the operational directorates. In review of 40 S&Gs received in the period 1 January 2017 to 31 August 2018 Internal Audit Noted the following issues:-

- 3 took 8-9 working days to issue after receipt from the issuing organisation
- 1 took 13 working days to issue after receipt from the issuing organisation
- 1 took 25 working days to issue after receipt from the issuing organisation.
- 1 case where the S&G ***"Resources to support the safe adoption of the revised National Early Warning Score NEWS 2"*** had been issued from the source organisation on 24 May 2018 but was not emailed to the operational governance leads until 20 July 2018 a delay of 42 working days
- 1 case where the S&G "***Flexible Scopes requiring a Sterile Status: Establishment of short life Task and Finish Group to develop reprocessing Best Practice"*** had been issued by the source organisation on 25 September 2017 but was not identified by Coprorate Team until 9 March 2018. The S&G had not been received into the corporate team and had been dealt with at the issue date through the Medical Directors office. The Corporate team picked this up as part of a compliance audit completed in March 2018. There was a delay of 120 days between receipt and dissemination to Governance Leads however the action required had been completed as it was Trust nomination to sit on the Task and Finish Group. Both these latter 2 cases were categorised as low risk

Implication

Non-compliance with procedures.
Potential for delays in issue of standards and guidelines to impact upon patient safety issues.

Recommendation 6.1	All standards and guidelines should be issued to the relevant governance staff in operational directorates within 1 week of receipt as per the process map.
Priority	2
Management Action	**ACCEPTED / REJECTED**
Responsible Manager	
Implementation Date	

Appendix A Definition of Levels of Assurance and Priorities

Level of Assurance

Satisfactory	Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.
Limited	There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.
Unacceptable	The system of governance, risk management and control has failed or there is a real and substantial risk that the system will fail to meet its objectives.

Recommendation Priorities

Priority 1	Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.
Priority 2	Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.
Priority 3	Failure to implement the recommendation could lead to an increased risk exposure.

Note to Report

This audit report should not be regarded as a comprehensive statement of all weaknesses that exist. The weaknesses and other findings set out are only those which came to the attention of Internal Audit staff during the normal course of their work. The identification of these weaknesses and findings by Internal Audit does not absolve Management from its responsibility for the maintenance of adequate systems and related controls. It is hoped that the audit findings and recommendations set out in the report will provide Management with the necessary information to assist them in in fulfilling their responsibilities.

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Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES

DIRECTOR OF ACUTE SERVICES WEEKLY GOVERNANCE MEETING

Date: Wednesday, 21st November 2018

1.0	**Present**: Esther and Trudy
2.0	**Governance Structure** – Update from finance in relation to Consultant PA's and band 5 and 6 posts SAI work load remains challenging in relation to capacity for reports and also engagement / response Esther will further discuss with Finance – including the PA's for consultant and audit facilitators. The role and importance of both roles were discussed in providing assurances regarding governance in the directorate Advert for Interim Acute Clinical Governance Coordinator closes Friday. SAI's that are currently in the system can be completed by Trudy if agreed by the new Medical Director
3.0	**Hyponatraemia** • HYPONATRAEMIA- o Meeting with lead nurses on 8th -Training development ongoing for ED, Trauma and Gynae nursing staff o Audit results for Acute continue to have areas for improvement Acrobat Document.pdf o **Oversight group** o Paper being developed for SMT regarding placement of children 14yrs to 16th birthday and patient choice o Clinical Recommendations 10-30 Trudy and Bernie to update- update to be shared with AD's for agreement o Dr Rooney coming to Trust SMT 28th November 2018 – Ask Anne or Ronan to attend o John Simpson – coming to Trust on 4th December 2018- Discussions regarding 'shared care'
4.0	**Waiting lists risks**- awaiting outcome of screening and refining DATIX search to identify incidents – reports are being run to identify any incidents where waiting lists may have led to an adverse outcome for patients (dermatology, endoscopy & cardiology may be identified)
5.0	**Cervical screening** – Family meeting update 9th November 2018 – meeting outcomes discussed and also complaints with OPPC and Belfast Trust.

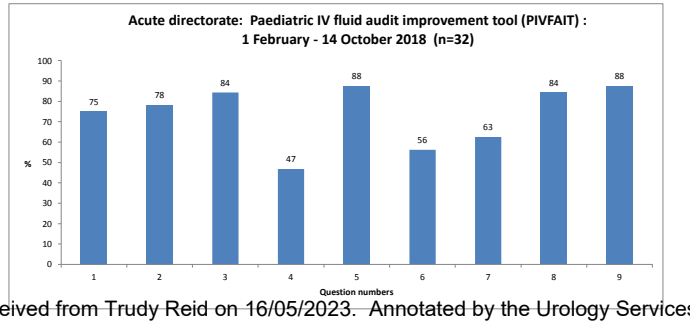
6.0	**Cross Boarder charges** – incident discussed – to be added to Acute Clinical Governance Agenda. Clinical risks should take precedence over financial issues
7.0	**Screening** – challenges remain with pressures regarding regular screening meetings, cases in screening attached  Screening 21 11 2018.xlsx Continued capacity issues with SAIs until recruitment is complete New Consultant PA's may also assist with this
8.0	**Homicide** SAI review for discussion  Letter to CE SHSCT 13 Nov 18.doc
9.0	**Internal Audit of S&G**  Working Draft Mgt of Standards & Guidelin Password is [redacted] Irrelevant information redacted by the USI Discussed the findings including the escalation of risk from Directorate to SMT.
10.0	**MT complaint** discussed. Esther met with MT, letter to be drafted for Esthers approval
11.0	**SM action plan**, Esther updated, • Guidance circulated for comment • Awaiting names of 2nd two patients • Waiting list data being requested
12.0	**Ombudsman complaint-** Possibility that the ombudsman will refer nurses to NMC Mrs McVey linking with RQIA regarding a request from the ombudsman regarding referral of 1N.
	Date of Next Meeting: Wednesday, 28th November 2018

Paediatric Intravenous Fluid Audit Implementation Tool

Child

Date	1/2/18 - 14/10/18	Ward/Dept	Acute

Q	1	2	3	4	5	6	7	8	9	Compliance %	Division	Ward
	Patient identification	Glucose Monitoring		Cumulative input and output totalling and fluid balance.	Patient weight	DFBC calculation guidance completed.		Electrolyte monitoring	12 hour assessment.			
	Are ALL the following **patient identifiers** provided on both sides of the DFBC? 1. Full Name 2. Date of birth 3. Hospital number	While the child is receiving IV fluids, is there a **Blood Glucose result** recorded on the DFBC (in accordance with the 2017 Paediatric Therapy Wallchart) i.e. at least 12 hourly?	Were ALL **Blood Glucose** measurements greater than 3mmol/L? If answer = No; Enter Hospital Number of those below 3mmol/L for Trust audit dept. to check for treatment.	Are ALL of the following amounts (in mls) recorded on the DFBC? 1. Oral/IV amounts, (all administered types of intake to be recorded). 2. Day and night totals. 3. Grand Total IN 4. Grand Total OUT 5. 24 hour Fluid Balance	Is there a **patient weight** in kgs, given on the DFBC?	Are the appropriate **calculation guidance** sections for the IV therapy completed?	Are there **coded indications** for the fluid administration provided?	Is there an **E&U result** recorded on the DFBC (in accordance with the 2017 Paediatric Therapy Wallchart)?	When IV fluids are administered for longer than 12 hours. is there a 12 hour **Reassessment box*** appropriately completed on the DFBC with an answer to the question: Is the infusion prescription still suitable - followed by a doctors signature? * Can be 10 - 14 hours			
Name or Number	*Record Yes = 1 , No = 0 (the only possible entries are e ther a 1 or a 0)*											
Personal	1	1	1	1	1	0	1	1	1	89	ATICS	Theatre CAH
Personal	1	1	1	0	0	0	1	1	1	67	ATICS	Theatre CAH
Personal	1	1	1	0	1	0	0	1	1	67	ATICS	Theatre CAH
Personal	0	1	1	1	1	0	1	1	1	78	ATICS	Theatre CAH
Personal	1	1	1	0	1	0	1	1	1	78	ATICS	Theatre CAH
Personal	1	1	1	0	1	1	1	1	1	89	S&EC	4 North
Personal	0	1	1	1	1	1	1	1	0	78	S&EC	4 North
Personal	1	1	1	1	1	1	1	1	0	89	S&EC	4 North
Personal	1	1	1	0	1	1	0	1	0	67	S&EC	4 North
Personal	1	1	1	0	1	1	1	1	1	89	M&UC	FMW
Personal	0	0	1	0	1	1	0	1	1	56	M&UC	AMU
Personal	1	0	0	0	1	1	0	1	1	56	M&UC	ED CAH
Personal	1	1	1	1	1	1	1	1	1	100	M&UC	ED DHH
Personal	1	1	1	0	1	1	1	1	1	89	M&UC	ED CAH
Personal	1	0	0	0	1	0	0	0	1	33	M&UC	ED CAH
Personal	1	1	1	1	1	1	1	1	1	100	M&UC	ED CAH
Personal	1	1	1	0	1	1	0	1	1	78	M&UC	ED DHH
Personal	0	0	0	0	0	0	0	0	1	11	S&EC	3 South
Personal	1	1	1	1	1	1	1	1	1	100	ATICS	Theatre CAH
Personal	0	0	1	1	1	1	0	0	1	56	ATICS	ICU
Personal	1	1	1	1	1	0	1	1	1	89	ATICS	Theatre CAH
Personal	1	1	1	0	0	1	0	1	1	67	ATICS	Theatre CAH
Personal	0	0	0	0	0	0	0	0	0	0	ATICS	ICU
Personal	1	1	1	0	1	0	1	1	1	78	ATICS	Theatre CAH
Personal	1	1	1	1	1	0	1	1	1	89	ATICS	Theatre CAH
Personal	1	1	1	1	1	0	1	1	1	89	ATICS	Theatre CAH
Personal	1	1	1	1	1	1	1	1	1	100	M&UC	ED DHH
Personal	0	1	1	1	1	1	1	1	1	89	ATICS	Theatre DHH
Personal	1	0	0	0	1	0	1	0	1	44	M&UC	ED CAH
Personal	0	1	1	1	1	1	0	1	1	78	M&UC	ED CAH
Personal	1	1	1	1	1	0	0	1	1	78	ATICS	DSU CAH
Personal	1	1	1	0	1	1	1	1	1	89	M&UC	ED CAH
	Total Audits Obs		32	Paediatric Version V0.13 July 2016			Total number fully Compliant Com			4		
Number of Charts completed	32	32	32	32	32	32	32	32	32			
Number of compliant cases	24	25	27	15	28	18	20	27	28			
	75	78	84	47	88	56	63	84	88			



Total number of charts completed	32
Total fully compliant	4

ED Screening				
Department	**Type**	**Name and H&C**	**Background**	**Screening update**
ED	SAI	Personal Information redacted by the	Internal discussion ongoing ED discharged returned OD - ICU Antrim -	24th August 2017 Meeting - Email doctor. Meeting with doctor cancelled to be reorganised – further information required – email consultant involved again review Wednesday. Not discussed 20/11/17. Need final decision re SAI 6.8.18 Paula provided S Gibson with timeline in order for him to provide information to Chair. 03/09/2018 – awaiting a chair 12/09/2018- reminder sent to S Gibson 12/09/2018- Dr Hampton requests this case is prioritised as urgent. A McVey emailed Simon Gibson 19/09/2018- 24/09/2018- Reminder to Simon Gibson for external chair for ED. 01/09/2018 Awaiting a chair 24/10/2018 Dr Murphy to email Simon Gibson for external chair 26.10.18 Simon emailed Trudy asking if she wished Dr Ahmed to approach S O'Reilly 5.11.18 Trudy emailed Simon happy with this approach 14.11.18 G Hampton has suggested to approach either Dr Peter Short or Dr Paul Kerr in BHSCT - Trudy to check with Simon Gibson if Dr Ahmed has approached S O'Reilly. 21/11/2018 Trudy sent email to Simon Gibson requesting update and ask to approach Belfast Trust.
ED	SAI	Personal Information redacted by	Blood gas issues?	10/1/2018 - Reviewed Dr Hampton wants to review in-depth. 17/01/2018 Reviewed by Dr Murphy probably SAI – for final review – needs discussed with Dr Wright. Discussed with Anne McVey. 24/01/2018 Further discussion with Dr Hampton & M Burke – will check blood gas machine time and signature -Await Dr Murphy discussion with Medical Director- Need a Notification form. 14/02/2018 RS email discussed Dr Murphy to discuss with Medical director 03/09/2018 Awaiting a chair 12/09/2018- Reminder sent to S Gibson 19/09/2018- 24/09/2018- Reminder to Simon Gibson for external chair for ED. 01/09/2018 Awaiting a chair 24/10/2018 Dr Murphy to email Simon Gibson for external chair 26.10.18 Simon emailed Trudy asking if she wished Dr Ahmed to approach S O'Reilly 5.11.18 Trudy emailed Simon happy with this approach 14.11.18 G Hampton has suggested to approach either Dr Peter Short or Dr Paul Kerr in BHSCT - Trudy to check with Simon Gibson if Dr Ahmed has approached S O'Reilly. 21/11/2018 Trudy sent email to Simon Gibson requesting update and ask to approach Belfast Trust.
ED	Internal	Personal	Sedation post spinal injury Internal	7/11/2018 Dr Murphy agrred ED notes and Sedation performa to be sent to Dr Robinson. Email sent to Dr Robinson. 14.11.18 Paula to contact Dr Robinson next week for her response 20.11.18 Paula emailed Dr Robinson for response
ED MUSC	SAI	Personal	CVA	21/08/2018 Meeting to review report, Dr McCormick updating report 03/09/2018 - Dr McCormick updating report 12/09/2018- report with Dr McCormick 24/09/2018- Reminder to Dr McCormick. 08/10/2018- reminder to Dr McCormick re report 24/10/2018 Report being finalised

ED SEC	Internal	Personal Information redacted by the	M&M outcome	Personal Information patient undergoing chemotherapy for myeloma presented to DHH ED at 14:02 with history of being unwell for 3/52, diarrhoea 1/52 poor mobility. 06:15 Cardiac arrest, 18 min CPR- PEA/asystole. Resuscitation stopped. Passed away 06:15 06:45 Verbal report of Ct abdomen available from Dr 6: multiple grossly small bowel loops with dilated transverse colon. 18/07/2018 INTERNAL REVIEW as per SEC – Dr McKay surgical rep, Linda Magowan ED rep-need medicine rep 8.8.18 Meeting arranged for 15.8.18. 20/08/2018- report to be drafted and circulated 05/09/2018- report being drafted 24/10/2018 as above 5.11.18 - Report being drafted
ED MUSC	SAI	Personal Information redacted by the HSI	Patient transferred to theatre from resus for insertion of lines and stabilization prior to transfer to ICU. Patient arrested and time of death was called at Persona Patient had a DNR in place.	06/03/2018- Email from Dr L Martin who suggests case needs to be discussed with ED/Medics to review the management prior to the arrest. 4/4/2018 Level 1 SAI 03/09/2018 – Update requested from Dr Moore 10/09/2018- waiting update from Dr Moore 18/09/2018- Meeting with Dr Moore. Letters to be sent to the 2 doctors involved to invite to a formal meeting. 24/09/2018- 01/10/2018 awaiting feedback re 2nd doctor 24/10/2018 email reminder to Dr Moore 13.11.18 Emails to Medical Work Force Governance to identify medical staff working in Cardiology Feb 2018 14/11/2018 Meeting scheduled between Trudy and Dr Moore 19/11/2018 Names of 2 doctors confirmed and emails to be sent to offer a meeting with Dr Moore 20.11.18 Trudy sent draft email to Dr Moore for approval

ED Radiology		Personal Information redacted by the USI	On 04/06/18 I was working as SHO in CAH ED. I saw a patient Personal who presented with hip pain. On reviewing her clinical notes and previous investigations it became apparent that she had a CT scan of her chest / abdomen / pelvis on 27/4/18. The clinical history on the request for this scan did not match those of the patient in question. It appears that it was requested and subsequently carried out in error.	07/06/2018 -The wrong patient had radiology investigation- will need informed of unnecessary radiology exposure. Possible checking issues at radiology in relation to patient age Investigation needs to take place of the inpatient that should have been scanned. Need to check that the right patient has been scanned. When ward/specialty identified to be discussed at appropriate screening meeting 15/06/2018 CT has not taken place for patient we think should have been referred Personal 18/06/2018- chart obtained for patient scan was intended. 2.7.18 To be discussed with Medicine 01/08/2018- Need initial referral?from?indication. Email to Denise Newell 01/08/2018- Need initial referral?from?indication. Email to Denise Newell response from email dated 2.8.18 “I cannot see a CT chest for this patient on date in question However, she had a request for a CT chest, abdomen and pelvis with contrast requested on 27/2/18Referral source: Gynae ward, Craigavon Referring clinician: Isam Yousif Clinical details23FAdmitted with unilateral headache/ rt shoulder pain/ rt arm and leg paraesthesia.Reported 10kg weight loss over 4 months - unplanned. Vasculitis screen negative Queried lymphoma on rheumatological review. For OP scan - patient has since been discharged Referral status: NHS. Referrer name: Niall Gallagher. Referrer grade: FYI 1-2. Referrer contact bleep detail: 1173. This examination was performed on 27.4.18” 03/09/2018 still no follow up of other patient, Dr Murphy will review if needed 05/09/2018- Trudy to discuss with Dr Murphy. 24/09/2018- Trudy to discuss with Dr Murphy 01/10/2018 notes with Dr Murphy 24/10/2018 Dr Murphy to send letter to patient's GP. CLOSE 5.11.18 Check with Dr Murphy if he sent to letter to patient 20.11.18 Paula left reminder for Dr Murphy re letter to patients GP 21/11/2018 Dr Murphy has sent letter to his secretary for typing and sending to GP. CLOSE
ED MUSC		Personal Information redacted by the USI	On 8/8/18 at 12.50 patient Per in Ward 2 North was confirmed as having Mycobacterium tuberculosis in a sputum sample. This patient initially presented to Daisy Hill ED on 31/7/18 with cough, pyrexia and abdominal pain. He was treated for pneumonia and admitted to Male Medical Ward. He developed increasing scrotal swelling and following discussion with the Urology team was transferred to CAH Ward 3 South for incision and drainage of a potential scrotal abscess on 3/8/18. He developed worsening hypoxia, consolidation, sepsis and a pleural effusion over the next few days and was transferred to Ward 2 north side room.	For screening & timeline. Obtain ED record & notes DHH&CAH 03/08/2018 - Time line to be completed- review screening for starting infliximab. Awaiting medical notes. 10/09/2018- Notes received. Timeline to be completed 01/10/2018 Time line to be completed Medical notes had been requested for clinics and Consultant request. Received 08/10/2018. 24/10/2018 Timeline reviewed. For referral to Medical M&M for guidance on commencement of biologics prior to treatment . Email sent to Dr Rory Convery and Dr John Harty 5.11.18 Timeline complete, Dr Convery " need a trust group to develop guidance for biologic treatment" Back to screening. Discussed at screening. Team members suggested to include representatives from GI team, Dr S Bhatt and Specialist Nurse, Rheumatology- Dr N Maiden 14/11/2018 Meeting dates circulated. ? need to add Pharmacist as per Dr Convery's email. Also to include TB nurse. 14.11.18 Paula sent email to Louise Devlin ETC 21/11/2018. Review team as previously discussed. Meeting to be confirmed.
ED		Personal Information	Patient attended ED DHH following a fall. Diagnosed multiple rib fractures, lung contusions, pelvic fractures and delay in transfer to RVH	24/10/2018 Discussed at screening. Dr Hampton to review medical notes and discuss with his colleagues. 14.11.118 G Hampton to discuss case with Dr D Mawhinney. To be presented at ED M&M. Mary Burke copy of notes for G Hampton. Leave with Mary Burke and Gareth Hampton
ED/ATICS	Internal M&M	Personal Information	Intubated and ventilated in ED	Discussed with Dr Scullion and at ED screening, consider an external chair. Dr Hampton will be ED rep waiting a ATICS rep 22.10.18 Dr Scullion nominated Dr Nidhi Gupta, Dr Scullion has suggested chair should be a senior doctor eg Dr Neta Chada, Dr Shahid Tariq. Trudy to discuss with Dr Murphy. 23/10/2018 Discussed with Mr Carroll and Dr Scullion who agreed Dr Tariq should be asked to chair the review team. Email to be sent. 24/10/2018 Discussed at ED screening and review team agreed. Email sent to Dr Tariq request to chair review team. 5.11.18 Meeting being arranged

NIAS	Intertrust		NIAS attended a call in Newry on the 20th November 2017. When the call was received from NIFRS Control at 18:27 the nearest available resources were S123 an S121 in Armagh some thirty-three minutes away with S327 and S325 in Craigavon estimated as thirty-seven minutes away. There had been only one crew on duty in Newry on the day shift which was allocated to AS1 Irrelevant in Crossmaglen and had arrived on scene at 18:28. In response to this request, the Area Control Officer allocated S123 at 18:31. When it became clear this was not the usual "persons reported" incident that normally requires one resource initially the Control Officer contacted Daisyhill Emergency Department at 18:38 attempting to secure the release of S520 which had been held at their department on AS1 Irrelevant since 16:55 due to the number of patients in their department. The staff stated they would release the crew in five minutes despite being told of the nature of the call. The crew of S520 contacted Emergency Ambulance Control at 18:57 to advise they were assisting the NIFRS staff who had just arrived at Daisyhill. There was little initial information received regarding this call, it built up in subsequent calls, while Daisyhill were not able to assist NIAS in permitting a crew to be released to a 999 call which was five minutes from their department. Attempts were made to secure the release of an ambulance crew from Daisyhill ED while other resources were travelling to the scene. Daisyhill ED failed to release the crew. The local Station Officer was deployed to Daisyhill ED to assist with casualty clearing and to establish the injuries suffered by each patient. The Station Officer arrived at Daisyhill at 19:04. As a result of media enquiries on 21 November 2017 the NIAS Communications Officer was given a complete report on the occurrence. He then liaised with the NIAS Director of Operations who advised me this incident would require a Serious Adverse Incident report.	19/09/2018 - Discuss with Dr Hampton – Email sent to Paul Smyth for review 14.11.18 Mary Burke to check attendances and rotas and to speak with Paul Smyth. Mary Burke to speak with Mark Cochrane (NIAS station officer)
ED	Screening	Personal Information redacted by the USI	Enoxaparin	24/10/2018- Discussed at screening. For round table discussion between ED, Dr K Boyd, Sr Sharon Holmes, Mr Imran Yousif. Meeting to be arranged. 14.11.18 Mark Feenan to sit on review team. Mary Burke to tell David Cardwell that it is an SAI. 20.11.18 Meeting being arranged
ED	Screening	Personal Information redacted by the USI No Datix	Complaint ref Person Patient attended ED CAH 24th,25th and 27th 29th July 2018. Admitted 30th July Severe abdominal pain and distension. Diagnosed sigmoid volvulus with necrotic bowel and had left hemicolectomy end colostomy and subsequent revision and reclipping.	12/11/2018 For screening as per Dr McGarry following M&M. Medical notes obtained. Timeline to be commenced. 14.11.18 Mary Burke to complete datix. Prob SAI. Meeting for Obs & Gynae, ED, Surgery. Elaine Campbell nurse for ED. Chair to be decided 21/11/2018 Discussed at screening- Dr Hampton, Dr Murphy, Mrs McVey Mrs T Reid and P McAloran. Datix to be completed by . Surgeons to Chair review team. David Mawhinney for ED, Meta to nominate, Elaine Campbell Nurse rep for ED, Obs & Gynae rep?
ED	Screening	Personal Information	Personal patient asked for payment in ED DHH	20.11.18 Email from Anne "Was there any feedback as a result of this case? I have experienced a similar case whilst on call and was on call for this one as well (see attached response from Brigid Quinn). Perhaps this should be discussed at Acute SMT, patient flow team, HOS and AD on call need to know how to manage these cases. 21/11/2018 For sharing at SMT.

ED	Screening	Personal Information redacted by the U	Patient had delayed transfer to RVH for PPCI. Attended GP with chest pain. ECG recorded >Inferior Stemi NIAS brought patient to ED. RVH PPCI nurse was not contacted. Brought to ED CAH . Arrived 11:35 1st ECG 12:21 (target <10mins) St Elevation 2nd ECG 12:54 St Elevation remains evident Seen by DR 13:05 RVH contacted 13:15 Transferred to RVH 13:30 Delayed transfer for emergency treatment.	ED notes obtained. 21/11/2018 Discussed at screening. Dr G Hampton to discuss with Denise Nelson. Patient should have went direct to RVH. SEA. NIAS to be informed.
ED/Radiology	SAI	Personal information redacted by the U	Patient seen in ED following RTC and CT carried out. CT report stated fractures of cervical spine but omitted to report multiple rib fractures and flail segment of chest. Patient referred to and transferred to RVH fracture clinic for admission. Patient later returned to CAH ED with no communication from RVH to advise of this. Multiple fractures only picked up on return from RVH as nursing staff were concerned regarding patient condition and asked ED consultant to review. As a result there was a significant delay in the appropriate management of this lady. Patient assessed by anaesthetics and transferred to theatre.	Timeline to be done. For screening 9/5/18- discharged home –discussed at ED screening - for screening by RADIOLOGY 07/06/2018 Flail chest is a clinical diagnosis not just radiological. The report was amended by outsourced company. The radiology report was incorrect and the medical director of the out sourced company has been informed. The clinical picture of significant bruising was not highlighted. When the patient returned to CAH further examination identified bruising and radiology were contacted and the report reviewed an amended. The radiology report was then amended. The patient outcome was not affected by the radiology discrepancy. Recommendation is that the case to be reviewed by Emergency Department again 11.10.18 Email from HSCB *I refer to the attached Interface Incident reported by the Southern Trust. This incident was recently discussed by the Acute SAI Review Team where it was agreed this should be reported as a SAI by Southern Trust, who will take the lead, with input from Belfast Trust. We would therefore expect to receive this by 24 October 2018.* Sent to Trudy to action

MUSC Screening				
Department	**Type**	**Name and H&C**	**Background**	**Screening update**
ED MUSC	SAI	Personal Information	CVA	21/08/2018 Meeting to review report, Dr McCormick updating report 03/09/2018 - Dr McCormick updating report 12/09/2018- report with Dr McCormick 24/09/2018- Reminder to Dr McCormick. 08/10/2018- reminder to Dr McCormick re report 5.11.18 - Report being finalised by Trudy
ED MUSC	SAI	Personal Information redacted by the USI	Patient transferred to theatre from resus for insertion of lines and stabilization prior to transfer to ICU. Patient arrested and time of death was called at 05:21 Patient had a DNR in place.	06/03/2018- Email from Dr L Martin who suggests case needs to be discussed with ED/Medics to review the management prior to the arrest. 4/4/2018 Level 1 SAI 03/09/2018 – Update requested from Dr Moore 10/09/2018- waiting update from Dr Moore 18/09/2018- Meeting with Dr Moore. Letters to be sent to the 2 doctors involved to invite to a formal meeting. 24/09/2018- 01/10/2018 awaiting feedback re 2nd doctor 5.11.18 Paula emailed Dr moore on 24.10.18 re 2 doctor. Dr Moore on leave until 5.11.18 12/11/2018 Meeting being arranged with Dr Moore and Trudy 19/11/2018 Names of 2 doctors confirmed and emails to be sent to offer a meeting with Dr Moore 20.11.18 Trudy sent draft email to Dr Moore for approval
MUSC Radiology	SAI	Personal Information redacted by the USI	Arrest post midazolam	03/09/2018 Family meeting fed back to screening, email doctor involved and present at ACG 05/09/2108- Coroner has indicated this will not go to formal hearing 10/09/2018- Passed at ACG. Report with Dr and Simon Gibson has a copy for Medical Director. 24/09/2018 – Further meeting to be arranged to discuss family questions 01/10/2018 meeting planned to address family questions 19/10/2018 Dr Polley, Dr Hull, T Reid, Dr McConville, Dr Yousif and Ms Redpath also need cardiology rep 5.11.18 Finalising response to family
MUSC	Intertrust	Personal Information redacted by the USI	VSD post infarct	Patient presented with anterior STEMI-not fit for primary PCI, stabilised in CCU and underwent triple vessel PCI in CAH LVEF 40-45% at the time. Went home thereafter. Readmitted following acute deterioration with reduced O2 saturation. M&M Learning Point - Case discussed at cardiology M&M and subsequently with cardiac surgeons MDT. Patient should not have been discussed at theatre team meeting. Post infarction VSD is a surgical emergency and correct management is to discuss with the emergency cardiac surgeon on call who will advise on management by current recommendations is surgical repair pending patient suitability for theatre 29/01/2018 Discussed – as there has been regional and local learning via M&M and MDT – SAI review not required M&M report – 4/4/2018 available in chart 03/09/2018 – Update requested from Dr Moore 10/09/2018- as above 18/09/2018- Meeting with Dr Moore. Difference of opinion between CAH Cardiology team and RVH Cardiology Team. As per email 18/9/18- "I have discussed this case again with Dr McEneaney, Clinical Lead for Cardiology, and we feel that it is not a SAI trigger but there should be an Interhospital Datix." 18/09/2018-Email to Kay Carroll who was Clinical Lead Feb 2017 for Datix to be done 24/09/2018 – Spoke to K Carroll requested datix to be completed, to be sent to Belfast as an intertrust 01/10/2018 Kay to complete datix 15/10/18 Notes left with Denise for datix completion 5.11.18 Paula emailed reminder to Denise Nelson- on leave until 13/11/18 19.11.2018 Datix completed. ?To be sent to Belfast as Intertrust. Trudy emailed Kay Carroll.
MUSC SEC	Complaint	Personal Information redacted by the USI	Crohns and Colitis treatment (Complaint) Subtotal colectomy May 2018	For discussion as per Dr Murphy email. 18/06/2018- Medical notes requested for timeline – received. 2.7.18 – Paula to do timeline. 23/07/2018-timeline to be done 30.7.18 – Acknowledgment for approval. Check with Dr Murphy the timeframe for SAI review 01/08/2018- Dr Murphy advises SEC to approve acknowledgement. Timeline to commence from 1st admission. 6.8.18 Acknowledgment approved by RC 8.8.18 – Timeline to be complete 03/09/2018 -1st meeting with Mr Epanomeritakis, 2nd meeting to be organised with Mr Bhatt 10/09/2018- meeting being organised 19/09/2018- Meting 19/09/2018 with Dr Bhatt 24/09/2018 – Report being drafted

MUSC	SAI	Personal Information redacted		6.8.18 – Response to family to be discussed at M&M 6.8.18 Dr P Murphy & M Burke said signed off. Paula to check with Trudy on her return. 05/09/2018- response approved and to be sent to family. 10/09/2018- report with DLS for approval 24/09/2018 – Reminder to E O'Neill in litigation regarding DLS approval of response to family 01/10/2018 awating DLS response, extra questions from Litigation to Anne and Philip 5.11.18 - DLS had additional queries re inquest. Trudy to meet with litigation
MUSC Dermatology		Personal Information redacted by the USI	Patient/ Personal Information was seen at Dermatology Clinic on 11/05/2017. Review was planned for 2-3 months. Patient did not receive review appointment. He was being treated for actinic keratosis on his nose. Whilst awaiting review lesion progressed and presented today with a large tumour in keeping with a squamous cell carcinoma. Today's appointment 16/08/2018, took place as patient phoned requesting urgent review.	For screening. Email sent to K. Robinson for information. See emails 20/08/2018- Discussed at screening. How are we managing Risk? What systems are in place? Need clear guidelines. Lisa is clarifying what is routine for AMcVey. 03/09/2018 – Complaint received – Screening team updated- Dr Murphy and Anne McVey to review waiting lists. 10/09/2018- Discussed at screening. SEA has taken place within Trust. Anne McVey to discuss with Kay Carroll. Dermatology to review forms/urgent/routine reviews. How we manage risk with long waiting times. Need to inform staff (doctors) re waiting times. ? SEA/SAI? 24/09/2018- Anne McVey to discuss with Kay Carroll 01/10/2018 Meeting with Mrs McVey, Dr Murphy and Lisa McAreavey to look at waiting lists has taken place - actions letter to be sent to all consultants re triage category - hold on report until actions complete 5.11.18 Acute to review datix incidents re dermatology. Examples of incidents to be obtained. 19.11.2018 Report received (see document)
ED MUSC		Personal Information redacted by the USI	On 8/8/18 at 12.50 patient Personal in Ward 2 North was confirmed as having Mycobacterium tuberculosis in a sputum sample. This patient initially presented to Daisy Hill ED on 31/7/18 with cough, pyrexia and abdominal pain. He was treated for pneumonia and admitted to Male Medical Ward. He developed increasing scrotal swelling and following discussion with the Urology team was transferred to CAH Ward 3 South for incision and drainage of a potential scrotal abscess on 3/8/18. He developed worsening hypoxia, consolidation, sepsis and a pleural effusion over the next few days and was transferred to Ward 2 north side room.	For screening & timeline. Obtain ED record & notes DHH&CAH 03/08/2018 - Time line to be completed- review screening for starting infliximab. Awaiting medical notes. 10/09/2018- Notes received. Timeline to be completed 01/10/2018 Time line to be completed Medical notes had been requested for clinics and Consultant request. Received 08/10/2018. 5.11.18 Timeline complete, Dr Convery " need a trust group to develop guidance for biologic treatment" Back to screening. 05/11/2018- Discussed at screening who should be on the group. GI specialist Dr and Nurse, Rheumatology Dr and Nurse, TB nurse. ? Dr R Forbes for Neurology. Dr Murphy suggested Dr Bhatt and Dr Maiden. 14/11/2018 Meeting dates circulated.
MUSC	SAI	Personal Information redacted by the USI	Datix re Missed bowel tumour	03/00/2018 Discussed at MUSC screening - Internal review in first instance as per SEC – Review team in agreement 10/09/2018- Meeting arranged for 17/09/2018- Mr K McElvanna and Dr S Bhatt 19/09/2018- Mr McElvanna to discuss with Mr McArdle. Dr Bhatt to discuss with Dr Hillemand and Dr S Murphy. 08/10/2018- Email to Mr McElvanna and Dr Bhatt for update 5.11.18 Report being drafted
ED MUSC	Complaint	Personal Information redacted by the USI	(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 for above Personal information redacted by USI	03/09/2018-Medical notes requested for timeline 10/09/2018- Timeline in progress 18/09/2018-TIMELINE COMPLETE- For screening 24/09/2018- Discussed at screening. Confirmed SAI. Issues: Missed in ED, handover and post take ward round. Nominations for review team: AMcVey to ask Dr David Craig, Dr Mumtaz Hussan, ? ED rep and Nurse. AMcVey to discuss with Sandra Burns. 24/09/2018- Email sent to AMcVey. Timeline to be reviewed. Meeting TBA. Charts copied for review team. Notification to be completed. 01/10/2018 To be completed as SAI- Datix required 08/10/2018 Dr Polley to complete Datix, medical notes provided. 16.10.18 Datix completed 5.11.18 Paula emailed AMcV re review team 19.11.2018 Dates for meeting proposed 30 Nov 2018. Review team is Dr McCaffrey /rep, Dr Chiara Byrne, Dr Mumtaz Hussain, Dr David Craig, Sandra Burns, Mary Burke.(Confirm)
MUSC	SAI	Personal Information redacted by the USI CCU DHH	Arrest in DHH post cardiac cath - Anaes and transfer issues	Discuss at screening. See email from Dr Scullion. 01/10/2018 Request notes and prepare a time line. Time line to be completed 15/10/2018 Discussed Dr Scullion views- still needs time line 22/10/2018 DHH Medical notes requested as CAH notes do not contain relevant information. 30/10/2018- Contacted Medical records- await medical notes ? in BCH ICU. 5.11.18 Notes received from Belfast. Timeline to be completed 19.11.2018 Timeline in progress
MUSC	SAI	Personal Information redacted by the USI	Endoscopy screening waiting times	08/10/2018-Discussed at screening. For timeline. Medical notes requested. 15/10/18 Identify delays from specialites with incidents 5.11.18 timeline to be completed by Jane Scott, notes with Jane
MUSC		Personal Information redacted by the USI	Patient with metastatic melanoma and known brain secondaries and bone secondaries admitted with increasing left arm pain and arm weakness and back pain. Seen by a number of professionals an I feel opportunities missed to diagnose spinal cord compression - which the patient was subsequently diagnosed with on 06/09/2018 Emergency MRI and emergency radiotherapy arranged and family and ward staff informed. Notes clearly documented and Barry Conway informed.	Notes needed for time line 29/10/2018. Medical notes received. 5.11.18 Paula to complete timeline
MUSC		Personal Information redacted by the USI	Pacing issues M&M SOM4	12/11/2018 DHH notes requested from Villa 3. Notes received 12/11/18.

MUSC	SAI	Personal Information redacted by the USI	Endoscopy screening waiting times Male patient Personal Information redacted by the USI referred for colonoscopy for investigation of iron deficiency anemia. Colonoscopy revealed mass in ascending colon (likely malignancy). Investigated for same in 2016 with colonoscopy when a polyp was removed from ascending colon (not retrieved due to poor bowel preparation) At that time recommendation was made for follow up colonoscopy in 12/12 as a safety measure due to poor bowel prep. This appears not to have happened. There was a new GP referral to OPD in Sep 2018 with anemia which was followed by a colonoscopy request from OPD.	5.11.18 Jane Scott to complete timeline - For screening.
MUSC	Screen	Personal Information redacted by the USI	Late upgrade of Red Flag referral A referral from Respiratory to Gastroenterology dictated on 06.09.18. Date Typed was 22.10.18. The referral was date stamped with 30.10.18 - Date received in RBC. It appears that referral was triaged on 31.10.18 and was marked as RF. This referral was then received into the Red Flag booking office on 02.11.18. Appointment was booked on 02.11.18 for 06.11.18. (61 Day wait from date of registration on PAS) The delay on this occasion appears to be with the typing of clinic.	
ED/MUSC	Screening	Personal Information redacted by the USI	This case was discussed by the Acute Services SAI Review Team who acknowledged the substantial joint working between cardiology teams in BHSCT and SHSCT and within the SHSCT between Cardiology and ED staff, to explore all the issues which arose from a number of primary PCI related cases. It has been reported that there has been substantial learning and additional staff training on both sites. The Lead Clinicians for Cardiology have drafted a summary of regional learning and all Trusts' Cardiology Clinical Leads have agreed modifications to the regional algorithm for primary PCI referral. In this case there was a delay of several hours from the time of an ECG which was diagnostic of STEMI to referral to the primary PCI co-ordinator but at that point it was considered that primary PCI was no longer appropriate. In light of the summary provided, the Acute SAI Team have agreed that a SAI should not be submitted from BHSCT, however the Southern Trust, having considered the learning that has already taken place should advise whether it is considered that there would be further benefit in completing a SAI within the Southern Trust.	14.11.18 For screening PCI.
ED	M&M	Personal Information redacted by the USI	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.	03/01/2018 – Reviewed by Dr Hampton- for full screening with Dr Murphy. 10/1/2018 Reviewed by Dr Murphy care appropriate for M&M discussion and PM feedback. 24/01/2018 Discussed with Dr Hampton & M Burke – Await further discussion with Dr Murphy following family letter – Dr Moan to review. ED M&M findings available 15/02/2018 for discussion Dec M&M findings ED- Deceased in ICU. General discussion was held regarding recording peak flow. Peak flow should recorded when the patient is well to assist with discharge planning. There were no issues with the ED management of the patient. Case to be discussed at CAH medical and ICU M&M. Learning point Have an adequate discharge plan. Action Case to be discussed at CAH medical and ICU M&M. Dr Moan is reviewing clinical information- 1/08/2018- Dr Murphy to confirm his nomination for meeting. ? need for ED rep. 6.8.18 – Dr P Murphy agreed to meet with family & Trudy. Dr Murphy said no need for ED rep. 03/09/2018 Meeting to be organised 12/09/2018- as above 19/09/2018- 24/09/2018- Meeting being arranged. 01/09/2018 Meeting being arranged 24/10/2018 Dr Murphy & Trudy Reid to agree a date for meeting 5.11.18 Trudy to discuss meeting the family with Dr Murphy 13.11.18 Dr Murphy has offered Monday 26 November, Monday 3 December & Tuesday 4 December
MUSC	Internal investigation	Personal Information redacted by the USI	Out of hospital arrest –	24/09/2018 – Notes sent to Kay Carroll for review. PAS checked and only one set of active medical notes. AmcVey emailed R Haffey for outcome of M&M 21/09/2018. M&M outcome "This case was brought to Medical M&M on Friday 21 September 2018 at the request of ICU. Following discussion, it was agreed that it would be most appropriate to bring this case back (with relevant scans and ECG results) to the next medical M&M meeting scheduled for Friday 19 October 2018".
MUSC	Interface	Personal Information redacted by the USI	Missed CVA Belfast Interface SAI	

SEC Screening

Department	Type	Name and H&C	Background	Screening update
SEC	M&M Internal	Personal Information redacted by the	Personal patient undergoing chemotherapy for myeloma presented to DHH ED at 14:02 with history of being unwell for 3/52, diarrhoea 1/52 poor mobility. Seen by Dr 1. Loose green stools. Reduced oral intake. Occasional mild general abdominal pain. One loose stool today, did not take chemo med. Worsening shortness of breath. No chest pain, on examination he was noted to be cachexic, frail. Bi-basal creps. Marked bilateral lower leg oedema. ECG Sinus rhythm, 2 BBB. BP 86/51 with fluids and legs raised. Distended abdomen query ascetic. Mild generalised tenderness, no masses felt, bowel sounds present Diagnoses: diarrhoea query secondary to chemo meds, associated dehydration and ?acute LVF. Seen by Dr 4 at 23:00- Distention for 1/12. One episode of vomiting. Just completed 4 cycles of chemo for multiple myeloma. ATSP re abdominal distention. Abdomen tympanic with generalised tenderness with some guarding. Bowel sounds scant. PR: external haemorrhoids ++. Will discuss with senior and review plain films. Will add to handover list and query review in am. Fast, NGT if vomiting continues. Stool chart. IVF and anti-emetics 02:04 Seen by Dr 5. History as above. On examination: abdomen firmly distended, tympanic. Mild generalised tenderness. AXR: gross bowel dilation in keeping with obstruction. Imp: bowel obstruction query underlying cause. 06:15 Cardiac arrest, 18 min CPR- PEA/asystole. Resuscitation stopped. 06:15 Passed away. 06:45 Verbal report of Ct abdomen available from Dr 6: multiple grossly small bowel loops with dilated transverse colon.	26/06/2018 Discussed with Mr Carroll and Dr Scullion – M&M January 2018 - Statement of Management to be provided: Medicine Statement of management: 3 - contained aspects that SHOULD² be improved (learning identified); the patient's eventual outcome was NOT 21/08/2018- Report to be drafted. Management of abdominal pain ED DHH Version 1(17April 2015) sent to Dr McKay and Dr Magowan 11/09/2018- Report in draft
SEC	Internal	Personal Information redacted by the HSI	Patient admitted with? Diverticular perforation. CT Shows likely perforated tumour. Not reported by radiology. Discharged home. Delay in diagnosis significant.	Discrepancy meeting outcome - Discrepancy, cognition and perception. Abnormality was felt to be solid and represented malignancy as opposed to a diverticular abscess. 01/02/2018 with Discussed Dr Yousaf The initial request highlighted abdominal pain, diarrhoea, tender LIF, previous unremarkable endoscopy, CRP 200, WCC 14.9,? Diverticular abscess,? localised perforation- the reported stated … Briefly collection/inflammatory exudate along descending colon – sigmoid in LIF likely to be cause of symptoms and signs. Gold standard for diagnosis is endoscopy not CT. This case has been discussed at the discrepancy meeting Follow up endoscopy – on 23/11/2017 – haemorrhoids – GI registrar 16/01/2018 CT CAP showed …suggestive of locally advanced, perforated tumour of the distal descending colon/proximal sigmoid colon….. From Radiology perspective does not meet the criteria for SAI 16/01/2018 CT CAP showed …suggestive of locally advanced, perforated tumour of the distal descending colon/proximal sigmoid colon….. From Radiology perspective does not meet the criteria for SAI 11/09/2018- Meeting being arranged. 13.9.18 Meeting arranged for Monday 12 November 13.11.18 Further meeting to be arranged. 19.11.2018 Meeting 28 November

SEC	Internal	Personal Information redacted by the	? Delay in Diagnosis of Recto-sigmoid adenocarcinoma. Issued raised by Mr Mc Kay. Patient had a US Abdomen 7/4/17 – Conclusion - Fatty Liver; CT Abdomen & Pelvis with Contrast 22/7/17 – Conclusion - Severe sigmoid colitis with evidence of localised perforation	24/07/2018- email to I Yousuf on 13/7/18 + 24/07/18 re discrepancy report. Mr Carroll updated 31.7.18 Wait discrepancy report from Dr Yousuf. 21/08/2018 reminder to Dr Yousef 11/09/2018-as above 25/09/2018- still to be discussed at radiology discrepancy meeting 22.10.18 Trudy emailed Dr Imran Yousuf re CT Abdomen and Pelvis dated 22/07/2017) has been discussed at discrepancy yet. Gail Lindsey replied not discussed but will expedite it. 5.11.18 To be discussed at coming audit day, Friday, 16th November at the next discrepancy meeting.
SEC	Internal	Personal Information redacted by the HSE	Delay in tumour management . Emergency admission with abdominal pain- initial CT 19/11/2015 showed retrocaecal appendicitis with localised perforation……soft tissue thickening is present at the base of the appendix/tip of the caecum and evaluation of this region is advised in due course to exclude other pathology- managed conservatively- Discharge letter noted RIF pain Initial Diagnosis ?appendicitis ?walled-off appendix ?malignancy. Following subsequent admission CT 2/12/2105 comment At some stage colonoscopy of the cecal pole will be required in order to exclude cecal pole mass/tumour (if not already performed). Possible caecal pole mass may be contributing to the ongoing inflammatory process as the appendix does appear distended and may be obstructed at the base. A prominent ileocaecal valve area is considered and is possible but there is not much fat in this abnormal area. Colonoscopy 4/2/2016 with subsequent pathology report stating 'The appearances are those of an adenocarcinoma. 07/02/2016 discussed at MDM for consideration of right hemicolectomy. Surgery on 08/03/2016	INTERNAL SEA – Need chair – wait for meeting minutes to be circulated then approach GH again minutes circulated request chair again 2/1/2018 - email sent requesting GH to chair 09/01/2018 - awaiting date for meeting 14/3/18 – Dr Haynes advised that Mr Hewitt to again be asked for a date for meeting if this is not provided he should be advised that a meeting will be scheduled in place of one of his theatre lists (in next 6 weeks). 6/4/18 – R Farrell to contact Mr Hewitt's sec re dates re dates for meeting 6/4/18 – T Reid email Mr Hewitt re dates re dates for meeting 26/06/2018 Mr Carroll update regarding no response from Mr Hewitt 13/07/2018 Mr Haynes has agreed to cancel elective surgery to allow Mr Hewitt to Chair the SEA report 11/09/2018- as above. wait response from Mr Hewitt. Email sent to W Clayton 25/09/2018- meeting scheduled for 03/10/2018. 22 10 2018 reschedule meeting 5.11.18 Meeting being arranged 19.11.2018 Waiting Mr Hewitt to agree dates
SEC	Internal	Personal Information redacted by the HSE	Following review at OP where new iron deficiency anaemia was diagnosed Pers was referred to for OGD and colonoscopy and subsequently CT abdomen and pelvis which was performed on 2/08/2016 and reported on 7/08/2016, there was an incidental finding of sub- segmental and segmental emboli seen in the R lung. 2/08/2016 reported 7/08/2016. This result was emailed to the referring consultant and a specialty doctor wrote to the consultant highlight this finding on 23/08/2016, Pers was also reviewed at a number of OP clinics where there was no documentation of CT findings CT showed PE not actioned	INTERNAL SEA – Need chair- wait for meeting minutes to be circulated then approach GH again minutes circulated request chair again 2/1/2018 - email sent requesting GH to chair 09/01/2018 - awaiting date for meeting 14/3/18 - Dr Haynes advised that Mr Hewitt to again be asked for a date for meeting if this is not provided he should be advised that a meeting will be scheduled in place of one of his theatre lists (in next 6 weeks). 6/4/18 – R Farrell to contact Mr Hewitt's sec re dates for meeting 6/4/18 – T Reid email Mr Hewitt re dates re dates for meeting 26/06/2018 Mr Carroll update regarding no response from Mr Hewitt 13/07/2018 Mr Haynes has agreed to cancel elective surgery to allow Mr Hewitt to Chair the SEA report 11/09/2018- wait response from Mr Hewitt. Email sent to W Clayton 25/10/2018- Meeting scheduled for 03/10/2018 09/10/2018- Mr Carroll updated meeting had taken place and report was in progress. 5.11.18 - Report being drafted

SEC	Complaint	Personal Information redacted by the HSI	On 19 January 2017 at 13:15 Personal Information redacted by the HSI presented to CAH ED with RUQ Abdominal & Epigastric Pain/vomiting C/O SOB ongoing 1/52 Pallor poor at triage/clammy. ECG done at 13:52 Troponin 105 @13:45. Referred to Surgical team query cholecystitis, query Malignancy. Troponin repeated @ 22:00 122 and ECG repeated at 22:37 Transferred to 4S @ 00:45 on 20/01/17. At approx. 17:21 Pers appeared to have seizure. Loss of consciousness- arrest team called. Pers did not respond to resuscitation efforts. Most likely cause of death- massive cardiac event. Coroner contacted on Saturday 21/01/17- patient for post mortem. Clinical summary sent	11/09/2018- Meeting took place. Questions answered. Report to be amended. Notes of meeting to be approved. 25/09/2018- as above 8.11.18 PCC requesting update on notes of meeting and as well as copies of last blood results
SEC Radiology	SAI	Personal Information redacted by the HSI	Missed diagnosis of Gallbladder CA	11/09/2018- Report was presented at ACG 7/9/18. AMD's/AD's suggest an Additional recommendation. Recommendation 2 The SHSCT should ensure that the WHO check list includes a question regarding all relevant results being signed off . Email to Mr Gudyma and Dr I Yousif for approval. 18/09/2018. Trudy Reid contacted Personal Information redacted by the HSI to discuss his requirements of SAI. 25/09/2018- Amendments made to report and sent back to Mr Gudyma and Dr I Yousif for approval 12/11/2018- Email on 22/10/18 to Dr Gudyma to check if he had a chance to share this report for factual accuracy with the staff involved. Mr Gudyma will discuss at Patient Safety meeting 16/11/18. 13/11/2018 Email to Mr Gudyma as a reminder report need to be shared with those involved. 13.11.18 Trudy Emailed - discuss case with Ronan Carroll & Mr Mark Haynes
SEC Paeds	SAI	Personal Information redacted by the HSI	Child with fractured tibia admitted to Paeds ward (3N) against Trust policy for observation. Child given Oramorph overnight. T&O team not contacted. Child given breakfast against T&O admission policy. Child found to have compartment syndrome on ward round the following morning	11/09/2018- Meeting 12/09/2018 to finalise report 25/09/2018- Report in draft 09/10/2018- Report finalised and for Acute Governance Meeting this Friday. 22 10 2018 emailed Belfast for rep, reconsider recommendations following meeting and presentation to Acute Clinical Goverance Email to Dr V Roberts to advise re outcome of ACG meeting. 13/11/2018 reminder email to BHSCT for nomination for review team
SEC	SAI	Personal Information redacted by the HSI	Pers was admitted with possible bowel obstruction on 30 April 2017, investigations included CT scan, IV access failed on route to the CT scanner. Pers aspirated in the CT scanner and developed respiratory failure, requiring intubation and ventilation. Pers had a subtotal colectomy and ileostomy, she was transferred to ICU post operatively but despite maximal treatment she continued to deteriorate and died on the Personal Information redacted by the HSI Cause of death a) Multi-organ failure b) Small bowel obstruction. Datix reflected CT scan without IV access, NG tube or fluid resuscitation	11/09/2018- report approved by review team. 18/09/2018- Report to be finalised before sending to family 25/09/2018- Report being amended 22.10.18 To Mr Gilpin for sharing with the staff involved before I circulate to the family, HSCB and the coroner. I always like to ensure those in the SAI have had a chance to review prior to wider circulation. This was passed via acute clinical governance. 30/10/2018- Report out for sharing, still some team members to review. 13/11/2018 Checking re factural accuracy reminders sent. (W Clayton and Dr Gilpin, Dr Campbell)
SEC	SAI Urology	Patient 13 Patient 16 Patient 12 Patient 14 Patient 11	Delay in diagnosis and treatment of prostate cancer - Review commenced	14/3/18 – Not discussed Acknowledgement letter sent. 25/09/2018- Report sent to Julian Johnston (Chair) for approval.
SEC	SAI	Patient 15 Urology	GP routine referral to Urology 30/08/2015. Raised PSA. Seen bty Urology 8/2/2016. Appears a 6 month delay in diagnosis. Referral wasn't upgraded through triage process.	K R to – double check falls in urology SAI – Dr Wright and Dr Johnston have agreed to it can be included in original SAI 14/3/18 – Added to Urology Time Line Acknowledgement letter not sent yet. HSCB Notification to be completed. 25/09/2018- Report sent to Julian Johnston (Chair) for approval.

SEC ED	SAI	Personal Information redacted by the USI PEG tube	PEG tube insertion - perforation	11/09/2018- Report being final 25/09/218- Amendments of report with Dr R Thompson. Mr Gilpin feels case should be presented to the Coroner 01/10/2018 Report to be amended as per Mr Thompson 22 10 2018 Update sent to Dr Thompson 6.11.18 Trudy emailed Mr Thompson with report for final approval 13/11/2018 Approved by Mr Thompson. Trudy to discuss at screening re Coroner. 13.11.18 Trudy emailed Ronan Carroll & Mr Haynes to discuss PEG SAIs regarding referral to coroner
SEC ED	SAI	Personal Information redacted by the USI PEG tube	PEG tube insertion - perforation	11/09/2018- Report being finalised 25/09/2018- report finalised and being prepared for sending to HSCB. Mr Gilpin feels case should be presented to the Coroner. 01/09/2018 Report finalised 13.11.18 Trudy emailed Ronan Carroll & Mr Haynes to discuss PEG SAIs regarding referral to coroner
ED/Anaest	SAI	Personal Information redacted by the USI	Patient transferred to theatre from resus for insertion of lines and stabilization prior to transfer to ICU. Patient arrested and time of death was called at 05:21 Patient had a DNR in place. Perso nal attended Craigavon Area Hospital (CAH) Emergency Department (ED) on 19th February 2018 with chest pain, low oxygen saturations, shortness of breath and pyrexia. Perso nal had a cardiac history. Initial ECG was unremarkable; however repeat ECG showed ST elevation, at 23:06. Perso nal condition deteriorated at approximately 02:15 [redacted] had a cardiac arrest, Cardiopulmonary Resuscitation was commenced, and Perso nal intubated and transferred to theatres for stabilisation. Do Not Attempt Cardiopulmonary Resuscitation was decided, Perso nal had a further period of cardiac arrest and died at 05:21.	31.7.18 Report with Dr Moore 21/08/2018 Email Dr Moore re finalising report- on leave until 28 August 11/09/2018 18/09/2018- Meeting with Dr Moore. Letters to be sent to the 2 doctors to invite to a meeting. 24/10/2018 email to Dr Moore 30/10/2018- reminder to Dr Moore- On leave until 5/11/18 12/11/2018 Meeting to be arranged with Dr Moore. Names of doctors received and contact details being sought as they no longer work in SHSCT 19/11/2018 Names of 2 doctors confirmed and emails to be sent to offer a meeting with Dr Moore 21/11/2018 Draft email to Dr Moore for approval before contacting doctors.
SEC ATICs	SAI	Patient 90 [redacted]	Patient admitted to ICU in extremis. Unexpected death after elective surgery. Preadmitted 03/05/2018 for 09/05/2018 care of Mr A O'Brien Urology. Patient transferred to ICU CAH and died. Post Mortem to be carried out. Case with Litigation.	31.7.18 Report being drafted 11/09/2018- as above 5.11.18 Report being drafted
SEC ATICs	SAI	Personal Information redacted by the US	Personal Information redacted by [redacted] who attended theatre in DHH for insertion of PEG tube on 15/05/2018. There are no traceability print outs for the scope and the scope used was potentially dirty. Possibly used on previous patient who had a flexible sigmoidoscopy? It was cleaned and rinsed with water but no detoxified.	31.7.18 With Dr Brown for final approval 21/08/2018 Further request to Dr Brown for approval 11/09/2018- email to Dr Brown 07/09/2018 for approval 25/09/2018- Further amendments to report sent to review team. 5.11.18 - For rediscussion
SEC ATICs	Internal	Patient 91 [redacted]	Patient admitted for ureterostomy on 18/05/18. Pyrexic and hypotensive following procedure. Transferred to ICU due to escalating inotropic support. Myocardial infarction. Despite aggressive intensive care management, patient's condition continued to deteriorate and death was confirmed on 20/05/18.	31.7.18 Mr Carroll & Dr Scullion agree internal review. Meeting on 21.8.18- Initial meeting held. Report to be drafted 11/09/2018- report to be drafted 25/09/2018- 5.11.18 Report to be drafted

SEC	SAI	Personal Information redacted by the USI	Pers was admitted via ED on 6/11/2017 to the Trauma Ward at CAH following a fall at home. Per was diagnosed with a fracture to her left neck of femur. Per had a number of Co-morbidities which included COPD, Congestive cardiac failure, aortic stenosis, left bundle branch block, hypothyroidism and chronic kidney disease stage 4. Pers acutely deteriorated at 05:30hrs on 08/11/2017 with a reduced level of consciousness low blood pressure and had acute kidney injury. She was felt to be opioid toxic and was given reversal 3 times with naloxone which made some improvement. Pers was transferred to theatre for intubation and transfer to ICU. Pers died 09/11/2017 at 00:50hrs.	2.8.18 – Notification approved by R Carroll 21/08/2018 Meeting scheduled for 29th August. 11/09/2018- Report to be drafted 5.11.18 - Report being finalised
SEC	SAI	Personal Information redacted by the USI	Admitted perforated diverticular disease and small bowel obstruction. Delay to surgery needs reviewed and discussion. Subsequently never recovered and died. I believe there is a coroners inquest. Requesting urgent case review meeting and SAI will need to take place Died - 27/05/2018	Notes requested (with Litigation) 3.7.18 Timeline to be complete and notification to be completed. 13/07/018 – Discussed at screening Mr McKay to be contacted to review what the exact issue is- email sent to Mr McKay 17/07/2018 Reviewed by Mr McKay delay in getting to theatre in 1st 24 to 72 hours email to Mr Carroll & Mr Haynes 30.7.18 – Discuss with Ronan - Delay to surgery needs reviewed and discussion. Damian has confirmed our thoughts that the patient should have had early surgical intervention based on his original CT scan or review and surgery with 72 hours as per the NASBO report with recommendations are attached. There were also issues with the level of staff review etc. 31.7.18 Mr Carroll & Dr Scullion asked for incident to be referred to Surgical M&M, Paula to follow up 31.7.18 Paula referred incident to Dr Thompson for Surgical M&M 14.8.18 Confirm if SAI and if so nominations of review team 21/08/2018 Reviewed by Mr Haynes- SAI to be completed – Mr McIlvenna to chair. 11/09/2018- Timeline completed. Need review team for meeting. 26/09/2018- Email to screening team for nomination 09/10/2018- Discussed with Mr Carroll who suggested Mr MrArdle DHH for review team. Email to Mr Haynes to confirm he is in agreement. 23/10/2018 Meeting to be scheduled. 5.11.18 Meeting confirmed for 8.11.18 @ 9am 12/11/2018 Mr McArdle and Mr McElvanna to interview medical staff and further meeting to be scheduled in 3 weeks. 19/11/2018 Mr McElvanna has offered dates for 1st week December 2018. (Mr McArdle & Trudy Reid)
SEC	SAI	Personal Information redacted by the USI	Delay in investigation / management of a red flag cancer patient. For SAI. Protocols review	21/08/2018 Reviewed by Mr Haynes- SAI to be completed – Mr Epanomeritakis to chair. 11/09/2018- Need review team to arrange meeting 26/09/2018- Email to screening team for nomination. 09/10/2018- Discussed with Mr Carroll who suggested Mr M Yousaf for review team. Email to Mr Haynes to confirm he is in agreement. 23/10/2018 Meeting to be scheduled after timeline is done. 5.11.18 Sharon Glenny completing timeline

SEC	M&M	Personal Information redacted by the USI	Clozpine levels and bowel obstruction Patient died from multiple organ failure on ICU on the Personal Information as a result of chronic constipation and acute-on-chronic renal failure. The chronic constipation was contributed to by long-standing clozapine use, prescribed for schizophrenia. This is a known side effect and the patient had had previous hospital admissions with same. While still a patient on the medical ward (admitted with recurrent falls), clozapine levels were taken on the 23rd May following a review by psychiatry. As clozapine is a named medication, prescribed only by psychiatry, levels are monitored commercially by a lab in England and results communicated (as I understand it) directly to psychiatry. Following a second psychiatry review on 1/6, these levels were noted to be high indicating a possible 'clozapine toxicity'. Said levels were not communicated to medicine or ICU. We currently have no method of obtaining these ourselves – and I've checked with Richard, the ICU pharmacist and he is unaware of a current mechanism by which we can do this. I don't know if they were ever phoned through to psychiatry or whether checking the results requires contact to the company. Not knowing the clozapine levels did not affect this patient's care - clozapine continued to be with-held on ICU. There is no specific therapy for clozapine toxicity. Clozapine toxicity did not cause death.	Email from Jilly Clozapine has been associated with varying degrees of impairment of intestinal peristalsis, ranging from constipation to intestinal obstruction, faecal impaction and paralytic ileus. On rare occasions these cases have been fatal. Particular care is necessary in patients who are receiving concomitant medications known to cause constipation (especially those with anticholinergic properties such as some antipsychotics, antidepressants and antiparkinsonian treatments), have a history of colonic disease or a history of lower abdominal surgery as these may exacerbate the situation. It is vital that constipation is recognised and actively treated. Should this incident be screened as a SAI to determine if all appropriate action had been taken regarding the risk of constipation and gastrointestinal obstruction both with patient prior to attendance and with management while in hospital. Should it be shared with MHD? 26/06/2018 reviewed with Mr Carroll and Dr Scullion NOT SAI from and anaesthetics perspective- has been forwarded to MHD for review 3.7.18 Timeline to be completed 17/08/2018 Discussed 13/07/2018 SEC screening, suggested surgeon reviews. Mr McKay is reviewing and will discuss radiology finding with Radiology and respond with outcome 24/07/2018- awaiting feedback from Mr McKay, Mr Carroll updated re Mr McKays discussion and possible radiology findings 31.7.18 Email to Dr McKay on 27.7.18 request to review CT result. 21/08/2018. CT reviewed and medical notes left with Mr McKay today 11/09/2018- 25/09/2018- Dr D McKay has referred to Surgical M&M. 23/10/2018 Discussed at screening. For referral to Medical M&M. ? Round table discussion between Mental Health and Surgeons.
SEC	Internal	Personal Information redacted by the USI	Complaint letter from patient and husband regarding her diagnosis, treatment and care. Patient treated for colitis subsequently had subtotal colectomy 14.5.18. (27.4.18 – 16.5.18)	26/06/2018 reviewed with Mr Carroll and Dr Scullion Probably not SAI as being taken through medical director process- email to be sent 26/6/2018 01/08/2018- Dr Murphy advises SEC to approve acknowledgement. Timeline to commence from 1st admission. 6.8.18 Acknowledgment approved by RC – Approved. 7.8.18 – Meeting confirmed for 3.9.18 10/09/2018- 2nd meeting being organised 11/09/2018- timeline complete. Internal review. Report to be drafted. 18/09/2018- Meeting with Dr Bhatt and Governance Team 19/09/2018. 25/09/2018- report to be drafted 5.11.18 report being drafted

SEC ED	Internal	Personal Information redacted by the	Personal admitted to ED with catastrophic intracerebral bleed. GCS 3 on presentation. Anaesthetic SHO known to be on transfer so ED kindly intubated patient and transferred for scan. Once bleed confirmed, ICU contacted. ICU SHO (non airway competent attended) and contacted ICU consultant (myself). Patient accepted for ICU care but no beds in hospital so instructions given to search for regional bed and to arrange NICCATS transfer. ICU SHO remained with patient to provide care. Anaesthetic team - registrar, SHO, consultant failed to attend ED for five hours to care for ventilated patient despite knowing presence of patient in department and aware they were ventilated. No anaesthetic nurse involvement despite request from ED. Patient not transferred to theatres for ongoing care. Patient remained in ED (on portable ventilator) under care of ED/ICU SHO. Full monitoring according to AAGBI standards of a ventilated patient did not occur - potential harm with regard to cerebral perfusion in a head injured patient. Non-airway competent trainee left unsupervised. Patient was unprepared for transfer when NICCATS team arrived. Substantial additional burden placed on ED nursing and medical staff.	24/07/2018- screening Discussed with Mr Carrol and Dr Scullion, the patient outcome was likely not compromised; however there appear to initially be some internal process issues. Round table internal SEA to be arranged for next week. Time line re patient clinical documentation to be started, Dr Scullion and Dr Hampton to interview or get statements from medical staff in preparation for the meeting. 30.7.18 Meeting arranged for 31.7.18 with Dr Hampton & Dr Scullion. 31.7.18 Mr Carroll updated re meeting earlier today 31.7.18 - Agreed internal SEA at present. Has been discussed at ED M&M. For discussion at ICU M&M in September. Meeting of MDT to take place. To include ED, ICU Anaesthetics, Nursing, Bed management and medical team. 7.8.18 – Meeting took place on 31.7.18 7.8.18 - Mary Burke Advised at ED screening on 6.8.18 – No need for meeting she will discuss directly with Patient flow team. Presented at ED M&M on 25.7.18 for discussion and learning shared. Discussed at ED Screening on 1.8.18 - Mary Burke to advise head of patient flow that anaesthetic nurse is on call. Close from ED perspective. 21/08/2018- For discussion at ICU M&M in September 11/09/2018- Dr Scullion advises ICU M&M meeting will be 20/09/18 25/09/2018- Update from Dr Scullion- Further discussions to take place within Anaesthetic team. 09/10/2018- Dr Scullion advises a meeting is scheduled 15/10/18 to discuss the case. 23/10/2018 SAI. Meetings to be arranged. Dr G Hampton, Nidhi Gupta and Dr Tariq to be asked to chair. Email sent to Dr Tariq 24/10/18. 13/11/2108 Dates circulated for meeting
SEC MUSC	Internal	Personal Information redacted by the HSI	Datix re missed bowel tumour	11/09/2018- Meeting scheduled 17/09/2018 with Mr S Bhatt and Mr K McElvanna 18/09/2018- Meeting held yesterday. Dr Bhatt to speak with Dr S Murphy and Dr C Hillemand. Dr McElvanna to speak with Mr G McArdle 09/10/2018- Meeting scheduled with Mr Bhatt and Dr Hillemand.Dr McElvanna has met Dr McArdle. 30/10/2018- Report in draft 5.11.18 Report being drafted
SEC		Personal Information redacted by the HSI	Patient Personal had ERCP in January 2016 for CBD stones but they could not be removed, a stent was inserted and he was referred for surgery. Lap chole and CBD exploration was performed in April 2016. Over past two months he has had 3 admissions with severe sepsis due to cholangitis. MRCP showed large stones in CBD. Per attended for ERCP to clear these stones and at the time of the procedure it was noted he still had a stent in his CBD. This was why he developed the recurrent stones and episodes of cholangitis. It should have been taken out at the time of surgery in 2016.	23/10/2018- Timeline in progress. Medical notes received. 30/10/2018 - Timeline completed. For screening.
SEC/Urology		Patient 138	Patient had TURBT 22/12/17 was listed for MDM 28.12.17 (virtual MDM) patient was closed on cancer tracker system and not followed up until GP phoned to enquire 25/10/18. Histology report 28/12/17 showed Transitional cell carcinoma.	Red Flag team investigating for timeline 19.11.2018 For screening.

SEC	Interface	Personal Information redacted by the USI	A Personal Information redacted by the USI attended the glaucoma service at the Wellbeing and Treatment Centre on 4 October 2018 and was seen at an additional clinic that had been set up to see long waiting new glaucoma referrals from the Southern Trust. At the appointment the patient stated that his vision had rediced in the left eye over the past year, vision was recorded as 6/48 on the Snellen Chart in the left eye. His left optic nerve showed early cupping with an early visual field defect. The patient was diagnosed with advanced glaucoma in the left eye and early glaucoma in the right eye. Personal Information redacted by the USI [redacted] The patient had been referred to ophthalmology outpatients in the Southern Trust in March 2017 by his community optometrist who queried glaucoma in his left eye. The referral letter stated that he had been previously referred in April 2015 but he had not been provided with an appointment. The delay in this patient being seen and treated has impacted on his overall outcome.	6.11.18 Email from Ronan Carroll "We need to follow our processes ie screen and a determination made as to the level of investigation required".
ICU	Screening	Personal Information redacted by the USI	40 minute delay in anaesthetist attending ED	24/10/2018 Discussed at screening. For referral to Anaesthetics. Datix sent to Mr R Carroll and Dr D Scullion 06/11/2018- Discussed with Dr Scullion and Mr Carroll. ED records sent to Dr Scullion to review. 13/11/2018 Dr Scullion to discuss with anaesthetist on duty. 19.11.2018 see email from Dr Scullion Bleep records requested.
ED	Screening	Personal Information redacted by USI	Ng tube inserted by anaesthetic SHO, without consultantion to CT scan and no report was available at the time. Ct scan showed base of skull fracture	5.11.18 For screening 14.11.18 Discussed at ED screening. Moved to SEC screeing. Dr Scullion to review.

O&G Radiology Labs Screening				
Department	**Type**	**Name and H&C**	**Background**	**Screening update**
Radiology	SAI	Personal Information redacted by the U	Patient seen in ED following RTC and CT carried out. CT report stated fractures of cervical spine but omitted to report multiple rib fractures and flail segment of chest. Patient referred to and transferred to RVH fracture clinic for admission. Patient later returned to CAH ED with no communication from RVH to advise of this. Multiple fractures only picked up on return from RVH as nursing staff were concerned regarding patient condition and asked ED consultant to review. As a result there was a significant delay in the appropriate management of this lady. Patient assessed by anaesthetics and transferred to theatre.	Timeline to be done. For screening 9/5/18- discharged home –discussed at ED screening - for screening by RADIOLOGY 07/06/2018 Flail chest is a clinical diagnosis not just radiological. The report was amended by outsourced company. The radiology report was incorrect and the medical director of the out sourced company has been informed. The clinical picture of significant bruising was not highlighted. When the patient returned to CAH further examination identified bruising and radiology were contacted and the report reviewed an amended. The radiology report was then amended. The patient outcome was not affected by the radiology discrepancy. Recommendation is that the case to be reviewed by Emergency Department again 11.10.18 Email from HSCB *I refer to the attached Interface Incident reported by the Southern Trust. This incident was recently discussed by the Acute SAI Review Team where it was agreed this should be reported as a SAI by Southern Trust, who will take the lead, with input from Belfast Trust. We would therefore expect to receive this by 24 October 2018.* Sent to Trudy to action
MUSC Radiology		Personal	Patient presented with headache and neck pain. Seen by neurology team who advised MRA. Attended for MR Angio at 1505 on 07/08/18. Noted at time of scan to be abnormal however medical staff told in MR that no one on to report scans that afternoon. Consultant escalated MRA report to be outsourced through bed management for report as if normal patient potentially for discharge. Informed turn around time would be 4hours. 25minutes post MRA patient developed left sided facial droop, slurred speech and left sided weakness. Thrombolysis call initiated and stroke team arrived. Felt not for lysis however concern about possible dissection. No consultant radiologist onsite available/ able to report MRA which was needed to guide management of patient. Stroke consultant present on ward. Significant effort expended by junior medical team seeking to obtain report of MRA. Consultant re-contacted bed management to escalate outsourced report. Ability to do this not widely known by junior staff and no available published protocols regarding its usage in or out of hours. Patient dropped GCS, anaesethetic team called and patient required intubation. MRA report back from Nighthawk showed multifocal ischaemic areas, lack of visualization of both vertebral arteries inc basilar artery. ?dissection ?thrombosis. Report time stamped 1650 however not visually available on PACS until 1730. Patient discussed with RVH Stroke and ICU, intubated and ventilated and transferred for out of hours clot retrieval. Significant difficulty in getting report of neuroimaging in emergency. No established protocols for accessing urgent or emergency report of otherwise unreported neuroimaging if necessary- would likely have been even greater issue if this had occurred during night shift.	Close from MUSC perspective – escalated to Radiology – (patient well) feedback requested to MUSC 19/09/2018- In review 24/09/2018- Dr McCaffrey advises she spoke with Dr Paul McGarry. Discussed at screening. Get formal feedback from Dr I Yousif. 01/10/2018- email to Radiology re review and ward re patient details

MUSC/Gynae		Personal	an you advise me if this lady's death was discussed at a gynae M+M given that she first presented to gynae and had problems identified on a CT scan that were not acted on and then referred to GI in Nov 17 but not seen by them either until admitted in Jan 18 terminal malignancy – so that I know whether she should be put down for discussion elsewhere. Was it recorded as an SAI?	Happy this lady is discussed at M+M but agree with David that the main learning will be through the radiology discrepancy process as the root cause problem was the initial CT report. She was referred to GI by gynae for management of her cirrhosis and ascites with a comment 'CT has shown no evidence of GI malignancy'. We get significant numbers of patients who are referred to initially to gynae with ascites who turn out to have cirrhosis. Patients with cirrhosis lose weight. The tumour markers inpatients with ascites can be elevated. She would have been urgent, not RF 5.11.18 Waiting on Radiology M&M
AHP		Personal Information redacted by	Sight loss	Report in draft - Emailed Belfast re Dr George meeting to be arranged with Grandfather.
ATICS		Personal Information redacted	30/09/2018 Personal was an acutely unwell child who presented to ED DHH. Anaesthetist was Fast bleeped on 4 occasions. Delay in reply and arrival to Resus for at least 40 minutes.	24/10/2018 Discussed at ED screening. For referral to Anaesthetics. Datix sent to Mr R Carroll and Dr D Scullion 19.11.18 Dr Scullion spoke to anaesthetics. See email. Paula has requested bleep records for date of incident.
Cancer team		Personal Information redacted by the	Staff member of Red Flag team emailed me, attaching the OC referral that had been upgraded at triage and advised that this was a late upgrade. I opened referral (06.11.18 due to annual leave) and could see that it was a referral from Respiratory to Gastroenterology. The date dictated on referral was 06.09.18. Date Typed was 22.10.18. The referral was date stamped with 30.10.18 - Date received in RBC. It appears that referral was triaged on 31.10.18 and was marked as RF. This referral was then received into the Red Flag booking office on 02.11.18. Appointment was booked on 02.11.18 for 06.11.18. (61 Day wait from date of registration on PAS) The delay on this occasion appears to be with the typing of clinic.	
ATICS	NIPCAS	Personal	So far we have identified about 200 exams that need an official report - until these have been reported we will not know if any harm has come to the patients	For screening.
Radiology	Screening	Personal Information redacted by the	patient admitted with unwitnessed fall + head injury- arrived at 14:00 and obs complete again at 19:15, CTB requested at 17:15 and completed at 21:30. On taking over care of the patient, I attempted to contact CT and radiographers multiple times as did the doctor who had seen the patient. eventually we were able to get in touch with them but patients CTB was delayed significantly with a significant result requesting neuro surgeon input	Medical notes requested. 7.11.2018- Notes received. For screening 14.11.18 Closed from ED. Mary Burke has discussed with Dr P McGarry. He has sent to Dr I Yousuf and spoke to Jeanette Robinson

Update on M&M

Patient name	Hospital number/HCN	Datix number	Date of incident	Division	Date to M&M	UPDATE
Personal	Personal	Perso	3.4.15	SEC		HSCB was notified of incident. To be presented at M&M Surgical Specialty specific M&M May 2017
Personal	Personal	Perso	22.6.16	MUC		Presented to ED M&M on 31.8.16
Personal	Personal	Irrele Complaint	19.1.17	MUC		4.9.18 Meeting held with sister and PCC.
Personal	Personal	Perso	21/12/2016	MUC		
Personal	Personal					No record to date case has been discussed at M&M
Personal	Personal		7.1.17	MUC	Feb 17 Cardiology M&M	There were areas of concern which may have contributed to this patients death SOM 4 – Just recently signed off by Dr McNeilly on IMMIX following receipt of Cardiology Sub-Speciality M&M minutes
Personal	Personal			MUC		This has been recorded as SOM 4 on IMMIX but is awaiting sign-off by ICU who completed IMMIX
Personal	Personal		6.4.17	MUC		Patient presented to ED DHH on 6/04/2017 with spontaneous pneumothorax – a Right sided chest tube in situ introduced via seventh intercostal space in anterior axillary line. From the insertion site the tube is directed cranially mildly compressing the base of the right lower lobe and impinging on the diaphragm. Per was admitted to hospital and discharged on the 10/04/2017 with a referral to thoracic surgery given that he had 2 spontaneous pneumothoraces on the same side
Personal	Personal					Discussion Case was screened for SAI however was considered not an SAI. Case IRI. If there is uncertainty around reversing Warfarin then discuss with Haematology or senior colleagues. Octaplex was available however was not refilled from previous use. It is essential that this is restocked as soon as possible after use. Training and availability issues with the Point Of Care INR machine in Daisy Hill were raised. Point Of Care INR is a useful tool to have. This should be available to the Emergency Department on a 24 hour basis. Actions Point of care INR machine to be kept in the Emergency Department. When Octaplex has been used then this should be restocked. If there is uncertainty around reversing Warfarin then discuss with Haematology or senior colleagues. ACTIONS Mary to put on ED Newsletter emails sent last on 22 10 2018
Personal	Personal	Perso	8.6.18	CCS		28/06/2018-timeline complete. Response from Radiology "I was on the Saturday and ran all requests via Aaron who said confusion shouldn't be scanned at per guidelines. Ward never contacted me or him about it and covering Drs never mentioned – I always ask anything else for me! Not sure why wasn't scanned Sunday or the Friday" 01/08/2018- Screened. For Medical M&M to review examination process/System. Email sent to Connie Connolly. Wait outcome from Medical M&M. 6.8.18 Paula to Email Dr J Hardy re DHH M&M- email sent 7/08/18 03/09/2018 – Awaiting feedback –Dr Harty on leave until 10/9/18 10/09/2018- reminder email sent to Dr Harty 12/09/2018- Dr Harty advises "We have not presented this case at the m+m. My feeling is that this will lead to a blame culture around named junior and senior doctors. It will be discussed within the department and with our radiology colleagues"
Personal	Personal					SAH discuss at surgical M&M re anticoagulation
Personal	Personal			MUC		Kay to review as per AmcV 2/7/2018- Reminder to Kay Carroll- Medical notes requested (notes received) 23/07/2018- Email reminder to Kay Carroll 01/08/2018- wait update 03/09/2018 email reminder to Kay 12/09/2018- Medical notes receivedOut of hospital arrest – Coroners case- M&M (ICU). This Personal was brought to hospital following a PEA cardiac arrest at home. Her family commenced bystander CPR and ROSC was achieved after 35 minutes with NIAS. This cardiac arrest occurred on the same day she was discharged from Craigavon Area Hospital where she had been an inpatient for 4 days receiving treatment for a Lower Respiratory Tract Infection, Acute kidney injury and electrolyte derangement. During this admission she had been on oxygen via nasal cannula- 3L SaO2 95% until the morning of her discharge. Her clinical observations as per the Nursing notes were SaO2 96% on room air immediately prior to discharge.
Personal	Personal			ED		Presented to ED with PV bleeding, pt had scheduled gynae appointment. Not checked in ED for PV loss. Large bleed. Etopic pregnancy.
Personal	Personal			ED		29/07/2018 - Pt attended ED after falling down flight of stairs, on initial assessment multiple spinal #S missed. Not picked up until reviewed by medical team in ED and CT 11 hrs later.
Personal	Personal	M&M referral		MUSC SEC		MUSC M&M SOM 1 SEC M&M waiting response from Mr Thompson
Personal	Personal			MUSC SEC		Presented to Surgical PSM 17/5/2017 outcome 2 recorded. Presented to ED PSM 25/1/2017 outcome 3. contained aspects that SHOULD² be improved (learning identified); the patient's eventual outcome was NOT affected i.e. Near Miss. Consider referring to Trust Incident Reporting System unless already considered or reported.
Personal	Personal	Perso	4.6.18	MUSC SEC MHD		26/06/2018 – Discussed with Mr Carroll and Dr Scullion – no SEC/ATICS issues referred to MHD 27/06/2018 Discussed with Dr Murphy and Dr Hampton – no ED issues referred to MHD 17/08/2018 Discussed 13/07/2018 SEC screening, suggested surgeon reviews. Mr McKay is reviewing and will discuss radiology finding with Radiology and respond with outcome 24/07/2018- awaiting feedback from Mr McKay, Mr Carroll updated re Mr McKays discussion and possible radiology findings 31.7.18 Email to Dr McKay on 27.7.18 request to review CT result. 21/08/2018 Mr McKay reviewing notes 03/09/2018 Mr McKay has reviewed chart- to go to Surgical M&M – screening meeting updated 25/09/2018- Dr D McKay has referred to Surgical M&M. 23/10/2018 Discussed at screening. For referral to Medical M&M. ? Round table discussion between Mental Health and Surgeons
Personal	Personal	Perso	8.7.19	MUSC SEC ICU		9.10.18 This case has been presented and discussed at the Anaesthetic Patient Safety Meeting on the 20/9/2018. Minutes with lessons learnt will be added when available. As pewr Laurie Martin ICU Has been discussed at ED M&M. For discussion at ICU M&M in September. Meeting of MDT to take place. To include ED, ICU Anaesthetics, Nursing, Bed management and medical team. 7.8.18 – Meeting took place on 31.7.18 7.8.18 - Mary Burke Advised at ED screening on 6.8.18 – No need for meeting she will discuss directly with Patient flow team. Presented at ED M&M on 25.7.18 for discussion and learning shared. Discussed at ED Screening on 1.8.18 - Mary Burke to advise head of patient flow that anaesthetic nurse is on call. Close from ED perspective. 21/08/2018- For discussion at ICU M&M in September 11/09/2018- Dr Scullion advises ICU M&M meeting will be 20/09/18
Personal	Personal	Perso	31.12.17	MUC		30.07.18 Meeting to be arranged with family, Dr Hampton attending need name of medical Dr to attend. 1/08/2018- Dr Murphy to confirm his nomination for meeting. ? need for ED rep.6.8.18 – Dr P Murphy agreed to meet with family & Trudy. Dr Murphy said no need for ED rep. 03/09/2018 Meeting to be organised 21/05/2018- email to litigation re PM report 2/05/2018 – Awaiting approval of report 6/4/18 – Report drafted by T Reid and share with MUSC 24.1.18 ED M&M findings sent to Dr Moan for review 10.1.18 Letter from family. For presentation at ED M&M.
Personal	Personal	Perso	2.10.18	MUC		Discussion at ED screening, it was requested that this incident is discussed at ED M&M Fall New Neurological deficit. Pt attended ED DHH head injury alcohol on board. CT head and neck NAD. Patient transferred to ward before surgical clerk in. CT spine ordered showed fracture T9 T10 T11

Personal Information	Personal			SEC		M&M referral DC conversions at ward level 18/12/2017 - DC conversion at ward level. Review -29/01/2018 – Discussed incident – also M&M findings – which state Complex co-morbidity – RCA undertaken – no change in outcome – SOM 1 was satisfactory. There were no particular Learning Lessons. Does not meet the criteria for SAI. 07/02/2018 - Review again following M&M M&M Issues: □ Interface between specialities □ DC cardioversion was carried out despite advice of medical SpR and Cardiology consultant against. □ Not appropriate to ask Junior Doctors to leave the wards to complete DC cardioversion □ Action: Forward to Surgical/ICU M&M with feedback to Medical M&M 30/04/2018 –being discussed at M&M – await formal sign off 18/06/2018- Close. (Keep on SEC) 31.7.18 – Wait formal signoff of surgical M&M. 21/08/2018-wait response from Dr Thompson re Surgical M&M 11/09/2018-as above 25/09/2018- No Surgical M&M report available
Personal	Personal			ED		09/02/2018 – Notes reviewed by Dr Hampton and Dr Murphy (no time line) no obvious lapse in care – surgery to review 12/04/2018 provisional M&M on ICU - ECR SOM1 was satisfactory there were no particular learning lesions .21/08/2018- as before. PM report sent to Dr R Thompson Mr Haynes aware 11/09/2018- wait surgical M&M 25/09/2018 No surgical M&M report available
Personal	Personal	Perso		SEC		Email from Jilly Clozapine has been associated with varying degrees of impairment of intestinal peristalsis, ranging from constipation to intestinal obstruction, faecal impaction and paralytic ileus. On rare occasions these cases have been fatal. Particular care is necessary in patients who are receiving concomitant medications known to cause constipation (especially those with anticholinergic properties such as some antipsychotics, antidepressants and antiparkinsonian treatments), have a history of colonic disease or a history of lower abdominal surgery as these may exacerbate the situation. It is vital that constipation is recognised and actively treated. Should this incident be screened as a SAI to determine if all appropriate action had been taken regarding the risk of constipation and gastrointestinal obstruction both with patient prior to attendance and with management while in hospital. Should it be shared with MHD? 26/06/2018 reviewed with Mr Carroll and Dr Scullion NOT SAI from and anaesthetics perspective- has been forwarded to MHD for review 3.7.18 Timeline to be completed 17/08/2018 Discussed 13/07/2018 SEC screening, suggested surgeon reviews. Mr McKay is reviewing and will discuss radiology finding with Radiology and respond with outcome 24/07/2018- awaiting feedback from Mr McKay, Mr Carroll updated re Mr McKays discussion and possible radiology findings 31.7.18 Email to Dr McKay on 27.7.18 request to review CT result. 21/08/2018. CT reviewed and medical notes left with Mr McKay today 11/09/2018- 25/09/2018- Dr D McKay has referred to Surgical M&M. 05/11/2018- Email to Dr Convery who advises for presentation at Medicine M&M November.
Personal	Personal	Perso		ED		
Personal	Personal	NONE	23.7.18	MUC		03/09/2018 Emailed Dr Murphy regarding presentation at M&M

Public Health Agency

Via Email

Mr Shane Devlin
Chief Executive
SHSCT

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13 November 2018

Dear Mr Devlin

I am writing to you in my capacity as Chair of an Independent Serious Adverse Incident (SAI) Review Panel which has been established following concerns raised regarding the scope and independence of the SHSCT SAI review into the homicide by Mr McEntee of Michael and Marjorie Cawdery on the 26th May 2017.

The SAI Review is a Level 3 Review which will examine the events leading up to the homicides and the subsequent care and support provided to the families and will adhere to the guidance produced by the HSCB, Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016).

As Mr McEntee received care and treatment from SHSCT I am requesting access to Mr McEntee's medical notes for members of the review panel and also to inform you that during the course of the review, panel members may need to speak with some staff from SHSC. I would appreciate your advice on how we can best co-ordinate the practical arrangements required in respect of these requests.

If you have any queries please do not hesitate to contact me.

Looking forward to hearing from you

Yours sincerely

Personal Information redacted by the USI

Miss Patricia Gordon
(Chair of Independent Review Panel)

Improving Your Health and Wellbeing

HSC Business Services Organisation

Southern Health & Social Care Trust

Management of Standards & Guidelines – 2018/19

nqa ISO 9001 Registered Quality Management

Contents

Acknowledgement

Internal Audit wishes to thank management and staff at the Southern Trust for their assistance and co-operation during the course of the audit engagement.

Control Log

Working Draft Issued On:	31 October 2018
Exit Meeting Held On:	02 October 2018
Management Meeting Held On:	26 November 2018
First Draft Issued On:	
Management Actions Due By:	**Add Date – 4 weeks following draft report issue**
Management Actions Received:	
Final Report Issued On:	

Distribution List

Shane Devlin	Chief Executive (final report only)
Dr Ahmed Khan	Acting Medical Director
Margaret Marshall	Assistant Director Clinical and Social Care Governance
Helen O'Neill	Acting Director of Finance
Alison Rutherford	Assistant Director of Finance

Introduction

In accordance with the 2017/18 Annual Internal Audit Plan, BSO Internal Audit carried out an audit of Management of Standards and Guidelines during September 2018. The last Internal Audit of this topic was performed during May 2015 when Satisfactory assurance was provided.

This audit reviewed corporate and directorate processes for the dissemination, prioritisation/risk assessment (where appropriate) and implementation of standards and guidelines.

Standards and Guidelines (S&G) are initially received by the Corporate Standards and Guidelines Team who will log the S&G on the central corporate register. On a weekly basis the Corporate Team forward the Standards and Guidelines received to Directorate Governance Officers, Pharmacy Governance and Medical Directors Office. In addition S&Gs received are available on the Trust Sharepoint site. Responsibility for identifying applicability, risk assessment and subsequent implementation of Standards and Guidelines within the Trust resides within the operational directorates. Each of the operational directorates has developed their own processes as to how Standards and Guidelines will be managed through Directorate Governance structures. As the majority of Standards and Guidelines fall within the remit of Acute Services, the directorate has established a Standards and Guidelines Review Group which meets on a bi-weekly basis. The role of this committee is to undertake a risk review of each clinical standard and guideline received and the identification of a change lead to take forward the required actions. The group is also responsible for the ongoing monitoring of those clinical standards and guidelines where full compliance has not yet been met.

Standards and Guidelines come from a variety of sources and are received by a number of regional bodies for regional endorsement. Such external agencies include the HSC Board, Public Health Agency (PHA) and Safety & Quality Unit at the DoH. These agencies disseminate the Standards and Guidelines to the HSC Trusts for action and in some instances, there is a requirement that an assurance will be provided to confirm that the required recommendations have been embedded within local practice. Standards and Guidelines are increasingly challenging for providers and commissioners to manage due to their increasing numbers and variety of sources involved.

There were 360 Standards and Guidelines received from January 2017 to August 2018 and of these 156 (43%) had been received from NICE and a further 76 (21%) from the Chief Medical Officer. In line with NICE Circular HSC (SQSD) 2/13 and Circular HSC (SQSD) 3/13, the HSCB seeks a positive assurance report on NICE Guidance issued from September 2011 on a bi monthly basis. This assurance includes confirmation the Trust has completed the initial actions of targeted dissemination, identification of a clinical/management lead and implementation planning within 3 months of issue and that the Trust has fully implemented all guidance within the required timescale. Where NICE Clinical Guidelines are not implemented or not on track for implementation within 12 months of issue, the Trust is required to complete a Section E template which sets out the major barrier/s to implementation, any specific requirements to address the major barriers and any immediate patient safety concerns if the clinical guideline is not implemented within the 12 month timescale. The HSCB requires the Trust to monitor and keep under review the Section E documents which are in place and provide updates on implementation. The Trust currently has 55 NICE guidelines within Acute Services where a Section E template is in place and notified to the HSCB.

The breakdown of Standards and Guidelines received are as follows:-

Issuing Organisation	Number of Standards and Guidelines (Issued January 2017 to August 2018)
NICE Technology Appraisal	93
CMO Letter	76
NICE Clinical Guideline	27
NICE Clinical Guideline Update	23
Safety & Quality Reminder of Best Practice Guidance	20
HSCB/PHA Letter	17
Medical Device Alert	17
HSCB Letter	16

Issuing Organisation	Number of Standards and Guidelines (Issued January 2017 to August 2018)
PHA Letter	15
DOH Letter	10
NICE Public Health Guidance	8
Drug Safety Update	5
NICE Interventional Procedures	5
Public Health Guideline	5
Various Others	23
TOTAL	**360**

Scope of Assignment

This assignment reviewed the processes in place for receipt, dissemination, implementation and corporate oversight for standards and guidelines received. It also reviewed processes in place for ensuring that systems were in place for reporting compliance to issuing organisations.

The audit was based on the risk that guidance and circulars may not be adhered to and required actions implemented in the absence of a robust process for dissemination of documents.

The objectives of this audit were:

- To ensure that there is an appropriate system in place for coordinating, disseminating and overseeing standards and guidelines.
- To ensure that Standards and Guidelines are appropriately disseminated and implemented in the Trust.
- To ensure that changes to practice/procedure following receipt of Standards and Guidelines is effectively communicated and implemented.
- To ensure that there are reporting arrangements in place in respect of guidance and circulars.

This audit did not include NIAIC or Drug Alerts received directly into Estates and Pharmacy

Note: We report by exception only, and where no issues and recommendations are made, the result of our work indicates that the key objectives and risks are being managed and that procedures are being adequately adhered to.

Level of Assurance

Limited

There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.

Executive Summary

Internal Audit can provide Limited assurance in relation to the Management of Standards and Guidelines within the Trust. While the Trust has in place good controls to record corporately the receipt and subsequent dissemination of all Standards and Guidelines to directorates, there is no corporate overview and reporting of the Trust's overall compliance against standards and guidelines. Weaknesses were also found in relation to completeness of data held on the Corporate Standards and Guidelines register and there is limited ongoing audit / follow up of compliance. There was evidence within the operational directorates of ongoing review, implementation and management of standards and guidelines, through Directorate Governance processes.

A satisfactory assurance was given in our previous audit of Standards and Guidelines in 2015/16. Since then there has been a reduction in the extent of corporate reporting e.g. previously the accountability report on compliance and implementation of Standards and Guidelines went to Governance Committee twice a year – currently there is no reporting through Governance committee.

There are two significant findings in this report that impacts on the assurance provided.

1. During the period September 2017 to September 2018, there had been no reporting of compliance with Standards and Guidelines presented to the Board Governance Committee. Consequently the Trust Board has not received assurance that all Standards and Guidelines are implemented on a timely basis and are subsequently being complied with.
   Previously the Trust prepared an Accountability Report for Standards and Guidelines which was presented to the Trust Governance Committee on a six monthly basis which detailed the Trust's compliance against each standard and guideline received. This Accountability Report is no longer compiled.
2. Review of the corporate register (spreadsheet) found that there are significant gaps in the information held. Data was incomplete to enable compliance progress against individual standards and guidelines to be tracked and reported corporately. There is no mechanism to issue reminders to prompt staff when actions are due, and there are no updates on actions taken by directorates. Both the corporate and operational governance teams raised concerns in relation to the completeness and usefulness of the corporate register for managing and monitoring status of Standards and Guidelines.

The other key findings of the audit are:-

3. When a Standard or Guideline is viewed as fully implemented, there is no formal audit or follow-up process in place to ensure ongoing compliance. Where a Standard and Guideline is for dissemination only, the operational directorates governance teams do not have a process in place to ensure that this has been disseminated to all relevant staff.
4. In review of the corporate process map, Internal Audit noted that whilst the process for dissemination and review of the Standards and Guidelines is outlined, it does not refer to how responses should be managed and collated centrally via the corporate team. Responses to the issuing organisation are agreed at Directorate level but there is no corporate overview or monitoring of these responses.
5. 24 of the 40 Standards and Guidelines reviewed had a response timeframe:
   - The Positive Assurance report for July 2018 had not been submitted to the HSCB at the date of audit fieldwork in September 2018.
   - In 3 out of 24 cases, the response date as per the Standard & Guideline had not been achieved, the Trust submitted responses 2, 4 and 7 weeks after the required submission date.
   - In 2 cases, the response was for a nomination from the Trust to attend a regional group – in these 2 cases the nomination had not been made through the corporate team as per procedures.
6. Standards & Guidelines are issued every week by the Corporate team to Governance Teams in the Operational Directorates. In review of 40 Standards and Guidelines the following exceptions were noted:-
   - 3 had not been issued to 8-9 working days after receipt from issuing organisation.
   - 1 had not been issued to 13 working days after receipt from issuing organisation.
   - 1 case where the S&G had been issued from the source organisation on 24 May 2018 but was not emailed to operational governance leads until 20 July 2018, a delay of 42 working days. 1 had been issued by the source organisation on 25 September 2017 but was only issued on 9 March 2018 by the corporate team – this S&G had not been received by the corporate team and had been issued directly to the Medical Directors office. The Corporate team picked this up as part of a compliance audit completed in March 2018. There was a delay of 120 days between receipt and dissemination to Governance Leads.

There are no other observations in this report.

Summary of Findings and Recommendations

Finding		Number of Recommendations		
		Priority 1	Priority 2	Priority 3
1.	Corporate Oversight and Reporting	1	-	-
2.	Register of Standards and Guidelines	-	1	-
3.	Follow-Up and Audit of Implemented Actions	-	1	1
4.	Corporate Process Map for Standards and Guidelines	-	1	-
5.	Performance Management – Meeting Target Responses Dates	-	1	-
6.	Compliance with Processes	-	2	-

Detailed Findings and Recommendations

1 Corporate Oversight and Reporting

Finding

There was evidence within the operational directorates of ongoing review, implementation and management of standards and guidelines, through Directorate Governance processes.

However, during the period September 2017 to September 2018 there had been no reporting of compliance with Standards and Guidelines received to the Board Governance Committee, either as a stand-alone item or as part of a broader Clinical Governance report or quality improvement report. Trust Board are not receiving assurances that Standards and Guidelines are being appropriately managed.

Previously the Trust prepared an Accountability Report for Standards and Guidelines which was presented to the Trust Governance Committee on a six monthly basis which detailed the Trust's compliance against each standard and guideline received. This Accountability Report is no longer compiled.

Implications

There is a lack of robust and formal oversight at a corporate level of the overall Trust compliance with Standards and Guidelines issued. Trust Board may not receive the necessary assurances that actions required in relation to Standards and Guidelines are being progressed and implemented.

Recommendation 1.1	Management should strengthen the governance and corporate oversight arrangements in respect of compliance with Standards and Guidelines. A regular report should be presented to Governance Committee in relation to compliance with Standards and Guidelines.
Priority	1
Management Action	**ACCEPTED / REJECTED**
Responsible Manager	
Implementation Date	

2 Register of Standards and Guidelines (Data Quality and Completeness)

Findings

Currently the Corporate Standards and Guidelines Register is held as an excel spreadsheet by the Medical Directorate. The purpose of the register is to provide a central record of all standards and guidelines received by the Trust, who they were disseminated to, risk rating and to monitor progress re implementation within designated timescales where applicable. Review of the corporate register found that there are gaps in the information completed e.g. Lead Directorate not always completed, applicable directorates not always completed. Additionally there is no mechanism or reminders to prompt staff when actions are required / overdue and there are no updates on actions being taken to ensure compliance.

Both the corporate and operational governance teams raised concerns in relation to the completeness of assurance data and usefulness of the corporate register for managing and monitoring the status of Standards and Guidelines.

There is currently no reporting mechanism to allow real time information on the Trust's actual compliance and progress against actions.

Implication

The current register may not be fit for purpose as it is incomplete.
Trust is unable to use the register to report corporately on the implementation status of standards and guidelines.

Recommendation 2.1	The corporate spreadsheet should be fully adopted across all directorates and processes introduced to ensure it is properly managed and timely updated. The corporate spreadsheet should be reviewed to ensure all fields are accurately completed and up-to-date and that all directorate data regarding progress and actions taken to comply with standards is recorded on a timely basis, and to allow accurate reporting of data.
Priority	2
Management Action	**ACCEPTED / REJECTED**
Responsible Manager	
Implementation Date	

3 Follow-Up and Audit of Implemented Actions

Finding

Each Directorate manages standards and guidelines through their directorate governance processes this includes ensuring dissemination to appropriate staff, were applicable identifying change leads. Where responses are required to issuing organisations these must be agreed by the Director in advance of submission to the corporate team who are responsible for forwarding these responses to the issuing organisation, including where applicable any barriers to implementation within the agreed timeframes etc.
However when a Standard or Guideline is deemed to be fully implemented, there is no formal audit process in place to ensure ongoing compliance. In addition where a Standard and Guideline is for dissemination only, the operational directorates governance teams do not have a process in place to ensure that this has been disseminated to all relevant staff.

Implications

On an on-going basis the Trust does not have assurance that they continue to be compliant with Standards and Guidelines received.
Not all relevant staff may receive the standards and guidelines.

Recommendation 3.1	Internal Audit acknowledges that due to the volume of standards and guidelines received it would not be feasible to audit compliance for all. However based on the overall risk rating or profile of the standard or guideline, management should include audits of compliance with Standards and Guidelines within directorate audit plans.
Priority	2
Management Action	**ACCEPTED / REJECTED**
Responsible Manager	
Implementation Date	

Recommendation 3.2	Where a Standard and Guideline only requires dissemination, governance teams in operational directorates should build into their initial email a request from Heads of Service to confirm dissemination of the Standard and Guideline to relevant staff in operational teams.
Priority	3
Management Action	**ACCEPTED / REJECTED**
Responsible Manager	
Implementation Date	

4 Corporate Process Map for Standards and Guidelines

Finding

There is a process map in place which details the dissemination of Standards and Guidelines from the corporate team to the operational directorates. However, whilst this corporate process map outlines the process for dissemination and review of the S&Gs, it does not refer to how responses should be returned centrally via the corporate team. Each directorate compiles their own response and agree this through their Governance processes before forwarding to the corporate team who are responsible for forwarding this to the issuing organisation. There is no corporate overview or monitoring of these responses.

Implication(s)

The process map does not reflect all processes which are undertaken by the Corporate Standards and Guidelines team.

Recommendation 4.1	The corporate process map should be reviewed, amended, updated and approved to reflect the complete process for the management of Standards and Guidelines within the Trust. • This should include the process in relation to NICE positive assurance. • The corporate co-ordination or submission of responses to the issuing organisation.
Priority	2
Management Action	**ACCEPTED/REJECTED**
Responsible Manager	
Implementation Date	

5 Performance Management Meeting Target Responses Dates

Finding

24 of the 40 Standards and Guidelines reviewed had a specific response timeframe stated.

15 of the 24 were in relation to NICE guidelines or technology appraisals. On a bi-monthly basis the Trust are asked to provide a Positive Assurance to the HSCB in relation to NICE guidelines and Technology appraisals at the date of audit fieldwork the Positive Assurance report for July 2018 had not been submitted to the HSCB.

In the remaining 9 cases which had designated response dates, Internal Audit noted the following exceptions:-

- In 3 cases the response date as per the Standard & Guideline had not been achieved, the Trust submitted responses 2, 4 and 7 weeks after the required submission date.
- In 2 cases the response was for a nomination from the Trust to attend a regional group – in these 2 cases the nomination was not through the corporate team as per procedure and had been submitted directly in one case by the Executive Director of Nursing (this was recorded as overdue on the central register) and in one case by the Medical Director.

A similar finding was previously reported in the 2015/16 Standards and Guidelines report.

Implication(s)

Failure to comply with issuing organisation response timeframes.

Recommendation 5.1	As previously recommended, the Trust should ensure that response to standards and guidelines are made by the designated response date. Where response timeframes are not achieved this should be included in the report to Governance Committee and reasons for none compliance or barriers to implementation.
Priority	2 *(Priority 2 under previous audit classifications)*
Management Action	**ACCEPTED** **Responsible Officer: -** Assistant Director of Clinical and Social Care Governance **Original Implementation Date: -** 28 February 2016
Responsible Manager	
Revised Implementation Date	

6 Compliance with Processes

Finding

Standards & Guidelines as per the corporate process map should be issued every week by the Corporate Team to Governance Teams in the operational directorates. In review of 40 S&Gs received in the period 1 January 2017 to 31 August 2018 Internal Audit Noted the following issues:-

- 3 took 8-9 working days to issue after receipt from the issuing organisation
- 1 took 13 working days to issue after receipt from the issuing organisation
- 1 took 25 working days to issue after receipt from the issuing organisation.
- 1 case where the S&G ***"Resources to support the safe adoption of the revised National Early Warning Score NEWS 2"*** had been issued from the source organisation on 24 May 2018 but was not emailed to the operational governance leads until 20 July 2018 a delay of 42 working days
- 1 case where the S&G "***Flexible Scopes requiring a Sterile Status: Establishment of short life Task and Finish Group to develop reprocessing Best Practice"*** had been issued by the source organisation on 25 September 2017 but was not identified by Coprorate Team until 9 March 2018. The S&G had not been received into the corporate team and had been dealt with at the issue date through the Medical Directors office. The Corporate team picked this up as part of a compliance audit completed in March 2018. There was a delay of 120 days between receipt and dissemination to Governance Leads however the action required had been completed as it was Trust nomination to sit on the Task and Finish Group. Both these latter 2 cases were categorised as low risk

Implication

Non-compliance with procedures.
Potential for delays in issue of standards and guidelines to impact upon patient safety issues.

Recommendation 6.1	All standards and guidelines should be issued to the relevant governance staff in operational directorates within 1 week of receipt as per the process map.
Priority	2
Management Action	**ACCEPTED / REJECTED**
Responsible Manager	
Implementation Date	

Appendix A Definition of Levels of Assurance and Priorities

Level of Assurance

Satisfactory	Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.
Limited	There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.
Unacceptable	The system of governance, risk management and control has failed or there is a real and substantial risk that the system will fail to meet its objectives.

Recommendation Priorities

Priority 1	Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.
Priority 2	Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.
Priority 3	Failure to implement the recommendation could lead to an increased risk exposure.

Note to Report

This audit report should not be regarded as a comprehensive statement of all weaknesses that exist. The weaknesses and other findings set out are only those which came to the attention of Internal Audit staff during the normal course of their work. The identification of these weaknesses and findings by Internal Audit does not absolve Management from its responsibility for the maintenance of adequate systems and related controls. It is hoped that the audit findings and recommendations set out in the report will provide Management with the necessary information to assist them in in fulfilling their responsibilities.

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Subject	Start	End
Tracey	09/01/2018	
Tracey re post	Thu 11/01/2018 13:30	Thu 11/01/2018 14:00
Tracey update	Wed 07/02/2018 15:30	Wed 07/02/2018 16:00
Tracey	06/03/2018	
Tracey	13/03/2018	
Tracey	Wed 18/04/2018 16:30	Wed 18/04/2018 17:00
Tracey	22/05/2018	
Tracey and Heather re structure	Wed 23/05/2018 13:00	Wed 23/05/2018 13:30
Tracey re structures and Lesley re dash board	Fri 25/05/2018 11:00	Fri 25/05/2018 12:00
Heather and Tracey	01/06/2018 09:30	01/06/2018 10:00
Tracey updated	Fri 01/06/2018 15:00	Fri 01/06/2018 15:30
Tracey and Dr Johnston	Mon 04/06/2018 14:00	Mon 04/06/2018 15:30
Meeting with Tracey	Fri 06/07/2018 09:00	Fri 06/07/2018 10:30
Tracey and Barry re response to family from Dr Henderson	Wed 11/07/2018 14:00	Wed 11/07/2018 15:00
SAI re urology with Tracey andSoibhan	Wed 22/08/2018 15:30	Wed 22/08/2018 17:00
Tracey	08/25/17 13:30	08/25/17 1:340
Prep for Tracey	Tue 24/07/2018 09:00	Tue 24/07/2018 10:00

Tracey	Wed 05/09/2018 11:00	Wed 05/09/2018 12:30
Tracey	23/10/2018	
Tracey	16/11/2018	
Tracey	03/01/2017	
Tracey	10/01/2017	
Tracey	17/01/2017	
Tracey	24/01/2017	
Tracey	01/02/2017	
Tracey	08/02/2017	
Tracey	21/02/2017	
Connie and Tracey	02/08/2017 11:00	02/08/2017 12:30
Tracey	Tue 21/02/2017 17:00	Tue 21/02/2017 17:30
Tracey	14/03/2017	
Tracey	28/03/2017	
Tracey	03/04/2017	
Tracey and Barry	Mon 05/06/2017 10:00	Mon 05/06/2017 10:30
Tracey	18/07/2017	
Tracey	Tue 25/07/2017 16:30	Tue 25/07/2017 17:00
Tracey re Margarets email	Fri 28/07/2017 11:30	Fri 28/07/2017 12:00
Tracey	01/08/2017	
Tracey	15/09/2017	
prep Tracey & audit meeting	Tue 19/09/2017 08:45	Tue 19/09/2017 09:30
Tracey	26/09/2017	
Heather and Tracey re POCT	21/11/2017 16:00	21/11/2017 16:30
Tracey	Tue 28/11/2017 15:30	Tue 28/11/2017 16:00
Tracey	Wed 29/11/2017 15:30	Wed 29/11/2017 16:00

Tracey	Mon 18/12/2017 16:00	Mon 18/12/2017 16:45
Tracey	21/12/2017 14:00	21/12/2017 14:30
Tracey staffing and dependencies	Tue 09/02/2016 11:00	Tue 09/02/2016 13:00
Tracey re EG	Thu 21/04/2016 12:00	Thu 21/04/2016 13:00
Tracey	Wed 27/04/2016 09:30	Wed 27/04/2016 10:00
Tracey	19/05/2016 14:00	19/05/2016 14:00
Tracey Boyce	07/06/2016 09:30	16/12/2016 10:00
Tracey	19/07/2016	
Tracey	16/09/2016	
Meeting with Esther and Tracey	Wed 15/06/2016 08:30	Wed 15/06/2016 09:30
Meeting with Esther and Tracey	Wed 22/06/2016 08:30	Wed 22/06/2016 09:30
Meet with Tracey	13/07/2016 14:00	13/07/2016 15:00
Tracey re JD and structure etc	Thu 18/08/2016 11:00	Thu 18/08/2016 13:00
Tracey	11/10/2016	
Tracey	18/10/2016	
Tracey and Heather	Thu 20/10/2016 15:00	Thu 20/10/2016 16:00
Tracey	15/11/2016	
Tracey - and Nigel	Thu 17/11/2016 09:00	Thu 17/11/2016 09:30
Tracey	23/11/2016	
Tracey	29/11/2016	
Tracey	06/12/2016	
Tracey	13/12/2016	
Tracey and Nigel re equipment	16/12/2016 09:00	16/12/2016 10:00

Subject	Location	Start	End
Meeting with Esther and Tracey and Patricia start of hand over		Mon 07/01/2019 08:30	Mon 07/01/2019 11:00
Esther		Wed 19/12/2018 12:00	Wed 19/12/2018 12:30
Esther		21/11/2018	
Esther re SM action plan		Thu 04/10/2018 11:00	Thu 04/10/2018 11:30
Esther		21/10/2018	
Esther		24/10/2018	
Esther		31/10/2018	
Esther		31/10/2018	
Esther		13/06/2018	
Esther		06/06/2018	
Esther		30/05/2018	
Esther		14/03/2018	
Esther		14/02/2018	
Esther		07/02/2018	
Esther cancelled due to snow		17/01/2018	
Esther		31/01/2018	
Esther		21/01/2018	
Esther		11/01/2017	
Esther		18/01/2017	
Esther		01/02/2017	
Esther		22/02/2017	
Esther		07/03/2017	
Esther		19/04/2017	

8.45 am Governance Meeting with Esther and Tracey	Esther's Office	Fri 21/04/2017 09:00	Fri 21/04/2017 10:00
Esther		26/04/2017	
Esther		26/04/2017	
Esther		31/05/2017	
Esther		01/08/2017	
Esther		02/08/2017	
		23/08/2017	
Esther		13/09/2017	
Esther		11/10/2017 Note from book	
Esther			
Esther		13/12/2017	
Esther		20/12/2017	
Meeting with Esther re complaint re stillborn		Tue 07/06/2016 12:00	Tue 07/06/2016 13:30
Esther		23/08/2016	
Meeting with Esther and Tracey		Wed 15/06/2016 08:30	Wed 15/06/2016 09:00
Meeting with Esther		Tue 21/06/2016 08:30	Tue 21/06/2016 09:00
Meeting with Esther and Tracey	Esthers office	Wed 22/06/2016 08:30	Wed 22/06/2016 09:00 every Wednesday from 08:30 to 09:00
Esther		20/7/2016	

Esther		23/08/2106	
Esther		05/10/2016	
Esther		26/10/2016	
Esther		09/11/2016	
Esther		15/11/2016	

Stinson, Emma M

From: Reid, Trudy [redacted]
Sent: 10 October 2018 21:49
To: McVey, Anne; Carroll, Ronan; Carroll, Anita; Conway, Barry; Boyce, Tracey; Gishkori, Esther
Cc: Stinson, Emma M
Subject: Governance reports
Attachments: Weekly Re-Opened Report 09.10.18.xlsx; Current Complaints 9.10.18.xlsx; Ombudsman weekly 011018.xlsx; Major & Catastrophic Incidents week ending 091018.xlsx; Incident Review Position as at 01.10.18.xlsx; SAI Report to 9.10.18.xlsx; SAI Recommendations 9.10.18 no action plan or report.xlsx

Please see attached governance reports for information and action

Regards,

Trudy

Trudy Reid
Acute Clinical & Social Care Governance Coordinator
Craigavon Area Hospital
SHSCT
Mobile [redacted]

DIRECTORATE OF ACUTE SERVICES
Report on Re-Opened Complaints - 9 October 2018

Ref	Record name	Div	Loc (Exact)	Re-Opened	Current Stage	Ack or Holding Letter
[redacted]	Personal Information redacted by the USI	MUC	1 North & 1 South	05.10.17	Comments from Litigation finalised (6.9.18) - for approal by A McVey at next 1:1 meeting (10.9.18). Two areas under Dr Kadhim still to be finalized. Complaints File and copy of medical notes with A McV (10.9.18)	21.8.18
		MUC & OPPC	AMU & Ramone WW	13.3.18	Draft Response almost finalized (1.10.18)	1.10.18
		MUC/SEC	ED/ENT/Neurology	11.5.18	Pre-Meeting held on 20 .8.18 with responses to concerns circulated for approval/amendment. Ronan Carroll to chair. Meeting in Sept cancelled by complainant with request to re-schedule November for clincal reasons. Meeting arranged for 12.11.18	N/A
		MUC	1 North	18.5.18	Draft Response approved by A McVey (9.10.18) but one query to be clarified by A McV (9.10.18)	24.8.18
		MUC	DHH -ED & Female Med	21.5.18	C Connolly to respond to outstanding queries (19.9.18) Discussion and reminder to Connie (4.10.18)	24.8.18
		MUC	ED	28.5.18	Draft Respose to A McVey for approval (10.9.18) - File and draft response with A McV as clarity required re swipe doors.	24.7.18
		MUC	1 North	19.7.18	To Esther for approval (9.10.18)	30.8.18
		MUC	ED CAH	23.8.18	A McVey to forward to Finance for advice (3.9.18) A McV sent request to fiance for advice 10.9.18. Reminder e-mail sent to A McVey (1.10.18)	23.8.18
		MUC	ED	28.8.18	Sent to Dr Patton, Sr Holmes, M Burke, P Smith - ? Response/?Meeting (28.8.18) Response received from Dr Patton - awaiting mgt plan from P Smith/M Burke (11.9.18)	23.8.18
		MUC	Booking Centre	3.9.19	Draft Response to Anita Carroll for Approval (4.10.18)	
		MUC	1 North / ED	11.9.18	Awating response from Kay Carroll / Ruth Weir (PT)	
		MUC	ED DHH	17.9.18	Meeting arranged for 10.10.18. Postponed by complainant - being re-scheduled for November 2018.	20.9.18
		MUC	ED CAH	25.9.18	To M Burke & Sister Holmes re possible meeting (1.10.18)	1.10.18
		MUC	ED CAH	2.10.18	New Complaint - For Advice	8.10.18
		MUC	ED CAH	2.10.18	Issued for advice on further response or meeting (8.10.18)	8.10.18
		MUC	AMU	3.10.18	New Complaint - For Advice	8.10.18

DIRECTORATE OF ACUTE SERVICES
Weekly Report on Formal Complaints - 9 October 2018

Ref	Record name	Div	Loc (Exact)	Date Received	Investigation due	Reply due	Working Days Overdue	Current Stage	Handler
AS55.18/19	Personal Information redacted by the USI	MUC	Diabetic Clinic	24/05/2018	08/06/2018	22/06/2018	78	To Director's office for approval 24/9/18 - checked with Emma, file still there, but queries raised / amendments needed 9/10/18	VK
AS62.18/19	Personal Information redacted by the USI	SEC	4North	30/05/2018	13/06/2018	27/06/2018	75	Still awaiting advice from Anne McVey re medical response (?Anne has file)	VK
AS202.18/19	Personal Information redacted by the USI	MUC	2 North Medical	31/05/2018	14/06/2018	28/06/2018		To Director's office for approval 3/10/18.	
AS80.18/19	Personal Information redacted by the USI	IMWH	Maternity Admissions	06/06/2018	20/06/2018	04/07/2018	70	To Director's office for approval 3/10/18.	VK
AS201.18/19	Personal Information redacted by the USI	IMWH	Maternity Admissions	12/06/2018	26/06/2018	10/07/2018		Draft notes awaiting amendment/approval.	VK
AS87.18/19	Personal Information redacted by the USI	MUC/SEC	ED / 4 South / Trauma Ward	14/06/2018	28/06/2018	13/07/2018	63	Awaiting further comment from Brigeen & Wendy 10/9/18	DC
AS106.18/19	Personal Information redacted by the USI	IMWH	Antenatal Clinic	02/07/2018	17/07/2018	31/07/2018	51	To Director's office for approval 25/9/18. - Emma to make minor change 9/10/18	VK
AS110.18/19	Personal Information redacted by the USI	IMWH	Maternity Assessment Unit	04/07/2018	19/07/2018	02/08/2018	49	To Director's office for approval 3/10/18.	VK
AS117.18/19	Personal Information redacted by the USI	MUC	ED	10/07/2018	25/07/2018	08/08/2018	45	Awaiting response from Urology (Ronan to advise)	DC
AS119.18/19	Personal Information redacted by the USI	IMWH	AAU	13/07/2018	27/07/2018	10/08/2018	43	To Director's office for approval 11/10/18.	VK
AS128.18/19	Personal Information redacted by the USI	MUC	ED	19/07/2018	02/08/2018	16/08/2018	39	Reminder to Mary Burke	DC
AS133.18/19	Personal Information redacted by the USI	MUC/SEC	DPU / Cardiology OPD	24/07/2018	07/08/2018	21/08/2018	36	Awaiting input from Marti McKenna 8/10/18	VK
AS148.18/19	Personal Information redacted by the USI	SEC	Urology	03/08/2018	17/08/2018	03/09/2018	27	To Director for signture 3.10.18	VK
AS153.18/19	Personal Information redacted by the USI	FSS/IMWH	1East	06/08/2018	20/08/2018	04/09/2018	26	To Anne McVey for approval 21/9/18	VK
AS154.18/19	Personal Information redacted by the USI	IMWH	2 East MLU	06/08/2018	20/08/2018	04/09/2018	26	To Director for signature 8/10/18	VK
AS161.18/19	Personal Information redacted by the USI	MUC	ED	09/08/2018	23/08/2018	07/09/2018	23	To Anne McVey for approval 08.10.18.	DC
AS164.18/19	Personal Information redacted by the USI	CCS/SEC	Radiology / Urology	13/08/2018	28/08/2018	11/09/2018	21	Response being drafted 9/10/18	VK
AS167.18/18	Personal Information redacted by the USI	MUC	Stroke/Rehab	14/08/2018	29/08/2018	12/09/2018	20	To Anne McVey for approval 08.10.18.	DC
AS172.18/19	Personal Information redacted by the USI	MUC/CCS	ED/Radiology	20/08/2018	04/09/2018	18/09/2018	16	Awaiting response from Jeanette Robinson	VK
AS174.18/19	Personal Information redacted by the USI	CCS	MRI	20/08/2018	04/09/2018	18/09/2018	16	To Director's office for approval 08.10.18.	DC
AS178.18/19	Personal Information redacted by the USI	MUC	ED / OPPC	20/08/2018	04/09/2018	18/09/2018	16	To Anne McVey for approval 8/10/18	VK
AS179.18/19	Personal Information redacted by the USI	MUC	Neurology Clinic	20/08/2018	04/09/2018	18/09/2018	16	Louise Devlin seeking advice from Dr Murphy	VK
AS175.18/19	Personal Information redacted by the USI	MUC	ED/2 North Medical	21/08/2018	05/09/2018	19/09/2018	15	Possible SAI	VK
AS180.18/19	Personal Information redacted by the USI	CCS	Delivery Suite	21/08/2018	05/09/2018	19/09/2018	15	Holding letter to complainant explaining delay in investigation - staff involved on maternity leave.	VK
AS182.18/19	Personal Information redacted by the USI	MUC	Neurology Clinic	23/08/2018	07/09/2018	21/09/2018	13	Awaiting response from Louise Devlin and Dr Craig.	VK
AS183.18/19	Personal Information redacted by the USI	CCS	EPPC	24/08/2018	10/09/2018	24/09/2018	12	To director for approval 8.10.18	VK
AS186.18/19	Personal Information redacted by the USI	SEC	Ophthalmology Clinic	30/08/2018	13/09/2018	27/09/2018	9	To Director for approval 8/10/18.	DC
AS189.18.19	Personal Information redacted by the USI	SEC	ICU	04/09/2018	18/09/2018	02/10/2018	6	Meeting being arranged.	DC
AS191.18/19	Personal Information redacted by the USI	SEC	Ophthalmology Clinic	04/09/2018	18/09/2018	02/10/2018	6	Awaiting response from Wendy Clayton.	DC
AS192.18/19	Personal Information redacted by the USI	MUC	Rheumatology Clinic	04/09/2018	18/09/2018	02/10/2018	6	Awaiting response from Lisa McAreavey and Louise Devlin	DC
AS193.18/19	Personal Information redacted by the USI	CCS	Colonoscopy Clinic	06/09/2018	20/09/2018	04/10/2018	4		DC
AS194.18/19	Personal Information redacted by the USI	MUC	EDDHH	10/09/2018	24/09/2018	08/10/2018	2	To Director's office for approval 3/10/18.	DC
AS196.18/19	Personal Information redacted by the USI	MUC	AMU	11/09/2018	25/09/2018	09/10/2018	1		DC
AS197.18/19	Personal Information redacted by the USI	MUC	EDDHH	12/09/2018	26/09/2018	10/10/2018		To Director's office for approval 8/10/18.	DC
AS198.18/19	Personal Information redacted by the USI	CCS	Radiology	12/09/2018	26/09/2018	10/10/2018		To Barry Conway for approval 9/10/18.	DC
AS199.18/19	Personal Information redacted by the USI	SEC	3 South	12/09/2018	26/09/2018	10/10/2018			DC
AS200.18/19	Personal Information redacted by the USI	CCS	Radiology	13/09/2018	27/09/2018	11/10/2018			DC
AS203.18/19	Personal Information redacted by the USI	MUC	ED	17/09/2018	01/10/2018	15/10/2018			DC
AS204.18/19	Personal Information redacted by the USI	MUC	Dermatology OPD	18/09/2018	02/10/2018	16/10/2018			DC
AS206.18/19	Personal Information redacted by the USI	MUC	General Medicine Clinic	20/09/2018	04/10/2018	18/10/2018		To Anne McVey for approval 8/10/18	
AS207.18/19	Personal Information redacted by the USI	CCS	Radiology - CT	20/09/2018	04/10/2018	18/10/2018			VK
AS208.18/19	Personal Information redacted by the USI	IMWH	Delivery Suite	20/09/2018	04/10/2018	18/10/2018			VK
AS209.18/19	Personal Information redacted by the USI	MUC	Cardiology Clinic	20/09/2018	04/10/2018	18/10/2018			DC
AS210.18/19	Personal Information redacted by the USI	MUC	ED	24/09/2018	08/10/2018	22/10/2018			DC
AS211.18/19	Personal Information redacted by the USI	MUC	ED	25/09/2018	09/10/2018	23/10/2018			VK
AS212.18/19	Personal Information redacted by the USI	MUC	ED	25/09/2018	09/10/2018	23/10/2018			DC
AS213.18/19	Personal Information redacted by the USI	MUC	ED	25/09/2018	09/10/2018	23/10/2018			DC
AS214.18/19	Personal Information redacted by the USI	MUC	ED	26/09/2018	10/10/2018	24/10/2018		Under investigation	VK
AS215.18/19	Personal Information redacted by the USI	CCS	GUM Clinic	26/09/2018	10/10/2018	24/10/2018		To Barry Conway for approval 9/10/18.	DC
AS216.18/19	Personal Information redacted by the USI	MUC	Male Medical	25/09/2018	09/10/2018	24/10/2018		Under investigation	VK
AS217.18/19	Personal Information redacted by the USI	IMWH	Community Midwifery	27/09/2018	11/10/2018	25/10/2018		Under investigation	DC
AS221.18/19	Personal Information redacted by the USI	SEC	General Surgery Clinic	01/10/2018	15/10/2018	29/10/2018		Under investigation	VK
AS218.18/19	Personal Information redacted by the USI	MUC	ED	02/10/2018	16/10/2018	30/10/2018		Response being drafted 9/10/18	DC
AS219.18/19	Personal Information redacted by the USI	MUC	ED	02/10/2018	16/10/2018	30/10/2018		Under investigation	DC
AS220.18/19	Personal Information redacted by the USI	SEC	Doctor	02/10/2018	16/10/2018	30/10/2018		To Director's Office for signature 08.10.18.	DC
AS222.18/19	Personal Information redacted by the USI	MUC	Diabetic Clinic	03/10/2018	17/10/2018	31/10/2018		Under investigation	DC
AS224.18/19	Personal Information redacted by the USI	MUC	ED	03/10/2018	17/10/2018	31/10/2018		Under investigation	DC
AS223.18/19	Personal Information redacted by the USI	FSS	Car Park	04/10/2018	18/10/2018	01/11/2018		Under investigation	PT
AS225.18/19	Personal Information redacted by the USI	CCS	Antenatal Clinic	04/10/2018	18/10/2018	01/11/2018		Under investigation	DC
AS227.18/19	Personal Information redacted by the USI	MUC	ED	05/10/2018	19/10/2018	02/11/2018		Under investigation	VK
AS226.18/19	Personal Information redacted by the USI	SEC	Urology Clinic	08/10/2018	22/10/2018	05/11/2018		Under investigation	DC
AS228.18/19	Personal Information redacted by the USI	MUC	ECG Clinic	08/10/2018	22/10/2018	05/11/2018		Under investigation	VK
AS229.18/19	Personal Information redacted by the USI	SEC/CCS	T&O/Physio	08/10/2018	22/10/2018	05/11/2018		Under investigation	VK
AS230.18/19	Personal Information redacted by the USI	CCS	Orchard Clinic	08/10/2018	22/10/2018	05/11/2018		Under investigation	VK

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DIRECTORATE OF ACUTE SERVICES
Current Ombudsman Requests as at 17 September 2018

Trust Ref	NIPSO Ref	Patient	Div	Date Trust Received	Date Acute Received	Date Due Ombudsman	Progress	Head of Service	Handler
[redacted]		Personal Information redacted by the USI	MUC				Action Plan to be agreed. Meeting arranged for 24.08.18.	Louise Devlin	David Cardwell
			MUC				Ongoing	Ruth Donaldson	David Cardwell
			MUC				Recommendations out to A/Ds and HOS for updating 1.5.18	A McVey, R Carroll, M Corrigan & K Carroll	Vivienne Kerr
			SEC				Ongoing	Brigeen Kelly	David Cardwell
			MUC				Ongoing	Kay Carroll	David Cardwell
			MUC	25.09.18	25.09.18	28.10.18	IPA circulated for comment.	Brigeen Kelly	David Cardwell
			MUC				Ongoing	Mary Burke	David Cardwell
			MUC				Ongoing	Louise Devlin	David Cardwell
			SEC	14.09.2018	14.09.2018	05.10.2018		Martina Corrigan	David Cardwell
			SEC	26.09.2018	1.10.2018	17.10.2018	First letter from Obudsman to assess the complaint	Wendy Clayton	Vivienne Kerr

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Acute Services Directorate
Major & Catastrophic Incidents 2 - 9 October 2018

ID	Incident date	Reporter	Division	Site	Loc (Exact)	Severity	Description	Action taken (Investigation)	Handler	Approval status
89159	06/10/2018	Personal Information	MUC	Craigavon Area Hospital	Emergency Department CAH	Major	PATIENT BROUGHT IN BY NIAS ON CHAIR WHO WAS A POLYTRAUMA, CAME OFF BIKE NECK BACK AND CHEST WALL INJURIES. HAD HAEMOTHARAX AND MULTIPLE RIB FRACTURES. WAS BROUGHT TO FRONT TRIAGE ON CHAIR NOT BOARDED. INSUFFICIENT HAND OVER. STAFF INFORMED PATIENT HAD JUST INJURED WRIST.		Mary Burke	INREV

Acute Services Directorate
Incident Position, awaiting and being reveiwed - as at 1 October 2018

Count of Division	In Review	Awaiting Review
Functional Support Services	52	17
IMWH - Cancer and Clinical Services	477	69
Medicine and Unscheduled Care	261	94
Pharmacy	26	35
Surgery and Elective Care	238	38

Division	In Review	Awaiting Review
Anaesthetics, Theatres and IC Services	112	
B Floor		
Bio-chemistry Lab	1	
Biomed Workshop	1	
Car Park/Grounds		
CEAW	1	
Corridor/Stairs		
CT Scanner		
Day Procedure/Day Surgery Unit	31	
Delivery Suite, DHH		
General Outpatients Reception/Waiting Area	1	
Health Records	2	
ICU (HDU)	9	
Pharmacy Dispensary	1	
Pre-operative Assessment Clinic	4	
Recovery Unit	2	
Scheduling Team	25	
Theatre	28	
Trauma Ward	1	
Trauma/Orthopaedic Theatre	5	

CCS Division	In Review	Awaiting Review
Acute Directorate AHP's		1
Car Park/Grounds		1
X-ray Dept (Radiology)		
Cancer Services	8	23
1 South Medical	1	
2 West Maternity Post Natal		1
Antenatal Clinic		1
Basement		1
Breast Clinic		2
Breast Screening Unit	2	
Delivery Suite, DHH		1
General Outpatients Reception/Waiting Area	1	1
Haematology Clinic	1	8
Laboratory		
Lurgan HSSC		1
Oncology Clinic, Mandeville Unit	3	7
Diagnostic Services	25	7
Breast Clinic	1	
Breast Screening Unit		
Car Park/Grounds		1
CT Scanner	6	
Day Hospital	1	
DEAW	1	
ED X-ray	1	1
EEG Clinic		
Male Surgical/HDU	1	
Maternity Admissions/Assessment Unit	1	
MRI Unit	1	
Oncology Clinic, Mandeville Unit	1	
Paediatric Ward	1	
Renal Clinic		1
Trauma/Orthopaedic Theatre	1	1
X-ray Dept (Radiology)	9	3
Genito-Urinary Medicine (GUM)	4	
John Mitchel Place, HSSC	4	
Laboratory Services	28	15
2 West Maternity Post Natal		1
3 South	1	
Antenatal Clinic	1	
Bio-chemistry Lab	5	
Blood Transfusion Lab	4	
Bronte Ward		
Cellular Pathology Lab	3	
Delivery Suite, CAH	2	5
Delivery Suite, DHH		3
Early Pregnancy Problem Clinic	1	
ED Majors		1
Emergency Department CAH	3	
Emergency Department DHH		2
Haematology Lab	3	
ICU (HDU)		
Laboratory	4	
Microbiology Lab	1	
Neonatal Unit/SCBU		1
Theatre		2

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FSS Division	In Review	Awaiting Review
Functional Support Services	52	17
Booking / Admin	7	1
Booking Centre	1	
Breast Clinic	1	
Day Procedure/Day Surgery Unit	1	
ENT Clinic	1	
General Surgery Clinic		1
Male Surgical/HDU	1	
Paediatric Ward	1	
Recovery Unit		
Theatre	1	
Decontamination Services	17	6
Sterile Services Dept	1	5
Theatre	8	1
Trauma/Orthopaedic Theatre	8	
Health Records	3	
Breast Clinic		
Dermatology Clinic		
E Floor		
Emergency Department CAH	1	
General Outpatients Reception/Waiting Area	1	
Health Records		
Theatre	1	
Linen Services		3
Laundry Room		3
Locality Support Services (A&D)	1	
Basement		
Kitchen	1	
Locality Support Services (C&B)	7	4
1 East Maternity/Gynae		
1 North Cardiology		
1 South Medical		
2 North Medical		
2 North Respiratory		
2 South Medical		
2 South Stroke		
2 West Maternity Post Natal		
3 South		
4 North		
4 South		
AMU		1
Antenatal Clinic		
Basement		
Bronte Ward		
Canteen/Dining Room		
Car Park/Grounds		
College of Nursing/ST Headquarters		
Corridor/Stairs		
Day Procedure/Day Surgery Unit		

FSS Division	In Review	Awaiting Review
Delivery Suite, CAH		
Dermatology Clinic		
Discharge Lounge		
ED X-ray		
Emergency Department CAH	1	1
Entrance/Exit		
Finance Department		
Firbank House		
General Outpatients Reception/Waiting Area		
Haematology		
ICU (HDU)	1	
Kitchen		1
Laboratory	1	
Laundry Room		
Lift		
Maternity Admissions/Assessment Unit		
Occupational Therapy Dept		
Oncology Clinic, Mandeville Unit		
Orthopaedic Ward		
Paediatric Ward		
Patient Support Office	1	
Physiotherapy Inpatient		
Physiotherapy Outpatients Department		
Public Toilets		
Ramone Ward		
Reception/Waiting Area		
Recovery Unit		
Rosebrook		
Silverwood Ward		
Staff accommodation	2	
Sterile Services Dept		
Switchboard		
The Elms		
The Oaks		
The Rowans		
Theatre	1	
Trauma Ward		
Trauma/Orthopaedic Theatre		
Urology Clinic		
Ward 2, Assessment and Rehabilitation		
Ward 3, Assessment and Rehabilitation		
Waste Transfer Station		
Willowbank		
Willows Ward		1
X-ray Dept (Radiology)		
Locality Support Services (Newry)	17	3
Canteen/Dining Room		
Car Park/Grounds		
Coronary Care Ward	1	

FSS Division	In Review	Awaiting Review
Daisy Hill Resource Centre		
Doctors Accommodation		
Emergency Department DHH		
Female Medical	1	
Female Surgical/Gynae	1	
General Male Medical,		
John Mitchel Place, HSSC		
Kitchen		
Male Surgical/HDU	2	
Maternity Ward		
Post Room	1	
Reception/Waiting Area	1	
Rehabilitation Ward	6	
Stroke / Rehab	4	
Switchboard		3

IMWH Division	In Review	Awaiting Review
Midwifery and Gynaecology	412	23
1 East Maternity/Gynae	14	2
1 West Gynae		
2 East Midwifery Led Unit	17	
2 West Maternity Post Natal	77	2
Antenatal Clinic	32	2
Bio-chemistry Lab	1	
Brownlow HSSC, Legahorry Centre	1	
Car Park/Grounds	1	
Colposcopy Clinic	2	
Crossmaglen Health Centre		
Daisy Day Clinical Centre		1
Day Obstetric Unit	1	
Day Procedure/Day Surgery Unit	1	
Delivery Suite, CAH	165	12
Delivery Suite, DHH	35	3
Emergency Department CAH	1	
Female Surgical/Gynae	1	
General Outpatients Reception/Waiting Area	4	
General OutpatientsTreatment Room	1	
Gynae Clinic	3	
Health Records	1	
Home of client	7	
Maternity Admissions/Assessment Unit	21	
Maternity Ward	20	
Non Trust premises		
Public place	1	1
SAUCS (GPOOH) Kilkeel	1	
SAUCS (GPOOH) Newry	1	
Staff accommodation	1	
Sterile Services Dept	1	
Theatre	1	

MUC Division	In Review	Awaiting Review
Medicine and Unscheduled Care	261	94
Acute Hospital Social Workers	1	
Corridor/Stairs	1	
Cardiac Services	22	9
1 North Cardiology	10	
1 South Medical		
AMU	1	
Bio-chemistry Lab		1
Canteen/Dining Room		
Cardiac Catheterisation Lab		
Cardiology Research	1	
Coronary Care Ward	3	1
Day Procedure/Day Surgery Unit	1	
Dermatology Clinic	1	2
ECG Clinic		
Emergency Department DHH		3
Haematology	1	
Home of client	1	1
Lift		1
Male Surgical/HDU	1	
Paediatric Ward	1	
Theatre	1	
X-ray Dept (Radiology)		
Emergency Department Services	89	29
	1	
AMU		
Ardmaine Nursing Home	1	
B Floor		1
Bio-chemistry Lab	2	
Bluestone Day Hospital	1	
Brooklands Nursing Home	2	
Canteen/Dining Room	1	
Car Park/Grounds	1	1
Corridor/Stairs		1
Discharge Lounge		
ED Majors	1	
Emergency Dental Clinic		1
Emergency Department CAH	48	13
Emergency Department DHH	16	
Entrance/Exit	3	
General OutpatientsTreatment Room		1
Home of client	1	1
Kitchen		
Male Surgical/HDU		
Maternity Admissions/Assessment Unit	3	
Minor Injuries Unit	4	9
Mountvale Nursing Home	1	
Non Trust premises		1
Pharmacy Stores / Distribution		

MUC Division	In Review	Awaiting Review
Public Toilets	1	
Reception/Waiting Area	1	
Ward 1, Stroke	1	
General Medicine	149	56
1 East Maternity/Gynae		1
1 North Cardiology		
1 South Medical	11	
1 West Gynae		1
2 North Medical	2	
2 North Respiratory	1	
2 South Medical	8	5
2 South Stroke	2	2
2 West Maternity Post Natal		1
3 South	4	
4 North	1	
Air (Respiratory) Lab		1
AMU	17	14
Anticoagulant Clinic		
Banbridge HSSC		1
Car Park/Grounds		1
Collegelands Nursing Home	1	
Coronary Care Ward	4	
Corridor/Stairs		1
Daisy Day Clinical Centre	6	
Day Hospital	1	
Day Procedure/Day Surgery Unit	3	
Dermatology Clinic		
Dermatology Ward		1
Discharge Lounge		
Emergency Department CAH	3	
Emergency Department DHH		
Entrance/Exit		5
Female Medical	24	1
Gastroenterology Clinic	1	
General Male Medical,	9	
General Medicine Clinic	2	2
General Outpatients Reception/Waiting Area		1
General OutpatientsTreatment Room		2
Haematology		
Haematology Clinic		1
Home of client	1	2
ICU (HDU)	1	
Male Surgical/HDU	2	
Maternity Admissions/Assessment Unit		
MEC		1
MRI Unit	2	
Non Trust GP premises		1
Non Trust premises		1
Patient Flow Team	12	2

MUC Division	In Review	Awaiting Review
Patient Support Office	1	
Pharmacy Dispensary	1	
Ramone Ward		
Reception/Waiting Area		2
Recovery Unit	1	
Rehabilitation Ward	2	
Renal Unit		
Rheumatology Clinic		3
Stroke / Rehab	23	3
Theatre	1	
Ward 1, Stroke	1	
X-ray Dept (Radiology)	1	

Division	In Review	Awaiting Review
Pharmacy	26	35
Anticoagulant Clinic	1	
Corridor/Stairs		
Emergency Department CAH	1	
Female Surgical/Gynae	1	
Haematology Clinic	1	
Non Trust premises	2	1
Paediatrics Ambulatory Ward	1	
Pharmacy Aseptic Unit	1	29
Pharmacy Dispensary	13	4
Pharmacy Medicines Information	1	
Pharmacy Stores / Distribution	1	
Silverwood Ward		1
Trauma/Orthopaedic Theatre	1	
Ward 2, Assessment & Rehabilitation	2	

Division	In Review	Awaiting Review
General Surgery	95	28
1 East Maternity/Gynae	1	8
1 West Gynae	3	
3 South	28	1
4 North	1	
4 South	4	
Car Park/Grounds		
CEAW		
Corridor/Stairs		1
Day Procedure/Day Surgery Unit	9	
DEAW		
Emergency Department CAH	1	
Emergency Department DHH	1	
Entrance/Exit		2
Female Surgical/Gynae	14	1
Fracture Clinic		
General OutpatientsTreatment Room	1	
General Surgery Clinic	1	
Male Surgical/HDU	6	4
Microbiology Lab	1	
Orthopaedic Ward	1	
Paediatric Ward	1	2
Physiotherapy Outpatients Department	1	
Reception/Waiting Area	1	
Recovery Unit	1	
Surgical Assement Unit		
Theatre	4	8
Trauma Ward	8	
Trauma/Orthopaedic Theatre	7	1
Urology Clinic		
Outpatients	2	4
Day Procedure/Day Surgery Unit		
Dermatology Clinic	1	
Discharge Lounge		
Entrance/Exit		
Fracture Clinic	1	3
General Outpatients Reception/Waiting Area		
General OutpatientsTreatment Room		
Opthamology Clinic		1
Theatre		
Thorndale Unit		
Urology Clinic		
Scheduling Team	28	6
1 East Maternity/Gynae		2
3 South		1
Booking Centre		
Day Procedure/Day Surgery Unit	17	3
General OutpatientsTreatment Room		
Pre-operative Assessment Clinic	1	
Scheduling Team	6	
Theatre	2	
Tower Block		
Trauma/Orthopaedic Theatre	2	

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HSCB
ACG

SAI Level 1

Lead Nurse	Incident date	Reporting Division	Date Reported on Datix	Datix ID	Patient Initials	Description of incident	Date SAI screening meeting Screening Team	SAI Form to Board/Date	Others informed (RQIA etc)	SAI Review Team Chair & Members & Coordinator	Date Report due	TOR Issued	Coroner informed Y/N Date	Family Details	Date family informed of SAI	Date DRO Queries received and responded.	Dates of SAI meetings	Date to Governance meeting	Date report submitted to Board	Report shared with family - outcome of family meeting	Date case Closed	Current Status	Coroner	Litigation
PS	3.4.15	SEC	10.9.15	Perso	Personal	Personal Information had a colonoscopy on 01/04/15 after a red flag referral. An abnormality was identified but not realized to be malignant. Biopsies were taken which showed low grade dysplasia. A review at outpatients was planned and Per presented to a different clinician on 17/08/15. Following this review, a red flag sigmoidoscopy was requested. The Sigmoidoscopy was repeated on the 24/08/15 and cancer was ndiagnosed. Missed cancer and follow up review delay of 2 months.	12.9.116 & 30.8.17 Dr C McAllister Mr Ronan Carroll Connie Connolly 30.9.15 Mrs Heather Trouton Mr Emaon Mackle Mr Paul Smyth	20.10.15	N/A	Mr Eamon Mackle Dr Hilleman Trudy Reid Edel Corr	17.11.15	N/A	N/A	Personal Information redacted by the HSI	9.4.18		6.12.18	9.3.18	23.4.18	26.4.18			No	No
PS	7.9.15	MUC	2.9.15	Pers	Personal	Pe presented to Minor Injury Unit on 7th September 2015 with a painful left lower leg, diagnosed toddlers fracture and plaster cast applied. Reviewed 16th September at Minor Injury Unit, X ray report stated no fracture. Child transferred to Craigavon Emergency Department for review. Admitted to pediatric ward Craigavon with query of cellulitis/osteomyelitis. Was transferred to RBHSC on 18th September, a CT scan and ultrasound scan of his calf showed an abscess. He went to theatre for drainage and returned to theatre 48 hours later for debridement of muscle. He was treated with intravenous antibiotics and splint.	14.10.15 Mr Barry Conway Mr Seamus O'Reilly Mr Paul Smyth	2.11.2015	N/A	Dr Gareth Hampton Chair Dr Phil Quinn Ruth Hickland Timothy Doyle Mr Paul Smyth	30.11.15	N/A	N/A	Personal Information redacted by the LSI	13.10.16 Report signed for. 7.10.16 report issued 4.10.16 advising report completed. 18.7.16 Holding letter issued Letter 29.10.15		9.3.16 16.6.16 24.8.16	9.9.16	4.10.16	7.10.16		6.4.18 Trudy emailed RC & SG advising G Donnelly has requested update on sons SAI. 19.12.17 - Report being reviewed by external experts under the chair of Dr R Wright To HSCB	No	No
CC	14.8.16	MUC	26.8.16	Pers	Personal	Personal patient attended CAH ED at 22:36 on 14 August 2016 regarding agitation and hallucinations. After Triage at 22:53, patient absconded from the department. At 00:35 15 August 2016 brought in by ambulance. Patient flagged down ambulance after jumping from bridge.There was a delay in completing comprehensive imaging and recognition of multiple trauma.	27.2.17 Dr Philip Murphy Mrs Anne McVey Dr Gareth Hampton Mrs Connie Connolly Mrs Trudy Reid	28.2.17		Mr P McGarry Mr Bruce Watson Mrs Brigeen Kelly Mrs Mary Burke	25.4.17	N/A	N/A	Personal	11.4.17 by registered post 31.3.17 By Telephone		2.2.17	8.12.17	10.1.18	10.9.18 2nd acknowledgment letter sent by registered post. 23.2.18 Letter returned by Post office. Patient did not sign for letter. 11.1.18 letter advising report complete.		To HSCB 10.1.18	No	No
TR	9.1.17 - 16.1.17	ATIC	16.1.17	65413	Decontaminating endoscopes	From 9.1.17 to 16.1.17 it was noted that when decontaminating endoscopy in STH the incorrect combination of disinfectant preparation was employed in two endoscope decontamination washer disinfectors. Endoscopes were used during a number of endoscopy lists during that time.	5.4.17 Ronan Carroll Trudy Reid	25.4.17	N/A	Marie Wilson Dr Martin Brown Sr Marti McKenna Mr Marshall Trudy Reid	20.6.17	N/A	No	N/A	N/A		18.1.17	20.7.18	24.7.18	N/A		HSCB		
TR	4.1.17	MUC	20.4.17	Pers	Personal	On 4.1.17 Personal patient presented to DHH ED at 19:00 hrs with difficulty breathing and slow AF. Initial diagnoses: bradycardia, miltral stenosis, pleural effusions. At approx.. 22:30hrspatient was noted to be increasingly frowsy and clammy – this was noted by medical staff. Concern escalated about patient being unresponsive at 00:00hrs prior to transfer to ward – ED consultant aware. Patient transferred to Coronary Care Unit on 5.1.17 at 01:30hrs GCS 3/15. Patient passed away at 09:25hrs. Coroner not contacted.	25.1.17 Dr Philip Murphy Mrs A McVey Dr Gareth Hampton Trudy Reid	1.8.17	N/A	Dr Michael McCormick Dr Cathy Daly Paul Smyth Trudy Reid	26.9.17	N/A	No	Personal Information redacted	31.7.18 by registered post 1.8.18		23.11.17 15.2.18					Meeting arranged 15.2.18		
TR	7.7.17	MUC	10.7.17	Pers	Personal	Pe attended ED 07/07/2017 following displacement of PEG tube, reinsertion performed by surgeons after failed attempt by ED staff. Patient re attended ED 07/07/2017 at 20:45 Following discharge back to Nursing Home, while at the Pe nursing home he pulled out his Peg Tube again with balloon inflated. Patient re attended 08/07/2017 at 16:09 Pe had been unwell from the morning, sweaty and vomiting coffee grounds. CT scan showed Miss-located gastrostomy catheter. The catheter should no longer be used and should be withdrawn. 2. Moderate sized hydropneumoperitoneum/mediastinum.3. Pulmonary atelectasis. 4. Cholelithiasis. 5. Mislocated urinary catheter…. Pe was admitted to ICU and later discharged to HDU in DHH, Pe died on 22/7/2017 cause of death was Bronchopneumonia, due to intraabdominal sepsis due to Iatrogenic Injury II Recurrent Aspiration	23.8.17 & 30.8.17 Dr P Murphy Dr Gareth Hampton Trudy Reid Edel Corr	22.9.17	N/A	Dr Conor Braniff Mrs Ashleigh Nelson Mr David Gilpin Mrs R Wright Trudy Reid	17.11.17	N/A	No	No NOK recorded	No NOK recorded		25.10.17					22.1.18 Reminder to Mr Gilpin if happy with report 6.12.17 Trudy has forwarded report to review team for commenting.		
TR	28.12.16	MUC	14.3.17	Pers	Personal	On Wednesday 28 December 2016 Perso presented to DHH ED at 06:15 hrs with having pulled out his PEG tube. Seen by Dr 1 who could not re-insert PEG. Seen by Dr 2 at 10:00 and size 14ch PEG re-inserted. Perso discharged back to NH at 12:50 hrs. Perso re-attended DHH ED on Thursday 29 December 2016 at 15:15 hrs with history of repeated vomiting since change of PEG. At 19:40 hrs CT of abdomen and pelvis with contrast done and reported at 21:29 which showed Misplaced PEG tube within the peritoneal cavity but not within the stomach, with consequence free fluid (likely introduced via PEG) and pneumoperitoneum. DNAR in place from 20:30 after family discussion. Perso passed away on 10 January 2017	5.4.17 26.4.17 11.9.17 20.9.17 Dr Philip Murphy Dr Gareth Hampton Anne McVey Trudy Reid	22.9.17		Dr Conor Braniff Mrs Ashleigh Nelson Mr David Gilpin Mrs R Wright Trudy Reid	17.11.17	N/A	NO	Personal	20.2.18 Holding letter issued 9.11.17 by letter 13.3.17 by phone		25.10.17					22.1.18 Reminder to Mr Gilpin if happy with report 6.12.17 Trudy sent final report to review team. To present to ACG meeting on 8.12.17		
TR	12.5.17	SEC	12.5.17	Pers Pers Pers Pers	Patient 13 Patient 12 Patient 14 Patient 11 Patient 15	1. Patient 13 referred to urology following an episode of haematuria on 28 July 2016. it appears the letter was not triaged and the patient was placed on a routine waiting list on 30 September 16. As part of an internal review this patient's referral letter was upgraded to a red flag referral and was reviewed at OPD on 31/01/17. Subsequent investigations diagnosed a pT4 TCC of bladder and prostate. Patient has locally advance bladder cancer (G3T4a). Perso 2. Patient 12 was referred to Urology Outpatients on 8 Sept 2016 for assessment and advice on lower tract symptoms and elevated PSA. Referral was marked urgent by the GP. Referral was not triaged on receipt. As part of an internal review the referral was upgraded to red flag and was seen in clinic on day 151, on day 197 the patient had a confirmed cancer diagnosis T3a with no nodal metastases. Personal 3. Patient 14 was referred to Urology Outpatients on 3 June 2016 for assessment and advice raised PSA. Referral was marked urgent by the GP. Referral was not triaged on receipt. As part of an internal review the referral was upgraded to red flag and was seen in clinic on day 246, on day 304 the patient had a confirmed cancer diagnosis. There has been a resultant 10 month delay in OP review and recommendation of treatment for a prostate cancer. Patient is aware of diagnosis but not delay he has decided to opt for active surveillance treatment. Personal 4. Patient 11 was referred to Urology Outpatients on 28 July 2016 for assessment and advice elevated PSA. Referral was marked urgent by the GP. Referral was not triaged on receipt. As part of an internal review the referral was upgraded to red flag and patient was seen in clinic on day 217, on day 270 the patient had a confirmed cancer diagnosis. There has been a resultant 9 month delay in OP review and recommendation of treatment for a prostate cancer. Patient is aware of diagnosis but not delay and has is currently thinking about his options for treatment. Personal	25.7.2017 Mr R Carroll Mr C Weir Paula McAloran Trudy Reid	21.9.2017		Dr Julian Johnston BHSCT Mr Mark Haynes Katherine Robinson Trudy Reid	16.11.17	N/A	NO	Individual patients	27.2.18 Letters issued to patients		24.10.17					Meeting arranged 12.2.18		
TR	5.12.16	SEC	12.5.17	Pers	Patient 16	Pati had a history of metastatic colorectal cancer, small volume lung metastases and a left pelvic mass associated with ureteric obstruction. Pati was considered for palliative pelvic radiotherapy in July 2016, urology stents management was required prior to radiotherapy: there was a delay in the management of stents. In December 2016 radiotherapy was no longer considered an option for Pati. Pati died 27 December 2016.	5.4.17 Mr R Carroll Mr C Weir Paula McAloran Trudy Reid	22.9.17	N/A	Dr Julian Johnston BHSCT Mr Mark Haynes Katherine Robinson Trudy Reid	16.11.17	N/A	No	Various patients	19.4.19							Report being drafted	No	No
CC	30.4.17	CCS	5.5.17	Pers	Personal	Patient Personal level 2 patient in HDU transferred for emergency MRI to CAH. Nurse escort. Ambulance did not fulfill return request Patient did not get back until 2145.	4.7.17, 25.7.17, 21.9.17. 9.11.17 R Carroll Mr M Haynes Mr C Weir Trudy Reid P McAloran	23.11.17	N/A	Mr D Gilpin Dr L Martin ED consultant Connie Connolly	18.1.17	N/A	No	Personal Information redacted by the LSI	30.11.17		20.2.18					Meeting arranged for 20.2.18	No	No
CC	7.10.17	MUC	9.10.17	Pers	Personal	Pe admitted to Craigavon Area Hospital Emergency Department on 7 October 2017 at 19.33 hrs. He was admitted with fractured tibia admitted to Paediatric Ward for observation at 01:10 hrs on 8 October 2017. Compartment syndrome noted on ward round that morning. Admitted to Barbour Ward in Belfast Hospital for Sick Children on 8 October 2017 and emergency fasciotomy done.	11.10.17 Dr P Murphy Mr R Carroll Mr M Haynes Trudy Reid	27.11.17	N/A	Ms Veronica Roberts Dr Michael Perry Dr Sam Thompson Paed	22.2.18	N/A	No	Personal Informa redacted by the LSI Received into from GP	Letter dated 1.3.18		15.1.18					Meeting arranged for 15.1.18 @ 9.30 Seminar room 2		
TR	27.3.14	CCS	27.10.17	Pers	Personal	Missed diagnosis of gallbladder CA. Pe had an USS and MRCP Nov 14 reported as gallstones. 27/3/15 inpatient Ultrasound Scan provisional report amended by consultant radiologist who suggested Red Flag CT Chest Abdomen and Pelvis. No reference made to USS done in March 2015 at the time of Lap Cholecystectomy June 2015 10/10/17 - Now has large inoperable mass, Suggestive of lymphoma. CEA, 3.7	8.12.17 Mr Mark Haynes Ronan Carroll Trudy Reid	21.12.17	N/A	Mr Gudyma Dr Imram Yousuf Trudy Reid	15.2.17	N/A	N	Personal	17.9.18 Mrs Reid Spoke to Person and outlined the SAI Process. 25.5.18		17.1.18					Meeting arranged for 17.1.18 @ 2 pm Committee room 1 DHH	No	No

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Lead Nurse	Incident date	Reporting Division	Date Reported on Datix	Datix ID	Patient Initials	Description of incident	Date SAI screening meeting Screening Team	SAI Form to Board/Date	Others informed (RQIA etc)	SAI Review Team Chair & Members & Coordinator	Date Report due	TOR Issued	Coroner informed Y/N Date	Family Details	Date family informed of SAI	Date DRO Queries received and responded.	Dates of SAI meetings	Date to Governance meeting	Date report submitted to Board	Report shared with family - outcome of family meeting	Date case Closed	Current Status	Coroner	Litigation
TR	29.11.17	MUC	29.11.17	Pers	Personal	Personal Information admitted to hospital for treatment of myeloma on 26 October 2017. Throughout admission XX had progressive neurological decline. On 29 November 2017, MRI head was done and XX received intravenous sedation prior to leaving ward and prior to scan in department which was administered by the Doctor in attendance. When Pe was removed from the scanner, XX was found to be unconscious and not breathing. Resuscitation was commenced and XX was transferred to ICU. XX passed away in the Intensive Care Unit on 1September 2017. Coroner has request a post mortem due to unknown cause of progressive confusion and agitation.	20.11.17, 18.12.17 , 1.8.18 Ann McVey Dr Philip Murphy Dr Shane Moan Dr P McCaffery Dr Una Bradley	23.1.18	N/A	Dr Liam Polley Dr Imran Yousaf Jilly Redpath Dr Barry McConville		N/A	Y 1.12.17	Personal Informatio	11.6.18		9.2.18 12.6.18					Meeting arranged for 9.1.18		
TR	20.2.18	MUC	20.2.18	Pers	Personal	Pers attended Craigavon Area Hospital (CAH) Emergency Department (ED) on 19th February 2018 with chest pain, low oxygen saturations, shortness of breath and pyrexia. Per had a cardiac history. Initial ECG was unremarkable; however repeat ECG showed ST elevation, at 23:06, which was not actioned. Per condition deteriorated at approximately 02:15 Per had a cardiac arrest, Cardiopulmonary Resuscitation was commenced, and Per intubated and transferred to theatres for stabilisation. Do Not Attempt Cardiopulmonary Resuscitation was decided, Per had a further period of cardiac arrest and died at 05:21.	14.3.18 Mr R Carroll Mr M Haynes Mrs T Reid 4.4.18 Dr P Murphy Dr G Hampton Mrs T Reid	11.5.18	N/A	Dr G Hampton Mr M Moore Mrs T Reid	6.7.18	N/A	No	NOK not registered	Unable to identify family		23.5.18					Report being drafted	No	No
TR	21.1.18	MUC	6.2.18	Pers	Personal	Per attended the Craigavon Area Hospital (CAH) Emergency Department (ED) 21 January 2018. Per initially presented with symptoms of left arm numbness and heaviness and lower back pain. Per was assessed by ED, symptoms were considered to be secondary to sciatica from twisting injury, and left arm heaviness from prolonged pressure from sleeping on it whilst supporting back. Documentation states no neurology elicited. Discharged home. Per represented to ED on 28 January 2018 with new neurological deficit, left sided weakness and confusion. Computed Tomography (CT) brain on the 28 January 2018 report concluded; Right Middle Cerebral Artery (MCA) territory infarct, no contraindications to lysis. Pe was not referred for stroke lysis and was admitted to the stroke ward on 28 January 2018. On the 29 January 2018 Per was assessed by the stroke team and diagnosed with a right partial anterior circulation stroke or encephalitis and received treatment for both, and CTA, and Magnetic Resonance Imaging (MRI) were planned. Pe deteriorated and was reviewed on 30 January 2018, repeat CT report concluded; Evolving right MCA infarct with surrounding oedema and hyper dense right MCA. Pe was transferred to Royal Victoria Hospital (RVH) on 30 January 2018 for consideration of hemicraniectomy. On transfer following investigation and GCS 15/15, there was no surgical intervention at that time. Per deteriorated and had an additional CT scan the report concluded: further progression of mass-effect and midline shift...Prominence of the temporal horn of the left lateral ventricle suggestive of early hydrocephalus development. Per died on the 31st January 2018.	Dr P Murphy Dr G Hampton Mrs A McVey Mary Burke Trudy Reid	11.5.18	N/A	Dr M McCormick Dr D Patton Mr Paul Smyth Mary Burke Paula McAroran	6.7.18	N/A	NO	Personal	2.5.18 by post		8.5.18						No	No
TR	1.5.17	MUC	2.5.17	Pers	Personal	Pe attended Daisy Hill (DHH) Emergency Department (ED) at 16:43 on the 28 April 2017 at triage he expressed feelings of suicide. Pe was assessed and discharged from ED at 18:43. Pe re attended DHH ED via ambulance at 16:33 on the 1 May 2017 having been found unresponsive at home. The impression on admission to ED was overdose with possible anoxic brain injury. Pe was intubated and transferred to Intensive Care in another Trust	11.12.17, 3.1.18, 10.1.18, 24.1.18	11.5.18	N/A	TBC	6.7.18	N/A	N	Personal on PAS	27.7.18 Issued registered post 1.8.18.									
TR	15.5.18	SEC	16.5.18	Pers	Personal	Personal who attended Daisy Hill Hospital (DHH) and attended theatre in for insertion of Percutaneous endoscopic gastrostomy (PEG) feeding tube on 15 May 2018. A colonoscopy previously used on another patient was used to perform an oesophago-gastrostomy prior to full decontamination.	25.5.18	6.7.18				N/A	No	Personal	31.7.18 by registered post 1.8.18									
TR	8.11.17	ITICs SEC	8.11.17	Pers	Personal	Per was admitted via ED on 6/11/2017 to the Trauma Ward at CAH following a fall at home. Per was diagnosed with a fracture to her left neck of femur. Per had a number of Co-morbidities which included COPD, Congestive cardiac failure, aortic stenosis, left bundle branch block, hypothyroidism and chronic kidney disease stage 4. Per acutely deteriorated at 05:30hrs on 08/11/2017 with a reduced level of consciousness low blood pressure and had acute kidney injury. She was felt to be opioid toxic and was given reversal 3 times with naloxone which made some improvement. Per was transferred to theatre for intubation and transfer to ICU. Per died 09/11/2017 at 00:50hrs.	26.6.18 Ronan Carroll Dr Damian Scullion Trudy Reid			Mr Mark Murnaghan Miss Jilly Redpath Trudy Reid		N/A											
TR	13.11.17	CCS	19.7.18	Pers	Personal	Complaint regarding the care Personal received by Optometry in Daisy Hill Hospital. Pers has been having eye tests since Personal , and she has been seen by the Optometry department in Daisy Hill numerous times. She has been seen by Claire Stevenson at her clinic up until November 2017. Pers was referred to the Royal Victoria Hospital in Belfast and they diagnosed her as having a brain tumour Personal believes that the Southern Trust failed to diagnose Personal therefore they are missing expertise. He believes that Pers could have been diagnosed sooner by Daisy Hill. He stated that back in 2016 Personal wrote a letter to Claire Stevenson to raise the concerns they had about them not being able to give Pers a diagnosis. Claire telephoned Personal offering to see her personally at the next clinic appointment, however they did not meet. Personal continued to raise her concerns, however she was continually told that they did not have a clear diagnosis for Pers .	28.6.18 Barry Conway Trudy Reid	20.8.18		Barry Conway Jane Hanley BHSCT Cathie McIlroy Clare Stephenson Trudy Reid			N/A	Personal Inf Personal Information	13.7.18									
TR	7.5.18	SEC	4.6.18	Pers	Personal	Admitted to CAH 30.4.18 with 48hr history abdominal pain, temperatures, N&V Elevated CRP and CT showing sigmoid diverticulitis, parasigmoid collection and intra-abdominal free air. Complicated by SBO. Conservative management for 7 days, then re - CT and subsequently laparotomy (Mr McKay) Patient died 27.5.2018, Cause of death: Ia) multi organ failure, b) Multi Laparotomies, c) Perforated Diverticular Disease Small Bowel Obstruction. Coroner's inquest.								Personal Inf	13.7.18									
TR	9.5.18	SEC	16.5.18	Pers	Patient 90	Patient admitted to ICU in extremis. Unexpected death after elective surgery. Pa was preadmitted on 03/05/2018 for elective urology surgery (cystoscopy, replacement of ureteric stents and bilateral ureterolysis) on 09/05/2018. Post operatively Pat was transferred to ICU CAH and died on 09/05/2018. Post mortem is being carried out.	25.5.18 Dr Scullion Dr M Haynes Mr R Carroll Mrs Trudy Reid			Mr T Glacken Dr Kieran O'Connor Mrs Trudy Reid							25.6.18						
TR	6.12.17				Personal	Patient attended ED DHH with H/O: Unwell Adult. Rapid onset. C/O Blood in urine + General decline. Decreased oral intake. Increased tiredness. On Apixaban. Pulse 105; BP 132/109; RR 21; Temp 34.8; SaO2 94; **PMH:** CPAP OSA; Type 2 RF; CVA with residual weakness; AS; CCF; AF; Type 2 Diabetic; no allergies; **Diagnosis:** 1) Frank Haematuria on NOAC 2) UTI 3) Type 2 Diabetic 4) Obstructive sleep apnoea 5) Old CVA 6) Atrial Fibrillation 7) Obesity Gross. Post take Medical Ward Round - Acidotic - Not picked up by ED + transferred to ward with no IV access or recognition of Acidosis & T2RF	20.11.17 Dr P Murphy Dr G Hampton Mrs A McVey Trudy Reid			Waiting on External chair to be nominated													
TR	16.11.17	SEC	4.6.18	Pers	Personal	GP Red flag referral 9.10.2017. Constipation with vomiting for 3 weeks. Delay in investigation / management of a red flag cancer patient.																	

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HSCB
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SAI Level 2

Lead Nurse	Incident date	Reporting Division	Date Reported on Datix	Datix ID	Patient Name	Description of incident	SAI screening meeting Date Screening Team	SAI Form to Board/Date	Others informed (RQIA) etc	SAI Review Team Chair & Members & Coordinator	Date Report due	TOR Issued to HSCB	Coroner informed Y/N Date	Family Details	Date family informed of SAI	Date DRO Queries received and responded.	Dates of SAI meetings	Date to Governance meeting	Date report submitted to Board	shared with family - outcome of family meeting	Date case Closed	Comments	Coroner	Litigation
TR	14.4.17	IMWH	15.4.17	Pers	Personal	A Personal was admitted to DHH on April 14 for caesarean section delivery due to major placenta praevia. Following the planned elective section, at 14:00h, the mother's condition deteriorated and she was returned to theatre for a laparotomy for a suspected intra-abdominal bleed. She quickly developed Disseminated Intravascular Coagulopathy and required 30 units of blood products to be transfused before transfer to Belfast. Arrangements for transfer was made primarily for intensive care with additional access to the facilities of interventional radiography, vascular surgery and possible further blood transfusion. The patient required a subsequent hysterectomy due to the considerable risk of ongoing secondary haemorrhage. The cause of the bleeding was considered to be related to an amniotic fluid embolism. This patient made a full physical recovery and was discharged home with her baby 8 days later.	Dr Martina Hogan Heather Trouton Patricia McStay Trudy Reid	16.8.17		Dr Aoife Curry Dr Colin Winters Patricia Kingsnorth Haematologist ICU consultant Blood Bank Staff member													
TR	31.7.17	IMWH	31.7.17	Pers	Personal	A Personal with a history of 2 previous normal deliveries at 14mn, was admitted on 30.7.17 for Induction of labour by prostin prsaary at Term plus 9 days gestation as planned antinatally. She was admitted to delivery suite for epidural analgesia and later required an emergency cesarean section delivery for fetal distress. She sustained a ruptured uterus and required admission to HDU for 7 days and treatment for sepsis. The baby was born in poor condition and was transferred to NNU in CAH for cooling for 72 hours and has possible diagnosis of HIE.	Heather Trouton Dr Martina Hogan Donna King	16.8.17		Dr Andrew Knox Chair Dr Phil Quinn Dr Laure Martin Wendy Clarke Donna McLoughlin Trudy Reid Donna King	15.8.17	22.9.17	NO	Personal	12.10.17			23.5.18	31.5.18	6.6.18 Issued registered Post				
TR	6.11.17	CYP/Acute	6.11.17	Pers	Personal	Personal Information redacted , attended Daisy Hill Hospital Emergency Department (ED) via ambulance on 6 November 2017 at 06:30 hours Pers [redacted] was pronounced dead at 06:50 hours with injuries in keeping Personal Information redacted Pe [redacted]				25.1.18 CYP requested input from Acute. Email sent to AMcV, MB Dr GH for response.				Personal	MHD taking lead							CYP/Acute SAI Level 2		
DK	5.3.18	IMWH	28.3.18	Pers	Personal	Personal who was planned for delivery at RJMS because of premature prolonged rupture of membranes at 22 weeks gestation. Patient contacted Daisy Hill Hospital at 29+6 weeks gestation with signs of advanced labour. Due to the travel time to Belfast patient attended DHH and was admitted for assessment. The baby was found to be in a breech presentation and the cervix was fully dilated. She progressed to an emergency caesarean section delivery at 11:07 due to delay in second stage and an abnormal fetal heart trace. The estimated blood loss at delivery was 1000mls. Maternal observations were within acceptable limits post procedure until 13.30 hours. At approximately 14:30hr anaesthetic review was sought for a maternal tachycardia. At 14:35 approximately 450mls of blood loss was noted vaginally and the Obstetric Consultant and middle grade asked to attend. Major blood loss protocol was initiated and patient was returned to theatre for management of bleeding. Despite maximum resuscitation efforts the patient died at 20:09. The coroner was informed and final post-mortem report is awaited		5.4.18	Coroner		5.4.18	10.5.18	N	Personal	16.4.18 by post									
TR	6.11.17	CYP/Acute	6.11.17	Pers	Personal	Personal Information , attended Daisy Hill Hospital Emergency Department (ED) via ambulance on 6 November 2017 at 06:30 hours Personal [redacted] was pronounced dead at 06:50 hours with injuries in Personal Information redacted by the USI																		
TR	25.8.18	ED CAH	25.8.18	Pers	Personal	On Saturday 25th August 2018 the Northern Ireland Ambulance Service (NIAS) pre alerted Craigavon Area Hospital Emergency Department (ED) regarding Person pregnant female (27+5 weeks) who had developed a sudden onset of shortness of breath. Cardiopulmonary resuscitation (CPR) had been started prior to Northern Ireland Ambulance Service arrival at the scene. The Patient presented in ED at 01:09 in cardiac arrest. CPR continued and despite maximum resuscitation efforts including peri-mortem Caesarean section at 01:14 there was no improvement in Patients clinical condition and there remained no cardiopulmonary effort. A full resuscitation team decision to stop CPR time of death was recorded as 01:42. At peri-mortem Caesarean section a female infant was delivered with no obvious cardiopulmonary effort. Full resuscitation was commenced however, there remained no cardiopulmonary effort. A full resuscitation team decision to stop CPR was made and the infant time of death was recorded as 01:40. Obstetric care had been provided to the patient by the Northern Trust with a referral to fatal medicine in the Belfast Trust. The Southern Trust has been in liaison with the NHSCT regarding this incident. It is anticipated that the NHSCT will participate in the review of this tragic case.		4.9.18					25.8.18											

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SAI Level 3 Report

Lead Nurse	Incident date	Reporting Division	Date Reported on Datix	Datix ID	Patient Initials	Description of incident	Date SAI screening meeting Screening Team	SAI Form to Board/Date	Others informed (RQIA etc)	SAI Review Team Chair & Members & Coordinator	Date Report due	TOR issued on	Coroner informed Y/N Date	Family Details	Date family informed of SAI	Date DRO Queries received and responded.	Dates of SAI meetings	Date to Governance meeting	Date report submitted to Board	Report shared with family - outcome of family meeting	Date case Closed	Comments	Coroner	Litigation
TR	18.5.16	MUSC/MHD	19.5.16	Perso	Pers onal	A Person patient died tragically following a fall within Craigavon Hospital. The patient attended the emergency department on 17th May 2016 and was admitted to the Acute Medical Admission ward on 18th May 2016. The Patient left the ward following which the fall occurred Personal Information redacted by the USI The Coroner, Health and Safety Executive and the PSNI have been informed of the incident. The Trust received a PSNI "Incidents of Sudden Death SD1" form on 19th May 2016.	Dr Philip Murphy Dr Una Bradley Mary Burke Connie Connolly Trudy Reid	20.5.16	20.5.16	Dr S McGovern Dr G Lynch Dr S Moan Mr P Smyth Dr Tony Black Ms L Hall Mrs K Carroll Mrs T Reid		1.12.16	Dr G Hampton informed coroner on 18.5.16	Personal Information	20.6.16		31.1.18 2.12.16	29.9.17	29.9.1	2.10.17 issued registered post.		Further meeting arranged for 31.1.18	Yes 29.9.17	Yes 29.9.17
DK	7.2.18	IMWH	13.2.18	Perso	Pers onal	The Southern Health and Social Care Trust was informed on 07/02/2018 that Personal became unwell on 05/02/18 and was transferred to Our Lady of Lourdes Hospital, Drogheda via ambulance and then onto paediatric intensive care in Temple Street Children's University Hospital, Dublin. The Trust was informed by the patient's General Practitioner that the baby died on 5/02/2018. The Trust was subsequently informed the possible cause of death was attributed to Group A Streptococcus.On the 06/02/2018 a member of the midwifery team contacted the Trust to inform them that she had been diagnosed with Group A Streptococcus, following a short illness. Initial investigation highlighted that this member of staff was involved in the care of baby's mother (her intranatal care). While no definite causative link has been established between the midwife's Group A infection and the baby's group A infection, the Trust plans to contact other patients cared for by this midwife and offer prophylactic antibiotic therapy as a precautionary measure.		23.4.18	Early Alert issued 7.2.18					Personal										

Internal SEA Report

Lead Nurse	Incident date	Reporting Division	Date Reported on Datix	Datix ID	Patient Initials	HCN	Description of incident	Date screening meeting Screening Team	Review Team Chair & Members & Coordinator	Date of meeting	Date to Governance meeting	Date case Closed	Current Status
SK	10.11.15	MUC	10.11.15	Personal Informatio	Personal Information redacted by the USI	Personal Information redacted by the USI	Inpatient Fall - Head injury	25.7.16					
SK	4.5.16	MUC	4.5.16	Personal Informatio	Personal Information redacted by the USI	Personal Information redacted by the USI	SC drug error on discharge	8.7.16 Dr Una Bradley Mrs Trudy Reid Dr Philip Murphy Mrs C Connolly	Mrs S Burns Miss Jilly Redpath Mrs Sharon Kennedy				
SK	20.6.16	MUC	21.6.16	Personal Informatio	Personal Information redacted by the USI	Personal Information redacted by the USI	Inpatient Fall - Head injury	25.7.16 Mrs Anne McVey Dr Una Bradley Ms Sharon Kennedy	Mr Paul Smyth Sr Lorna Cullen Ms Sharon Kennedy				
SK	25.7.16	MUC	25.7.16	Personal Informatio	Personal Information redacted by the USI	Personal Information redacted by the USI	Cardiac Arrest NEV	Dr Philip Murphy Dr Una Bradley Mrs Anne McVey Ms Sharon Kennedy	Mr Paul Smyth Sr Lorna Cullen Ms Sharon Kennedy				
		MUC			Personal Information redacted by the USI		DKA	Dr Philip Murphy Dr Una Bradley Dr McCaffrey T Reid					
TR	24.11.16	MUC	25.11.16	Personal Informatio	Personal Information redacted by the USI	Personal Information redacted by the USI	Resusitation in corridor						Closed
TR	12.4.17	MUC	13.4.14	Personal Informatio	Personal Information redacted by the USI	Personal Information redacted by the USI	Cervical spine injury awaiting transfer to RVH	Dr P Murphy Dr G Hampton Trudy Reid	Dr E Holmes Paul Smyth Trudy Reid	26.1.18			Meeting arranged 26.1.18
CC	19.6.17	SEC	19.6.17	Personal Informatio	Personal Information redacted by the USI	Personal Information redacted by the USI	Pt fall back of head and nose bleed.	Ronan Carroll Mr C Weir/Mr Hayes Paula McAloran Trudy Reid Dr P Murphy Dr U Bradley Mary Burke	Dr C Hillemand Josie Matthews Margaret Donnelly Connie 4 Nurses TBC	31.1.18		14.3.18	Closed
TR	22.9.17	CCS	16.1.18	Personal Informatio	Personal Information redacted by the USI	Personal Information redacted by the USI	Patient admitted with? Diverticular perforation. CT shows likely perforated tomour. Not reported by radiology. Delay in diagnosis dignificant.	Mr Mark Haynes Mr Ronan Carroll Mrs Heather Trouton Mrs Trudy Reid	Mr Adrian Neill Dr Shiraram Bhat Dr Imran Yousuf Mrs Trudy Reid	3.9.18			Meeting arranged for 3.9.18
TR	17.11.17	CCS	19.7.18	Personal	Personal Information redacted by the USI	Personal Information redacted by the USI	Complaint letter from patient and husband regarding her diagnosis, treatment and care. Patient treated for colitis subsequently had subtotal colectomy 14/05/2018. (27.4.18 – 16.5.18)	Mr Ronan Carroll Mr Mark Haynes Mrs Trudy Reid	Mr Epanameritakis Dr Bhatt Trud Reid	3.9.18			
TR	20.5.18	SEC	22.5.18	Personal Informatio	Personal Information		Patient admitted for ureterostomy on 18.5.18. Pyrexic and hypotensive following procedure. Transferred to ICU due to escalating inotropic support. Myocardial infarction. Despite aggressive intensive care management, patient's condition continued to deteriorate and death was confirmed on 20.5.18	25.5.18 Dr Damian Scullion Mr Mark Haynes Mr Ronan Carroll Mrs Trudy Reid	Mr Mark Haynes Emma Jane Kearney Trudy Reid	21.8.18			

TR					Personal Information redacted by the USI		Personal Information redacted by the USI patient undergoing chemotherapy for myeloma presented to DHH ED at 14:02 with history of being unwell for 3/52, diarrhoea 1/52 poor mobility. Seen by Dr 1. Loose green stools. Reduced oral intake. Occasional mild general abdominal pain. One loose stool today, did not take chemo med. Worsening shortness of breath. No chest pain, on examination he was noted to be cachexic, frail. Bi-basal creps. Marked bilateral lower leg oedema. ECG Sinus rhythm, 2 BBB. BP 86/51 with fluids and legs raised. Distended abdomen query ascetic. Mild generalised tenderness, no masses felt, bowel sounds present Diagnoses: diarrhoea query secondary to chemo meds, associated dehydration and ?acute LVF		Dr Hillemand Mr D McKay Dr L Magowan Paula McAloran	15.8.18			
TR	2.6.18	MHD	4.6.18	Personal Informatio	Personal Information redacted by the USI	Personal Information redacted by the USI	Clozpine levels and bowel obstruction.					
					Personal Information redacted by the USI		On 04/06/18 I was working as SHO in CAH ED. I saw a patient Personal Informati who presented with hip pain. On reviewing her clinical notes and previous investigations it became apparent that she had a CT scan of her chest / abdomen / pelvis on 27/4/18. The clinical history on the request for this scan did not match those of the patient in question. It appears that it was requested and subsequently carried out in error.					
TR	21.4.18	SEC	23.8.18	Personal Informatio	Personal Information redacted by the USI	Personal Information redacted by the USI	Patient with severe colitis noted to have mass lesion on a background of colitis upper rectum 2016. Should at that point have been referred to Colorectal surgeon for assessment. Biiopsies showed possible dysplasia. Patient then returned with a perforated tumour at that site. He went on to have surgery in DHH with a surgeon who does not operate on rectal cancer and the distal margin of the resection was involved by tumour meaning he would need difficult further surgery to remove this. He has now developed widespread metastatic disease and is unlikey to survive for more than a year. This case was discussed at the IBD review meeting and Dr P Murphy has been in correspondence with Dr S Murphyl don't believe the case has been discussed at any m+m or at the IBD mdt. about the incident.		Mr Kevin McElvanna Dr Shivaran Bhat Trudy Reid	20.9.18			

Patient name	Hospital number/HCN	Datix number	Date of incident	Division	Date to M&M	Outcome	Attachments	
Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Informatio Complaint		SEC	Apr-17	discussed at M&M today. Agreement that this must be brought to Combined M&M for further discussion		
Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Informatio	21.4.16	MUC	Apr-17			
Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Informatio Complaint		MUC	Apr-17		L:\Acute Governance Team\SERIOUS ADVERSE INCIDENTS\M&M\ Personal Information red PSM May 2017 - extracts for Trudy Reid.docx	L:\Acute Governance Team\SERIOUS ADVERSE INCIDENTS\M&M\ Personal Information M&M Thursday 17th May 2017.docx
Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Informatio	10.3.17	MUC		ED M&M June 2017 ED 169		
Personal Information	Personal Information redacted by the USI	Personal Informatio	3.4.15	SEC		HSCB was notified of incident. To be presented at M&M Surgical Specialty specific M&M May 2017	L:\Acute Governance Team\SERIOUS ADVERSE INCIDENTS\M&M\ Personal General Surgical PSM May 2017 - extracts for Trudy Reid.docx	L:\Acute Governance Team\SERIOUS ADVERSE INCIDENTS\M&M Personal \Surgical M&M MMThursday 17th May 2017.docx
Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Informatio	22.6.16	MUC		Presented to ED M&M on 31.8.16		
Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Informatio Complaint	19.1.17	MUC				
LPP Information redacted by the USI	Personal Information redacted by the USI	Personal Informatio	21/12/2016	muc				
Personal Information redacted by the USI	Personal Information redacted by the USI					No record to date case has been discussed at M&M		
Personal Information redacted by the USI	Personal Information redacted by the USI		7.1.17	MUC	Feb 17 Cardiology M&M	There were areas of concern which may have contributed to this patients death SOM 4 – Just recently signed off by Dr McNeilly on IMMIX following receipt of Cardiology Sub-Speciality M&M minutes	L:\Acute Governance Team\SERIOUS ADVERSE INCIDENTS\M&M\ Personal Information \M&M report.pdf	
Personal Information redacted by the USI	Personal Information redacted by the USI		11.3.17	MUC	Dec-17	There were areas of concern which may have contributed to this patients death SOM 4 - presented Medical M&M December 2017 – minutes not yet approved therefore SOM not confirmed.	L:\Acute Governance Team\SERIOUS ADVERSE INCIDENTS\M&M\ Personal Informatio \M&M report.pdf	
Personal Information redacted by the USI	Personal Information redacted by the USI			MUC		This has been recorded as SOM 4 on IMMIX but is awaiting sign-off by ICU who completed IMMIX	L:\Acute Governance Team\SERIOUS ADVERSE INCIDENTS\M&M\ Personal Information \M&M report.pdf	
Personal Information redacted by the USI	Personal Information redacted by the USI		11.5.15	MUC	Apr-17	IMMIX completed by ICU – presented at Medical M&M April 2017 for information – awaiting sign off by ICU	L:\Acute Governance Team\SERIOUS ADVERSE INCIDENTS\M&M\ Personal Information M&M report.pdf	
Personal Information redacted by the USI	Personal Information redacted by the USI		6.4.17	MUC		Patient presented to ED DHH on 6/04/2017 with spontaneous pneumothorax – a Right sided chest tube in situ introduced via seventh intercostal space in anterior axillary line. From the insertion site the tube is directed cranially mildly compressing the base of the right lower lobe and impinging on the diaphragm. Personal was admitted to hospital and discharged on the 10/04/2017 with a referral to thoracic surgery given that he had 2 spontaneous pneumothoraces on the same side		
Personal Information redacted by the USI	Personal Information redacted by the USI							
Personal Information redacted by the USI	Personal Information redacted by the USI							
Personal Information redacted by the USI								
Personal Information redacted by the USI								
Personal Information redacted by the USI								
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Personal Information redacted by the USI								

SAI's awaiting screening

Patient name	Hospital number/HCN	Date of incident	Division	Background	What needs done to bring this for screening
Personal Information redacted by the USI			MUSC	?? Missed sepsis	Final review with M&M report to allow closing
Personal Information redacted by the USI			MUC	Cardiology - Escalation to respiratory and NEW's escalation	Screened Internal review
Personal Information redacted by the USI			MUSC	DKA in hospital	Screened 3/4/2017 not SAI - internal review facilited by ACG
Personal Information redacted by the USI	Personal Information redacted by the USI		MUC	A patient Personal Information redacted by the USI attended DHH in Oct 2015... Had a CXR through A&E... abnormality reported on CXR... Was for further CXR or CT but never actioned	Further information regarding how report was shared required
Personal Information redacted by the USI				No CT available during power failure	Reviewed 24/04/2017 delay in CT did not impact outcome Not SAI but meeting to be organised for learning
Awaiting confirmation of name			MUC	patient had biopsy carried out of large lesion right cheek October 2014, DNA on appointment Sept 15. Not see since despite clinician saying needed 3 month	
Personal Information redacted by the USI		Personal Information	MUC	Patient with known cervical spine injury awaiting transfer to RVH. Required wound closure and important for spinal injury to remain immobilised. Became agitated and decision to give IV sedation. Patient then suffered respiratory arrest and required intubation, repeat CT of head and neck (which were unchanged) and critical care transfer to RICU	Meeting arranged for 1.9.14 Nursing input required for screening to review again
Personal Information redacted by the USI		Personal Information	MUC CCS	Patient diagnosed MGUS – was for 6 month review – delayed review-presented to medicine was admitted with disease progression	
Personal Information redacted by the USI			ATTICS	A male maintenance haemodialysis (HD) patient was admitted to Craigavon Area Hospital (CAH) on 12/02/16 with a history of haematemesis and diabetic ketoacidosis. At 15:15 hours on 12/02/16 there was a cardiac arrest call where it was noted that the patient was bradycardiac with an unrecordable blood pressure (ECG showed slow atrial fibrillation with underlying heart block). He was admitted to CAH intensive care unit (ICU) and had a coronary angiogram which showed diffuse coronary disease but no critical stenosis. A temporary pacing wire was inserted and he remained in ICU. The temporary pacing wire was removed on 14/02/16. The patient continued on an adrenaline infusion. His case was discussed with the Nephrology team in Belfast City Hospital (BCH) on 15/02/16 as the patient would require ongoing HD and transfer to BCH Nephrology was requested. The Nephrology team requested that the patient was stable off inotropic support with a satisfactory heart rate for 24 hours prior to transfer as the Nephrology wards do not have any cardiac monitors. The Nephrology team expressed significant concerns about the risk of further bradycardic episodes or cardiac arrest occurring on the Nephrology ward because of the lack of cardiac monitoring facilities. Transfer was	

Awaiting external responses					
Personal Information redacted by the USI			NIAS	and he remained in ICU.	Escalated to NIAS- response from NIAS forwarded to Dr Hampton
Personal Information redacted by the USI			NIAS	The temporary pacing wire was removed on 14/02/16. The patient continued on an adrenaline infusion. His case was	Patient details obtained - further information requested from NIAS, initial internal investigation started by MUSC (not screened SHSCT)
Personal Information redacted by the USI			NIAS	discussed with the Nephrology team in Belfast City Hospital (BCH) on 15/02/16 as the patient would require ongoing	awaiting information from NIAS (not screened SHSCT)

Personal Information redacted by the USI			MUSC	HD and transfer to BCH Nephrology was requested. The Nephrology team requested that the patient was stable off	
Personal Information redacted by the USI			MUSC	inotropic support with a satisfactory heart rate for 24 hours prior to transfer as the Nephrology wards do not have any	

Received from Trudy Reid on 16/05/2023. Annotated by the Urology Services Inquiry.

Rejected SAI's

Incident date	Reporting Division	Datix ID	Date Reported on Datix	Patient Initials	Summary of incident	Date of screening	Screening Team	Outcome
17.10.14	MUC	Personal Information	17.10.14	Personal Information redacted by the USI	Personal Information redacted by the USI admitted to MAU on 16/10/14 with hx of being off his feet, ?TIA and fall. Past hx of vascular dementia, diabetes CVA (false left eye) Confused on admission. Had CT of brain at 14:30. Unwitnessed fall on 17/10/14. Falls protocol followed. CT showed dense CVA. 18/10/14 08:35 Respirations ceased. Rest in Peace	17.2.15	Mr Philip Murphy, AMD for Acute Medicine, Mr Simon Gibson, Assistant Director for Acute Medicine, Mrs Connie Connolly, Lead Nurse Acute Governance	1. Did the unwitnessed fall impact or contribute to the neurological changes which were detected. There was agreement that the fall was managed in a timely manner. Given the written evidence and observations, the screening panel did not contribute the fall on the ward to any of the neurological findings. It is probable that the neurological changes were attributable to a spontaneous cerebral infarct which caused the patient to fall. 2 Did the clinical documentation clearly reflect timely management . Yes, and there was excellent documentation in relation to keeping the family and patient informed of events and rationale for same.
14.10.14	MUC	Personal Information	14.10.14	Personal Information redacted by the USI	Personal Information patient was transferred to DHH Level 6 on 16/09/14 with fall and subsequent frontal lobe axial bleed. On warfarin. Past hx of AF, vascular dementia, diabetes. Witnessed fall on the ward on 14/10/14. CT showed acute bleed on chronic SDH. RVH Neuro advised conservative treatment only. Left pupil larger than right. RVH Neurosurgery contacted. D/W RVH Neurosurgery-no need for intervention at present, would not advocate another CT in 24 hours. GCS remained 14/15 due to persistent confusion until Neuro observations were ceased on 17/10.14. This patient progressed and was discharged home on 05/11/14	17.2.15	Mr Philip Murphy, AMD for Acute Medicine, Mr Simon Gibson, Assistant Director for Acute Medicine, Mrs Connie Connolly, Lead Nurse Acute Governance	1. Did the fall impact or contribute to the neurological changes which were detected. There was agreement that the fall was managed in a timely manner. Given the written evidence and observations, the screening panel did not think the fall on the ward was a cause of the change in neurological findings. It is probable that the neurological changes were attributable to a progression of the current frontal lobe extra axial bleed with left occipital lobe intracerebral haemorrhage. Did the clinical documentation clearly reflect the timing and management input from all specialties and regional input. Yes, and there was excellent documentation in relation to keeping the family and patient informed of events and rationale for same.
14.10.14	SEC	Personal Information	21.6.14	Personal Information redacted by the USI	Alerted by patient on ward that patient had fallen from chair reaching for tissue on floor. Found by staff nurse McClung head first on floor.	14.1.15	Mr E Mackle Mrs H Trouton Mrs C Connolly	
14.1.15	MUC	Personal Information	28.1.15	Personal Information redacted by the USI	Patient was assessed at an outpatient GI clinic on 12.1.15 due to ongoing vomiting the previous few weeks. He was discharged with a plan for OGD as a day case. He was assessed by his GP later that afternoon and referred to the Emergency Department Craigavon. Following assessment there he was admitted to the Medical Assessment Unit. initial diagnosis was sepsis. He was transferred from MAU to 1 South on the 14 January. His condition deteriorated on transfer and he was subsequently transferred to theatre for emergency suegery. A perferated and ischemic colon was discovered, there was also an incidential tumour of the hepatic flexure of the large bowel and gross faecal contimination of the peritoneal cavity. The patient remained in ICU and died 21.1.15.	2.2.15	Mr Barry Conway AD MUSC Dr Philip Murphy AMD Dr Una Bradley Medical Consultant Mr Paul Smyth Lead Nurse Mrs Connie Connolly Lead Nurse	The screening team take the view that this patients diagnosis was difficult to detect. He had a history of Alzheimer's and was subsequently a poor historian. He was seen at various stages by senior medical staff and management plans formulated. His initial abdominal examinations recorded abdomen as soft and non-tender. His clinical observations did deteriorate on 14/01/15 with an elevated NEWS score recorded by nursing staff. The screening team noted that there was limited recording on the back of the NEWS chart in relation to escalation to senior doctors. However from review of the medical and nursing notes, escalation and subsequent assessment of the patient by senior doctors was evident.
16.1.15	OPPC	Personal Information	16.1.15	Personal Information redacted by the USI	Personal Information redacted by the USI admitted into medical ward DHH on 12.1.15 with increased breathlessness and sputum production. She was discharged 3 days later that evening and GP OOH contacted and sugsequently requested ambulance. Patient suffered respiratory/cardiac arrest 23.25 while being put into ambulance. Resuscutation unsuccessful.	16.1.15	Mr Barry Conway AD MUSC Dr Philip Murphy AMD Dr Una Bradley Medical Consultant Mr Paul Smyth Lead Nurse	The screening team reviewed the inpatient notes. They reviewed the medical and nursing notes. They felt the discharge notes were appropriate and the patient was stable with clinical observations stable at the time of discharge.

9.2.15	MUC			Personal Informatio	On Monday 9 February 2015, this Personal Information redacted by the USI was admitted to 4 South bia CEAWfor suegery to remove a tumout in the transverse colon. Extended right hemicolectomy with partial gastrectomy was done on 9.2.15 was uneventful. On Friday the 13 February 2015 at 1600 hours patient was complaining of shortness of breath, seen by doctor at 16.00 hrs. At 1700hrs, CXR showed no acute changes, no sign of infection and a raised hemi-diaphragm. Patient was seen by FY2, while SpR and consultant informed of rising NEWs score at 1750 hrs. Plan: CT AP and prepare for surgery. Patient was reviewed on 6 occasions between 1830 hrs and 2100 hrs by F2 and SpR. NEWs score between 6 and 11. Seen by anaesthetist at 2100hrs. Clinical findings in keeping with anastomotic leak. Patient's oxygen levels started disaturating immediately prior to transfer to theatre. Patient arrived in theatre at 2200hrs. Marked deterioration from leaving the ward. Patient vomited, placed on side and suctioned, possible aspiration. No palpable radial pulse. Arterial line inserted. Loss of output and asystole at 2235hrs. CPR commenced. Decision to stop CPR at 2306hrs.	25.02.15	Mr Eamon Mackle AMD Surgical Mr Ronan Carroll AD CCS Mrs Amie Nelson HOS for Surgery Mrs Connie Connolly, Lead Nurse NOT RECORDED ON DATIX	The screening panel agreed that while the patient's death was unexpected, the sudden deterioration was escalated promptly and appropriately by both clinical and nursing teams. Research indicates that there is a higher risk of anastomotic leak when resecting the large bowel and when metastatic disease in present. The patient's initial recovery was uneventful and would not have indicated any predictable deterioration. The screening panel unanimously agreed that there was very limited if no new learning within this incident and this should not be considered a SAI. It is the opinion of the Screening Panel that there was only one area of concern which was in relation to the detail within the operating notes. There was a lack of clarity within the operating note in relation to the stomach- how it was removed and closed. The significance of this missing information is related to identifying the possible source and/or cause of the leak within the abdominal cavity. The Panel believe that the issue in relation to the operating note should be addressed through clinical line management rather than the Trust SAI process.
24.11.14	MUC	Personal Information	24.11.14	Personal Information redacted by the USI	Personal Information Patient admitted to the Female Medical Ward in Daisy Hill Hospital on 28 October 2014 at 01:20 hours with 5/7 history of nausea , intermittent central abdominal pain, weight loss. Past medical history of lung ca, asthma , reflux, COPD, Abdominal Aortic Aneurism, Hiatus hernia and prolapsed lumbar disc. Personal Informatio made slow and gradual progress in relation to the resolving nausea, and a atypical chest infection was noted and treated. On Monday 24 November 2014 Personal Informatio had an unwitnessed fall at the bedside. Personal Information stated that she tripped on her blanket. Landed on the Left side. Analgesia prescribed and x-ray of Left hip and shoulder ordered. On 25 November 2014, formal report of left hip xray revealed fractured inferior pubic rami.	8.6.15	Mr Barry Conway AD MUSC Dr Philip Murphy AMD Dr Una Bradley Medical Consultant Mrs Connie Connolly Lead Nurse	It is the opinion of the screening panel that this fall could not have been predicted or prevented and that all Falls management documentation was completed as per policy. The fracture did not have a substantial impact on the length of stay as medical management complex. This patient made a full recovery following rehabilitation.
1.4.14	SEC	Personal Information	18.3.15	Personal Information redacted by the USI	On 31 March 2014 at 20:07 hrs Personal Information attended Craigavon Area Hospital (CAH) Emergency Department (ED) with left leg pain. Painful left foot 2 weeks ago- left iliac stenosis/ruptured plaque and mitral thrombosis. Stented on 14 March 2014 in RVH. Past medical history: insulin dependent diabetic and Chronic Obstructive Pulmonary Disease (COPD). Sudden onset of left groin pain 31 March 2014. Discussed with (d/w) vascular SpR Dr 2. Following d/w consultant- foot still viable, no beds in RVH, needs admission for CTa and management can be by Dr 3. Likely blocked stent and not good for surgery. On aspirin, no DAPT d/w Surgical SHO- admit, might not see until 01:00. Admitted to 4N at 23:20. On 1 April 2017 at 01:40 Pt seen by Dr 4. Internal iliac artery occlusion CT 13 March 2014. Onset today 31 March 2014 leg/groin pain. CRT 4s left foot/2s Right foot/Left foot cool. d/w with Dr 2 in RVH. No beds in RVH, Admit CAH for CTa tomorrow. Dr 3 to review. Likely blocked stent. Pulses throughout right leg. Left femoral just palpable. No others in Left leg palpated. Cool to touch. Left leg sensation intact, moving toes. Summary: stent occlusion Left external iliac. Plan: CT Angiogram (angio) tomorrow (requested).	3.6.15	Mr Eamon Mackle AMD Surgical Mrs Heather Trouton AD SEC Mrs Connie Connolly, Lead Nurse	It is the opinion of the screening panel that this fall could not have been predicted or prevented and that all Falls management documentation was completed as per policy. The fracture did not have a substantial impact on the length of stay as medical management complex. This patient made a full recovery following rehabilitation.

24.2.15	SEC	Personal Information	24.4.15	Personal Information redacted by the USI	Personal Information patient admitted to CAH following fall at home. Fractured Left Neck of femur identified. Past medical history of CVA Sept 2014. NIDD. On clopidigrel 75 mg once daily. Patient had insertion of Left Dynamic Hip Screw on Wednesday 19 February 2015. Post operatively, National Early Warning Score (NEWS) ranged between 1 and 3. Haemoglobin ranged from103 (pre op) to 65. Blood transfusion completed on Day 2 post op. Sunday 23 February 2015 at 22:00 hrs, patient complained of extreme left leg pain. Orthopaedic Registrar contacted on Sunday 23 February at 22:50 hrs- Ortho Reg asked for FYI to assess patient. FY1 arrived to ward on Monday at 01:30 hrs and was not able to stay due to ward pressures within hospital NEWS was 3 at this time. NEWS score was 3 at 06:00 hr, then elevated to 7 at 06:10 hrs. Level on consciousness decreasing, patient very pale and clammy. Medical FY1 fast bleeped at 06:10 hrs, will attend ward. Medicine FY1 Fast-bleeped again at 06:25- unable to attend ward. Surgical SHO fast-bleeped at 06:25 hrs. Clinical details handed over. Clinical Co-ordinator and cardiac arrest team contacted. Seen by Surgical CT2: Summary- hypoxic, shocked, swollen left thigh, K+ 6.8mmol. Possible ischemic bowel, Pulmonary Embolus more likely. Medical ST3 in attendance at 06:35 hrs. Temp 36.0, pulse 118, b/p 110/55 Resps 18 Oxygen at 2l in progress. Seen by Anaesthetic SHO at 07:00hrs. Impression: intra-abdominal/sepsis/ischemia/bleeding. No i/v access. 07:30 peri-arrest, Anaesthetic ST3 in attendance. Intubated at 08:20. Transferred to ICU. At 10:45 hrs, patient transferred to theatre for evacuation of haematoma of left DHS wound. Transferred from ICU to Trauma Ward on 1 March 2015. On 4 March 2015, some left arm weakness noted, ? may have occurred after haemodynamic insult on 24 February. Discharged to Lurgan for rehabilitation on 6 March 2015.	22.5.15	Mr Eamon Mackle AMD Surgical Mrs Heather Trouton AD SEC Mrs Connie Connolly, Lead Nurse	Rationale: It is the opinion of the screening panel, that this incident does not meet the criteria of an SAI. The NEWS score prior to deterioration was monitored appropriately. The management of the deteriorating patient from 06:00 was excellent. There were no obvious actions omitted which would have prevented this event or eliminated the risk of this complication. The panel believe that in retrospect there is learning in relation to communication between the Registrar on-call and ward staff in the event assessment is delayed or not available. There is also learning for the ward and clinical staff in relation to observing NEWS scoring which may not be overtly alarming, but that over time, has not dropped to 0.
29.8.14	SEC/ATICS			Personal	Personal Information patient transferred from South West Acute Hosptial (SWAH) to 3 South CAH on 18.8.14 for management of hydronephrosis secondary to large abdominal mass. Nephrostomies inserted in CAH on 19.8.14 (Lt) and 21.8.14 (Rt). Patient returns to SWAH to Gynae ward on 23.8.14. A HSC Incident Notification Form was submitted on 31.10.14 (Incident date 29.8.14 by Assistant Medical Director (AMD) in the Western Health and Social Care Trust (WHSCT) stating. "Female patient suffered significant intra-abdominal haemorrhage following nephtostomy insertion in CAH. Unable to Transfer patient back to CAH and eventually transferred to BCH. Very poor service from CAH with no ownership of patient". Email from Serious Incidents-Acute Service SAI Review Team stating it was agreed that this should be reported as a Level 1 SAI investigation by SHSCT.	22.7.15	Mr Eamon Mackle AMD Surgical Mrs Heather Trouton AD SEC Mrs Martina Corrigan HOS Mrs Connie Connolly, Lead Nurse	The screening panel have agreed the issue raised by the Intra Trust Notification is not a SAI, as the CAH Urology Team did engage and support the SWAH team as necessary. The Screening panel also agreed that this patient needed a multi -disciplinary/multi -specialty approach following further deterioration which could not be facilitated within the SHSCT. Panel members also noted the difficulty in reaching the on-call anaesthetic team on Saturday 30 August 2015 which was documented in the SWAH ICU notes. The Screening panel unanimously agree that there would be benefit in meeting with the SWAH (Acute) team to discuss this case including ICU contact, along with issues around access to radiological intervention.

15.8.15	MUC	Personal Information	17.8.15	Personal Information redacted by the USI	Personal Information patient presented to DHH ED at 13:52 on 15 August 2015 hrs with past history of being increasingly unwell for 2-3 days. Feeling short of breath, poor oral intake. Has not passed urine for 48 hours. Seen by Dr at 15:15 hrs. Couple of vomiting episodes on 13/08/15. None since. Very lethargic. No complaints of abdominal pain/diarrhoea. Distended abdomen and tympanic. Bowel sounds sluggish, soft. Impression: cold sepsis ? source. RR 38 SpO2 87-88% room air. Poor access to lung bases. Clammy and cold. Commenced on Tazocin and Gentamycin, arterial blood gas, Intravenous fluids (i/v) Urinary catheter inserted for 60 mls of dark urine. Bloods and cultures done. Urine sent. CXR done. NEWS 8 at 16:40 prior to discharge from ED. Admitted to FMW at 17:55. NEWS 10 at 17:55. Clerked in at 18:30hrs. D/W surgical SHO re obstruction. AXR requested rather than CT abdomen Abdominal xray done at 20:27. At 21:02 Multiple dilated loops of bowel noted on AXR by surgical SpR. DNAR agreed by family. Wide bore NG insertion attempted at 22:02 and >500mls of faecal fluid was passed via the tube and by vomiting. Patient become unresponsive and sadly passed away.	19.8.15	Dr Philip Murphy AMD for Acute Medicine, Mr Simon Gibson, Assistant Director for Acute Medicine, Dr Seamus O'Reilly AMD for Emergency Medicine, Mr Eamon Mackle AMD for Surgical Services, Mrs Mary Burke, HOS for Emergency Medicine obo Mr Barry Conway Mrs Catriona Kavanagh, HOS for Medicine Mrs Connie Connolly, Lead Nurse Acute Governance.	The Screening Panel agree that this incident does not meet the SAI criteria for the following reasons: There was detailed documented evidence that this critically ill patient was provided appropriate clinical and nursing care throughout admission. There was careful scrutiny of the NEWS monitoring. The Screening Panel agrees that there were clear gaps in frequency and a lack of documented escalation. The Panel agreed that this needed to be addressed by the ED and FMW teams internally, but this issue in itself did not warrant a SAI. The Screening Panel accepts that there could have been concern about this patient being transferred to the Medical Ward, but it had not been recorded. The Panel agree that an update for both teams is needed in relation to the HDU Admission Criteria. This issue does not warrant a SAI. The Screening Panel did accept that it would have been preferable that the painless abdominal distension was included as part of the 'work-up' in ED. The retrospective review did confirm that the care management in ED at the time was appropriate but the Screening Panel agree that this should be raised as learning within the ED Departments. This observation does not warrant a SAI The Screening Panel propose that NEWS management, review of HDU admission criteria and the management of painless abdominal distension, are included in the Terms of Reference for the proposed internal review within ED and FMW. The Panel would also like to propose that this incident is presented at both the ED and Medical Morbidity and Mortality meetings.
6.6.15	MUC	Personal Information	8.6.15	Personal Information redacted by the USI	Personal Information patient admitted to DHH HDU on 2 June 2015 with sudden onset of abdominal pain and jaundice. Diagnosed with cholecystitis, new AF and pulmonary oedema. Patient's condition deteriorated during the night of 2 June 2015 and patient was transferred to CAH for ERCP and ICU support. On 3 June 2015 Consultant Intensiveist reviewed patient and opined that an escalation of care would not be appropriate. Transferred to 1S on 6 June 2015. Syringe driver with analgesia and anti-emetic erected on arrival to ward. Family distressed that there was no side ward initially. On 8 June 2015 patient's husband requested i/v fluids for the patient (had been taken down in ICU). Patient passed away peacefully on 9 June 2015.	11.9.15	Dr Philip Murphy AMD for Acute Medicine, Dr Charles McAllister, AMD ATICS, Mr Simon Gibson, Assistant Director for Acute Medicine, Mrs Connie Connolly, Lead Nurse Acute Governance.	The Screening Panel agree that events described within the formal complaint do not meet the criteria of a Datix reportable incident or meet the criteria of a Serious Adverse Incident because: The documented clinical treatment for Personal was entirely appropriate given the diagnosis. It is the opinion of the Clinical specialists within the screening team that the management and care provided neither hastened or prolonged, the death of Personal.
3.9.15	MUC	Personal Information	11.09.15	Personal Information redacted by the USI	Personal Information patient presented with shortness of breath, low oxygen saturations. Recently discharged after paracentesis 2/52 ago. Known alcoholic decompensated liver disease. Multiple attempts made to obtain i/v access. 22g venflon inserted into top of Right foot In ED. Terlipressin prescribed- 2mg i/v QID on 3/09/15 when in 1South. Doses given via this site at 19:00 and 22:00hrs on 3/09/15 I n 1South. On 4/09/15 at 05:30 hrs site extravisated and removed. Patient transferred to ICU in the afternoon of 4/09/15. On 5/09/15 in ICU, pitting oedema to thigh. Feet cool, right foot mottled, and more swollen. Right forefoot required urgent surgical review. Stop terlipressin. Clinically not like emobli or thrombus event. ? Settling bruising from previous venflon site. Right foot bruising and oedema secondary to Terlipressin extravasation. Likely to become necrotic over the next few days and surgical debridement will be needed. 10/11/15- remains an in-patient and receiving wound management via tissue viability.	15.11.15	Mr Simon Gibson Dr Philip Murphy Mr Barry Conway Dr Una Bradley Dr Shane Moan Mrs Connie Connolly	The Screening Panel agreed the following: The Consultant prescribed the Terlipressin appropriately There was unanimous agreement that this patient was extremely difficult to initiate and maintain intravenous access due to a high number of co-morbidities and poor medical baseline. It was agreed that the clinical need for Terlipressin was greater than waiting for insertion of central line insertion to facilitate the administration of Terlipressin. There is evidence to support that Terlipressin is administered via venflons within the medical directorate. Extravisation is a known and acceptable clinical risk with any intravenous drug administration. There is clear documentation that the venflon site was observed and monitored as per policy and when there was evidence of extravasation, the venflon was removed. It is the opinion of the Screening Panel that this incident does not meet the criteria of a Serious Adverse Incident. Extravasation is a known clinical risk and the very poor venous access for this patient was fundamental reason why a larger bore venflon was not utilised. The Screening Panel agree that the clinical need for Terlipressin was greater than the need to wait for the insertion of a Central line for drug administration. Finally, the panel agree that this incident and Screening outcome is presented to the MUSC M&M by the patients consultant for learning for all medical staff.

4.9.15	MUC	Personal Information	4.9.15	Personal Information redacted by the USI	On 4 July 2015, Personal Information patient with increasing confusion over the past few days to ED. NIDDM. CXR taken to rule out LRTI. Admitted to MAU/2NH 3/7/15-12/7/15, seen in SOPD 20/7/15. CXR report highlighting thickened hilum and further investigation issued on 28/07/15. Presented to CAH ED 11/8/15 and admitted to 3S until 13/8/15. Abnormal CXR finding was not noted until 26 August 2015. Carcinoma confirmed 4 September 2015.	5.11.15	Mr Barry Conway, Assistant Director for Emergency Medicine , Mr Simon Gibson AD Acute Medicine (tele link) Dr Philip Murphy AMD Medicine, Dr Una Bradley, Mrs Connie Connolly, Lead Nurse Acute Governance.	Given progress in relation to SAI Personal Information (identical issue raised), it has been agreed to not proceed with short-term working group at this time. It is the view of the Moderation panel that issues raised with Personal Information, will be addressed with recommendations from Personal Information. The actions needed will be awaited and if there are any outstanding issues specific to Personal Information, this will be reviewed on completion of SAI Personal Information.
21.12.14	MUC	Personal Information	16.2.15	Personal Information redacted by the USI	This Personal Information redacted by the USI was admitted to MAU on 03:20 on Sunday 21 December 2014 with confusion, pyrexia. Recent anti-biotic for UTI. History of falls at home, increasing confusion. Type 2 diabetic. Previous CVA. MRI on 09/11/14 showed Rt Frontal Lobe infarct, or small subarachnoid cyst. On no anti-coagulation. On-going Right sided arm weakness. Extensive bruising to patient's neck, across both flanks and entire lower back noted on admission to MAU. Family aware of same- pt fell against door and chair at home. Falls assessment and care plan completed on admission. + UTI. In MAU on 21/12/14 at 07:20 hrs, patient found on floor lying on left side. Seen by ST1 at 07:30. For CNS obs. GCS 14/15 due to on-going confusion. Transferred to 2S Medical on 22/02/15 at 22:00. Found sitting on the floor with her back against the chair. Seen by FY1 at 08:30 hrs, no LOC, nil ordered. GCS 15/15. Seen on ward round by Dr Nelson, CTB ordered in view of facial and neck bruising. CTB done at 14.00 hrs Findings discussed with Radiologist at 14:30 hrs. Lesion in Right frontal lobe. Will need further imaging. For neurosurgical opinion, and discussion at neuro-radiology meeting on 24/12/15. D/W family, informed CTB showed small amount of bleeding in Right frontal area. ?evoloving. D/W Neuro-Radiology meeting, agrees that there is bilateral sub-arachnoid haemorrhage and sub-dural haemorrhage posterior falx. Lt posterior skull fracture with Right frontal likely haematoma. Sub-acute infarct Left cerebellum and likely Right temporal infarct. To d/w Neurosurgery again in view of fracture detection. Neuro radiology suggest CTA. RVH state skull fracture does not require any surgical intervention. D/W Dr McCormick, Acute cerebellar infarct, to repeat CTB in 2/52. Throughout this period, GCS remained between 14/15 or 15/15- some transient confusion.	16.2.15	Mr Philip Murphy, AMD Acute Medicine, Mr Simon Gibson, Assistant Director for Acute Medicine Mrs Connie Connolly, Lead Nurse Acute Governance.	Screening panel members reviewed all patient documentation in relation to this admission. Discussions assessed were: 1. Did the fall(s) shortly after admission impact or contribute to the neurological changes which were detected. There was agreement that the fall was managed in a timely manner. Given the written evidence and observations, the screening panel did not contribute the fall on the ward to any of the neurological findings. It is probable that the neurological changes were attributable to a fall or event prior to admission. The presentation of old bruising on admission and the lack of clinical evidence that the patient hit her head during the fall support this opinion. 2 Did the clinical documentation clearly reflect the timing and management input from all specialties and regional input. Yes, and there was excellent documentation in relation to keeping the family and patient informed of events and rationale for same.
17.9.14	MUC	Personal Information	18.9.14	Personal Information redacted by the USI	Personal Information redacted by the USI referred to the local Emergency Department (ED) for assessment with a history of heavy vaginal blood loss. A review from the Gynae SHO was requested. Personal passed a large blood clot which was queried to be a gestational sac measuring approximately 20 x 3cms in size. The clots were placed on incontinence pads by nurse. The pad was placed on a silver dressing trolley; this was intended to be left for Gynae SHO for examination. This trolley was wheeled outside the cubicle. The pad could not be found. It is assumed it had been placed in a bin in resuscitation room. The bins were searched and only a blood stained pad could be found.		Mr Seamus O'Reilly Mr Paul Smyth	
1.1.15	MUC	Personal Information Complaint ID 4818		Personal Information redacted by the USI	Personal Information redacted by the USI admitted via ED on 01/01/15 with confusion, decreased co-ordination and reduced oral intake. Discharged from Orthopaedic ward (medical outlier) 3 weeks later on 22/01/15 to Nursing home. Transferred back to CAH by nursing home shortly after arrival on 22/01/15. Nursing home submitted letter complaint		Mr Simon Gibson Dr Philip Murphy Mr Barry Conway Dr Una Bradley Mr Paul Smyth	The patient was kept for an extra day due to an episode of hypotension, which resolved. She had been assessed by the medical inpatient team and reviewed the next morning by the consultant. After this review she was discharged. The patient's clinical observations were within normal limits with a NEWS score of 0. The team feel the nursing home queries in relation to communication and documentation on discharge could be addressed in a formal response by the nursing team.

7.6.15	MUC	Personal Information	18.6.18	Personal Information redacted by the USI	Personal Information redacted by the USI re-admitted to 2N Medical from Lurgan Hospital on 03/06/15 due to Lower respiratory tract infection. In-patient since April 2015. Past medical hx of epilepsy, NIDM, NSTEMI, occipital infarct 11/05/15. Recent confusion. On Sunday 7 June 2015 Family reluctant to wake patient for nursing intervention. Seen by consultant, patient unresponsive. GCS 3/15. Emergency 30mls i/v 10% glucose and push i/v 5% dextrose. BM 7.3 again. Alert GCS 13/15. Patient had no BM's done from 17:30 hrs on Saturday 06/06/15 until 11:20hrs on Sunday 07/06/15. Patient fully recovered from hypoglycemic episode.	15.7.15	Dr Philip Murphy Mr Barry Conway Mrs Connie Connolly	The Screening panel also agreed that this patient needed a multi -disciplinary/multi -specialty approach following further deterioration which could not be facilitated within the SHSCT. Panel members also noted the difficulty in reaching the on-call anaesthetic team on Saturday 30 August 2015 which was documented in the SWAH ICU notes.
6.3.15	MUC	Personal Information	6.3.15	Personal Information redacted by the USI	On Friday 6 March 2015, Personal Information redacted by the USI discharged from Medical Ward DHH at 1030hrs. Patient presented at DHH ED at 1546hrs with Glasgow Coma Scale of 3/15. Blood sugar 3mmol corrected. No improvement in coma scale. Patient readmitted to medical ward	20.4.15	Dr Philip Murphy Mr Simon Gibson Dr Una Bradley Mrs Connie Connolly	
10.11.15	MUC	Personal Information	11.11.15	Personal Information redacted by the USI	Personal Information presented to ED DHH post head injury. Initially for discharge but failed MDT assessment so referred for medical admission. 8.5 hours into stay in ED patient became unrespopnsive. CT brain performed large intracranial haemorrhage, admitted medically comfort.	18.11.15	Barry Conway Seamus O'Reilly Paul Smyth	The team felt this case did not meet the criteria for level 1 SAI • There was no indication for earlier CT brain • The initial CNS observations had been 15/15 and deteriorated to 3 at 18:30 hours Staff had arranged MDT follow up prior to discharge
11.12.15	MUC	Personal Information	12.12.15	Personal Information redacted by the USI	A Personal Information redacted by the USI (PMH CCF, T2DM, OSA with CPAP at night, HTN, long term Oxygen therapy, Obesity) was admitted to AMU 10/12/15 via ED with Shortness of breath and pitting oedema legs and flanks. Developed hypoglycaemia and hyperkalaemia on ward, treated accordingly. Assessed in AMU by Cardiology, Respiratory and Intensivists teams. Transferred to 2 North respiratory for NIPPY 11/12/15 at 15:00 hours. Was transferred on chair as unable to get into bed. Suffered respiratory arrest on arrival to 2 North respiratory ward on chair.	21.12.15	Barry Conway Philip Murphy Una Bradley Paul Smyth	The inpatient care and assessment by specialities had been appropriate. The ICU team felt the patient was not a candidate for ICU. The transfer to 2NR was an appropriate plan. The screening team felt that an internal review of the actual transfer would be beneficial to assertion if there was any learning.
14.10.15	MUC	[redacted]	7.1.16	Personal Information redacted by the USI	NIAS sumitted and interface incident form. Stating taking patient from DHH ED to RVH Cath Lab. Was informed of drugs fiven / morphine, maxalon, GTN + aspirin. Were were not informed verbally or on hadover sheets that Pt was given IV paracetamol previous NIAS crew weingin previous 4 hours. Pt stated he hadn't had any paracetamol. The attending parametic administered a further 1g (IV) for hip pain. NIAS is concerned that the second parametic was not provided with information, either verbally or in documentation, in relation to the first dose of paracetamol.	14.10.15	Barry Conway Mr Seamus O'Reilly Paul Smyth	The Team felt this case did not meet the criteria for level 1 SAI This was a drug error by an operative of another Trust. There was documentation in the ED notes to state that this patient did already get IV paracetamol. It is possible that the NIAS were not told of this but it was legible on the ED notes.
22.2.15	SEC	Personal Information	7.1.16	Perso nal	Personal Information redacted by the USI admitted to CAH for an elective palmer fasciectomy on left ring finger on 10 February 2015. On 11 February 2015, patient had PEA arrest in bathroom. Resuscitation successful.	30.9.15	Heather Trouton Eamon Mackle Connie Connolly	The Screening Panel discussed the clinical timeline and pre-operative assessment of this patient. The panel agreed that this did not meet the criteria of a SAI because: The patient was appropriately assessed pre-operatively. 2 anaesthetists passed patient fit The initial recovery was uneventful and the sequence of events which followed could have not been predicted.
24.7.15	MUC	Personal Information	7.1.16	Personal Information redacted by the USI	A Personal Information redacted by the USI presented to Craigavon Hospital Emergency Department with painful right calf and alcohol dependency. Following assessment he was diagnosed with alcohol intoxication and a possible Deep Venous Thrombosis. He was booked a Doppler scan for the 28/07/15 (4 days later) and shown how to self-inject with enoxaparin. The nursing notes stated he showed good technique. He was discharged at 04:47 hours just over 5 hours after his attendance in ED. he did not turn up for his Doppler on the 28/07/15. A letter was posted to patient Personal Informatio first class with a new appointment time of 31/07/15. He suffered cardiorespiratory arrest and died on 4th August 2015.	9.12.15	Barry Conway Mr Seamus O'Reilly Paul Smyth	The team felt this did not meets the criteria for a SAI investigation as • Appropriate diagnosis and treatment plan which unfortunately patient did not follow • Follow up and further Doppler booked when patient did not attend for Doppler

29.8.14	SEC	Personal Information	7.1.16	Personal Information redacted by the USI	Personal Information patient transferred from South Western Acute Hospital (SWAH) to 3S Craigavon Area Hospital (CAH) on 18/08/14 for management of hydronephrosis secondary to large abdominal mass. Nephrostomies inserted in CAH on 19/08/14 (Lt) and 21/08/14 (Rt). Patient returned to SWAH to Gynae Ward on 23/08/14. A HSC Incident Notification Form was submitted on 31/10/14 (incident date 29/08/14) by Assistant Medical Director (AMD) in the Western Health and Social Care Trust (WHSCT) stating, "Female patient suffered significant intra-abdominal haemorrhage following nephrostomy insertion in CAH. Unable to transfer patient back to CAH and eventually transferred to BCH. Very poor service from CAH with no ownership of patient." Email from Serious Incidents-Acute Services SAI Review Team stating it was agreed that this should be reported as a Level 1 SAI investigation by the SHSCT (19/02/15).	22.7.15	Eamon Mackle Heather Trouton Martina Corrigan Connie Connolly	The screening panel have agreed the issue raised by the Intra Trust Notification is not a SAI, as the CAH Urology Team did engage and support the SWAH team as necessary. The Screening panel also agreed that this patient needed a multi -disciplinary/multi -specialty approach following further deterioration which could not be facilitated within the SHSCT. Panel members also noted the difficulty in reaching the on-call anaesthetic team on Saturday 30 August 2015 which was documented in the SWAH ICU notes. The Screening panel unanimously agree that there would be benefit in meeting with the SWAH (Acute) team to discuss this case including ICU contact, along with issues around access to radiological intervention.
14.2.15	MUC		7.1.16	Personal Informatio	On Monday 9 February 2015, this Personal Information redacted by the USI was admitted to 4S via CEAW for surgery to remove a tumour in the transverse colon. Extended Right hemi-colectomy with partial gastrectomy was done on 09/02/15. Initial post- operative recovery period (09/02/15 to 12/02/15) was uneventful. On Friday the 13th of February 2015 at 16:00 hrs, patient was complaining of shortness of breath. Seen by Dr at 16:00 hrs. At 17:00 hrs, CXR showed no acute changes, no sign of infection and a raised hemi-diaphragm. Patient was seen by FY2, while SpR and consultant informed of rising NEWs score at 17:50 hrs. Plan: CT AP and prepare for surgery. Patient was reviewed on 6 occasions between 18:30 hrs and 21:00 hrs by F2 and SpR. NEWs score between 6 and 11. Seen by anaesthetist at 21:00 hrs. Clinical findings in keeping with anastomotic leak. Patient's oxygen levels started desaturating immediately prior to transfer to theatre.	25.2.15	Eamon Mackle Amie Nelson Ronan Carroll Connie Connolly	The screening panel unanimously agreed that there was very limited if no new learning within this incident and this should not be considered a SAI. It is the opinion of the Screening Panel that there was only one area of concern which was in relation to the detail within the operating notes. There was a lack of clarity within the operating note in relation to the stomach- how it was removed and closed. The significance of this missing information is related to identifying the possible source and/or cause of the leak within the abdominal cavity. The Panel believe that the issue in relation to the operating note should be addressed through clinical line management rather than the Trust SAI process.
22.2.15	SEC	Personal Information	12.1.15	Perso nal	Personal Information redacted by the USI admitted to CAH for an elective palmer fasciectomy on left ring finger on 10 February 2015. On 11 February 2015, patient had PEA arrest in bathroom. Resuscitation successful. Transferred to Medical Ward for NIV for poor respiratory effort. CTB negative. VQ scan ordered and booked for 13/02/15. No contrast available, scan deferred. Referral to haematology, to treat as PE. On 13/02/15 NEWS 9, patient acidotic, no NIV machine available. Commenced on humidified oxygen. VQ scanned booked for 17.02.15. Ward contacted, contrast has failed quality control. VQ scan postponed until 20/02/15. DNAR agreed 18/01/15. Too unwell to undergo VQ scan on 20/02/15 and sadly passed away on 22/02/15.	30.9.15	Heather Trouton Eamon Mackle Connie Connolly	The Screening Panel discussed the clinical timeline and pre-operative assessment of this patient.
13.2.2009	SEC	Personal Information	5.4.16	Personal Information redacted by the USI	Personal Information redacted by the USI had left hemi-colectomy 28 Jan 2009 for Dukes C1pT4 N1. As part of follow-up CT of Chest/Abdomen and Pelvis done on 13 February 2009. Report concluded that lung parenchymal nodules are consistent with metastasis. Patient had protracted recovery from Surgery. Reviewed in Cancer Centre on 5 March 2009 and 26 March 2009 and it was agreed that due to slow recovery and the CT findings, that Pers onal would not avail of any adjuvant therapy. Perso nal discharged from Oncology Service. Pers onal attended his GP on 11 February 2013 with poor appetite and queried the potential of adjuvant therapy given the length of time of survival after CT diagnoses. On 18 February 2013, Pers onal admitted to hospital with sub-acute bowel obstruction and sadly passed away on 8 March 2013.	15.3.16	Heather Trouton Eamon Mackle Connie Connolly	The panel agreed that this did not meet the criteria of a SA

14.4.16	MUC	Personal Information	15.4.16	Personal Information redacted by the USI	Patient admitted to hospital with COPD on NIV. Patient got up of commode unaided and appeared to hit her head on the end of the bed before she was assisted to the floor –witnessed fall, staff present. Patient sustained:- 1. Acute subarachnoid haemorrhage in quadrideminal cistern and anterior to the right cerebellar hemisphere, no significant mass effect Small left lateral intracranial haemorrhage 2. Focus of extra-axial haemorrhage 3. Impacted fracture of Left wrist Patient discharged home on 22/04/2016 Falls risk assessment was completed on admission, staff with patient at time of fall, Post falls GSC observations, CT scans, liaison with neurosurgery team in RVH, Radiology in CAH and haematology in CAH. Care was deemed to be appropriated and timely .	25.4.16	Mrs Anne McVey Dr Philip Murphy Mrs Trudy Reid Mrs Connie Connolly	The patient was appropriately assessed pre-operatively. 2
20.4.16	MUC	Personal Information	20.4.16	Personal Information redacted by the USI	Patient had and elective angiogram, appropriately consented including risk of CVA. Post procedure developed CVA. Patient was transferred to RVH for consideration for clot retrieval, it was decided this was not indicated when assessed in RVH, returned to CAH. The patient has been discharged to Lurgan Hospital for rehabilitation.	27.4.16	Mrs Anne McVey Dr Philip Murphy Mrs Trudy Reid Mrs Connie Connolly	The initial recovery was uneventful and the sequence of ev
14.10.15	NIAS	Not recorded		Personal Information	Northern Ireland Ambulance service submitted an interface incident form. It stated that “Taking Pt from DHH ED to RVH Cath Lab. Was informed of drugs given / morphine, maxalon, GTN +aspirin. We were not informed verbally or on handover sheets that Pt was given IV paracetamol by previous NIAS crew within previous 4 hours. Pt stated he hadn't had any paracetamol. The attending paramedic administered a further 1g (Iv) for hip pain. NIAS is concerned that the second paramedic was not provided with information, either verbally or in documentation, in relation to the first dose of paracetamol”	18.11.15	Seamus O'Reilly Barry Conway Paul Smyth	The team felt this did not meet the criteria for an SAI investigation. This was a drug error by an operative of another Trust. There was documentation in the ED notes to state that this patient did already get IV Paracetamol. It is possible that the NIAS crew were not told of this but it was legible on the ED notes.
1.2.16	MUC/NIAS	Personal Information	2.2.16	Visitor	Personal Information visitor collapsed at the front doors of the main hospital entrance Daisy Hill. The head of service attended the scene and contacted an ambulance to take the lady to the Emergency Department. ED staff (Doctor and nurse) attended the lady prior to NIAS arrival.	9.3.16	Seamus O'Reilly Barry Conway Paul Smyth	Discussed with Director and AD and AMD who feel this is not an SAI. The collapsed lady did not come to harm and none of the SAI criteria (4.2.1) were satisfied. The collapsed lady was not left unattended on the floor. The screening team acknowledge that the Head of Service should not have contacted the ambulance. The ED sister should not have liaised with NIAS to justify the request. The lady could have been transported to ED without the NIAS. The Screening team also noted the date submitted by NIAS was incorrect (see attached timeline). The ward manager ED will speak to the ED sister to advise on points for reflection and learning The AD will speak to the Head of Service to advise on points for reflection and learning. The procedure for collapsed visitor in the hospital needs shared with bed managers.
23.6.14	MUC	Personal Information	12.5.16	Personal Information redacted by the USI	Personal Information redacted by the USI patient presented to CAH ED with chest pain on 23/06/16. Chest xray taken which identified an irregular area of shadowing in the right upper zone suggestive of neoplasia and advised further investigation. Patient re-attended CAH ED on 20/03/16 with shortness of breath. Chest xray revealed advanced lung changes with right upper lobe shadow. Chest xray taken in 2014 had not been followed up. Discussed with Mrs E Gishkori at length, not SAI, to be included in 'review of results workstream' chaired by Dr Boyce	23.5.16	Dr Philip Murphy, Dr Una Bradley, Mary Burke (obo Anne McVey) Trudy Reid Connie Connolly	It was agreed that the contributing factors in relation to this incident can be addressed within the Xray management project group. Not for management as an SAI.

09/11/2015	MUSC	Personal Information	09/11/2015	Personal Information redacted by the USI	Patient admitted to Cath Lab for elective DCC which was cancelled initially due to shortness of breath and low O2 Sats. Admitted to Ward for further Investigations. During her admission patient had several episodes of self terminating VT and had treatment to prevent it re-occuring An attempt was made a few days later to carry out an angiogram but was unsuccessful. On Monday 09/11/15 an Angiogram was commenced and patients condition deteriorated rapidly leading to Cardiac Arrest, Blood Transfusions x 2 and transferred to RVH to Cardiac Theatre, had Double Bypass. Prognosis poor. Patient sadly passed away in RVH.	08/07/2016	Dr Philip Murphy Dr Una Bradley, Trudy Reid, Connie Connolly	Recognised Post Procedure Complications
1.5.16	MUSC	Personal Information	13.5.16	Personal Information redacted by the USI	Out of hospital arrest. Resus unsuccessful. Recent Cardiac stemting.	8.7.16	Dr Philip Murphy Dr Una Bradley, Trudy Reid,	
5.5.16	MUSC	Personal Information	13.5.16	Personal Information redacted by the USI	Stemi on arrival to ED DHH. Cardiac arrest 5 minutes after arrival. Resusitation unsuccessiful. Recent cardiac stenting. Personal Information patient with history of Triple Vessel Disease/Hyperlipidaemia/Diabetes on Insulin Had previous PCI and attended for further Angiogram, outcome of which was further PCI or CABG. 1 month post Angio, patient presented in ED with Chest Pain, Cardiac Arrest 10 mins post arrival, which was unsuccessful	8.7.16	Dr Philip Murphy Dr Una Bradley, Trudy Reid,	KC to follow up at M&M NOT SAI – Discuss at M&M learning to be shared with nursing staff re escalation of NEWS KC TO DISCUSS AT CARDIOLOGY M&M – TO RE-ESCALATE IF ANY ISSUES NOT AN SAI
16.2.16	OPPC	Personal Information	16.2.16	Personal Information redacted by the USI	Personal Information redacted by the USI Patient had history of metal heart valve since 2006, warfarin stopped in December 2015 as INR were unstable and patient had been referred for Red Flag OGD. OGD done 02/02/16. Acute Care at Home Team stopped Warfarin and commenced Enoxaparin in advance of OGD. Apparent gap in Enoxaparin administration post OGD on 09/02/16. Personal was admitted to 2SS on 16 February 2016 after being found unresponsive at 23:20 hrs 15 February 2016 and sadly passed away on 17 February 2016 secondary to acute cerebral infarction.	24.8.16	Dr Charlie McAllister, Mr Ronan Carroll, Mrs Trudy Reid & Mrs Connie Connolly.	This incident did not meet the criteria of an Acute Services SAI for the reasons stated within discussion. The screening panel recommended that the details of this incident were escalated to the AMD of Older People and Primary Care along with the Director of Older People and Primary Care for review. 24/08/16- Referral to OPPC validated by EG. Improved written patient discharge information to be developed by SEC and re-establishment of Anti-Coagulant Group requested-as per EG.
21.4.16	MUSC	Personal Information	6.5.16	Personal Information redacted by the USI	Patient attended ED feeling weak and lethargic, vomiting and necrotic foot. Diagnosed Lisfranc # L foot needed Medical and Ortho Input. On 21/04/16 Ortho had been bleeped but no response. Medically patient was unwell due to ↑BM's(new Type 11 Diabetic) , ↑Keytones, ↑CRP (sepsis), had MI , AKI. Ortho had been contacted again late evening on 22/04/16 and subsequently seen at 09:00 on 23/04/16. Patient was taken to theatre on 25/04/16 and had a below-Personal information redacted by USI was taken to ICU and his condition deteriorated rapidly over the next week. Patient sadly passed away on 06/05/16.	25.8.16 25.7.16 by SEC 20.7.16 by MUC	25.8.16 Mrs Anne McVey, Dr Philip Murphy, Mr M McCann, Dr Gareth Hampton & Trudy Reid 25.7.16 Mrs Anne McVey, Dr U Bradley & Sharon Kennedy 20.7.16 Seamus O'Reilly. Dr Charlie McAllister. Ronan Carroll & Sharon Kennedy	Screened 20/07/16 – thought not to belong to ED – for screening with Medicine.Screened 25/07/16 – should have been surgical admission, needs Ortho input and joint discussion. M Burke and B Kelly to develop guidance in relation to contacting Ortho Doctors after 5 pm. Sharon to speak with Paul regarding ED input – to speak with A McVey.01/08/16 - Dr Bradley to speak with Gareth Hampton on his return from A/L. 16/08/15 – To meet with Dr Hampton and Dr Bradley to discuss joint investigation.25/8/2016 Discussed at screening meeting following in-depth discussion it was decided that care was appropriate. Patient was admitted for stabilisation post MI and newly diagnosed diabetes. Patient was treated for acute coronary syndrome and sepsis.Discuss with T&O regarding slight delay in contacting/assessing patient and timing of surgical procedure and amputation.Advised case to be discussed at M&M surgical/T&O and ED/medicine – notes of same to be attached to file and DATIX Case to be discussed at T&O M&M. For presentation at M&M 2nd time 13/12/2016 at medicine
21.9.14	MUSC	Personal Information	16.5.16	Personal Information redacted by the USI	Tragic death of Personal on 23/09/2014. Personal was admitted via ED to MAU on 21/09/2014, she was admitted to ICU on 22/09/2014 following peri-arrest requiring massive transfusion- Cause of death 1 Thoraco-abdominal aneurysm rupture, II Hypotension Failure to escalation / missed AAA		Dr P Murphy, Mr M McCann, Dr G Hampton, Mrs A McVey & Mrs T Reid	The screening panel discussed that learning regarding this case was shared via M&M process. The panel felt the outcome would not have changed and given the time delay and a recent thoracic aortic aneurysm case and a failure to escalate in the SAI process – additional learning would not be achieved by the SAI process in this case. Learning for nurses will be via review of case at ward and department level. AMU and ED staff are to complete the ALERT course

22.6.16	MUSC	Personal Information	22.6.16	Personal Information redacted by the USI	BIBA at 03:25, triaged at 03:41 Priority code 3 Presentation –Head injury Discriminator- uncontrollable minor haemorrhage Delay in CT – SAH diagnosed -	30/08/2016	Dr P Murphy, Mr M McCann, Dr G Hampton, Mrs A McVey & Mrs T Reid	The screening panel decided that that the delay in CT scan did not alter patient care or outcome. However the panel decided that Dr Hampton and Dr McCann would discuss with staff and send an email to medical staff highlighting the importance of escalation to a Consultant. Case to be discussed at ED M&M with interface with Radiology – minutes to be attached to file and Datix when available
3.9.16	MUSC	6665 Complaint		Personal Information redacted by the USI	Personal Information redacted by the USI presented to Out of Hours Service on 30 August 2016, and CAH ED on 31 August 2016, twice on the 2 August 2016 and on the 3 August with a 4 week history of acute back pain. Symptoms were initially acute pain, fall at home, difficulty walking, urinary retention. On 3 August 2016, patient could not walk. Diagnosed with spinal cord compression secondary to epidural mass. Probable lymphoma. Personal Information was 'blue light' to RVH for emergency surgery.	26.9.16 & 29.9.16	Dr P Murphy, Dr G Hampton, Mrs A McVey, Connie Connolly & Mrs T Reid	There was agreement that this incident was not going to be managed as SAI as the cause of the incident was known. The root cause was secondary to human error. The Screening panel agreed the following actions: Completion of datix Clinical supervision by allocated clinical mentor for Dr 2 re incident and learning. Presentation of incident to ED M&M (to be attached to datix) Presentation to ED Nursing Safety Briefing. (dates and minutes to be attached to Datix) Dr Hampton and Mrs McVey to complaint response - Complaint response sent
25.8.16	MUSC	Personal Information	23.9.16	Personal Information redacted by the USI	Personal Information redacted by the USI with known history of intercranial haemorrhage, testicular Ca, CVA, epilepsy, recurrent DVT, IVC in place, thrombophilia, malignant melanoma. Complaint received from mother. Mother alleges that Personal Information redacted by the USI and patient was referred back to CAH Dermatology for follow up and Dermatology did not carry out a review. Personal has now been diagnosed with lung cancer and the complaint alleges the Trust is liable for this mistake.	26.9.16	Dr P Murphy, Mrs M Burke, Dr Una Bradley, Dr Shane Moan, Dr Pat McCaffrey. Trudy Reid & Connie Connolly.	260916-the clinical timeline and communication in relation to this incident was reviewed. There was failure by the Plastic Surgery team to arrange adequate review of Personal in relation to his malignant melanoma. The Review panel agree that this is to be raised as an interface incident to the South Eastern Plastic Surgery Service for review and investigation. Refer via Interface Incident process
29.11.15	MUSC	Personal Information	30.11.15	Personal Information redacted by the USI	A Personal Information redacted by the USI presented to Daisy Hill Emergency Department at 11:43 hours on 29/11/15 with abdominal pain and vomiting, he was type 1 diabetes. He had taken his morning insulin at home at breakfast. His initial BM was 12.7 mmol/l at 11:43 hours. Patient developed DKA while in ED. was treated in HDU. He had not been prescribed his afternoon and evening insulin while in ED. discharged 02/12/15.	9.12.15	S O'Reilly Barry Conway Paul Smyth	Patient initially did not present with DKA but this developed during long period in ED. The DKA was picked up in ED and treatment commenced. An internal review to address management of diabetic patients is underway
29.12.14		Not recorded		Personal Information redacted by the USI	This cannula remained in situ until the 4/1/15 when the patient complained of painful cannula site at 1900hrs and it was removed. Note iv fluids were discontinued on 3/1/14- records state rationale for cannula was for maintenance- no saline flush prescribed as per standard 5.		Dr Moan Dr Brown Sr McKnight IPCN Matthews	RCA MRSA/MSSA
22/02/2016	SEC	Personal Information		Personal Information redacted by the USI	Personal Information redacted by the USI had mechanical fall at home on 14/02/16. P/H #tib/fib, Bowens disease, hypertension, registered blind. Attended ED, admitted medically,, diagnosed with # tib/fib on 15/02/16. POP applied at fracture clinic. Patient discharged to PNH, on 23/02/16, for review in one week. Reviewed on 01/03/16, had pressure sore on heel and plantar aspect of sole, plaster changed and window cut to observe heel. d/c back to PNH. On 08/03/16, telephone call from PNH, patient had blackened toes – advised to come to fracture clinic immediately – admitted with necrotic area right foot and heel, no pulses. R Below Personal Information redacted by USI performed on 10/03/16 – wound did not heal – patient had R Personal Information redacted by USI on 24/03/16. Also had grade 2 sacrum and grade 4 left heel. Had 2 days IVAB for chest consolidation. Discharged back to PNH ON 13/03/16. Patient sadly passed away in Nursing Home on 22/05/16		MR RONAN CAROLL, MRS TRUDY REID, DR C MCALLISTER, MS SHARON KENNEDY	Discussed at screening. To present at appropriate Trauma and Orthopaedic M+M. Deemed as rare complication, but care appeared appropriate.
	MUSC		22/06/2016	Personal Information redacted by the USI	Delayed screening Barretts oepophagus- last screening 2012	30/08/2016	Dr P Murphy, Dr M McCann, Dr G Hampton, Mrs A McVey, Mrs T Reid	Personal Information redacted by the USI cases would be reviewed in the 'delays' working group. As patient came to no harm, investigation showed patient had repeat scope with no adverse effect, no forma screen ing form was required

11/05/2016	MUSC	Personal Information		Personal Information redacted by the USI	Personal Information patient, recently diagnosed Mast Cell Leukaemia. Had been in hospital since 15/03/16, P/H Parkinson's Disease, Mild MR, OA, Bil TKR, HTN, L Mastectomy. EPIPEN was advised and prescribed to be used in acute flares. On 10/05/16 patient developed acute episode of Mast Cell Mediator release with sudden hypotension, tachycardia, pyrexia, vomiting and diarrhoea. EPIPEN was not given and patient continued to deteriorate and developed AKI. DNAR was put in place and patient sadly passed away at 07:45.		**MRS A MCVEY** **DR UNA BRADLEY** **SHARON KENNEDY**	Internal learning. Consultant, as per datix review, has already spoken with Medical staff involved in patients care – Memo issued to all Junior Doctors. Memo requested on 27/07/16 – same received. Memo to be issued to all Nursing Staff via Head of Service. 09/08/16 – memo sent to Sr Carson and Mrs Carroll for sharing with staff.
01/05/2016		Personal Information		Personal Information redacted by the USI	Personal attended DHH ED on 25/04/2016 with ACS, ST depression. Personal was transferred to CAH PCI on 26/04/2016, transferred back to DHH and was discharged home 29/04/2016. 1/5/2016 collapsed at home wife started CPR- NIAS transfer to DHH ED – Personal tragically died in the emergency department DHH		DR P MURPHY DR U BRADLEY MRS T REID MRS C CONNOLLY	NOT FOR SAI – KC TO REVIEW CARDIOLOGY M&M
28/08/2016	ATTICS		Personal Information	Personal Information	Death post surgery for #NOF Personal Information redacted by the USI, trauma list for #NOF left side h/o advanced dementia, private nursing home resident, AF, trop rise (52), Hgb 95 for Left hemiarthroplasty. Uneventful spinal & FNB for anaesthesia, relatively stable in theatre, some drops in BP requiring occasional bolus 1ml metaraminol, BP on leaving theatre approx. 130/70. HR through procedure AF rate 100-140. Sats 96-100 on 4l/min. In theatre had been given 1 unit packed cells plus CSL 500 ml during procedure. transferred to recovery, at handover difficulty getting BP reading, given ephedrine boluses, carotid pulse felt rate 120, few min later noted to have gone apneic, emergency cord pulled, assistance arrived and CPR commenced (no output). Ongoing CPR, 3 adrenaline given in total, reversible causes investigated (blood glues 7.4/ potassium 4.8, Hgb 122). Discussed with ortho team, CPR discontinued approx. 1310. Life extinct confirmed			01/09/2016 email trail from Mr Carroll 12/12/2016 reviewed DATIX- closed by ATTICS on 06/09/2016 - see datix for detail
	MUC/ED			Personal Information redacted by the USI	Hyponatraemia - ED Alerted by ProParamedics to myself at approximately 17.15pm, patient had ?fallen over fence/collapsed in car park. On assessment patient was alert but not verbally responding, smelt of alcohol and appeared jaundice. Patient was transferred onto a wheelchair and brought to ED for assessment. Following triage patient took a seizure outside Resus doors.		Philip Muprhy, Una Bradley, Mary Burke, Trudy Reid and Connie Connolly	Not SAI as patient admitted with hyponatraemia and cannot be responsible for visitors in ED who leave the department no further investigations required.
31/08/2016	MUSC/ATTICS	Personal Information	31/08/2016	Personal Information redacted by the USI	Massive transfusion called on Personal after 2 Oneg, 2 FFP and 2 Group Specific issued. Red alert protocol enacted to fill tariff of 10 units + FFP and platelets. 1 unit returned outside of time and wasted, 1 unit of FFP returned inside 30 min. Documentation and communication present. Recorded as IR1 as per policy for tracking and trending. Red alert tariff fulfilled once MBL protocol was called. Patient received multiple units of red cells and plasma. As of 10:20 31/8/2016 there remains 4 units of RBC and 2X FFP in issue. (Patient born before 1996 UK derived plasma appropriate for use in this case)Massive blood loss protocol activated appropriately. Blood delivered to ED at 05:06 hours. Patient transferred to theatre at 05:10 hours. Blood & blood products accompanied patient to theatre. Unused units were returned to ED to be sent back to labs. Labs phoned and informed of this. protocol adhered to - appropriate use of same.			Final approval by G Hampton 31/08/2016 Discussed with ATTICS- Dr McAllister, Helena Murray, Ronan Carroll and Connie Connolly - NOT SAI - significant known comorbidities
03/04/2015	SEC	Personal Information	10/09/2015	Personal Information	Missed rectal cancer - specialty docotor initial scope	12/09/2016	Dr McAllister, Ronan Carrol, Trud	Reviewed by Dr McAllister, Ronan Carrol 12/09/2016, to be reviewed in M&M with images - Mr McArdle informed, re emailed 12/12/2106 re outcome

22/09/2016	SEC	Personal Information	23/09/2016	Personal Information redacted by the USI	Crash trolley used twice within 1 hour. at 2nd use, battery in de fib and suction stopped working after approx. 30mins. De fib borrowed from other source. Maintenance contacted and investigation being carried out. Temporary de fib to be given. Battery being checked by maintenance. Feedback to be given. BC H&C number Subtotal colectomy on 19th Sept . Peri arrest last night then full arrest after . Defib failed . MR and BO'C contacted in am , defib removed and replaced . Datix sent and NIAC reportable .. time line completed . Escalated to HOS and AD .. ??SAI screening			Discussed with Mr Carroll - lead nurses to investigate - CLOSED by SEC 3/10/2016 Biomedical engineer returned De Fib 28/9/16 to 4s Check shows that it was battery life that caused De Fib to lose power due to using in quick sucession and continued monitoring Normal battery life is 1hr 40 min we got 2.5 hrs Formal report available
	SEC	No datix		Personal Information redacted by the USI	Received via Surgical M&M - Patient had bowel resection - died post operatively in Ulster Hospital ICU		Ronan Carroll and Dr McAllister	Not screened as no datix - to go via M&M process - presnted 21/01/2016 ATTICS and 20/07/2016 at joint M&M - see M&M rpeort and email dated 21/102016
		No datix		Personal Information redacted by the USI	Referral from M&M screened back to M&M			discussed at both the cardiology M+M and main medical M+M. The were no concerns about the management of the patient but there was agreed learning around the process of transfer of patients between teams
17.12.15	MUC	Personal Information	2.2.16	Personal Information redacted by the USI	Patient had been admitted to DHH with erratic blood sugars on 17/12/15, had been prescribed usual LANTUS insulin in morning and HUMALOG PRE-BREAKFAST, PRE-LUNCH, PRE-TEA(doses had been increased as per BGM chart). During this admission, it was documented that patient had 'self-administered' Insulin on a number of occasions, however 2 nurses signatures were not always recorded and no documentation regarding supervision of patient administering her own Insulin. Patient left DHH on 19/12/15 prescribed LANTUS AND HUMALOG. Patient admitted again to DHH with erratic blood sugars on 12/01/16, prescribed usual LANTUS AND HUMALOG. On admission to the ward, patients BMs continued to rise and by 07:00 on 13/01/16, patients BM 26. Patient had then administered her own Insulin and it was discovered it was APIDRA instead of LANTUS. Patient thought it was the same brand, ? where APIDRA was dispensed. Education given to patient on different Insulins by Diabetic Specialist Nurse.		A McVey P Murphy	Internal review by Jillian Redpath/Catriona McGoldrick. What has been changed Staff will be reminded of documentation of patient's own supply, supervision and return of medication on discharge. Recomendations following review The incident will be shared with staff to highlight possibility of incorrect supply of insulin as a possible cause of unexpected erratic blood glucose.
22.1.15	MUC	Personal Information	26.1.15	Personal Information redacted by the USI	On 22.1.15 information received from BMS by Haemovigilance Practitioner. A porter collecting a 2nd unit of blood for a patient observed a discrepancy with the DOB and informed BMS. Investigation confirmed wrong DOB on the unit and documentation. BMS relabelled the unit contacted the clinical area and identified that the 1st unit with the incorrect DOB had been accepted into the clinical area and transfused. New set of traceability labels for the 1st unit were sent by the blood bank to the clinical area where staff replaced the original labels on the blood documentation woth the amended labels. 1st unit transfused without incident.	2.2.15	Dr P Murphy Barry Conway Dr U Bradley Connie Connolly	Screening panel were satisified there was no actual harm to this patient. The panel believes that the information provided clearly demonstrates that the Trust has a robust policy and process in relation to blood administration.

19.11.15	SEC	Personal Information	27.2.16	Personal Information redacted by the USI	On 19 November 2015 Personal Information redacted by the USI admitted via DHH ED to MSW with 6/7 hx of abdominal pain. CT scan done on admission and conservative treatment was commenced. Discharged home on 26 November 2015 with arrangements made for a repeat CT in 3/52 and colonoscopy in 10/52. Will be seen in SAU in 1/7. On 2 December 2015, pt seen in SAU, rising CRP and WCC, and admission arranged. CT repeated. CT Abdomen and pelvis. Comparison made with previous CT of 19/11/15. 10x10x5.5 cm collection in Rt iliac fossa. Marked thickening of proximal stump of appendix and posterior caecal wall which is highly concerning for neoplastic lesion. Two ill-defined hypodense lesion in the liver. These are too small to characterise however the differential diagnoses include metastatsis. USS/MRI suggested for further evaluation. CT guided drainage of abscess done on 4/12/15. On 9/12/15, pt had open drainage of appendix abscess done under General Anaesthetic. Discharged home on 18/12/15. Attended SAU on 30/01/16. Admitted with wound tenderness and superficial swelling. CT repeated on 31/01/16 On-going right iliac fossa inflammatory abnormality with appendicitis. There has been a considerable reduction in size of the abscess. At some stage, colonoscopy of the caecal pole will be required in order to exclude ceacal pole mass/tumour(if not already done) Possible caecal pole mass may be contributing to the ongoing inflammatory process as the appendix does appear distended and may be obstructed at base. Carcinoma of caecum confirmed by Colonoscopy which was done 5/02/16.	2.3.16 Validated 23.3.16	Heather Trouton Eamon Mackle Connie Connolly	The Screening panel reviewed the clinical evidence and agreed that: There was no serious injury to the pt There was no evidence of process, systems or documentation failure All information supporting clinicians was timely and accurate Cause of delay in management of Carcinoma of ceacum is known. There were no outstanding contributing factors identified which requires further investigation.
	MUC			Personal Information	Patient with incurable cancer was diagnosed with sepsis.			to M&M for discussion
	MUC	No Datix		Personal Information redacted by the USI	Complaint received from family: Issue 1 Family had issue with the management of NG feeding and lack of aftercare upon discharge. Issue 2 was in relation to a pressure ulcer on patient foot whick was treated in the community.	26.10.15	Dr S Moan Dr U Bradley Mr S Gibson Connie Connolly	Panel carefully reviewed the complaint and the formal draft response and written communication from Consultant in Intensive Care Medicine in Kings college London. The creening panel believed that the referenced information provided assurance that there were no elements of the complaint which met the requirement of a SAI. Panel satisifed Dr SM took advice from associated specialist when necessary.
	SEC	No Datix		Personal Information redacted by the USI	Personal Information redacted by the USI admitted to CAH for an elective palmer fascietomy on left ring finger on 10.2.15. On 11.2.15 patient had PEA arrest in bathroom. Resuscitation successful. Transferred to medical ward for NIV for poor respiratory effort. CTB negative. VQ scan ordered and booked for 13.2.15. No contrast available, scan deferred. referral to haematology, to treat as PE. On 13.2.15 /news 9, patient acidotic, no NIV machine available. Commenced on humidified oxygen. VQ scanned booked for 17.2.15. ward contacted contrast has failed quality control. VQ scan postponed until 20.2.15. DNAR agreeded 18.1.15. Too unwell to undergo VQ scan on 20.2.15 sadly passed away 22.2.15.	30.9.15	H Trouton Mr E Mackle C Connolly	Panel discussed clinical timeline and pre-operative assessment of this patient. Panel agreed not SAI 1. the patient was appropiately assessed pre-operatively. 2. Anaesthetists passed patient fit. The initial recovery was uneventful and the sequences of events which followed could not have been predicted.
25.2.15	MUC	Personal Information	8.6.15	Personal Information	Personal Information admitted to MAU CAH on 16.2.15 with history of falls, deterioration in mobility, cronic alcohol abuse. Transferred to 1S medical 21.2.15. 24.2.15 patients condition deteriorated rapidly. NEWS 11 at 23.00. condition discussed informally with intensivist who was on the ward reviewing another patient. Their opinion paitnet was not a canditate for ICU but this is not documented as no formal referral was made. Patient passed away 04.30 in 25.2.15. Case reviewed as it initally appeared that the escalation rocess had not been properly followed. However on review it was clear that this happened because of the informal advice that the patient would not b a canditate for ICU.	9.9.15	Simon Gibson Dr P Murphy C Connolly	Case presented to M&M on 16.6.15. Outcome was staff need to be reminded that casual and informal referrals cannot be assumed as being accepted by sub-speciality teams. 15.10.15 Incident raised at Nursing M&M on 17.9.15 to trust wide ward managers in relation for the need to have writted specialty to specialty referrals documented.
10.5.16	MUC	Personal Information	25.5.16	Personal Information redacted by the USI	Personal Information redacted by the USI, recently diagnosed Mast Cell Leukaemia. Had been in hospital since 15/03/16, P/H Parkinsons Disease, Mild MR, OA, Bil TKR, HTN, L Mastectomy. EPIPEN was advised and prescribed to be used in acute flares. On 10/05/16 patient developed acute episode of Mast Cell Mediator release with sudden hypotension, tachycardia, pyrexia, vomiting and diarrhoea. EPIPEN was not given and patient continued to deteriorate and developed AKI. DNAR was put in place and patient sadly passed away at 07:45.		A McVey Dr U Bradley Connie Connolly	Consultant, as per datix review, has already spoken with Medical staff involved in patients care – Memo issued to all Junior Doctors. Memo requested on 27/07/16 – same received. Memo to be issued to all Nursing Staff via Head of Service. 09/08/16 – memo sent to Sr Carson and Mrs Carroll for sharing with staff.

22.4.15	MUC	Personal Information	22.4.15	Personal Information redacted by the USI	Patient transferred from CCU to FSW 19/04/15 as no side ward available. Pt had Hx of diarrhoea, sample sent from FSW. C-diff confirmed 20/04/15. Reviewed by physicians and requested pt be returned to medical ward. Transfer not arranged. Pt became unwell early hrs of 21st, transferred to HDU and ventilated.		Mr E Mackle Mrs H Trouton Mrs C Connolly	250615cc- this patient has been an inpatient between DHH CAH ICU and Mater ICU. Notes ordered. 250915cc-this incident has been screened and is not a SAI. Learning to be gained, has been handed over to PL in Pt flow to investigate and feed back. Close
8.3.15	SEC	Personal Information	8.3.15	Personal Information	Patient found unresponsive in male toilet. Appeared to have fallen and hit left side of head. ENT REG on ward, cardiac arrest team bleeped and reviewed by medical team. Urgent CT Brain	11.3.15	Mr E Mackle Mrs H Trouton Mrs C Connolly	180315cc-this is being screened as an SAI. Awaiting tentative diagnoses. Now out of ICU. Await records and screening outcome. Documentation requested from OOH.15/04/15cc awaiting return of notes. this has been downgraded from major to moderate.220415cc- chart review: this patients fall was secondary to his clinical deterioration which was suspected menigicoccal meningitis. This patient was managed in ICU and later in 3S. Multiple and complex investigations were undertaken. The pt has made a full recovery. The fall/collapse was managed as per policy and requires no further action. Close
	MUC	Complaint 4905		Personal Information redacted by the USI	Complaint from Personal Information redacted by the USI unhappy that Personal Information who had a blood clot was not given the appropriate treatment and care.			Family received response from informal complaint. Requests no further contact.
26.6.13	MUC	Personal Information	28.6.13	Personal Information redacted by the USI	On the 22nd June 2013 a female patient fell in the MAU CAH. The patient was found on the floor bedside the toilet at approximately 4.30pm. The fall was unwitnessed and the patient stated that she had hit her head against the wall. The patient had a tear observed on her thumb. Following the fall the patients News score was 3, GCS 14/15. The patient had been for discharge on the day of the fall. A falls risk assessment was undertaken on admission. Following the fall the patient spent an additional night in hospital in order that neurological observations were carried out.	24.10.14	B Conway S Gibson Dr U Bradley M Marshall C Connolly	The screening team concludes that the fall does not meet the criteria of SAI. No omission in falls assessment or management post fall was identified. However learning was identified regarding the interface with OPPC, the Adult Protection Team and the Acute Directorate. The patient involved in this case was resident in a PNH. Following discharge from hospital the PNH raised a safeguarding alert due to extensive discolouration and bruising to the patient on discharge. The patient was reviewed by her GP on Friday the 27th June who determined the likely cause of bruising as long term steroid and aspirin therapy, and clexane therapy. There appears to have been no communication/discussion with the acute directorate throughout the vulnerable adult investigation (Connie to confirm) Learning In order to minimise this breakdown of communication in future cases the following actions should be taken • Discuss with Heads of Service/Lead Nurses to confirm that communication involvement did not take place • In the event of it not a communication to be drafted to the Head of Adult Safeguarding highlighting the learning re the case.

14.2.15	SEC	Personal Informatio	7.1.16	Personal Informat	On Monday 9 February 2015, this Personal Information redacted by the USI was admitted to 4S via CEAW for surgery to remove a tumour in the transverse colon. Extended Right hemi-colectomy with partial gastrectomy was done on 09/02/15. Initial post- operative recovery period (09/02/15 to 12/02/15) was uneventful. On Friday the 13th of February 2015 at 16:00 hrs, patient was complaining of shortness of breath. Seen by Dr at 16:00 hrs. At 17:00 hrs, CXR showed no acute changes, no sign of infection and a raised hemi-diaphragm. Patient was seen by FY2, while SpR and consultant informed of rising NEWs score at 17:50 hrs. Plan: CT AP and prepare for surgery. Patient was reviewed on 6 occasions between 18:30 hrs and 21:00 hrs by F2 and SpR. NEWs score between 6 and 11. Seen by anaesthetist at 21:00 hrs. Clinical findings in keeping with anastomotic leak. Patient's oxygen levels started desaturating immediately prior to transfer to theatre. Patient arrived in theatre at 22:00 hrs. Marked deterioration from leaving ward. Patient vomited, placed on side and suctioned, possible aspiration. No palpable radial pulse. Arterial line inserted. Loss of output and asystole at 22:35 hrs. CPR commenced. Decision to stop CPR at 23:06 hrs.	25.2.15	Mr Eamon Mackle, AMD for Acute Medicine, Mr Ronan Carroll, Assistant Director for Clinical and Cancer Services, Mrs Amie Nelson, Head of Service for Surgery and Elective Care Mrs Connie Connolly, Lead Nurse Acute Governance.	The screening panel agreed that while the patient's death was unexpected, the sudden deterioration was escalated promptly and appropriately by both clinical and nursing teams. Research indicates that there is a higher risk of anastomotic leak when resecting the large bowel and when metastatic disease in present. The patient's initial recovery was uneventful and would not have indicated any predictable deterioration. The screening panel unanimously agreed that there was very limited if no new learning within this incident and this should not be considered a SAI. It is the opinion of the Screening Panel that there was only one area of concern which was in relation to the detail within the operating notes. There was a lack of clarity within the operating note in relation to the stomach- how it was removed and closed. The significance of this missing information is related to identifying the possible source and/or cause of the leak within the abdominal cavity. The Panel believe that the issue in relation to the operating note should be addressed through clinical line management rather than the Trust SAI process.
17.8.15	CCS	Personal Informatio	30.9.15	Personal	(provided from Datix incident report) Patient had palliative bypass for metastatic Rectal cancer. Plan was on Sunday for CT if patient deteriorated. Decision made at 4pm to request CT. Not scanned until 12.30am Scan showed a leak- Cons not informed. Booked for theatre at 7.16am Patient not sent for by 10am and not asleep until almost midday. There were multiple delays in the patient's care- Delay organising scan / delay by registrar in not acting on scan report. Delay by theatre who should have sent for the patient when he was booked. Delay getting the patient to sleep. In terms of the surgical delay,CS of the trainee and Mr AN as AES, have discussed the importance of timely intervention and appropriate escalation to senior team on call at night. Life threatening emergencies needs to be brought in so all staff- surgical / theatres / anaesthetics are immediately aware that the patient should be in theatre within 1 hour of booking. The patient did survive although he had a prolonged hospital stay.	23.3.16	Mr Eamon Mackle Mrs H Trouton Mrs C Connolly	The SEC Screening Panel proposes that this incident is handed over to ATTICs for Review and investigation, pending the Approval of the Director of Acute Services. 230316 Validation meeting with Director of Acute Services. The Director has validated the SEC position and asks that a Serious Adverse Event investigation is undertaken to establish if there is any learning within the theatre or radiology setting which could have expedited this patient's journey. Incident to be handed over for ATTICs to investigate and close.
6.1.17	CCS	Personal Informatio	11.1.17	Personal Information redacted by the USI	6 month delay in Breast Family History review in vulnerable adult Patient has been diagnoses with locally advanced Breast Cancer	26.9.16	Mrs Heather Trouton Dr David Gracey Mrs Trudy Reid	27/03/2017 The case was discussed in-depth including the likelihood of earlier diagnosis if Mammogram and appointment had been sooner. As the Mammogram and TOM not overly worrisome, and the GP letter states symptom duration of 3 days the panel felt it was unlikely an earlier appointment would have changed the patient outcome. However the panel did consider there was learning from this case and new systems are being put in place within the Breast Family history service. The case is to be shared at M&M for local learning. Action plan to be attached to Datix when complete.

1.9.2016	MUC CCS	Not on Datix consultant complaint to Director		Personal Information redacted by the USI	Delay in CT reporting - patient collapsed and arrested at home 19/07/16 Personal Information redacted by the USI with RF referral from Dr 1 to Gastroenterology re vomiting and weight loss. 20/07/16 Arrived at 14:55. Seen by Dr 2 at 15:40. 2 month hx of vague abdominal pain. Pain at present, all of the time. Associated with vomiting after eating. Feels the need to be sick minutes after eating. Bowels normal, pain not radiating. PMHx: Rt sided mastectomy, schizophrenia. Appears comfortable, apyrexial. Abdomen: RUQ tender. Bowel sounds normal. Imp: non-specific abdominal pain. Plan: await bloods. Referred to own GP. 02/08/16- s/b Dr 3. Referred for investigation of abdominal pain and weight loss. Intermittent vomiting. In view of abnormal bloods, symptomology and examination, it would be important to rule out an occult malignancy. RF CT and review booked. 01/09/16 13:55 OOH cardiac arrest at friend's house. CPR in progress on paramedic arrival. Output achieved after 31 min. 21:20 Admitted to CAH ICU following out of hospital cardiac arrest by Dr 16. Noted under 'GI' a likely aggressive invasive colonic tumour on recent CT. 03/09/16 Seen by Dr 14.very slow lactate clearance, evidence of hepatic injury apparent also. Recent CT Abdomen, while would clearly be in keeping with malignant mass, this was view not shared by Dr 15 this morning. d /w findings with family. Agreed to withdraw ventilator support in view of all clinical evidence. Personal Informatio passed away with family in attendance. Death certificate cause of death: I) Myocardial infarction, II) breast cancer, schizophrenia. Coroner not informed	1.9.2017	Dr David Gracey Mrs Heather Trouton Trudy Reid Faciliator Dr Philip Murphy Dr Gareth Hampton Mrs Anne McVey Mrs Mary Burke	ED/Medicine screening 01/03/2017: - Screening panel agreed that there were elements of learning in relation to her presentation to ED in July. The ED CD will discuss this with the Dr involved in Personal Information care and the case will be presented ED M&M for wider learning. The screening team agree that this episode of care did not contribute to her subsequent cardiac arrest. Does not meet the criteria of a MUSC SAI- to be screened by Radiology. 27/03/2017 Radiology screening The review panel reviewed notes and blood results available in the chart and NICER. The patient had a poor prognosis from hear cancer and subsequent cerebral hypoxia, which the panel ascertained were discussed with the family. The panel felt there appeared to be no obvious causative effect from the delay in reporting the CT scan and the subsequent cardiac arrest. Local learning regarding time to CT and subsequent was longer than expected and this will be shared for local learning.
21.1.2017	SEC	Not on Datix		Personal Information redacted by the USI	On 19 January 2017 at 13:15 Personal Information redacted by the USI presented to CAH ED with RUQ Abdominal & Epigastric Pain/vomiting C/O SOB ongoing 1/52 Pallor poor at triage/clammy. ECG done at 13:52 Troponin 105 @13:45. Referred to Surgical team query cholecystitis, query Malignancy. Troponin repeated @ 22:00 122 and ECG repeated at 22:37 Transferred to 4S @ 00:45 on 20/01/17. At approx. 17:21 Personal appeared to have seizure. Loss of consciousness- arrest team called. Personal did not respond to resuscitation efforts. Most likely cause of death- massive cardiac event.	1.3.17	Mr Philip Murphy, Dr Gareth Hampton, Mrs Anne McVey, Mary Burke Trudy Reid	Dr Moore suggested Personal Information could have been discussed with cardiology in view of the troponin, however, no immediate intervention would have made any change to Personal Information redacted by the USI outcome, particularly in view of her PM result of normal coronary arteries. Dr Moore is going to present the case at Cardiology M&M and I highlighted that the Surgical team were going to present the case at surgical M&M. If you are happy I will reflect this on the SAI screening form and take the case of the potential SAI list.
7.10.16	CCS Theatres	Personal Informatio	7.10.16	Personal Information redacted by the USI	3/10/16- Personal Information redacted by the USI presented to DHH ED c/o abdominal pain since 29/09/16. Persistent blood stained diarrhoea while in ED. Admitted to HDU. Past history of diabetes and alcohol abuse. 6/10/16 Colonoscopy up to HF. Pale rectal mucosa, but no ulcers. Deep multiple ulcers in proximal colon up to HF with pale mucosa. No necrosis. 7/10/16 emergency laparotomy for ischemic small and large bowel Not compatible with life. Pers onal passed away in theatre 11:34 hrs.		Ronan Carroll and Connie Connolly	M&M report Received 3/4/17 Await M&M presentation 18/11/16
15.3.17	SEC	Personal Informatio	17.3.17	Personal Information redacted by the USI	Personal Information redacted by the USI known diabetic presented to ED with abdominal pain, query pancreatitis at 13:06 Blood Glucose 6.2 on admission. pH7.463 & glucose 13.5mmols/L at 14:15. Admitted to surgery 15:30 blood glucose at 16:35 was noted to be 25.3 GKI protocol commenced. Pers onal was in the ED department for 2 hours 24 minutes. The review team considered patient management to be appropriate in the ED, Pers onal was not acidotic during his admission.	3.4.17	Dr P Murphy Dr Gareth Hampton Mrs Anne McVey Trudy Reid	This incident does not meet the criteria for an SAI
10.3.17	MUC	Personal Informatio	11.3.17	Personal Information redacted by the USI	Personal Information redacted by the USI, known diabetic, presented to ED at 17:15 on 10/03/2017 with severe pain and vomiting. GM 9.8mmols/l, Urine glucose++++ and ketone++++. Patient commenced on DKA protocol at 00:35 on 11/03/2017, referred to ICU and accepted discharged home 14/03/2017	5.4.17	Dr Philip Murphy Dr Gareth Hampton Trudy Reid	The review panel considered that while this case did not meet the criteria for SAI there was some internal learning in relation to recording of Blood Glucose in the emergency department and while the doctor completing the medical clerk in instigated IV fluids and sc insulin there was an opportunity for the DKA protocol could have commenced earlier Actions Diabetes management and frequency of blood glucose recording to be discussed with nursing staff in ED including euglycemic diabetic ketoacidosis Dr Hampton will present at ED M&M for learning Case to be discussed with clerking in doctor for learning

18.8.16	MUC	Not on datix		Personal Information redacted by the USI	Personal Information patient undergoing chemotherapy for myeloma presented to DHH ED at 14:02 with history of being unwell for 3/52, diarrhoea 1/52 poor mobility. Seen by Dr 1. Loose green stools. Reduced oral intake. Occasional mild general abdominal pain. One loose stool today, did not take chemo med. Worsening shortness of breath. No chest pain.o/e cachexic, frail. Bibasal creps. Marked bilateral lower leg oedema. ECG Sinus rhythm, 2 BBB. b/p 86/51 with fluids and legs raised. Distended abdomen ? ascetic. Mild generalised tenderness, no masses felt, bowel sounds present Diagnoses: diarrhoea ?secondary to chemo meds, associated dehydration and ?acute LVF Seen by Dr 4 at 23:00-Distention for 1/12. One episode of vomiting. Just completed 4 cycles of chemo for multiple myeloma. ATSP re abdominal distention. Abdomen tympanic, generalised tenderness with some guarding. Bowel sounds scant. PR: external haemorrhoids ++. Will d/w senior and r/v plain films. Will add to handover list and ? r/v in am. Fast, NGT if vomiting continues. Stool chart. IVF and anti-emetics 02:04 Seen by Dr 5. Hx as above.o/e: abdomen firmly distended, tympanic. Mild generalised tenderness. AXR: gross bowel dilation in keeping with obstruction. Imp: bowel obstruction ? underlying cause. 06:15 Cardiac arrest, 18 min CPR- PEA/asystole. Resuscitation stopped. Passed away 06:15 06:45 Verbal report of Ct abdomen available from Dr 6.:multiple grossly small bowel loops with dilated transverse colon. Incident referred from M&M for screening	1.3.17	Dr Philip Murphy Dr Gareth Hampton Mrs Anne McVey Mrs Trudy Reid	Screening panel discussed the ED findings in depth. There was a comprehensive ED note. Findings of diarrhoea secondary to chemotherapy with associated dehydration. Chest xray and ECG were requested by the Medical team (not ED medics). Completed at 21:00, indicating a delay. There appears to be a delay in referring to the surgical team. The Screening Team considered that there was individual learning which would be forwarded to the clinician involved by the CD for Emergency Medicine. This case will be presented at ED M&M for wider learning. While there were lapses in care, the team considered that this did not impact the patient outcome due to the underlying carcinoma and other underlying co-morbidities. The Panel are willing to review the screening decision, should the consensus and M&M identify an SAI is required. Reviewed by surgery, treatment and care appears appropriate and timely given the comorbidities, the initial presenting picture was not of obstruction. This does not meet the criteria for SAI
21/12/2016	MUC	Personal Information		Personal Information redacted by the USI	Upper GI bleed admitted with aspiration pneumonia- dispute between medics and surgeons re who should accept patient for admission - NIV started by surgeons as a surgical outlier in 2NR- later further aspirated and admitted to ICU – extubated- ceiling of care decided and later died peacefully on ward - Care was deemed to be appropriate however case is to be presented to Medical M&M as screening panel felt Personal should have been admitted medically	26/04/2017	Dr Philip Murphy Dr Gareth Mrs Trudy Reid	Case is to be presented to Medical M&M as screening panel felt Personal should have been admitted medically. Does not meet the criteria for SAI
19.6.17	MUC	Personal Informatio	20.6.17	Personal Information redacted by the USI	Patient referred to medicine by ED prior to having had xrays, no bloods back at time of referral. Presented with 2/52 hx reduced oral intake and recurrent vomiting, lactate 2.1 on vbg Transferred to AMU with xrays to be taken on transfer No review of XRAYS by ED staff Pt. seen by AMU staff - free air under diaphragm, urgent referral to surgeons			Paul Smith to review 19/01/2018 Discussed at MUSC governance meeting=- cardiac event - decision made not for SAI review- closed

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SAI's CLOSED
FROM 1 OCTOBER 2014

Lead Nurse	Incident date	Reporting Division	Date Reported on Datix	Datix ID	Patient Initials	Description of incident	Date SAI screening meeting Screening Team	SAI Form to Board/Date	Others informed (RQIA etc)	SAI Review Team Chair & Members & Coordinator	Date Report due	TOR Issued to HSCB	Coroner informed Y/N Date	Family Details	Date family informed of SAI	Dates DRO Queries received and responded to	Dates of SAI meetings	Date to Governance meeting	Date report submitted to Board	Report shared with family - outcome of family meeting	Date case Closed	Other information	Coroner	Litigation
CW	22.8.14	MUC	23.8.14	Pers	P	A female patient was referred by her GP to the ED Department CAH on the 22/08/2014 with a 4 day history of chest pain. Following assessment the patient was referred to the rapid chest pain clinic. Tragically on the morning of the 23/08/14 the patient was found deceased in her bed. The SHSCT wish to submit this case as an SAI in order to establish areas of learning relating to the patients treatment and care.		1.9.14	N/A	Mr Conor O'Toole Mrs Charlotte Wells Dr A McClelland Mr Paul Smyth Sr Cochrane	29.9.14		Yes 23.8.14	Personal Information redacted by the U	Met with family on 29.8.14				23.10.14		30.10.14			
PS	29.9.14	MUC	29.9.14	Pers	Pers	Personal Information attended ED on 26/9/2014 following a fall at home. He had a haematoma to right side of head. He subsequently was admitted as an in-patient and on 29/9/2014 the patient fell and sustained a # femur. The patient is currently undertaking a period of rehabilitation. The SHSCT wish to submit this incident as an SAI in order to establish any areas of learning.	10.10.14 Dr Damian Gormley Mrs Margaret Marshall Mrs Connie Connolly Mrs Anne Quinn	13.10.14	N/A	Chair Dr Damian Gormley Mrs Kay Carroll Mr Paul Smyth Sr E McGibbon Sr Irene Brennan	10.11.14		No	Personal Information redacted by the U	14.11.14		10.10.14	14.11.14	10.12.14		1.5.15			
PS Cyp	9.8.14	MUC		Pers	P	Personal		13.8.14	N/A	Mr Seamus O'Reilly Mr Paul Sheridan Mr Paul Smith	10.9.14		Yes. 9.8.14	Personal Information	No contact with family untile outcome of final report as per Notification to Board.			20.3.15	2.4.15		30.4.15			
CC	27.6.14	MUC	27.6.14	Pers	P	Personal Information 16/6/2014. Found on floor at bottom of bed on 27/6/2014. The patient sustained a head injury and had a CT carried out which showed subarachnoid haemorrhage. Tragically the patient died on 30/6/2014.	Dr Philip Murphy Mr Simon Gibson Mrs Connie Connolly Miss Paula Fearon Mrs Anne Quinn	28.10.14	N/A	Chair Dr Damian Gormley Mrs Kay Carroll Sr S Rooney Mrs Connie Connolly	25.11.14		Yes 30.6.14	Personal Information redacted by the	30.6.14 18.11.14 Letter issued to Person 15.12.15 preport issued to Person				20.3.15	10.4.15 2.4.15 Letter to family advising report has been completed and offering to share findings and meet with family.	3.6.15			
CC	18.10.14	MUC	31.10.14	Pers	Pe	Personal Information patient admitted to medical ward on 22 September 2014 with neutropenic sepsis. Patient had an unwitnessed fall. Patient was seen by Doctor. CT performed post fall was performed was abnormal. Neurology, RVH were contacted and advised conservative management.		3.11.14	N/A	Dr Damian Gormley Mrs Anne McVey Mr Gibson Mrs Kay Carroll Sr E Gibbon Mrs Connie Connolly	31.10.14		No	Personal Information redacted by	3.12.14 Letter issued to family adviseing of SAI. Family to be contacted within 2 weeks			20.3.15	25.3.15	25.3.15 Email to family advising of report. 27.3.15 - Report posted to family.	25.6.15			
PS	20.12.14	MUC	31.12.14	Pers	Perso	Patient on warfarin attended emergency department and diagnosed with intra cerebral bleed following head injury 2 days previously. Patient had been assessed at Minor Injury Unit on day of fall and discharged.	14.1.15 Seamus O'Reilly Mr Barry Conway Mr Pauls Smith	26.1.15	NO	Dr Hilda Nicholl Olive Sloan ENP Mrs Mary Burke Mr Barry Conway Mr Paul Smith	23.2.15		No	Personal Information red by the USI	23.2.15 acknowedgement 11.6.15 advising report complete 26.6.15 offering dates for meeting 3.7.15 Confirmation of meeting and report issued. Meeting cancelled by Person 31.7.15 Confirmation of meeting	Received 26.1.15 responded to 1.5.15.	3.2.15	8.5.15	10.6.15	Meeting rearranged with family for 2.9.15	9.7.15			
PS	23.9.14	SEC	19.11.14	Pers	Pe	A Personal had surgery for a left fractured proximal ulnar and displaced radial head on 22/9/2014. Post-op instructions were to monitor for compartment syndrome. A decision was taken at 08:40 to split the backslab. The procedure was not carried out until 11:30 hours. On splitting the backslab there was evidence of fasciitis and the patient had a series of operations in SHSCT and the Ulster Hospital.	Mr Eamon Mackle Mrs Heather Trouton Mrs Connie Connolly Mr Paul Smyth	19.11.14	N/A	Mr Jonathon Bunn Mr Paul Smyth Sr P Chambers Sr Cochrane S/N TBC	17.12.14		No	Personal Information redac	22.4.15 letter issued to patient. Consultant was unable to speak with patient as he did not attend appointments.		15.1.15		10.6.15	11.6.15 - Letter issued to advise patient report complete.	28.7.15			
LF	10.4.14	CCS	11.4.14	Pers	Pe	Patient admitted to CAH on 3.4.14 to a medical ward. On 8.4.14 patient developed abdominal pains and was taken to theatre on 10.4.14 where he tracially died prior the surgery commencing.				Dr Glynis Magee Dr Hisham Hurreiz Mr Ronan Carroll Mrs L Fegan									26.3.15		25.8.15			
PS	14.10.14	MUC	16.10.14	Pers	Per	Personal was admitted for angiography, which was performed on 14/10/2014. On the basis of angiography, the Consultant proceeded to PCI. The patient suffered a cardiac arrest during the procedure; resuscitation was commenced. A decision was taken to transfer the patient to RVH. Tragically the patient subsequently died.	Dr Philip Murphy Mr Simon Gibson Mrs Connie Connolly Miss Paula Fearon Mrs Anne Quinn	17.10.14	N/A	Chair Dr Ian Menown Mrs Kay Carroll Dr John Hinds Mrs Brigeen Kelly Mr Paul Smyth	9.1.15		15.10.14	Personal Inf redacted USI	Acknowledgement 24.10.14 Advising of complete report 17.7.15 2 Copies of report issued 29.7.15		13.11.14		20.7.15	29.7.15 report posted to family	2.10.15			
PS	18.10.14	MUC	24.10.14	Pers	P	Personal attended ED, DHH via ambulance on 18/10/2014 with shortness of breath and "off feet". Ambulance obs showed tachycardia and respiratory rate 26. Patient had a cardio-respiratory arrest in ED. Tragically resuscitation was unsuccessful.	Mr Seamus O'Reilly Mrs Anne McVey Mr Paul Smyth Mrs Anne Quinn	16.6.15	N/A	Chair Mr Seamus O'Reilly Mr Paul Smyth Sr Debbie Murnan Rn Louise McConnell Dr Richard Wilson NIAS TBC	14.7.15		18.10.14 Answer phone. Followed up on 19.10.14	Personal Information redact	3.12.14 letter issued to family informing them of SAI.Next of Kin to be confirmed. Letter advising NOK of review will be issued 2 weeks after death				10.9.15	14.9.15 - Letter advising report completed.	2.10.15			
PF	9.9.14	SEC	15.10.14	Pers	Pe	A Personal patient had a Rt radical nephrectomy secondary to renal cell carcinoma in August 2012. The patient was reviewed in Feb 2013. In August 2014, the patient presented to GP with pain, weight loss and anaemia. A CT was carried out which revealed widespread metatastic disease.	Mr Eamon Mackle Mrs Heather Trouton Mrs Connie Connolly Miss Paula Fearon Mr Paul Smith	19.11.14	Dr Tony Glackin Mr Simon Gibson Mrs Helen Forde Mrs Margaret Marshall Miss Paula Fearon	11.2.15			No	N/A	2.3.15		17.12.14		2.9.15	15.9.15 Report issued registered post. Mr O'Brien spoke with patient. Acknowledgement issued.	17.9.15			
PF	21.2.08	SEC	8.11.13	Pers	Pers	On 05/11/07 the patient presented to OPD with history of PR bleeding. A Barium enema was requested following her attendance. The Barium enema was performed on 04/01/08. On 25/2/08 the Consultant contacted the GP confirming that an outpatient flexible sigmoidoscopy had been arranged following the findings of the Barium enema. On 30/10/13 the patient presented with a history of rectal bleeding and had a colonoscopy carried out. The colonoscopy indicated concerns of malignancy. On 12/11/13 the patient underwent a right hemicolectomy and anterior resection with extensive invasion.	Mr Eamon Mackle Mrs Heather Trouton Mrs Connie Connolly Miss Paula Fearon Mr Paul Smith	19.11.14	Dr Damian McKay Mrs Anne McVey Mrs Katherine Robinson Miss Paula Fearon	11.2.15			No	N/a	8.7.15 - Letter advising pt report complete. 23.2.15 -Acknowledgement issued.		11.3.15		2.9.15	21.2.15 Copy of report to Pers . Mr Mackle spoke with family Acknowledgement issued on 9.2.15.	21.9.15			
CC	28.10.14	MUC	28.10.14	Pers	Per	Per presented to ED on 26.10.14 at 10:30am. Cardiac Arrest Standby call from Ambulance Control. Personal Information pale & lifeless. CPR commenced by ambulance crew & continued until death pronounced at 10:53am	6.11.14	3.11.14	N/A	Mr S Gibson Dr A Khan Mr S O'Reilly Ms W Clarke Ms A McMullen Mrs C Connolly	1.12.14		26.10.14	Personal Information redacted t				Report approved by Acute on 20.3.15 and CYP on 21.4.15.	23.4.15	Given to family at meeting.	30.6.2015			
PS	14.9.14	SEC	19.11.14	Pers	P	A Personal who had a number of drug allergies, one of which was allergy to penicillin. The patient received a dose of IV penicillin which resulted in an anaphylaxis reaction. Treatment for the anaphylaxis was carried out immediately and was successful.	Mr Eamon Mackle Mrs Heather Trouton Mrs Connie Connolly Mr Paul Smyth Miss Paula Fearon Mrs Anne Quinn	19.11.14	N/A	Chair Connie Connolly	17.12.14		No	Personal Information redacted by	14.4.15 - Acknowledgement issued. 25.3.15 Paul Smith spoke to Pers advising her of SAI and she would receive acknowledgement and a report shortly afterwards.			20.3.15	21.4.15	22.4.15 by email and letter.	25.6.2015			
PS	24.4.15	MUC	24.4.15	Pers	Pe	Personal arrived by ambulance to Craigavon Hospital Emergency Department on 24/04/14 at 01:02 hours Personal Information redacted by the USI A subsequent CT showed Subdural haemorrhage and possible # C7.	29.4.15 Mr Barry Conway Mr Seamus O'Reilly Mr Paul Smith	6.5.15	N/A	Mr Erskine Holmes Sr Sharon Holmes Sr Amy Acheson Mr Paul Smith	3.6.15		No	Personal Information redacted by th USI	Barry Conway spoke with P er 24.6.15 - letter issued			9.10.15	12.10.15	20.10.15 Report issued to patient. 12.10.15 Letter sent to advise report complete	22.12.15			
PS	24.3.15	MUC	25.3.15	Pers	Pe	A Personal attended Craigavon emergency department on 20th March 2015 with a crush injury to his abdomen caused by a machine. He was assessed and subsequently discharged. He re-attended the next day with worsening pain and was discharged after assessment. He re-attended 24th March (third attendance) and was admitted to a surgical inpatient ward. He required laparotomy where a small bowel mesentery tear, ischemic small bowel, infected haematoma were detected and treated	1.4.15 Mr Barry Conway Mr Seamus O'Reilly Mr Paul Smith	13.4.15	N/A	Dr Gareth Hampton Chair Mr Hurriez Sr Sharon Holmes Mr Paul Smyth	11.5.15		N/A	Personal Information redacted	17.6.15			9.10.15	12.10.15	11.2.16 Report issued to patient Perso 12.10.15 to Person a	22.12.15			
PS	19.11.13	MUC	3.6.15	Pers	Pe	Personal was assessed at the Dermatology OPD Craigavon Hospital on 19/11/13. A dermatofibroma was diagnosed and a plan to review him in 2 months at the Dermatology Outpatients Clinic was planned. There was a delay in his review, he was actually reviewed 23/12/14, At this review a diagnosis of possible cancerous nodule was made. This was excised on 12/03/15. He has been referred to plastics UHD for possible further surgical excision. He has been referred to oncology.	1.6.15 Mr Simon Gibson Dr Philip Murphy Mr Paul Smyth	3.6.15	N/A	Dr Art O'Hagan Mrs Kay Carroll Sr Jeanette Collins Mr Katherine Robinson Mr Paul Smyth	1.7.15		No		6.6.15 Letter to Patient advising of suspension of complaint and SAI began.			9.10.15	12.10.15	20.10.15 report issued to patient. 12.10.15 Letter to Patient advising report complete.	22.12.15			
PS	11.5.15	MUC	11.5.15	Pers	Pe	Personal was admitted to 4 North following fall at home on 10th May 2015. She had sustained a head injury and was on warfarin. Initial CT showed no intracranial haemorrhage. She had another fall on the ward at 5am the next morning and sustained another head injury. Repeat CT showed intracranial haemorrhage. She sadly died on the 14th May	3.6.15 Mrs Heather Trouton Mr Eamon Mackle Mr Paul Smyth	10.6.15	N/A	Mr Epanomeritakis Sr Sheila Mulligan Mr Paul Smyth	8.7.15		Yes 14.5.15	Personal Information redacted	21.10.15 advising family report complete. 1.9.15 - Family advised of SAI			9.10.15	13.10.15	21.10.15 advised family report complete. 28.10.15 issued report registered Post.	22.12.15			

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PS	9.3.15	MUC	9.3.15	Pers	Pe	Patient admitted 6th March 2015 and was commenced on Sando K supplement for 4 days as initially hypokalaemic. Patient suffered cardiac arrest on 9th March 2015, resuscitation was unsuccessful. Potassium level checked during cardiac arrest and shown to be 8.1. Urea and Electrolytes last checked 6th March, the patients' blood had not been checked the previous 2 days prior to cardiac arrest.	24.3.14 Mr Simon Gibson Mr Philip Murphy Dr Una Bradley Mrs Mary Burke Mr Paul Smith	22.4.15	N/A	Dr Mark Roberts Dr S Walker Sr L Cullen Mrs Kay Carroll Mr Paul Smyth	20.5.15		YES	Acknowledgement issued 23.4.15 to Persona Inform	23.4.15			13.11.15	24.11.15	4.1.16 Report issued 24.11.15 - Letter to family	22.12.15	
PS	13.2.15	MUC	14.2.15	Pers	P	Inpatient with unwitnessed fall in Medical Assessment Unit on 21/01/15. He was transferred to 2 South Medical where a fractured femur was diagnosed the next day on the 22/01/15. Following medical stabilisation a DHS fixation was undertaken on the 24/01/15	2.2.15 Mr Barry Conway Dr Philip Murphy Dr Una Bradley Mr Paul Smith Mrs Connie Connolly	12.3.15		Mr Barry Conway Dr Damian Gormley Sr Lorna Cullen Mr Paul Smyth	9.4.15		N/A	N/A	Acknowledgement 29.7.15			12.6.15	15.9.15	16.9.15 advising report complete.	22.12.15	
PF Not risk rated	4.4.12	SEC	31.7.14	Pers	Per	Personal presented with lower abdominal pain on 11/12/2011. Patient underwent elective open cholecystectomy.on 26/3/2011. On 21/7/2012 the patient presented at BHSCT with jaundice and widespread liver metastases. The BHSCT informed SHSCT of this case. RIP - March 2015	Mrs Heather Trouton Mr Eamon Mackle Mrs Connie Connolly Mr Paul Smith Miss Paula Fearon Mrs Anne Quinn	11.12.14	Mr Gerarde McArdle Mrs Anitha Carroll Dr Nora Scully Mr Enda Coulan Miss Paula Fearon	5.3.15	22.12.15		No	Personal Informatio redacted by t USI P e	21.12.15 email advising report complete 27.4.15 acknowledgement issued 17.1.15	22.12.15		11.12.15	22.12.15	26.1.16	22.12.15 Report issued by registered post. 21.4.15 - Acknowledge ment letter with Director for approval and signing. ?? Mr Lewis spoke with Daughter	
PF	25.11.14	SEC	27.11.14	Pers	P	A Personal was admitted via ED, CAH on 22/11/14 after a fall. She was diagnosed with # of left neck of femur, which was repaired on 23/1/14. The patient became unwell on 24/11/14 after developing post operative ileus. The patient deteriorated in the early hours of 25/11/14. Shortly thereafter the patient had a cardiorespiratory arrest. Tragically resuscitation was unsuccessful.	Mr Eamon Mackle Mr Simon Gibson Mrs Connie Connolly Mrs Anne Quinn Mr Paul Smith	10.12.14	Mr Adrian Neill Dr Simon Porter Sr Tracey McArdle Mrs Trudy Reid Miss Paula Fearon	4.3.15	1.5.15		25.11.14 26.11.14	Personal Information redacte by t	21.12.15 Copy of report issued. 16.12.15 - P Fearon spoke with son. 9.2.15 - Acknowledgement issued.		20.4.15	11.12.15	16.12.15	21.12.15	26.1.16	
PS	29.5.15	MUC	29.5.15	Pers	Pers	A Personal fell from a chair on ward 1 South Craigavon hospital and sustained a fracture to his right hip.	8.6.15 Mr Barry Conway Dr Philip Murphy Dr Una Bradley Mr Paul Smyth	10.6.15	N/A	Dr Andrew Murdock Mrs Louise Devlin Mr James Gilpin Mr Paul Smyth	8.7.15		N/A	Personal Informati redacted by the USI	15.6.16 - response to issues raised by family. 15.1.16 Report issued to mother of patient. 4.1.16 Letter issued advising patient report complete. 21.12.15 Paul Smyth contacted patient to advise of SAI. Letter issued same day.			11.12.15	21.12.15	15.1.16	8.3.16	
PS Not risk rated	13.7.14	MUC		Pers	Pe	A S Personal presented at ED DHH on the 13/07/14. Person had fallen while running and sustained an injury to the left elbow... A 'back slab' was applied and review planned at the fracture clinic in 1 weeks' time, subsequently following clinic review of Persona x-ray the review was rescheduled for 3 weeks' time.	Belfast Trust Mr Seamus O'Reilly Mr Barry Conway Mr Paul Smith Mrs Margaret Marshall	23.1.15	N/A	Mr Seamus O'Reilly Mr Barry Conway Mr Paul Smith	20.2.15		N/A	Personal Information redac the US	3.9.15 By letter from Mr O'Reilly. 1.9.15 By letter from Governance office.		11.2.15	11.9.15	18.9.15	22.9.15 Letter confirming meeting. 22.9.15 Report issued 15.9.15 Letter advising report complete.	10.11.15	
PS	2.2.15	MUC	4.2.15	Pers	P	Personal presented to Craigavon Hospital Emergency Department with abdominal pain and vomiting, diagnosed gastritis and discharged from ED. Two days later patient collapsed at home, re-attended ED emergency via emergency ambulance. ECG showed STEMI, transferred to cath lab for pacing and subsequently intubated and ventilated. Patient eventually discharged to nursing home.	Mr Seamus O'Reilly Mr Barry Conway Mr Paul Smith	4.3.15		Mr Gareth Hampton Chair Sr Sharon Holmes Dr David McEneaney	18.9.15		No	Personal Information reda USI	27.2.15 by phone. 15.6.15 by letter.			13.11.15	27.1.16	9.12.15 Letter advising report was complete 7.4.16 No further correspondance from family.	8.3.16	
PS	28.12.14	SEC	28.12.14	Pers	Pe	Personal fell in nursing home, attended emergency department where a fractured neck of femur was diagnosed. Transferred from emergency department to inpatient trauma ward. Patient deteriorated and subsequently died next day	Mr Seamus O'Reilly Mr Barry Conway Mr Pauls Smith OPPC rep	28.1.15		16.2.16 Mr Seamus O'Reilly Dr David McMurray Dr Kevan Duffin Sr Cherith Douglas Mr Paul Sheridan Mr Paul Smyth	24.11.15		28.12.14	Personal Information reda ed by th	Telephone 4.3.15 Letter 1.6.15		4.3.15	13.11.15	30.11.15	13.1.16 notes of meeting issued. 9.12.15 Meeting with family. 23.11.15 report issued	8.3.16	
PS	4.5.15	MUC	5.5.15	Pers	Pe	A Personal had a seizure after being administered Intravenous tramadol as analgesia for abdominal pain. He had been administered 200mgs IV as opposed to the 100mgs prescribed.	14.5.15 Mr Barry Conway Mr Seamus O'Reilly Mr Paul Smyth	29.5.15	N/A	Mr Paul Kerr Sr Sharon Holmes Mr Paul Smyth	26.6.15		No	Personal Informatio n	28.5.15 Dr Tom Young contacted patient, Letter of acknowledgement issued 8.6.15.			13.11.15	24.11.15	2.3.16 Report issued 24.11.15 - Advising report complete 8.6.15 Acknowledgement	25.3.16	
PS	09.01.16	MUC	11.1.16	Pers	P	A Personal was brought by ambulance to the Emergency Department on the 09/01/16 in cardiac arrest. Pers was back seat passenger in a car in a motor vehicle accident and CPR was in progress on route to ED. Resuscitation was unfortunately unsuccessful.	13.1.16 Barry Conway Seamus O'Reilly Paul Smyth	28.1.16	N/A	Seamus O'Reilly Paul Sheridan Paul Smyth	26.2.16		Yes 9.1.16	Personal Informa redact US	Family not informed			13.5.16	23.5.16	Report not shared with family.	29.6.16	
CC	1.5.15	SEC	27.4.15	Pers	P	Personal patient under surgical review from 16/08/13. On 17/06/14 patient was seen in Surgical Outpatients: CT colonoscopy done on 13/05/14- the examination was poor and neoplasia could not be excluded. The patient was to be reviewed in the Outpatient clinic in due course to monitor symptoms. This review did not take place. Patient then presented to CAH ED on 18/04/15 with cecal tumour and liver metastases.	22.5.15 Mrs Heather Trouton Mr Eamon Mackle Mrs Connie Connolly	4.6.15	N/A	Mr Robin Brown Dr Richard McConville Mrs Katherine Robinson Amie Nelson Mrs Connie Connolly	2.7.15		N/A	Personal Information reda	30.6.15			11.3.16	25.4.16	24.6.16 meeting arranged with family to discuss report. 1.6.16 report issued 23.5.16 advising report complete	20.6.16	
CC	20.12.14	MUC	17.6.15	Perso	Pe	Patient presented to ED after Right knee injury. Xray initially read as normal by ED Doctor. Official report available revealing fracture 48 hours later. Patient not recalled for 17 days.	2.9.15 - Mr Seamus O'Reilly Mr Barry Conway Mrs Connie Connolly	11.9.15	N/A	Dr Mark Feenan (Chair) Mrs Jeanette Robinson Mr Barry Conway Mrs Helen Forde/Ms Sinead Corr Mrs Irenee Hewitt Mrs Connie Connolly	9.10.15		N/A	Personal Information redacted by the	10.5.16 Advised report complete. 25.9.15 patient telephoned. 28.9.15 Letter issued.		12.11.15	11.3.16	22.4.16	18.5.16	20.6.16	
CC	26.8.14	SEC	19.11.14	Pers	Pe	4.12.14 Notification not sent to board. Personal Information seen in Surgical Outpatients on 25 February 2014. There was a suspicion of a colon lesion in mid sigmoid colon. Red Flag colonoscopy to be arranged. 2 polyps removed during colonoscopy on 06 March 2014. Diagnosis: tubular adenoma, high-grade dysplasia. Repeat colonoscopy needed due to difficulties during the first procedure. Second colonoscopy performed on 05 April 2014. Third polyp removed. Diagnosis: Sigmoid polyp- adenocarcinoma. Reviewed in Surgical Outpatients on 26 August 2014. There was an unintentional 14 week delay in informing patient of diagnoses and commencing treatment.	26.11.14 Mr Mackle Mr S Gibson Mrs Connie Connolly Mr Paul Smyth Mrs Anne Quinn	11.3.15		Mr Hewitt Chair Mr Murugan Ms Amie Nelson Mr Paul Smyth	8.4.15			Personal	10.5.16 Advised report complete. 1.12.14 Letter issued to P informing him of SAI.		6.1.16	11.3.16	25.4.16	18.5.16	20.6.16	
CC	14.7.15	CCS	14.7.15	Pers	Pe	Personal patient admitted with frequent falls, poor oral intake and shortness of breath. Upon admission, found to have post- menopausal vaginal bleeding, microcytic anemia and acute kidney injury. Patient scheduled for hysteroscopy. Patient had cardiac arrest upon induction of anesthesia prior to hysteroscopy and sadly passed away.	16.7.15 Dr Philip Murphy Mr Simon Gibson Mr Tim McCormick Mrs Patircia McStay Mr Ronan Carroll Dr Chris Clarke Mrs Connie Connolly	22.7.15	Dr Des Orr Dr Mark Roberts Mr Tim McCormick Mrs Heather Trouton Mrs Kay Carroll Mrs Connie Connolly	TOR issued on 26.8.15 Report due 14.10.15	19.8.15		Yes 14.7.15	Personal Informatio redacte Us	10.5.16 Advised report complete. By phone 11.9.15 by post 11.9.15		29.10.15	3.3.16	22.4.16	Not requested	20.6.16	
CC	23.3.15	SEC	27.3.15	Pers	Per	Personal Information had rectal resection 11/02/14 for carcinoma of the rectum. In November 2014, patient booked for a reversal of stoma. Added to elective surgery waiting list. Patient admitted for surgery on 23/03/15 for reversal of stoma. Once anaesthetised, the abnormal CT findings were discovered. Procedure abandoned. Patient informed of rationale and referred for palliative chemotherapy	10.6.15 Mr Eamon Mackle Mrs Heather Trouton Mrs Connie Connolly	17.6.15	Mr Jaroslaw Gudyma Ms Anne Tate Mrs Nicola McClenaghan Mrs Katherine Robinson Mrs Connie Connolly	28.9.15 Amended TOR issued to HSCB 9.9.15 TOR & membership 15.7.15			No	Personal Information redacted by the	1.10.15 - decision taken by AD for SEC not to contact patient or family as both patient & spouse was suffering from cancer.			11.3.16	25.4.16	Not being shared.	20.6.16	
PS	10.9.15	MUC	23.9.15	Pers	P	A Personal attended the emergency department on the 10/09/15 by ambulance. Personal Information redacted by the USI P was subsequently found dead the next day at home. The coroner's preliminary post mortem is inconclusive and awaiting toxicology which make take several months.	30.9.15 Mr Barry Conway Mr Seamus O'Reilly Paul Smyth	18.11.15	Dr Cathy Daly Jayne Agnew Paul Sheridan Paul Smyth	3.2.16	18.1.16		11.9.15	Personal Information redacted by	18.1.16	31.1.16 Query from DRO.		13.5.16	23.5.16	1.6.16	14.7.16	
PS	25.9.2015	MUC	30.9.2015	Pers	Pe	Patient admitted with Diabetic ketoacidosis, on admission had urinary catheter inserted in ED 22/09/15. Developed severe paraphimosis - underwent surgical repair on 27/9/15. Discharged 01/10/15	14.10.2015 Mr Barry Conway Mr Seamus O'Reilly Mr Paul Smyth	21.10.2015		Dr Paul McGarry Chair Sr M Hamill Sr L Cullen Mrs Mary Burke	18.11.15		N/A	Personal Information redacted by the US	16.6.16 report issued to Patient. Telephone 25.9.15 Letter 2.11.15			13.5.16	23.5.16	23.5.16 Letter advising report complete.	14.7.16	

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PS	20.10.15	MUC	14.12.15	Perso	P	A Personal presented to the Minor Injury Unit South Tyrone on 20/10/15 with a history of a fall the previous day and alcohol abuse. She complained of a head injury with facial bruising. The examination noted no cervical spine tenderness. Following assessment and facial bones x ray she was discharged home with her husband with head injury advice. She attended Daisy Hill Emergency Department on 22/10/15 with persistent vomiting following the head injury. In ED the examination stated no tenderness over the cervical spine. She was assessed in ED and a CT brain scan revealed no acute intracranial injury. She was admitted. She still complained of neck pain and a CT of her cervical spine on the 23/10/15 revealed a cervical spine (C2) fracture. She was discharged on the 09/11/15 for follow up and fracture clinic RVH.	18.11.15 Barry Conway seamus O'Reilly Paul Smyth	15.12.15	N/A	Dr Hilda Nicholl Chair Mr Conor O'Toole Sr Olive Sloan Mr Paul Smyth	12.1.15		N	Personal Information redact	21.12.15			13.5.16	23.5.16	1.7.16 Report issued to Solicitor. 23.5.16 letter advising report complete.	14.7.16	
PS	12.5.15	MUC	27.5.15	Pers	P	An Personal attended emergency department following a fall in the nursing home with a head injury and neck pain on 12/05/15. She had x rays taken which were reviewed. She was discharged back to the nursing home the next morning. She returned to Craigavon ED on the 15/05/15 from the nursing home via emergency ambulance as she had been unwell and off feet. She was admitted to an inpatient ward Craigavon with falls, UTI. She suffered cardiac arrest later that morning and was resuscitated, but unfortunately she died on 16/05/15. A fracture of her Cervical spine (C 2) was not identified at her initial attendance on 12/05/15.	21.5.15 Barry Conway Seamus O'Reilly Paul Smyth	29.5.15	Dr Erskine Holmes Chair Dr Suzie Smyth Dr Enda Conlon Mr Paul Sheridan Ms Jane Green Mr Paul Smyth	TOR due 26.6.15 Report due 21.8.15	16.9.15		Yes 1.6.15	Personal Information redacted by	7.7.15			13.5.16	23.5.16		14.7.16	
PF	7.9.14	SEC	7.9.14	Pers	P	On the 25th August 2014 the patient was admitted to MAU CAH following a fall at home due to a kidney infection. On the 7th September 2014 the patient had an unwitnessed fall and it subsequently was confirmed that the patient has sustained a fractured humerous following the fall. The patient condition deteriorated and the patient subsequently died on the 14/10/14.	24.10.14 Mr Simon Gibson Dr Una Bradley Mrs Connie Connolly Mr Paul Smith Mrs Margaret Marshall	27.11.14		29.12.14 Dr Michael McCormick Mrs Catriona McGoldrick Mrs Kay Carroll Paula Fearon	11.12.14		14.10.14	Personal Information redacted by the	29.9.15 2 copies of report sent to family. 1.12.14			14.9.15	28.9.15 To Board and Coroner		14.7.16	
CC	9.7.15	MUC	19.8.15	Perso	Pe	7/7/15 at 05:00 hrs patient presented to Emergency Department with acute onset of epigastric pain and vomiting and diarrhoea. Discharged home from the Emergency Department with treatment for gastroenteritis at 12:15 hrs 9/7/15 at 13:42 hrs with severe abdominal pain. Diagnosed with thrombus in superior mesenteric artery at 18:00 hrs. Patient transferred to RVH as an emergency and underwent small bowel resection for bowel necrosis.	2.9.15 Mr Seamus O'Reilly Mr Barry Conway Mrs Connie Connolly	11.9.15		Mr Michael McCann (Chair) Mr Adrian Neill Mr Ian Crawford Mr Ronan Carroll Mrs Connie Connolly	4.12.15	28.9.15 Amended TOR issued to HSCB 14.9.15	N/A	N/A	5.10.15 Acknowledgement 16.6.16 Advising report complete 22.6.16 SAI report issued		3.12.15 4.11.15	10.6.16	22.6.16	22.6.16 report issued to patient. 16.6.16 Letter advising report complete.	7.9.16	
CC	14.9.15	MUC	14.9.15	Pers	Pe	Personal Patient admitted to Daisy Hill Female Medical Ward on 28 August 2014 with infective exacerbation of COPD. Past medical history of Chronic Obstructive Airway Disease (COPD), Falls, depression, osteoporosis, and weight loss. On Sunday the 14 September 2014 at 03:20 hours, Pe had an un-witnessed fall. Complaining of severe weakness and pain in Right leg. X-rays hip, pelvis, lumbar, thoracic and CT of Brain ordered and completed. X-ray report at 11:20 hours reveals confirmed fracture of Right neck of femur. Pe was accepted for transfer and management in RVH. Ct of Brain result at 14:50 hours was, Nothing Abnormal Detected. Right hemi arthroplasty performed on 17 September 2014. Per was returned to Daisy Hill on 23 September 2014. Pe made slow, steady progress in relation to her fracture and the infective exacerbation of COPD and was discharged home on 23 October 2014.	23.3.14 Mr Philip Murphy Mr Simon Gibson Mrs Mary Burke Dr Una Bradley Mrs Connie Connolly	24.3.15		Dr Shane Moan Sr Anne Harris Mrs Connie Connolly	28.4.15		No	Personal Information redacted by	Dr S Moan contacted family on 18.5.15. Follow up letter issued on 18.5.15.		12.2.16 18.5.15	10.6.16	22.6.16	22.6.16 2 copies of report issued to family. 16.6.16 Letter advising report complete.	12.9.16	
CC	14.1.15	SEC	15.1.15	Pers	Pers	This Personal Information was admitted to the Trauma Ward on 07/01/15 following a fall at home. Past hx of AF, pulmonary fibrosis, chronic kidney disease, and gallbladder perforation. On Dibigitran. Confirmed comminuted unstable fractured Rt shoulder. Conservative management was decided as treatment. Over the next 7 days, this patient had a number of episodes of shortness of breath, low oxygen saturation, and transient confusion. The Dibigitran was recommenced on 09/01/15 after confirmation of no neurological aetiology after his fall at home. It was noted that there were 2 doses of Dibigitran omitted on the 9/10/11 January 2015. On 14 January 2015, at 15:00 NEWS were noted to be 5. There are no further NEWs recorded until 20:30 when the patient was found breathless and cyanosed. After full resuscitation efforts for 20 minutes, this patient was pronounced dead.	21.1.15 Mr Eamon Mackle Mrs Heather Trouton Mrs Connie Connolly	28.1.15		Dr Michael McCormick Dr Jilly Redpath Sr Sheila Mulligan Mrs Anne McVey Mrs Connie Connolly	25.2.15		14.1.15	Personal Information redacted	Call from Dr McCormick on 8.4.15. Letter issued on 15.4.15. 8.6.15 Letter of consent issued to family.			10.6.16	17.6.16	16.6.16 Letter advising report complete.	14.10.16	
PS De-escalated	15.10.15	MUC	9.12.15	Pers	Pers	A Personal Information attended the emergency department on the 15/10/15 with chest pain and shortness of breath. He had been discharged from an inpatient ward Daisy Hill the previous day. He was assessed and diagnosed as a possible pulmonary embolism. He was admitted to an inpatient ward and was to have a chest x-ray enroute to the ward. On admission to the ward, the x-ray was reviewed and a pneumothorax was diagnosed.	13.1.16 Barry Conway Seamus O'Reilly Paul Smyth	29.1.16	N/A	Michael McCann Paul Sheridan Paul Smyth	26.2.16		N/A	N	Personal Information redacted						De-escalated on 6.10.16	
PS	29.3.15	MUC	29.3.15	Perso	Pers	An Personal attended the emergency department at Daisy on 28th ill Hill on 28st March 2015 at 23:52 hours with vomiting and abdominal pain. He was assessed and diagnosed constipation and subsequently discharged. He returned 6 hours later and collapsed in the emergency department, he was carried to the resuscitation room. Resuscitation was commenced but was very sadly unsuccessful	30.3.15 Mr Barry Conway Mr Seamus O'Reilly Mrs Mary Burke Mrs Anne McVey Mr Paul Smith Mr Paul Sheridan Mr Conor o'Toole Mr Erskine Holmes Dr Tracey Boyce	30.3.15 31.7.15 TOR & Membership submitted to Board.		Mr P McGarry Chair S Thompson Paeds Mr John Campbell A McKinney WHSCT Robert Gilliland External Sr S Holmes Mrs Mary Burke Miss Paula Fearon Mr Paul Smyth	22.6.15	31.7.15	29.3.15	Personal Inf	13.5.15 Acknowledgement 16.7.15 Holding letter issued. 31.7.15 Confirmation of meeting.			1.9.15	15.9.15	Followup meetings on 20.5.16 & 5.8.16. 2.9.15 Report given to family at meeting.	12.12.16	
PS	17.4.14	MUC	23.4.14	Pers	Per	Patient attended emergency department Daisy Hill on 7th April with abdominal pain, after assessment was discharged. Patient returned to Daisy hill ED on 8th April and 9th April with vomiting and diarrhea and was reassessed and discharged both occasions. _Patient returned on 17th April unwell, diagnosed bowel obstruction and was transferred to theatre for laparotomy and subtotal colectomy.	14.1.15 Mr Seamus O'Reilly Mr Barry Conway Mr Paul Smith	29.1.15		Mr Paul Kerr Mr Manos Epanimerotakis Sr Sharon Holmes Dr Richard Wilson External Mr Paul Smyth	23.4.15	8.9.15	No	Personal Informa	13.10.16 report signed for. 11.10.16 confirmation of meeting on 27.10.16 DHH 6.10.16 report issued 14.7.16 advising report complete By phone 20.8.15 by post 8.9.15			8.7.16	14.7.16	27.10.16 meeting arranged in DHH 11.10.16 report posted registered post.	29.12.16	HSBC to share learning in Learning matters Newspaper
CC	16.10.15	MUC	28.12.15	Pers	Pe	Personal with history of Crohn's Disease admitted with pancytopenia on 11/12/15. Pt commenced on Azathioprine 200mg on 16/10/15. TPMT result from 2011 not available in hardcopy within patient charts. TPMT in 2011 indicated this patient should not receive Azathioprine. Patient was not re-screened prior to prescription and commencing Azathioprine in 2015.	11.4.16 Dr Philip Murphy Dr Una Bradley Mrs Connie Connolly 14.3.16 Dr Philip Murphy Dr Una Bradley Mr Simon Gibson Mrs Connie Connolly	17.5.16		Dr Michael Gibbons Ms Jilly Redpath Mrs Connie Connolly	14.6.16	N/A	No		13.7.16 letter advising report complete. 28.12.15 by phone. 3.6.16 by letter			8.7.16	13.7.16	20.7.16 report issued.	29.12.16	
CC	28.2.15	MUC	2.3.15	Pers onal	Pers	Personal Information presented to Daisy Hill ED on Saturday 28 February 2015 at 10:25 hrs via ambulance complaining of severe back pain. On tramadol and paracetamol at home. Know allergy to Codeine. Seen by Dr at 12:55hrs. Analgesia given as prescribed. At 15:45, rash on face, Dr informed. Slight rash ? secondary to drug allergy. Chlorphenamine 10mg given i/v at 16:00 hrs for rash. Discharged home at 16:30 hrs. The rapid discharge after treatment for systemic rash is contrary to the Trust Anaphylaxis Policy. On Saturday 28 February 2015 at 18:46 hrs (2 hrs 16 min later) this gentleman presented to DHH ED via ambulance with allergic reaction with airway compromise. Fibre optic intubation performed and patient was transferred to ICU in Craigavon Hospital. Admitted to CAH ICU at 23:05hrs.	4.2.15 Mr Seamus O'Reilly Mr Barry Conway Mrs Connie Connolly	11.3.15		Dr Dave Patton Sr Sharon Holmes Dr Jilly Redpath Mrs Connie Connolly	8.4.15	N/A	No	Personal Information redacted by the USI	12.9.16 Report issued to family. 24.6.15 Dr David Patton spoke with Son. 24.6.15 letter issued after discussion with son.		20.1.16 7.1.16	9.9.16	12.9.16		29.12.16	HSBC to share learning in Learning matters Newspaper
CC	14.12.14	SEC	14.12.14	Pers	Pe	Personal admitted to High Dependency Unit in Daisy Hill Hospital 07/12/14 with collapse and vomiting. Past history includes anemia, depression, asthma, codeine dependence, renal abscess, duodenal ulcer, learning difficulties and? Wilkies Syndrome. OGD done 10/12/14 which revealed gross ulceration and erythema. On 14/12/14, patient complained of severe abdominal pain. General condition continued to deteriorate and laparotomy was performed at 13:00hrs. While patient was being prepared for transfer to CAH ICU post-operatively, the patient went into asystole. CPR was carried out but there was no response to treatment. This patient died at 20:30 hours in the Daisy Hill Theatre Recovery Ward.	17.12.14 Mr Eamon Mackle Mr Philip Murphy Mrs Heather Trouton Mr Simon Gibson Mrs Connie Connolly	20.7.15 Level 3 to Board. 30.12.14 TOR due 13.8.15 Report due 9.10.15		24.3.15 Dr Andrew Murdock Dr Graham Turner External Mr Manos Epanimerotakis Mrs Anne MCVey Mrs Connie Connolly	24.3.16	15.12.14	5.11.15	Personal Information redacted by	16.6.16 report issued to Pe 14.1.16 further holding letter issued. 18.5.15 Letter advising of SAI 5.10.15 Holding letter issued. 15.12.14 phone call.	18.5.15		10.6.16 3.12.15 19.11.15		15.6.16 - Report posted.	29.12.16	

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CC	23.6.14	SEC	25.7.14	Pers	Pe	The patient presented initially at the Emergency Department on the 23/06/14. On the01/07/2014 the patient collapsed at home and represented at the Emergency Department in a peri- arrest state on admission. Following resuscitation the patient was transferred to theatre and an emergency laparotomy was performed. Postoperatively the patient was transferred to ICU in CAH. The patient has now been discharged from ICU and remains a patient in DHH.	23.7.14	1.8.14		Dr Gareth Hampton Mr Colin Weir Sr Sharon Holmes Mrs Connie Connolly	24.10.14	24.11.15	No		12.9.16 Letter advising report complete 1.3.16 Acknowledgement issued. Presently the patient remains ill. A decision has been taken that at present it would not be in his best interest to inform him of this referral. This decision is under review			9.9.16	12.9.16		5.1.17	
CC	20.12.13	SEC	20.12.13	Pers	Pe	A Personal patient was admitted on 19/12/2013 with a leaking nephrostomy tube. The patient had an unwitnessed fall on 20/12/2013. The patient sustained a # femur. Surgery was performed on 24/12/2013. Following his surgery, the patient was transferred to Lurgan Hospital on 3/1/2014 for a period of rehabilitation. Tragically the patient died on 27/2/2014.	3.11.14 Mr Eamon Mackle Mrs Heather Trouton Mrs Connie Connolly Mr Paul Smith Mrs Anne Quinn	1.5.15		Dr Damian Gormley Mrs Martina Corrigan Mr Tony Glackin Sr S Kennedy Mrs Connie Connolly	29.5.15	N/A	No	Personal Information redacte			31.3.15	10.6.16	22.6.16	No	5.1.17	
CC Not Risk rated properly	5.3.15	MUC	5.3.15	Pers	Per	On Wednesday 4 March 2015 at 18:52 hrs Personal presented to Daisy Hill Hospital ED with abdominal pain. Sudden onset of left lower quadrant pain in the morning. Home with analgesia. Return if any concerns. GP if pain not settling.(Departure time 22:15hrs)On Thursday 5 March 2015 at 12:20hrs, P arrived to Daisy Hill Hospital Emergency Department at 12:20 hrs unresponsive after out of hospital arrest team present and sadly passed away.	1.4.15 Mr Barry Conway Mr Seamus O'Reilly Mr Paul Smith Mrs Connie Connolly	13.5.15 TOR & Membership to Board on 24.6.15		Chair Dr David Patton Dr Sean McGovern ext Dr G McArdle Sr Linsey Sheerin Belfast Mrs Mary Burke Connie Connolly Previous Panel Dr Hilda Nicholl Chair Dr Andrew Kennedy Dr D Patton Dr G McArdle Dr Damian McKay Mr Barry Conway Mrs Mary Burke Miss Paula Fearon	6.7.15	9.11.15	YES 13.4.15	Personal Information redacted by the USI	27.4.16 report issued to both sisters. 15.7.15 holding letter issued. 18.5.15 - Letter issued. 13.5.15 - Consultant spoke to relation by phone.		New Review Team 1.12.15 Ist Review team 15.5.15 23.6.15 7.7.15	11.3.16 minor amendments to be made, 25.4.16 approved for sending to HSCB	27.4.16	26.4.16	5.1.17	
CC De-escalated	25.4.16	MUC/ATICS	25.4.16	Pers	P	Personal patient presented to hospital following witnessed collapse at home on 6 April 2016. History of alcohol abuse and 7 day history of vomiting and diarrhea. Glasgow Coma Scale 15/15. Admitted under Medical directorate and transferred to ICU following gradual clinical deterioration.Level of consciousness did not improved and on 25/04/16, CT Brain revealed appearances of likely central pontine myelination.Glasgow Coma scale remains 3/15.	16.5.16 reviewed 23.5.16 Anne McVey Dr P Murphy Dr Una Bradley Trudy Reid Paul Smyth Dr Pat McCaffery Dr Shane Moan Connie Connolly	26.5.16		Dr Peter Sharpe Dr Rayburn Forbes ICU TBC Sandra Burns Facilitator TBC	18.8.16		No								17.1.17 - De-escalated by HSCB.	
CC	4.3.15	SEC	9.3.15	Pers	P	On 2 March 2015, Personal presented to CAH ED with feeling unwell, swollen penis for 24 hours. Commenced on Flucloxacillin 2g given intravenously (i/v) and benzylpenicillin 1.2 g i/v. Then commenced on Tazocin 4.5 g i/v three times daily and Daptomycin 475 mg i/v OD prescribed. Oral Clindamycin 300 mg prescribed TID on March 4 2015. On 9th March 4 2015, it was noted by Microbiology Consultant that the dose of clindamycin was too low for the indication and that the intravenous route would have been more appropriate.	Original 22.5.15 Not SAI Further review on 3.6.15 SAI Mrs Heather Trouton Mr Eamon Mackle Mrs Connie Connolly	8.6.15	N/a	Dr Mark Haynes Dr Martin Brown Dr Jilly Redpath Mrs Gillian Henry Mrs Connie Connolly	6.7.15	N/A	N/A	Personal Information redacted US	Letter 15.12.15			28.11.16	28.11.16	28.11.16 family advise report completed.	17.1.17	
PS De-escalated	19.5.15	MUC	20.5.15	Pers	Pe	A Personal Information with multiple co morbidities fell from a chair while an inpatient on the rehab ward in Daisy Hill Hospital on late evening 19th May. He sustained a fracture to his right hip. He was transferred to the Trauma ward Craigavon Hospital for surgery. Patient Pe became unwell prior to his surgery and was transferred to the Intensive Care Unit; he suffered a cardiac arrest and sadly died on 21st May 2015.	8.6.15 Mr Barry Conway Dr Philip Murphy Dr Una Bradley Mr Paul Smyth	10.6.15		John Harty (Chair) Andrew Ferguson Martin Brown Catriona McGoldrick Brigeen Kelly Facilitator - Connie Connolly	18.10.16 amended TOR & Membership issued to HSCB. TOR due 8.7.15 Report due 2.9.15	19.11.15	Yes 21.5.15	Personal Information redacted by th	15.7.15 Acknowledgement letter to Perso						17.1.17 De-escalated by HSCB	
CC	12.10.15	MUC	12.10.15	Pers	P	Perso patient admitted to medical ward with cough and shortness of breath. Long-standing history of Chronic Obstructive Airway Disease. Unwitnessed fall on 12/10/15 at 05:30 hrs. X-ray confirmed fractured Left femur. Fracture repaired on 14 October 2015 after maximum efforts to optimize and prepare this patient for theatre. Patient discharged home on 27 October 2015.	16.11.15 Simon Gibson Dr Philip Murphy Connie Connolly Tele link Barry Conway Una Bradley Shane Moan	16.11.15		Dr Michael McCormick Sr Anne Harris Mrs Connie Connolly	14.12.15	N/A	N/A	Personal Information redacted U US	16.6.16 Letter advising report complete. 3.3.16 Letter advising complaint being addressed within SAI 26.1.16 Call to Personal 26.1.16 Followup letter		19.1.16	10.6.16	21.6.16	30.6.16 report issued to patient. 16.6.16 advising report complete.	18.1.17	
CC	7.5.15	SEC	12.5.15	Pers	Pe	On Saturday 2 May 2015 at 12:06 hrs, patient attended Craigavon Area Hospital Emergency Department following fall at home. Fractured Lt subtrochanter confirmed by xray at 12:30 hrs. Noted to be extracapsular, comminuted and impacted. Insertion of Gamma Nail on 6 May 2015. Patient developed upper GI bleeding due to stress ulcer. Patient sadly passed away on 21 May 2015.	17.6.15Mrs Heather Trouton Mr Eamon Mackle Mrs Connie Connolly	29.7.15		Chair Dr Tim Bennett Mr Jonny Bunn Mr Hisham Hurreiz Mrs Anne McVey Mrs Trudy Reid Dr Neal Morgan Mrs Connie Connolly	21.10.15	22.9.15 Reviewed TOR issued to include Surgeon. 14.9.15	22.5.15	Personal Information redacted by the USI	23.6.16 Report signed for. 17.6.16 Report issued along with confirmation of meeting for 30.6.16. 10.5.16 Advised report complete. Telephone call on 8.9.15 Letter issued 14.9.15.			22.4.16 - report signed off11.3.16 submitted to SMT, retrned for minor amendments.	22.4.16	Meeting arranged for 30.6.16 Report issued on 17.6.16	14.2.17	
CC	15.11.15	MUC	15.11.15	Pers	Pe	Personal admitted to sideward with weakness and diarrhoea on 11/11/15. On clopidigrel and i/v fluids. On 15/11/15, patient up to notify nursing staff re i/v fluids running out and fell backwards, hitting head. CT revealed traumatic Rt occipital fracture, sub arachnoid haemorrhage and sub- dural haemorrhage. Patient never recovered neurologically and sadly passed away 17/01/16.	14.3.16 Dr Philip Murphy Dr Una Bradley Mr Simon Gibson Mrs Connie Connolly	23.3.16		Dr Eimear Savage Mrs Mary Burke Mrs Connie Connolly	20.4.16	N/A	17.1.16	Personal Information redacted by the L	23.11.16 Solicitors letter acknowledged 16.11.16 Letter from solicitor requesting update to SAI report. 27.9.16			28.11.16 approved 14.10.16	28.11.16	28.11.16 Report issued. Posted 1.12.16 by registered post.	22.3.17	
CC	15.1.16	SEC	15.1.16	Pers	Pe	An Personal fell and fractured her right neck of femur as an inpatient in the Trauma Ward on the 15th January 2016. She had Orthopaedic surgery on the 19th January and is recovering.	10.2.16Mrs Heather Trouton Mr Eamon Mackle Mr Paul Smyth	11.2.16		Dr Johnathan Bunn Sr Cherith Douglas Connie Connolly		N/A	No	Personal Information redac	3.10.16 by phone 4.10.16 by post.		3.10.16	14.10.16	5.12.16	5.12.16 Advising report completed	22.3.17	
PS	14.1.16	MUC	18.1.16	Pers	Pe	A Personal was admitted to ICU on the 07/01/16 with shortness of breath. CTPA confirmed multiple bilateral pulmonary emboli. Despite treatment Pe sadly died on the 14/01/16. A CTPA from 2014 was re-examined and pulmonary embolus was retrospectively diagnosed. It had not been picked up in 2014 radiology report.	14.3.16 Mr Simon Gibson Mr Barry Conway Dr Philip Murphy Dr Una Bradley Mr Paul Smyth	4.2.16		Dr David Gracey Chair Dr Alexander John Miss Jilly Redpath Dr Kathryn Boyd Sandra Burns Connie Connolly	28.4.16	16.9.16 amended Membership & TOR issued. 16.3.16 Membership & TOR issued.	14.1.16	Personal Information redacted by	14.12.16 2 copies of report issued by recorded delivery 28.11.16 letter advising report complete. 23.9.16 by phone and letter.			28.11.16	28.11.16	14.12.16 Issued by registered post.	12.6.17	
CC	17.2.16	SEC	17.2.16	Pers	P	Personal Information admitted from Nursing Home with suspected cellulitis of left ankle. X-ray of ankle taken on 02/02/16. Patient transferred to Trauma Ward 03/02/16 and had an un-witnessed fall on 17/02/16 and sustained fractured Lt neck of femur.	15.3.16 Mr Eamon Mackle Mrs Heather Trouton Mrs Connie Connolly	22.3.16		Mr Raj Kumar Dr David Gracey to nominate radiographer Sr Joanne Cochrane Sr Cherith Douglas	20.4.16	N/A	No	Personal Inform redacte	11.5.17 by phone 23.5.17 by letter			14.4.17	26.5.17	14.6.17	28.7.17	
CC	27.7.14	SEC	19.11.14	Pers	P	On 22/07/14 a Personal admitted with haematemesis and PR bleeding. The patient had an OGD/Laparotomy carried out on 22/07/14. A 5-lumen CVC line was inserted during surgery. The patient was transferred to ICU post-operatively and was transferred to the ward on 25/7/2014. On removal of the patient's NG tube on 27/7/2014, the patient appeared to take a seizure and lose consciousness. Whilst being clinically assessed, it was noted that the brown lumen was open to air.	14.11.14 Mr Eamon Mackle Mrs Heather Trouton Mrs Connie Connolly Mr Paul Smyth Miss Paula Fearon Mrs Anne Quinn	19.11.14	N/A	Mr Robin Brown Dr Rutherford Jones Mrs Connie Connolly Sr Sheila Mulligan Mrs Amie Nelson	17.12.14	N/A	No	Personal	13.4.15		19.7.16 letter and report issued to Pers 24.4.15 Letter of acknowledgement sent to P er	8.7.16	14.7.16	19.7.16 Letter & report Personal	23.5.17	
PS	17.5.15	MUC	18.5.15	Pers	P	An Personal self-presented to Daisy Hill Emergency Department with a swollen right hand and vomiting on 16th May at 23:47 hours. He had cut his hand the previous day in his green house. He was assessed by the emergency department doctor and administered antibiotics and IV fluids. He was then referred to the medical inpatient team Daisy Hill with an initial diagnosis of cellulitis. He was reassessed by the ED doctor and referred to the surgical inpatient team Daisy Hill with a revised possible diagnosis of necrotizing fasciitis. The surgical team had initially planned to transfer him to Plastics UHD but he was transferred to theatre for stabilization. He subsequently had debridement of the hand wound in theatre and was transferred to the Intensive Care Unit Craigavon on the afternoon of 17th May. He remained quite ill and unfortunately died on 18th May at 09:40 hours with a diagnosis of toxic shock syndrome.	20.5.15 Mr Barry Conway Mr Seamus O'Reilly Mrs Mary Burke Mr Conor O'Toole Mr Paul Smyth	21.5.15		Dr Gareth Hampton Dr Andrew Fergison Mr Alistair Lewis Sr Sharon Holmes Mr Paul Smyth	26.6.15 TOR due 21.8.15 Report due	24.8.15	Y 1.6.15	Personal Information	28.11.16 Advising report completed 30.7.15 - Acknowledgement 18.7.16 Holding letter			28.11.16 14.10.16	28.11.16	5.12.16 Report issued by registered post. 18.7.16 Letter advising report complete.	28.7.17	
CC	25.1.15	SEC	25.1.15	Pers	P	This Personal patient to transferred from South West Area Hospital to Craigavon Area Hospital on 19 January 2015 with renal calculi and sepsis. The patient is a brittle epileptic, with a history of thrombocytopenia, ulcerative colitis, and ureteric colic. A urethroscopy and stenting was done on 22 January 2015 and patient was managed in the Intensive Care Unit until Day 2 post op. On Sunday 25 January 2015 at 16:00hrs , this patient had a prolonged epileptic seizure for approximately 30 min which required input from ICU Intensivists. Upon review of the medicine kardex, there were documented omissions of anti-epileptic medication.	11.3.15 25.2.14 Mr Eamon Mackle Mrs Heather Trouton Mrs Connie Connolly	20.3.15		Dr Karen McKnight Dr Jilly Redpath Sr C Hunter Mrs Trudy Reid Mrs Connie Connolly	17.4.15	N/A	N/A	Personal Information redacte the U	12.1.16 Letter to Per 7.12.15 Telephone call to Pers		10.12.15 12.1.16	28.11.16 14.10.16	28.11.16	5.12.16 Report issued registered post 28.11.16 family advise report completed.	28.7.17	

Received from Trudy Reid on 16/05/2023. Annotated by the Urology Services Inquiry.

PS	5.4.16	MUC	13.5.16	Pers	Pe	A Personal presented to the Emergency Department (ED) on the 05/04/16 expressing thoughts of harming others. He had a history of schizophrenia. Following assessment in ED he was referred to psychiatry. Psychiatry assessed him in ED and decided to admit him to an inpatient psychiatric bed. He had denied taking any drugs to the ED doctor and Psychiatric staff. Once he arrived in the Psychiatric Unit he told staff there he had taken 42 Lyrcia tablets the previous day. He was transferred back to ED. He had a subsequent respiratory arrest and was intubated and ventilated. He was admitted to ICU for a day and was discharged back to the Psychiatric unit on the 07/04/16.	11.5.16 Anne McVey Seamus O'Reilly Paul Smyth Trudy Reid Mary Burke	13.5.16		Dr Mark Feenan Sr Sharon Holmes Mr Paul Smyth	10.6.16	N/A	No	Personal Information	5.9.16 report issued to patient. 17.8.16 letter advising report complete. 14.6.16 Letter issued.			12.8.16	17.8.16	5.9.16	28.7.17	
PS	12.1.15	MUC	19.2.15	Pers	P	Personal presented to ED with chest pain and Shortness of Breath, diagnosed spontaneous pneumothorax. Attempted aspiration done in ED, no improvement, so admitted Clinical Decision Unit overnight. Repeat chest x ray in morning showed complete pneumothorax and pleural effusion. Chest drain inserted and 1400mls of blood was evident in drain. Transferred to inpatient ward Craigavon. A further 1500mls of blood drained on 12/01/15. Patient transferred to thoracic team in RVH.	Seamus O'Reilly Mr Barry Conway Mr Paul Smith	23.1.15		Mr Conor O'Toole Dr R Doyle Dr A Ferguson Sr S Holmes Brian Magee Dr Mark Feenan Mr Paul Smith	20.2.15	N/A	No	Personal Information redacted b	27.3.15 by letter		11.3.15	13.5.16	23.5.16	1.6.16 report issued.	28.7.17	
PS	29.4.16	MUC	4.5.16	Pers	Pe	A Personal Information presented to the Emergency Department (ED) Daisy Hill Hospital by ambulance on the 28/04/16 with palpitations. He had a cardiac history and had stents inserted in the Cath Lab on the 18/04/16. Following examination and tests in ED he was discharged home after 6 hours in ED. He was found dead in his house on the 29.4.16. The fire service advised that there was a positive carbon monoxide reading in the house.	11.5.16 Mrs Anne McVey Mr Seamus O'Reilly Mr Paul Smyth Mrs Trudy Reid Mrs Mary Burke	12.5.16		Dr Erskine Holmes (Chair) Dr Peter Sharpe Sn Elaine Campbell Paul Smyth Mary Burke		28.11.16	12.5.16	Personal Information redacted by the USI	30.5.17				26.5.17	30.5.17	28.7.17	
CC	13.2.15	SEC	24.3.15	Pers	Pers	On Monday 9 February 2015, this Personal Information was admitted for surgery to remove a tumour in the transverse colon. Extended Right hemi-colectomy with partial gastrectomy was done on 09/02/15. On Friday the 13th of February 2015 the patient rapidly derteriorated and sadly passed away.	Initial Screening 25.2.15 with Mr Eamon Mackle Mr Ronan Carroll Mrs Amie Nelson Mrs Connie Connolly Further screening on 23.3.15 with Mr Eamon Mackle Mrs Heather Trouton Mrs Amie Nelson Mrs Connie Connolly	13.4.15		Mr Gerry McArdle Dr Rutherford Jones Dr Anthony McBrearty Mr Ronan Carroll	26.8.15 - TOR & Membershipsent to HSCB	8.9.15	Y 14.2.15. Telephone call made to Coroner at 09.50 hrs followed by Clinical summary sent to coroner.	Personal Informatio redacte	12.9.16 Report issued to family 16.3.15 Mr Mackle contacted Per 9.7.15 Acknowledgement letter issued.		24.2.16	9.9.16	12.9.16	Report emailed on 12.9.16 Mr Yousaf spoke to family, Acknowledgement issued on 16.4.15.	3.5.17	
PS	1.8.15	MUC	2.8.15	Pers	P	Personal patient, was transferred from a Nursing home to Craigavon Hospital Emergency Department with shoulder pain/septic arthritis on 30 July 2015. She was admitted to an inpatient ward. She fell on the ward on 1 August 2015 and sustained a fractured right femur. She was transferred to the Trauma ward and had surgery on 3 August. She is recovering on the Orthopaedic ward.	3.8.15 Mr Simon Gibson Dr Philip Murphy Mr Paul Smyth	10.8.15		Dr Ryan Boyle Sr Maria Hamill Paul Smyth	10.9.15	N/A	No	Personal Information redacted by the U	RIP 27.8.2015			12.2.16	23.5.16		31.8.17	
CC	20.12.14	MUC	22.12.14	Pers	Pe	On 14/12/14, patient complained of severe abdominal pain. General condition continued to deteriorate and laparotomy was performed at 13:00hrs. While patient was being prepared for transfer to CAH ICU post-operatively, the patient went into asystole. CPR was carried out but there was no response to treatment. This patient died at 20:30 hours in the Daisy Hill Theatre Recovery Ward.	19.1.15 Mr Philip Murphy Mr Simon Gibson Mrs Connie Connolly	28.1.15		Initial Chair-Dr Ryan Boyle (has since left SHSCT), Dr Una Bradley (Chair) , Mrs Trudy Reid, Mrs C Connolly	26.2.15	N/A	NO	P spoke with Personal)." I have explained the process and she is aware it will be some months before we have a report through. I have invited her to contact me at any point in the future if she is wondering how things are progressing."	24.2.15			14.4.17	20.4.17	20.4.17 Advising report complete	3.10.17	
PS	12.04.12	MUC	20.7.15	Pers	Per	Patient Pers attended Craigavon Hospital Emergency Department with chest pain on 12 April 2012 and was subsequently discharged. He had a chest x-ray which was reported as a soft opacity projected over the right lower zone and further assessment was advised. He had a further chest x-ray on 21 April 2013 that did not mention opacity. On 16 June 2015 a further chest x-ray report recorded suspicions of lung neoplasm. A CT chest on 10 July 2015 confirmed a bronchogenic carcinoma.	22.7.15 Mr Barry Conway Mr Seamus O'Reilly Mr Paul Smyth	13.8.15	N/A	Dr David Patton Mrs Anita Carroll Mr Barry Conway Mrs Mary Burke Consultant Radiologist tbc Mr Paul Smyth	10.9.15	N/A	N/A	Personal Information redacted US	23.7.15 by telephone 29.7.15 by letter				26.5.17	14.6.17 report issued to family 30.5.17 advised family report complete.	12.9.17	
PS	22.12.14	MUC	22.12.14	Pers	Personal	Patient fell on inpatient ward on 22 December 2014, 4 hours after admission with urinary tract infection. She hit her head off the end of the bed. She was assessed post fall. A CT brain was carried out, which showed minor to moderate Sub Arachnoid Haemorrhage. Further imaging, a MRI scan and a repeat CT brain were carried out on 29 December 2015 to confirm diagnosis. Patient made good progress and was transferred to rehabilitation. She was discharged home 27 January 2015.		11.8.15				N/A									De-escalation approved by HSCB 26.10.17	
PS	21.1.16	MUC	21.1.16	Pers	Personal	Per was brought to ED by ambulance on 21/01/2016 at 08:45 hours. The preceding history was 36 hours of vomiting and Pe was found lifeless at home by Personal at 08:00 hours on 21/01/2016. There was no response to resuscitation in ED and Pe was declared deceased at 08:57 hours in ED. Pe presented to ED in DHH in February 2015 and was admitted to the Childrens Ward CAH with vomiting, hyponatraemic dehydration but no low blood sugar. Preliminary post mortem indicates that Pe had cerebral oedema and may have had Addison's disease.	CYP to take forward					N/A			CYP					9.5.16	CYP taking lead.		
CC	22.1.16	MUC	22.1.16	Pers	Personal	Personal patient admitted for Chemotherapy on 7 January 2016. During course of treatment, patient acquired Norovirus while an in-patient on 13/01/16. Patient admitted to Intensive Care and sadly passed away on 24/01/16.	14.3.16 Dr Philip Murphy Dr Una Bradley Mr Simon Gibson Mrs Connie Connolly	4.4.16		Dr Katherine Boyd Stephanie Carson Patricia Loughan Sharon Holmes Connie Connolly	3.5.16	N/A	25.1.16	Personal Inform redacte the U	1.3.17 by letter 1.3.17 by phone		25.10.16		20.9.17		1.11.17	To HSCB 20.9.17 Letter dated 15.9.17 advising report complete	YES	YES
TR	19.8.16	IMWH	20.8.16	Pers	P	Personal Information who attended CAH at 33+2 weeks gestation on the 19/8/16 with spontaneous onset of labour and spontaneous rupture of membranes. P was counselled by the obstetric registrar and consultant regarding mode of delivery. Pe wished to proceed with vaginal delivery. P progressed to a vaginal breech delivery of Person at 21:59 hrs on 19/08/16. Person was delivered with Apgar scores of 0 at 1 minute, 0 at 5 minutes and 0 at 10 minutes of life. Emergency resuscitation was performed by paediatric staff and Person was admitted to the NNU. Person required ventilation and administration of anticonvulsant medication; Person remained critically unwell requiring maximum intensive neonatal support. The decision was made to withdraw treatment and Person sadly passed away on 25/08/16 at 03:00 hrs	Dr Martina Hogan Dr Beverley Adams Wendy Clarke	8.9.16		Dr Katherine Loane Patricia Kingsnorth Dr P Quinn Paeds Alison Little Trudy Reid	6.10.16 Membership & TOR 1.12.16 report due	5.12.16 TOR & Membership to Board	25.8.16	Personal Information redacte the US	24.8.16 by Dr Hogan & 19.9.16 by post.				4.10.17	2.10.17 issued by Registered post.	1.11.17		4.10.17	
CC	16.2.16	MUC/OPPC	7.6.16	Pers	Personal	Admitted with Total Stroke Syndrome 16/02, recent endoscopy procedure for anaemia, was being investigated, did not receive clexane post endoscopy and subsequently presented with new severe stroke. Issues with prescription and case was discussed with coroner. Insisted on a post mortem which confirmed stroke and valvular heart disease. Notes are with medico-legal department and awaiting return. noted two valves with mitral valve replacement.				Acute review team Christophe Hillemand Marie Wilson Jilly redpath Trudy Reid	16.12.16	6.3.17	Yes						25.7.17		11.9.17	25.7.17 report to HSCB & coroner From M&M forwarded to OPPC for their input - not SAI in Acute meeting with non acute 9.9.16- Stroke syndrome following OGD- enoxparin missed does		
CC	15.2.15	SEC	15.2.15	Perso	Personal	On 3 February 2015, Personal patient admitted to Craigavon Area Hospital. after fall at home on 2 February 2015. Past medical history of Hodgkin's Lymphoma, Right (Rt) Cerebral Vascular Accident (CVA), Pancreatitis, alcohol dependence, and fatty liver. Imp: fractured Lt sub-trochantric fracture. During recovery period on 15/02/15, patient fell while mobilising independently. X-rays confirm fractured Right proximal femur. Patient made full recovery and was discharged home on 25/02/15.	9.9.15 Heather Trouton Eamon Mackle Connie Connolly	11.9.15		Mr David McMurray Dr Damian gormley Sr Chrerth Douglas Mrs Connie Connolly	9.10.15	N/A	N/A	Personal Information redacted by the USI	19.1.16 by phone and letter		8.3.16 @ 11.30am	18.1.17	14.10.16	Report posted 6.2.17	23.5.17	HSCB Patient RIP 25.5.16 18.1.17		
TR	21.1.16	MUC	26.1.16	Pers	Personal	Personal admitted to 1 North via ED 12/01/16 with NSTEMI. Went to Cath Lab CAH 19/01/16, showed vein graft aneurysm had significantly increased in size. Transferred RVH 21/01/16 for day case closure of vein graft aneurysm. Returned to I North 17:45 hours 21/01/16, felt unwell 19:00, cardiac arrest 21:30. Unsuccessful resuscitation.	16.5.16 Anne McVey Dr Philip Murphy Dr Una Bradley Trudy Reid Connie Connolly	17.5.16		Dr Anthony McClelland Kay Carroll Shona McKeown Trudy Reid	14.6.16	N/A	No	Personal Information redacted by th	20.5.16 by letter 27.4.16 by phone		5.9.16 @ 11.30am		26.5.17	28.4.17	14.8.17	HSCB		

Received from Trudy Reid on 16/05/2023. Annotated by the Urology Services Inquiry.

CC	5.10.15	MUC	7.10.15	Perso	Personal Informati	Monday 5 October this patient was admitted to Medical Admissions Unit with acute exacerbation of asthma and abdominal pain. There was a delay in surgical assessment. There was then a further delay in imaging of abdomen. Following assessment and diagnoses of perforation, patient continued to deteriorate and was taken to theatre for an emergency laparotomy on 6 October 2015.Pt is currently in ICU on high dose inotropic support following laparotomy.	19.10.15 Dr Philip Murphy Dr Shane Mone Dr Una Bradley Mr Barry Conway Mr Simon Gibson Mrs Connie Connolly	20.10.15		Dr Thomas McNeilly Chair Dr Simon Porter Dr David Patton Mr Alister Lewis Dr Neville Rutherford Jones Connie Connolly	17.11.15	10.11.15	Y	Personal Information redacted by the	22.10.15 by an Anaesthetist			28.11.16 approved by ACG team 14.10.16	28.11.16	29.11.16 Report issued to family. Posted 1.12.16 registered post. 25.11.16 letter advising report complete	14.11.17	To HSCB		
CC	22.6.15	MUC	3.7.15	Perso	Personal	Personal patient with a past history of psychotic depression. Admitted on 22 June 2015 following 3 weeks of bizarre, erratic behaviour, slurred speech-polydipsia and polyuria for 3/7. Had been seen by Mental Health Rapid Treatment for 4 days prior to attendance. Blood sugar on admission 33.3mmol/l. Commenced on Hyperosmolar Hyperglycemic protocol. Over the next 24 hours patients serum sodium level rose to 173mmol/l despite fluid therapy. Patient transferred to ICU. On 3 July 2015, patient sadly passed away.	15.7.15 Mr Seamus O'Reilly Dr Philip Murphy Mr Barry Conway Dr Chris Clarke Mrs Connie Connolly	23.7.15		Chair Dr Ryan Boyle Dr Peter Sharpe Dr Raymond McKee Ms Jilly Redpath Mr Barry Conway Dr Joanne Minay Mrs Connie Conolly	TOR due 20.8.15 Report due 15.10.15	2.10.15 - Amended Membership sent to HSCB 14.9.15	3.2.17 Closed by coroner Yes 3.7.15	Personal Information redacted by the	22.4.16 report issued to family 4.9.15 17.11.15		8.12.15 17.11.15 21.9.15	22.4.16	22.4.16	22.4.14	30.11.17	To HSCB	Yes	
CC	15.5.16	MUC	17.5.16	Pers	Personal	Delayed diagnosis of Thoracic Aortic Aneurysm and subsequent death of patient at induction of anesthesia. Patient attended ED in CAH on 13/05/2016 with chest pain following investigation patient was discharged home from ED at 04:50 14/05/2016. Re- attended ED in CAH 15/05/2016 and was admitted with infectious exacerbation of COPD. Diagnosed with Thoracic aortic dissection on 16/05/2016. Patient was transferred to RVH, Cardiac Theatres, where her systolic Blood Pressure was 80, and was given half a milligram of Metaraminol, subsequently her blood pressure drifted up to 188 systolic, then started to lose her Cardiac output, arrested with Pulseless Electrical Activity. CPR was started immediately, Adrenaline was given, however due to no sufficient Cardiac Output and Saturation, the decision was made to stop CPR and patient passed away at 14:04 on 16/05/2016.	15.6.16 Mr Seamus O'Reilly Mr Paul Smyth Mrs Trudy Reid	4.8.16		1.3.17 Dr Michael Perry Mrs Kay Carroll Mr Paul Smyth Dr Eimear Savage	27.10.16	1.9.16	Yes 16.5.16	Personal Information redacted by the USI	30.10.17 Advising report complete. 7.3.17 by letter. 1.3.17 by phone.		9.11.16	13.10.17	13.11.17	10.11.17 letter advising report complete	30.11.17		YES	YES
TR	30.8.16	MUC	19.11.16	Pers	Personal	Personal patient who presented to ED on 29/08/2016 with chest pain and subsequently admitted to AMU. Patient was discharged home on the 30/8/2016 without referral to Cardiology for review. Pa died on 19/11/2016 from myocardial infarction.	3.4.16	18.10.17		Kay Carroll Dr Micahel Moore Mary Burke Trudy Reid				Personal Information redac USI	19.4.17		28.6.17	13.10.17	26.10.17	26.10.17	30.11.17	To HSCB	Yes	Yes
CC	4.12.16	MUC	1.3.17	Pers	Person al	ECG's done at 10:05 which indicated anterior ST elevation. No action was taken. AT11:17 ECG was repeated and patient referred and accepted by RVH PCI team at 11:25. Time of arrival to RVH was estimated as 12:15. Patient did not leave CAH until 12:30 hrs and arrived to RVH in cardiogenic shock. It is the view of the RVH Cardiology senior cardiology team that the delay in decision making by CAH coupled with delay in patient transfer requires further investigation	22.2.17 Mr Philip Murphy Dr Gareth Hampton Mrs Anne McVey Mrs Mary Burke Mrs Connie Connolly	2.3.17		Dr Gareth Hampton Chair Mark Cochrane NIAS Mrs Mary Burke Connie Connolly	27.4.17	N/A	N/A	Personal Information redacted by the	12.4.17 Letter issued by registered post. Dr Hampton made numerous attempts to contact Pers by phone. Landline dead & no answer from mobile.		19.4.17	13.10.17	15.11.17	15.11.17 letter advising report complete	2.1.18	To HSCB	No	No
AL	5.9.16	IMWH/CYP	5.9.15	Pers	Personal	Personal Information .Non immune hydrops , congenital heart disease ,prematurity. Withdrawal of care following maximum intensive care support , input from Regional NISTAR team and consultation over 23 hour period from birth with Regional Specialists in Neonatal and Cardiology . Parents fully involved in decision making throughout.		27.1.16		Alison Little, Risk Midwife, Nuala Sherry, Risk Coordinator Anne O'Reilly, Nursing Governance Coordinator Dr Sam Thompson, Paediatric Consultant, SHSCT Dr Katharine Loane, Consultant Obstetrician, Denise Quinn, Advanced Neonatal Nurse Practitioner, Donna McLoughlin, Acting Risk Midwife P Mc Dermott, Neonatal Transport Coordinator,			Y	Alison Little, Risk Midwife, Nuala Sherry, Risk Coordinator Anne O'Reilly, Nursing Governance Coordinator Dr Sam Thompson, Paediatric Consultant, SHSCT Dr Katharine Loane, Consultant Obstetrician, Denise Quinn, Advanced Neonatal Nurse Practitioner, Donna McLoughlin, Acting Risk Midwife P Mc Dermott, Neonatal Transport Coordinator,										
CC	20.11.16	MUC	22.11.16	Pers	Perso nal	On 20 November 2016 at 00:22 hrs, Personal arrived via NIAS to DHH ED following a fall from bar stool and hitting head on shelf while intoxicated (no spinal immobilisation in situ) . While in ED at 04:45 Pa appeared to have a cardiac arrest for approx. 3 min with return of spontaneous circulation. CT Brain 05:30-NAD. Complained of pain between shoulder blades. CT of c-spine at 06:30. CT spine: complete subluxation and dislocation fracture of C7/T1. Imp: spinal fracture, cardiac arrest secondary to spinal shock and aspirate pneumonia. Pe was transferred to RVH ED Resus as requested at approx. 09:30. Patient subsequently died in RVH on 26 November 2016.	8.12.16 validated 13.12.16 Dr P Murphy Dr G Hampton Trudy Reid	15.12.16		Dr Cathy Daly Chair Dr Imran Yousaf Dr Nigel Ruddell Mr Paul Smyth Mrs Connie Connolly	9.3.16	26.1.17	By RVH	Personal Information redacted b	13.3.17 by letter		25.5.17 16.2.17	13.10.17	21.11.17	17.11.17 Sent report by registered post.	26.1.18		Yes	Yes
TR	25.12.16	MUC/MHD	28.12.16	Pers	Personal	On 28/12/2016 the Trust was notified, via the community, Personal Information was known to/referred to mental health and related services, in the 12 months prior to the incident; Pers was known to Support and Recovery services; she attended her last appointment on 03/10/2016. Pers was known to the Home Treatment/Crisis Response Team; the last contact was on 06/09/2016 Pers was seen by Psychiatric Liaison; the last contact was on 26/10/2016.				Dr Neta Chada Elizabeth Williamson Kiera Lavery joanne McKinney Maria McCaffrey Joanne Minay Trudy Reid				N/A MHD									
TR	14.11.16	MUC/MHD	21.11.16	Pers	Pers onal	The Southern Health and Social Care Trust were advised, via the community, Pers was known to Mental Health Services, in the 12 months prior to the incident. The Trust contacted HM Coroner, who advised that the cause of death is undetermined at this time. Personal was known and/or referred to; the Primary Mental Health and Care Team (PMHCT), Addiction Services, Liaison Psychiatry and the Home Treatment/Crisis Response Team. Personal last contact with Mental Health Services was on 18/10/2016.								N/A MHD				3.10.17					
TR/ BHSCT	25.8.16	MUC	23.9.16	Pers	Personal	patient with Melanoma. seen in dermatology and transferred to plastic surgery for wide excision. on discharge from plastics surgery no correspondence was copied to dermatology and therefore no follow was arranged. patient was also attending oncology service. patient has developed metastatic disease			N/A	Trudy Reid BHSCT SAI		N/A	No	N/A	N/A	N/A	N/A	N/A	18.12.17	N/A		18.12.17 - BHSCT sent report to HSCB		
CC	23.12.15	SEC	30.12.15	Pers	Perso nal	Personal insulin dependent diabetic admitted with pancreatitis. Pt fasted for scan and insertion of central line. No i/v fluids or insulin erected. No BM testing. Subsequent Diabetic Ketoacidosis requiring readmission to ICU. Difficulty in establishing patient management and support between MUSC/SEC/CYP and ATTICS was a substantive issue throughout inpatient stay.		30.12.16	N/A	Chair Dr Neta Chada Dr Shilpa Shah Dr Andrew Ferguson Mr Robin Brown Mrs Grace Hamilton Sr Tracey McGuigan Mrs Trudy Reid	15.6.16	31.8.16	No		Decision taken not to inform patient/family.	N/a	4.5.17 17.10.16	13.10.17	21.11.17	DRO aware patient not contacted. Awaiting guidance from DRO regarding contact with patient	20.6.18		No	No
CC	21.11.16	MUC	2.12.16	Pers	Personal	A male patient was admitted to CAH on 15.11.16 with hypothermia, confusion and acute kidney injury (AKI). He was accepted for transfer to Nephrology, Belfast City Hospital on the norming of 20.11.16 for consideration of haemodialysis. At the time of referral and acceptance for transfer the hand over from the medical team in CAH described progressive AKI, oliguria and some dusky discoloration of the feet. On arrival at approximately 11.00am to ward 11 North, Neurology, BSH the patient was found to have frank necrosis covering most of the plantar surface of both feet and also involving all toes. There was superficial sloughing of skin bilaterally to mid-calf level. Both lower limbs were cold and pale with absent pulse below femoral level. Vascular surgery input was immediately sought and CT angiogram performed on the day of transfer (see section 8 for more details). Following transfer to Vascular surgery the patient underwent bilateral above Personal on 22.11.2016.	21.12.16 Anne McVey Dr Philip Murphy Mrs Trudy Reid	21.12.16	N/A	Dr Alexander John Mr Lewis Mrs Sandra Burns Sr Leonard	15.2.16	N/A	No	Personal	9.1.18		3.5.17	5.1.18	8.1.18	No request for copy of report	27.2.18		No	No
CC	6.1.16	SEC	6.1.16	Pers	Person al	Had a CT scan 24/6/2014 as follow-up of bowel cancer. CT showed an abnormal renal cyst with two further cysts in the right kidney.US performed 24/7/2014 showed solid elements within the anterior lower pole cyst and recommended an MRI to further evaluate.MRI performed 2/9/2014 Referral to Urology was not triaged on receipt Pers sent OP appointment for 6/1/2016. Pers was seen in clinic on 6/1/16. The sequence of events was outlined and surgical treatment of a suspected cystic renal cancer recommended after completion of up to date staging with a further CT scan. There has been a resultant 18 month delay in OP review and recommendation of treatment for a suspected kidney cancer.	15.3.16 Eamon Mackle Heather Trouton Connie Connolly	22.3.16		Mr Anthony Glackin Dr David Gracey Mrs Katherine Robinson Mrs Connie Connolly	14.6.2016	4.4.2016	N	Personal Information redacted	16.3.17 Letter advising report complete 6.1.16 Mr Haynes advised patient at appointment SAI being conducted.			10.2.17	16.3.17	31.3.17 meeting confirmed for 10.4.17 to meet with Pers 30.3.17 report issued to Pers	20.1.18	To HSCB		

TR	15.1.18	MUC	28.2.18	Pers	Personal Infor	Personal Information with a background of recent gastric cancer treatment who was admitted via the Emergency Department (ED) in Craigavon Area Hospital (CAH) with haemoptysis and left sided chest pain. She was found to have metastatic cancer and subsequently developed bilateral subdural haematomas, disseminated intravascular coagulation and thrombocytopenia which were felt to be secondary to her metastatic cancer. Pe was admitted to CAH on 15 January 2018 with a two to three day history of haemoptysis and left sided chest pain. On admission there was concern about a possible pulmonary embolism (PE) and she received a dose of Enoxaparin 80mg (at this point Pe had platelets of 42). However a Computerised Tomography Pulmonary Angiography (CTPA) did not demonstrate a pulmonary embolism but did demonstrate skeletal metastases. Pe had low platelets and was resuscitated with multiple platelet infusions and cryoprecipitate On 16/1/2018 Pe complained of a headache and she had a Computerised Tomography of Brain (CTB) which demonstrated bilateral subdural haematomas and cerebral oedema. Her case was discussed with Neurosurgery who felt that intervention at this point was not appropriate. Pe died on 25/01/2018 Following discussion with the Coroner a Medical Certificate of Death was issued which stated cause of death: 1. a) Bilateral subdural haematomas b) Disseminated intravascular coagulation and thrombocytopenia c) Metastatic gastric cancer 11. Hypertension; Uterine fibroids.	31.1.18 Dr P Murphy Dr U Bradley Mrs A McVey Dr G Hampton Trudy Reid Paula McAloran	11.5.18	N/A	Dr K Boyd Dr M Feenan Trudy Reid	6.7.18	N/A	Yes 25.1.18	Personal	19.7.18 sent registered post 1.3.18 Letter returned on 13.4.18 "not called for"		8.1.18	8.6.18	19.7.18	6.9.18 Meeting with Family 1.8.18 issued registered post.	24.8.18			
TR	11.5.17	MUC	12.5.17	Pers	Personal	Personal presented to ED via ambulance – initial diagnosis Acute Kidney Injury, while in ED she fell of the ED trolley rails (over trolley safety rails) onto the floor (unwitnessed fall). Patient sustained C1 burst fracture (Jefferson fracture) and left occipital condyle fracture. Patient was transferred to Royal Victoria Hospital for management of her spinal fracture.	5.4.17 Dr P Murphy Dr G Hampton Mrs Ann McVey Trudy Reid	5.6.17	N/A	Dr Eleanor McCormick Dr Damian Gormley Paul Smith Trudy Reid		N/A	No	Personal Information redacted by	8.3.18 advising family report complete 5.7.17 following complaint from family		21.9.17	9.2.18	8.3.18	10.5.18 report issued	28.8.18		No	No

Received from Trudy Reid on 16/05/2023. Annotated by the Urology Services Inquiry.

All Legacy SAI's Closed

Incident date	Datix ID	Patient Initials	Description of incident	SAI Review Team Chair & Members & Coordinator	Date report submitted to Board	Date case Closed
4.10.10	Per	Personal	Personal Information redacted by the USI ICU patient was seen on ward round and it was decided to insert a chest drain for right pleural effusion following examination of x ray and pleural tap which drained fluid. Insertion of the chest drain was attempted by two of the clinical team but was unsuccessful. The patient's condition deteriated, a senior clinician was called and successfully inserted a chest drain which drained approx. 600ml of blood and fluid. The patient's condition stabilized for a short period and then deteriated again. The surgical team decided to perform a laparotomy but unfortunately the patient arrested and died as they were being prepared for theatre.	Dr R Convery. Dr N Rutherford Jones Dr S Hall Mr Ronan Carroll Ms L Lennon Mrs B Moonan	7.7.11	13.3.12
15.6.11	Personal Informatio	Personal	A Personal Information redacted by the USI was admitted to CAH ED on the 20th March 2013 at 08:28 hours following a road traffic accident with Head, chest and lower limb injuries. Ongoing resuscitation in process. Tragically resuscitation was unsuccessful and Personal Information was pronounced deceased at 09:07 hours on the 20th March 2013.	Dr Don Hull Dr Graham Scott Mrs Patricia Watt Tom McGarey Sister Sharon Holmes	23.9.11	7.12.11
5.10.11	Personal Informatio	Personal	Patient admitted for emergency surgical procedure. Immediately on completion of the procedure, patient had cardiac arrest. Resuscitation attempted. Patient died.	Mr R Hannon Dr M Morrow Mrs M McGeough Mrs T Reid Mrs M Marshall	24.5.12	6.7.12
13.10.11	Personal Information	Audio incident	The NHSP clerical officer alerted NHSP Co-ordinator about a recording result on Personal Information screened on 28.9.10. The recording and the result did not match. Co-ordinator confirmed this. She proceeded to check results from the previous and discovered there were others.	Mrs A Davidson Ms A McGarry Ms A Watson Mrs M Marshall	23.3.12	4.10.12
15.10.11	Personal Informatio	Personal	Patient attended Daisy Hill Hospital Emergency Department via ambulance on 15/10/11 following a fall. Patient was assessed in the Emergency Department and admitted to a ward for observation. The patient's condition deteriorated overnight and was transferred to Royal Victoria Hospital. The patient subsequently died.	Dr J Harty Mr G Hewitt Mr S O'Reilly Dr A Ferguson Sr S Mulligan Sr S Holmes Mr B Conway Mrs H Trouton Mrs M Burke Mrs M Marshall	20.1.12	1.5.14
11.8.11	Personal Informatio	Personal Information	Baby born normal delivery and died approx. 2 hours post delivery in Neonatal Intensive Care Unit	Mrs A McVey Dr A Morsy Sr S Thompson Mrs A Donnelly Mrs P Kingsnorth Mrs M Marshall	6.4.12	23.5.12
8.1.11	Personal Informatio	Personal Informatio	Patient in DHH hospital sustained a fall from bed on 08/07/11. Deterioration in patient's condition following fall. CT scan carried out on the 09/07/11 Subdural Haematoma observed. Patient died on 15/07/11.	Dr Raeburn Forbes Mrs Burke Sr M Hamill Mrs M Marshall	20.1.12	1.5.14
27.10.11	Personal Information	Personal Information	Patient was admitted to HDU via Accident and Emergency in Daisy Hill Hospital. The patient had sustained multiple fractures, heamothorax of left lung and small subdural haematoma following a road traffic accident. Following assessment and treatment the patient was transferred to the RVH. It has been reported that on arrival the patient's condition had deteriorated. The patient's condition has now stabilized.	Dr J Hinds Mr S O'Reilly Mrs H Trouton Mrs M Marshall	19.3.13	6.11.13

25.10.11	Personal Information	Personal	CT and bone scan were undertaken on a patient who did not require these investigations.	Mr Young Dr Fawzy Mrs A Davidson Mrs D Newell Mrs M Marshall	6.4.12	23.5.12
28.12.11	Personal Information	Personal	Patient attended ED DHH on the 28/12/11. The patient had a history of chest pain and had been feeling generally unwell. Following assessment and treatment the patient was discharged. The patient subsequently died at home.	Dr U Bradley Mr S O'Reilly Sr Sharon Holmes Mrs M Marshall	18.5.12	6.7.12
13.3.12	Personal Information	Personal	Personal Information redacted by the USI was transferred from A&E to MAU on 13/03/12. Noted to have breeched time in A&E. On transfer to MAU, the patient was noted to have hypotension and hypoxia. Working diagnosis was chest sepsis. An arterial blood gas was performed, which demonstrated a worsening metabolic acidosis, compared to that documented in A&E. The only action taken at this point was to stop metformin. During the period of 1810 to 1945, the patient was documented as having "unrecordable" BP and pulse rate in MAU. It was also documented that they were "unable to get" oxygen saturations during this time period. There is no documentation of any intervention during this period, in the medical notes. It was only following this prolonged period, that ICU were contacted and made aware of the patient. This was seen to be a delayed admission to ICU.	Mr C O'Toole, Dr S Moan, Dr R McKee, Mrs E Murray Mrs C Armstrong, Mrs M Marshall,	22.10.12	15.11.12
7.9.12	Personal Information	Personal Information	Patient had Laparotomy and Ileo caecal resection carried out in DHH on the 05/09/12. Subsequently the patient became unwell and following x ray on the 07/09/12 'a X ray detectable swab' was noted. The patient returned to theatre and a laparotomy was carried out.		24.12.12	29.10.13
14.5.12	Personal Information	Personal Information	Patient attended Emergency Department on the 9/04/12 and the 11/04/12. Following assessment of the patient on the 11/04/12 the patient was admitted for investigation and treatment of a painful left buttock. The patient's condition deteriorated resulting in admission to ICU on the 14/05/12. The patient died on the 15/05/12. As this was a sudden unexpected death the Southern Trust wish to submit this incident as an SAI in order to establish possible areas of learning relating to the patients treatment and care.	Dr Harty Chair Mr J Bunn Mrs H Trouton Mrs D Burns Mr Alistair Taggart Dr G Glynn Dr D Swain Mr G Hewitt Mrs M Marshall	9.8.13	6.11.13
22.12.12	Personal Information	Personal Information	Patient admitted for an elective ERCP on 13/12/12. Following the procedure the patient complained of pain and was admitted for observation and investigations. The patient's condition deteriorated and the patient subsequently died on the 22/12/12. The SHSCT are submitting this death as an SAI in order to establish possible areas of learning relating to the patients treatment and care.	Dr P McCaffrey Dr A Murdock Mrs M Marshall	19.11.13	30.1.14
23.2.13	Personal Information	Personal	Patient attended ED DHH on the 23/02/13 complaining of back pain. Following assessment the patient was discharged. Patient presented at ED on the 26/02/13 at 17.39hrs having suffered a cardiac arrest at home. The patient was pronounced dead at 17.50hrs. The Southern Trust wish to submit this incident as an SAI in order to establish possible areas of learning relating to the patients treatment and care.	Dr H Nicholl Mr A Lewis Mr B Conway Mr Paul Smyth Miss P Fearon	3.10.13	9.1.14
4.3.13	Personal Information	Personal	After induction of anesthesia cardiovascular collapse occurred, CPR was commenced at 11.59 hours. Arrest alarm in theatre activated and assistance was obtained from ICU and other theatres. Despite effective CPR, all intervention, cardiology advice and maximum therapy there was no improvement. Resuscitation attempts were discontinued at 13.12 hours.	Dr N Rutherford Jones, Sr P Fitzpatrick Mr D Sim Mrs L Fegan	2.10.13	3.9.14
18.6.13	Irrelevant information	Infection Control	When setting up the ISIS (AER)for self-disinfect at the end of an endoscopy list, it was discovered that in the chemical drawer of the machine there were 2 activator disinfectant bottles instead of a base and an activator.	Ms M Wilson Mrs H Trouton Miss P Fearon	8.10.13	CLOSED
5.5.13	Personal Information	Personal	Personal Information redacted by the USI attended ED CAH 31.10.12. Patient had chest X-ray carried out and review and followup were requested. Patient presented to ED 5.5.13 following further investigation patient was diagnosed as having a lesion on the lung.	Dr S Moan Dr G Hampton Dr Munir Ahmed Miss Paula Fearon	9.8.13	29.11.13
24.11.13	Personal Information	Personal	A Personal Information redacted by the USI was admitted to CAH ED department at approximately 18:30hrs on the 24/11/2013 via ambulance following a collapse at home. The patient suffered a cardiac arrest on route, resuscitation was unfortunately unsuccessful. The patient was pronounced deceased at 23.20hrs. The NIAS have been made aware of this notification and a joint review of the incident is planned. This incident will be referred to the HSCB re 4.2.2 of SAI criteria. The death was reported to the coroner. Preliminary post mortem results have identified no cause of death. Initial toxicology screening is negative however the results of the full toxicology result will not be available for approximately 6-8weeks. In view of the toxicology results to date there is no indication at present that the death was 'substance related'This incident is being referred as an early alert as the patient was Personal Information and the cause of death is as yet unknown.	Mr E Holmes Dr L Lavery Mr P Smyth Sr S Holmes Mr T McGarey Mr R McKee Mrs M Marshall Miss P Fearon Mrs L Fegan	24.3.14	6.6.14

26.11.13	Personal Information	Personal	A Personal Information redacted by the USI presented at the ED department, accompanied by the PSNI at 23.16hrs. Prior to presentation to ED the patient had been behaving strangely and had admitted to the PSNI that he had taken 'speed'. On admission the patient was agitated and confused. The patient remained, accompanied by the PSNI in ED and the behavior settled. Following assessment a 'card before you leave' was given to the patient. The patient was discharged from the ED at 02.00hrs following assessment and discussion with liaison mental health service.At approximately 13.00hrs on the 26/11/2013 the ED became aware that the patient had assaulted a member of the public.	Mr E Holmes Sr S Holmes Dr N Chada Mr A Ruck	26.6.14	8.7.14
20.10.12	Personal Information	Personal	Presented at ED on 20/10/2012 complaining of a tender left calf. At the time a diagnosis was made of superficial thrombophlebitis. Patient returned to ED on 28/10/2012 and presented in cardiac arrest. Resuscitation was commenced but tragically the patient died.	Dr G Hampton Mr J Hinds Mr P Smyth Miss P Fearon	3.2.14	24.2.14
2.1.14	Personal Information	Personal	Delay in calculation of fluid deficit and therefore Glycine absorption due to lack of familiarity with equipment		13.8.14 requested to stand down SAI	9.9.14
8.1.14	Irrelevant information	Assault on Nurse	On 8.1.14 at approx 22.00 hrs a nurse reporting for her shift in CAH site was allegedly assaulted by two males in the carpark at CAH.PSNI immediately notified and are currently investigating the incident.	Mrs S Carroll Mrs K Corley Mrs M Avreill Mrs C Campbell Ms R King Mr C Maguire Mrs M Wilson Mrs H Walker Mrs L Fegan	9.4.14	1.5.14
30.9.13	Personal Information	Personal	A Personal Information redacted by the USI had elective mastoid surgery undertaken in Sept 2013 in SHSCT. He was subsequently readmitted to SHSCT OM 03/10/13 with a left temporal lobe abscess. He was transferred to the Royal Victoria Hospital ICU on the same day. Whilst a patient in the Royal Victoria Hospital the patient has required significant further surgery and prolonged antibiotic treatment of the abscess followed by a craniotomy and repair of the skull defect. The patient also developed post-operative meningitis requiring further antibiotics.	Mr DG Quigley Mr J G Toner Mrs Trudy Reid Mr Hall Mr McNaboe Sr Linda Murphy Miss P Fearon	9.2.15	16.3.15
2.4.14	Personal Information	Personal	Following discharged from ICU on to a Surgical Ward the patients clinical observations (NEWS) scores were recorded from admission. The patient's condition showed signs of deterioration whilst on the ward resulting in re admission to ICU. The Southern Trust wish to submit this incident as an SAI in order to establish areas of learning relating to the recording of NEWS scores and subsequent actions.	Dr R McKee Mrs K Carroll Sr S Mulligan Dr J Ong Miss P Fearon	19.9.14	1.5.15
20.3.14	Personal Information	Personal	A Personal Information redacted by the USI was admitted to CAH ED on the 20th March 2013 at 08:28 hours following a road traffic accident with Head, chest and lower limb injuries. Ongoing resuscitation in process. Tragically resuscitation was unsuccessful and Personal Information was pronounced deceased at 09:07 hours on the 20th March 2013.	Dr Paul McGarry Dr Don Hull; Mr Graham Scott; Mrs Patricia Watt; Sr Sharon Holmes; Mr Tom McGarey Miss Paula Fearon	14.10.14	18.11.14
18.4.14	Personal Information	Personal	A Personal Information redacted by the USI was referred to ED on the 17th April 2014 by his GP with abdominal distention query obstruction. The patient was diagnosed as having chronic constipation and discharged home. On the 18th April 2014 the patient presented at ED via ambulance following a cardiac arrest. Resuscitation was carried out in the ED department but were unsuccessful and the patient was pronounced dead in the ED department.	Dr P McGarry Dr P Rice Mr M Yousaf Mrs H Trouton Mr A McIlwee Mrs L Fegan	3.7.14	26.3.15
23.6.14	Personal Information	Personal Informatio	Smear possitibe TB in Personal Information redacted by the USI. Potential delay in diagnosis.			Deescalated on 26.1.15 per MM
10.3.14	Personal Information	Personal	Patient notted to be off cardiac monitoras tracing stopped coming through.Monitor room nurse alerted nurse to check patient who found him sitting at the side of the bed with monitor leads on floor and central line in his hand. Nurse called for help, patient aggitated, assisted into bed, patient collasped. PEA with arrest team present with anaesthetist. Aspiration via central line unsuccessful and patient resuscitation unsuccessful.	Dr D Scullion Dr D McCaul Mrs C McGoldrick Mrs L Fearon	19.9.14	22.12.15 DRO queries closed 2.10.14

13.4.14	Personal Information	Personal	The Southern Health and Social Care Trust have identified a delay in the transfer of body tissue from the hospital mortuary to the Department of Neuropathology, Royal Hospitals Belfast, for onward transfer to a Brain Bank. This Tissue was donated by the patient and their family for the purpose of research. The incident will be reported to the Human Tissue Authority within two days.	Mr B Magee Dr G McCusker Dr J Heaney Dr Raeburn Forbes Mr D Smart Miss P Fearon	19.9.14	31.10.14
20.2.14	Personal Information	Personal Information	Patient attended ED CAH on the 20th March 2014. The patient presented unwell with a history of cellulitis, vomiting and diahorrea Following assessment and treatment the patient was transferred to 1 West. The patient's condition continued to deteriorate and the patient subsequently suffered a cardiac arrest, resuscitation was commenced but was tragically unsuccessful.	Dr S Moan Dr C Clarke Dr C Daly Mr D Gilpin Mrs E Murray Dr T Boyce Miss P Fearon	11.12.14	11.12.14
23.12.12 CYP/Acute	Personal Information	Personal	Personal Information redacted by the USI admitted to DHH on 22 December 2012 with adbominal pain and vomiting with a past history of asthema. A review was undertalen by the Emergency Department and Surgery. Personal Information was transferred to the care of the Paedritcians, and admitted as an inpatient. A CT scan was requested on 23 Evening for further investigation of abdominal pain and during this procedure the patients condition actually deteriorated. Prolonged resustitation was carried out however tragically Personal Information subsequently died.	Mr M Epanomeratikis Dr M Smith Dr D Gracey Dr J Hynds Mrs Anne McVey Mrs Bernie McGibbon Emma Laird Francesca Leyden Mrs Margaret Marshall	19.9.14	13.10.14
8.12.13 CYP/Acute	Personal Information	Personal	Personal Information redacted by the USI arrived in the ED department CAH at approximately 15.50hrs accompanied by Personal Information redacted by the USI . On presentation Personal Information was not breathing and was unresponsive. Resuscitation commenced at 15.50hrs. Tragically Personal Information was pronounced deceased at 17.00hrs.	Dr B Aljarad – (Chair) Dr Brian Craig Dr Gary Doherty Dr Karen McKinney Mr C O'Toole Patricia McStay Julianne Lee Margaret Marshall Daphne Johnston Paula Fearon Anne McMullan	23.1.15	2.1.15
10.5.12	Personal Information	Personal Information	The patient was admitted to CAH on the 06/05/12 and following investigation a diagnosis was confirmed as myocarditis. The patient's condition deteriorated resulting in admission to ICU on the 10/05/12. The patient died on the 10/05/12.	Mr S Hall Dr P Donnelly Dr M Nelson Mrs A McVey Mrs M Marshall Independent Mr N Bailie Dr D Edgar	22.10.13	29.10.15
8.8.12	Personal Information	Personal Information	A Personal Information redacted by the USI presented with abdominal pain and weight loss over a 12 month period.During this time 3 CT scans of the patient's abdomen and an MRI small bowel study were carried out and reported on. It transpired that an abnormality in the patient's upper abdomen was present and not correctly reported. During this time frame the patient was under the care of several specialties Following the outcome of an internal review of the case the SHSCT wish to submit it as a SAI as several areas of learning have been identified.	Dr T Tham Mr W J Campbell Dr E Napier Miss P Fearon	18.2.14	29.10.15
4.7.14	Personal Information	Personal	The patient presented at the ED department on the 04/07/14 with a history of a chest infection and was subsequently admitted to a medical ward. The patient's condition deteriorated following admission and the patient subsequently died on the 04/07/14. The patient had a complicated medical history and was very ill on admission.	Dr Paul McKeveney Mrs Eileen Murray Dr Iqbal Ms Charlotte Wells	30.09.15	29.10.15

12.3.14	Personal Information Personal	Chest x-ray carried out preoperatively prior to a surgery following a fractured neck of femur on the 12/03/14. Patient discharged following surgery and re admitted on the 26th May 2014 with SOB and reduced stats. Further chest x-ray showed right pleural effusion and suspicious lesion. The pre-operative x-ray report suggested possible lung cancer however a delay in the management of the patient occurred due to possible communication and/or process issues.	Mr Timothy Doyle, Dr Gail Browne Dr Hilda Nicholl, Ms Wendy Clayton Mrs Anita Carroll, Mrs Loretto Fegan	29.9.15	
21.1.14	Personal Information Personal	Patient was prescribed and administered wrong dose of insulin. Patient was admitted to Male Medical Ward at 00.30and. Found unresponsive at 07.10. Unsuccessful resuscitation.	Dr P Murphy Dr C Daly Mrs A McVey Dr G Redpath Ms S Henning Mrs M Marshall Miss P Fearon	17.11.14	25.8.2015
7.6.14	Personal Information Personal	The patient presented at the ED department on the 07/06/14 with a history of oliguria, and previous UTI and was subsequently admitted to a medical ward. The patient's condition deteriorated overnight and she was transferred to ICU.	Dr Raymond McKee Mrs Anne McVey Mr Paul McGarry Mr Paul Sheridan Dr Seamus Murphy Ms Charlotte Ann Wells	14.11.14	9.7.15
17.2.14	Personal Information Personal	The patient has been under the care of urology since 2001.On the 17/02/14 he was admitted to 3 South CAH where Personal Information redacted by the USI on the 18/02/14. The patient has been known to mental health services since 2010. The Southern Trust wish to submit this incident as an SAI in order to establish possible areas of learning relating to the patients treatment and care.	Mr M Young Dr C Clarke Mr P Sheridan Mr A Corrigan Mrs D O'Loan Mr T Black Dr J Minay Mrs L Fegan	24.10.14	3.12.15

Reporting Division	Date Reported on Datix	Datix ID	Patient Name	HCN	Description of incident	Date screening meeting Screening Team	Date case Closed	Current Status
SEC	16.11.17	Personal Information	Personal Information redacted by the USI	Personal Information redacted by the USI	Patient wrongly Identified			Sharing letter being drafted.

Received from Trudy Reid on 16/05/2023. Annotated by the Urology Services Inquiry.

ACUTE SERVICES - SAI Recommendations

Date recommendation completed with evidence

SAI Number	Patient	Location of incident	Location report	Date Approved	Description of Incident	Deceased	Level	Responsible Division	Recommendations	Action Plans	Lead	Timeframe	Updates	Date Recommendations complete with evidence.	SAI Report	Coroner Inquest Date
Perso	Personal	ED CAH	ED CAH	May-14	A Personal presented at the ED department, accompanied by the PSNI at 23.16hrs. Prior to presentation to ED the patient had been behaving strangely and had admitted to the PSNI that he had taken 'speed'. On admission the patient was agitated and confused. The patient remained, accompanied by the PSNI in ED and the behavior settled. Following assessment a 'card before you leave' was given to the patient. The patient was discharged from the ED at 02.00hrs following assessment and discussion with liaison mental health service.At approximately 13.00hrs on the 26/11/2013 the ED became aware that the patient had assaulted a member of the public.	No	2	MUC	**Recommendation 1 -** The purpose and procedure for using CBYL scheme must be reviewed in tandem by the Psychiatric and ED services. The pathway must be clarified.				Document			No
Perso	Personal	ED CAH	ED CAH	02/05/2014		No	2	MUC	**Recommendation 2 -**Training should be undertaken with Nursing and Medical staff within all Southern Trust EDs and Psychiatric Referral Services regarding "The Mental Health Risk Assessment Tool" and CBYL protocol and pathway.							
Perso	Personal	ED CAH	ED CAH	02/05/2014		No	2	MUC	**Recommendation 3 -**Training must be undertaken with ED in relation to completion of required documentation in relation to the Mental Health Assessment							
Perso	Personal	ED CAH	ED CAH	02/05/2014		No	2	MUC	**Recommendation 4 -** All discussions with Psychiatric personnel must be fully documented in the medical notes							
Perso	Personal	ED CAH	ED CAH	02/05/2014		No	2	MUC	**Recommendation 5 -** Referral for Psychiatric Assessment must be clearly requested by the ED doctor and recorded in the patient's medical notes.							
Perso	Personal	ED CAH	ED CAH	02/05/2014		No	2	MUC	**Recommendation 6 -** Currently there is an ongoing review into the Mental Health Liaison Service within Northern Ireland. The ED and Psychiatric services must communicate regarding the outcome/s of this to ensure a cohesive patient service..							
Perso	Personal	Cath Lab CAH	Cath Lab CAH	02/05/2014	Personal attended the Emergency Department (ED) of Daisy Hill Hospital (DHH) at 18.45 on 02/07/13. The ED Flimsy records Per presenting complaint as chest pain; with a discriminator of "query cardiac pain". The triage text indicates pain was present from 09.00 that morning.	Yes	2	MUC	**Recommendation 1 -** The external Cardiologist recommends that the ED in DHH reviews procedures for review of ECG tracings and lysis administration in order to eliminate delays.							
Perso	Personal	Cath Lab CAH	Cath Lab CAH	02/05/2014		Yes	2	MUC	**Recommendation 2 -** It is recommended that the requirement to fully complete the administration section of the ED Prescription is reinforced with all staff that uses this record							
Perso	Personal	Cath Lab CAH	Cath Lab CAH	02/05/2014		Yes	2	MUC	**Recommendation 3 -** It is recommended that prior to transferring a patient into the care of ambulance crew or another service the nurse who is in charge of the patient's care in the transferring ward should document a nursing summary of: where the patient is going; for what reason; and the patient's condition at time of transfer.							
Perso	Personal	Cath Lab CAH	Cath Lab CAH	02/05/2014		Yes	2	MUC	**Recommendation 4 -** For non-emergency procedures full dual anti-platelet therapy should be administered prior to arrival at a Cath Lab. Absorption time must be factored into the prescription administration schedule. The review team suggests current protocols should be reviewed to reflect this.							
Perso	Personal	Cath Lab CAH	Cath Lab CAH	02/05/2014		Yes	2	MUC	**Recommendation 5 -** It is recommended that the requirement to fully complete the administration section of the Prescription Record is reinforced with all staff that use this record within the Cath Lab.							
Perso	Personal	Cath Lab CAH	Cath Lab CAH	02/05/2014		Yes	2	MUC	**Recommendation 6 -** It is the view of the external Cardiologist that, due to the complexities of the procedure, consideration should be given to stipulate the Grade of Doctor who discusses the procedure and completes the Consent form with the patient. The grades of Specialist Registrar or Cardiac Consultant are suggested.							
Perso	Personal	Cath Lab CAH	Cath Lab CAH	02/05/2014		Yes	2	MUC	**Recommendation 7 -** The Review Team requests that the Consent Form for Cardiac Catheterisation is reviewed so that consideration is given to stipulating the small risk of death on the Consent Form.							
Perso	Personal	Cath Lab CAH	Cath Lab CAH	02/05/2014		Yes	2	MUC	**Recommendation 8 -** The external view is that images should be undertaken during catheterisation procedures and that mechanisms should be put in place to reduce the likelihood of images being lost. The review team are aware that this recommendation has already been addressed within the Cath Lab.							
Perso	Personal	Cath Lab CAH	Cath Lab CAH	02/05/2014		Yes	2	MUC	**Recommendation 9 -** Blood pressure/ECG readings should be recorded at no more than 5 minute…intervals during arrest/peri-arrest and emergency procedures, provided that the staff are not actively involved in resuscitation.							
Perso	Personal	Cath Lab CAH	Cath Lab CAH	02/05/2014		Yes	2	MUC	**Recommendation 10 -** All major events should be recorded with timings in sequential order and where possible contemporaneously.							
Perso	Personal	Cath Lab CAH	Cath Lab CAH	02/05/2014		Yes	2	MUC	**Recommendation 11 -** It is recommended that the requirement to fully complete the administration section of the Prescription Record is reinforced with all staff that use this record within the Cath Lab.							
Perso	Perso	ED DHH	ED DHH	02/05/2014	Personal was discovered lying at the bottom of a flight of stairs by friends. A 999 call was placed at 11.18 on 13/04/2013. The Northern Ireland Ambulance Service (NIAS) Patient Report Form indicates the ambulance arrived at 11.21.	Yes	Internal review	MUC	**Recommendation 1 -** The make-up of the Majors Trauma Team should include representation from ED, Anaesthetics, and Surgery at the level of CT4 or above.							
Perso	Perso	ED DHH	ED DHH	02/05/2014	Perso was noted to be pale and cold to touch, there was an obvious head injury with "massive blood loss". Person Blood Pressure (B/P) and Oxygen saturation levels (SaO2) were unrecordable. Pulse (P) was 122 and Respiratory Rate (RR)	yes	Internal review	MUC	**Recommendation 2 -** The Majors Trauma Team Leader should be at the Level of CT4 or above, and be clearly identified to the entire Trauma Team.							
Perso	Perso	ED DHH	ED DHH	02/05/2014	13. Glasgow Coma Scale (GCS) was 4 Perso was making incomprehensible sounds. Both pupils were dilated. They were not reacting to light. Perso had a guedel airway placed.	Yes	Internal review	MUC	**Recommendation 3 -** All documentation should be completed as contemporaneously as possible in emergency situations.							
Perso	Perso	ED DHH	ED DHH	02/05/2014	Suction was undertaken and 15 litres of oxygen per minute was commenced. A wound dressing and cervical collar were applied and Perso was placed on a spinal board. Intravenous (I.V.) access was not possible. Emergency Department (ED)	Yes	Internal review	MUC	**Recommendation 4 -** Fluid Balance and Medication Prescriptions should be completed in keeping with Trust Guidelines and Policy.							
Perso	Perso	ED DHH	ED DHH	02/05/2014	Daisy Hill Hospital (DHH) was advised to expect the patient. Arrival time at ED is recorded as 11.36 on the NIAS record.	Yes	Internal review	MUC	**Recommendation 5 -** Discussions with patients and or family members regarding both prognosis and organ donation should be clearly documented in the patient's notes.							
Perso	Perso	ED DHH	ED DHH	02/05/2014		Yes	Internal review	MUC	**Recommendation 6 -** The Review Team recommends that consideration is given to adapting the current anaesthetic recording sheet so that it may be used to record patient information in those who present to ED with Major Trauma.							

Perso	Perso	ED DHH	ED DHH	02/05/2014		Yes	Internal review	MUC	**Recommendation 7 -** Patient notes should be reserved for information pertaining to the patient. Personal differences amongst staff should be resolved informally if possible, or through the appropriate personnel or professional channels.							
Perso	Perso	ED DHH	ED DHH	02/05/2014		Yes	Internal review	MUC	**Recommendation 8 -** Junior medics should raise unresolved concerns about patient management with their senior team members. Senior team members must acknowledge and appropriately address such concerns.							
Perso	Perso	ED DHH	ED DHH	02/05/2014		Yes	Internal review	MUC	**Recommendation 9 -** Consideration should be given to undertake teaching/awareness sessions within the Directorate to reinforce the information contained within the "Policy for Organ and Tissue Donation after Death" (2013).							
Perso	Personal	Theatres STH	Theatres STH	02/05/2014	due to very poor quality of fluoroscopic images it was imposible to perform planned procedure/treatment for the patient. Pt agreed to have a different procedure which doesn't require x-ray. Pt informed this may not give same expected relief	No	Internal review	CCS	**Recommendation 1 -** Point of care testing should be available to measure serum sodium and haemoglobin							
Perso	Personal	Theatres STH	Theatres STH	02/05/2014		No	Internal review	CCS	**Recommendation 2 -** At this time TCRF should be performed in Main Theatres where point of care testing is available close by.							
Perso	Personal	Theatres STH	Theatres STH	02/05/2014		No	internal review	CCS	**Recommendation 3 -** There should be a trained nurse dedicated to recording input and output.							
Perso	Personal	Theatres STH	Theatres STH	02/05/2014		No	Internal review	CCS	**Recommendation 4 -** There should be a machine to calculate the deficit of fluid in real time (LEMKE PUMP). Training to use the LEMKE Pump is essential. The LEMKE PUMP may be used for diagnostic hysteroscopy, a low risk procedure, to allow staff to become familiar with its use.							
Perso	Personal	Theatres STH	Theatres STH	02/05/2014		No	Internal review	CCS	**Recommendation 5 -** Practice drills for TCRE and TCRF are needed.							
Perso	Personal	Theatres STH	Theatres STH	02/05/2014		No	Internal review	CCS	**Recommendation 6 -** The Standard operating procedure (SOP), procedure specific fluid monitoring chart and guidance for monitoring serum sodium levels have been drawn up							
Perso	Personal	Theatres STH	Theatres STH	02/05/2014		No	Internal review	CCS	**Recommendation 7 -** Standard Operating Procedure to be kept live and updated							
Perso	Personal	ED DHH	Home Treatment	06/06/2014	I was contacted by an SHO to assess a patient in a&e DHH at 20.00, the patient had received sedation at 18.00, I queried if she was fit for assessment so soon after being sedated. i was advised the patient was very drowsy, i advised the SHO to call back when she was awake and fit to speak to me or consider medical admission, he agreed to medical admission. At 20.15 I recieved a call from the A&E consultant, he was very abrupt with me and demanded I attend and assess the patient and arrange her transfer to a psych bed. I agreed to attend. I went to a&e for 20.30. the patient was heavily sedated and I was unable to assess her mental state. I explained this to the ward sister who replied "I am not accepting that, you will transfer this patient to a psych bed". I explaind that was not possible as patient had not agreed to a voluntary admission, the sister would not accept what I had to say. I felt she attempted to bully me into compliing with her demand despite the legalities of the situation.	No	Internal review	MUC	**Recommendation 1 -** Establish interface meetings between mental health and ED staff							
Perso	Personal	ED DHH	Home Treatment MHD	06/06/2014		No	Internal review	MUC	**Recommendation 2 -** Develop guidance on the management of patients presenting with mental health issues to include the referral and transfer process to a psychiatric unit							
Perso	Personal	ED DHH	Home Treatment MHD	06/06/2014		No	Internal review	MUC	**Recommendation 3 -** Provide local training to facilitate medical and nursing staff in ED / medical wards regarding the role of mental health liaison staff and Home Treatment staff, relevant legislation and person centred care for patients with mental health needs							
Perso	Personal	ED DHH	Home Treatment	06/06/2014		No	Internal review	MUC	**Recommendation 4 -** Roll-out the regional self-harm pathway							
Perso	Personal	ED DHH	Home Treatment	06/06/2014		No	Internal review	MUC	**Recommendation 5 -** Ensure patients are registered on arrival to ED							
Perso	Personal	ED DHH	Home Treatment MHD	06/06/2014		No	Internal review	MUC	**Recommendation 6 -** Review the ED environment to further promote safety, privacy and dignity for patients presenting with mental health needs							
Perso	Personal	ED DHH	Home Treatment	06/06/2014		No	Internal review	MUC	**Recommendation 7 -** Review ED security arrangements							
Perso	Personal	1 North CAH	1 North CAH	28/10/2014	Patient noted to be off cardiact monitor as tracing stopped coming through. Monitor room nurse immediately alerted nurse to check patient who found him sitting at the side of the bed with monitor leads on floor and central line in his hand. Nurse called for help; patient aggitated; assisted into bed. 00:13 patient collapsed. PEA arrest with team present plus anaesthetist. Likely cause of arrest felt to be air embolism. Aspiration via central line unsuccessful and patient resusitation unsuccessful. (NB Central line had been blocked ? from the 08/06/14 -not removed. Peripheral line had been used for IV antibiotics.	Yes	2	MUC	**Recommendation 1 -** Central venous catheters (central lines) should not be in situ without clinical indication.							
Perso	Personal	1 North CAH	1 North CAH	28/10/2014		Yes	2	MUC	**Recommendation 2 -** Review policy / procedure regarding the management of central venous lines in accordance with evidence based practice.							
Perso	Personal	1 North CAH	1 North CAH	28/10/2014		Yes	2	MUC	**Recommendation 3 -** Include the management of central venous lines in the newly developed Trust guidelines website.							
Perso	Personal	1 North CAH	1 North CAH	28/10/2014		Yes	2	MUC	**Recommendation 4 -** Provide update training for registered nurses in relation to the management of central venous catheters.							
Perso	Personal	1 North CAH	1 North CAH	28/10/2014		Yes	2	MUC	**Recommendation 5 -** the central line pathway to include a prompt to escalate removal of a central venous catheter when it is no longer fit for purpose or if it is not required.							
Perso	Personal	ED CAH	ED CAH	03/102014	A female patient was referred by her GP to the ED Department CAH on the 22/08/2014 with a 4 day history of chest pain. Following assessment the patient was referred to the rapid chest pain clinic. Tragically on the morning of the 23/08/14 the patient was found deceased in her bed. The SHSCT wish to submit this case as an SAI in order to establish areas of learning relating to the patients treatment and care	Yes	1	MUC	**Recommendation 1 -** In patients with a strong family history AND a classic history of cardiac pain even with normal initial investigations (ECG/Bloods), consideration should be given to admission							
Perso	Personal	ED CAH	ED CAH	03/10/2014		Yes	1	MUC	**Recommendation 2 -** The findings of SAI reviews must be shared with the Chairs of Morbidity & Mortality Meetings for dissemination							
Perso	Personal	Community	Community CYP	03/10/2014	A Personal was admitted to CAH ED on the 20th March 2013 at 08:28 hours following a road traffic accident with Head, chest and lower limb injuries. Ongoing resuscitation in process. Tragically resuscitation was unsuccessful and Pe [redacted] was pronounced deceased at 09:07 hours on the 20th March 2013.	Yes	1	MUC	**Recommendation 1 -** Following a traumatic event, de-briefing sessions to: review event; support staff; and learn from traumatic events should occur on the day of the incident and should be led by the senior nurse and clinician involved in the case.							
Perso	Personal	Community	Community CYP	03/10/2014		Yes	1	MUC	**Recommendation 2 -** To ensure clear communication among all the stakeholders (ED /Blood Bank / Portering), the process for ordering "O negative" blood should be further developed to ensure agreed terminology is used to describe the situations when "O negative" blood is required, and the arrangements for the ordering and collection of this.							
Perso	Personal	Community	Community CYP	03/10/2014		Yes	1	MUC	**Recommendation 3 -** Display Red Alert pathway in prominent place in ED							
Perso	Personal	Community	Community CYP	03/10/2014		Yes	1	MUC	**Recommendation 4 -** Red Alert drills must be carried out in ED.							
Perso	Personal	3 South CAH	3 South CAH	03/10/2014	The patient has been under the care of urology since 2001.On the 17/02/14 he was admitted to 3 South CAH where Perso [redacted] on the 18/02/14. The patient has been known to mental health services since 2010. The patient was found yelling in the toilet, staff went into the toilet to attend the patient. Personal Information redacted by the USI [redacted]	No	1	SEC	**Recommendation 1 -** Any discussion in relation to the possibility of a tertiary referral to treatment provided outside the Southern HSC Trust should be only consultant led.							
Perso	Personal	3 South CAH	3 South CAH	03/10/2014		No	1	SEC	**Recommendation 2 -** The Trust's Procedure for the Management of a Patient being Absent without Leave from a Hospital Environment should be fully implemented as follows:							

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28067	Powell Martin	3 South CAH	3 South CAH	03/10/2014		No	1	SEC	**Recommendation 3 -** As part of the induction process when patients are admitted, patients should be made aware that whilst they are at liberty to leave and return to the ward at any time, it must be planned and agreed with the nurse in charge							
28067	Powell Martin	3 South CAH	3 South CAH	03/10/2014		No	1	SEC	**Recommendation 4 -** When patients leave the ward without indicating to staff their intention to do so and / or if a family member expresses concerns, this should be acted on immediately and a search commenced.							
28067	Powell Martin	3 South CAH	3 South CAH	03/10/2014		No	1	SEC	**Recommendation 5 -** When a patient absconds and subsequently returns to the ward, regardless of their demeanour, a conversation should take place with the patient to provide the patient with the opportunity to explain their rationale for leaving the ward							
28067	Powell Martin	3 South CAH	3 South CAH	03/10/2014		No	1	SEC	**Recommendation 6 -** Staff should ascertain from the patient / their relatives how they wish to have their complaints / concerns responded to, informally or via a formal written response from the Trust.							
28067	Powell Martin	3 South CAH	3 South CAH	03/10/2014		No	1	SEC	**Recommendation 7 -** In cases where patients' clothing is heavily stained, staff should sensitively discuss with the patient / relatives regarding their preferred option for disposal / laundering.							
32716	Oliver Margaret	1 North CAH	1 North CAH	07/11/2014	The patient presented at the ED department on the 07/06/14 with a history of oliguria, and previous UTI and was subsequently admitted to a medical ward. The patient's condition deteriorated overnight and she was transferred to ICU.	No	1	MUC	**Recommendation 1 -** Strive to achieve assessment in the Emergency Department within the appropriate timescales particularly for those triaged as priority 1, 2 or 3 (based on the Manchester Triage system) and establish monitoring arrangements to show compliance against those standards							
32716	Oliver Margaret	1 North CAH	1 North CAH	07/11/2014		No	1	MUC	**Recommendation 2 -** Improve the identification and management of sepsis and septic shock both in ED and at ward level for Nursing and Medical staff by focussing on education. Consideration should be given to the development of a pathway for recognition and management of severe sepsis and septic shock and its inclusion at Junior Medical staff induction							
32716	Oliver Margaret	1 North CAH	1 North CAH	07/11/2014		No	1	MUC	**Recommendation 3 -** Ensure all relevant staff are aware of the up to date Antimicrobial prescribing guidelines and their use in conjunction with clinical triggers to determine choice of therapy: these are available on the Trust intranet and discussed at Junior Medical staff induction.							
32716	Oliver Margaret	1 North CAH	1 North CAH	07/11/2014		No	1	MUC	**Recommendation 4 -** Ensure ongoing awareness and education of the importance of the NEWS escalation protocol and guidelines among all Nursing and Medical staff.							
27137	Denny Leo	ED DHH	ED DHH	07/11/2014	On the 21/01/14 an 81yr old male presented at the ED Department Daisy Hill Hospital (DHH) with fluctuating blood sugars and a history of vomiting on route to hospital. The	Yes	2	MUC	**Recommendation 1 -** Insulin dose must be addressed in advance of or at the time of requirement							
27137	Denny Leo	ED DHH	ED DHH	07/11/2014	patient was an insulin dependent diabetic who lived alone. The patient's normal doses of Insulin were as follows: Novomix 30 in the morning/ Novomix 10 in the evening. As part of the patient's treatment plan, the patients usual does	Yes	2	MUC	**Recommendation 2 -** The terms used to describe the time at which a patient should received their pre tea time insulin dose must be standardised throughout the SHSCT.							
27137	Denny Leo	ED DHH	ED DHH	07/11/2014	of insulin were reduced by 4units in the morning and 4 units in the evening, i.e.: Novomix 26 units in the morning/Novomix 6units in the evening. On prescribing the evening dose for administration whilst in the	Yes	2	MUC	**Recommendation 3 -** The "Glucose Monitoring Chart/ Subcutaneous insulin prescription and administration" documentation must be used within the EDs of SHSCT.							
27137	Denny Leo	ED DHH	ED DHH	07/11/2014	ED department (23.15hrs)an error occurred in the amount of insulin prescribed which resulted in the morning dose of insulin (the greater dose) being administered to the patient. The patient was subsequently admitted to the ward. The patient was found unresponsiveness at 07:10HRS. Resuscitation was commenced but tragically was	Yes	2	MUC	**Recommendation 4 -** The staff who administer the insulin dose where possible must check the following with the patient *prior* to administering any prescribed insulin: Name of insulin usually prescribed & Dose of insulin usually prescribed at this time							
27137	Denny Leo	ED DHH	ED DHH	07/11/2014	unsuccessful. The death was reported to the coroner	Yes	2	MUC	**Recommendation 5 -** Patients on insulin who are in the ED at meal times must have an assessment of dietary and insulin requirements in keeping with their clinical picture. This plan must be recorded in the ED record and appropriate measures put in place to address identified need and monitor dietary intake. Meals and snacks must be provided as required.							
27137	Denny Leo	ED DHH	ED DHH	07/11/2014		Yes	2	MUC	**Recommendation 6 -** Training programmes for both Nurses and Doctors must be reviewed and altered if required to support staff learning and understanding in regards to the different types of insulin and the correct administration times for these.							
27137	Denny Leo	ED DHH	ED DHH	07/11/2014		Yes	2	MUC	**Recommendation 7 -** The established system to log mandatory training must be used and current.							
27137	Denny Leo	ED DHH	ED DHH	07/11/2014		Yes	2	MUC	**Recommendation 8 -** This should be clearly stipulated within insulin safety training for nursing and medical staff							
27137	Denny Leo	ED DHH	ED DHH	07/11/2014		Yes	2	MUC	**Recommendation 9 -** If insulin has not been given at the time at which it is usually prescribed it cannot be assumed that it is safe to prescribe at a different time. This should be clearly stipulated within insulin safety training for nursing and medical staff							
27137	Denny Leo	ED DHH	ED DHH	07/11/2014		Yes	2	MUC	**Recommendation 10 -** A Consultant to Consultant/Senior Doctor discussion must take place if there is a difference of opinion as to whether or not a patient should be admitted from ED.							
27137	Denny Leo	ED DHH	ED DHH	07/11/2014		Yes	2	MUC	**Recommendation 11 -** Verbal handover at the point of transfer from nurse to nurse and doctor to doctor takes place. These handovers must include all relevant information documented in the ED slip.							
35671	McGuigan Oannis	ED CAH	ED CAH	07/11/2014	Lady in Resus presented with pv bleeding passed large clot ? gestational sac. Clot placed on inco pad and set on dressing trolley . Nurse went to deal with another patient	No	1	MUC	**Recommendation 1** - Copies of protocol "Transfer of miscarriage/Products of Conception to laboratory" to be made available to both emergency departments	Action Completed, Protocol posted in both Daisy Hill and Craigavon ED. Protocol sent to ward sisters for dissemination.	P Kingsnorth	Complete 24.10.14				
35671	McGuigan Oannis	ED CAH	ED CAH	07/11/2014	Inco pad not on trolley when doctor from gynae came to see patient.	No	1	MUC	**Recommendation 2 -** Traceability book for collection of Products of conception to be left in both emergency departments	Book stored in sisters office CAG ED and DHH	P Kingsnorth	Complete 24.10.14				
35671	McGuigan Oannis	ED CAH	ED CAH	07/11/2014		No	1	MUC	**Recommendation 3 -** Information sessions to raise awareness of protocol for Emergency department staff to be arranged	Dr McCusker and Ann Coyle to provide information sessions for staff. First session planned for 19 Novenber 2014 for CAH ED	S Holmes S Sheridan	Ongoing 2014				
35671	McGuigan Oannis	ED CAH	ED CAH	07/11/2014		No	1	MUC	**Recommendation 4 -** Product containers to be stored in ED where staff have ready access to them	Container to be ordered form Lab. Over 12 Week box to be sourced from mortuary	P smyth	Oct-14				

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Perso	Personal Informa	2 North CAH	2 North CAH	07/11/2014	Personal Information attended ED on 26/9/2014 following a fall at home. He had a haematoma to right side of head. He subsequently was admitted as an in-patient and on 29/9/2014 the patient fell and sustained a # femur. The patient is currently undertaking a period of rehabilitation.		1	MUC	**Recommendation 1 -** Falls risk assessment section of care plan must be completed on all admissions
Perso	Personal	ED DHH	ED DHH	09/01/2015	A Personal was referred to ED on the 17th April 2014 by his GP with abdominal distention query obstruction. The patient was diagnosed as having chronic constipation and discharged home. On the 18th April 2014 the patient presented at ED via ambulance following a cardiac arrest. Resuscitation was carried out in the ED department but were unsuccessful and the patient was pronounced dead in the ED department.	Yes	2	MUC	**Recommendation 1 -** If an opinion is sought from a radiologist on a plain x-ray film then the radiologist involved should record the discussion by way of a formal written report completed either at the time of the discussion or as soon as practically possible afterwards.
Perso	Personal	ED DHH	ED DHH	09/01/2015		Yes	2	MUC	**Recommendation 2 -** General Practitioners working within the emergency department should undertake the same induction programme as other medical staff to include formal teaching on the presentation of sigmoid volvulus with reference in particular to institutionalised patients and patients with learning difficulties.
Perso	Personal	Theatres CAH	Theatres CAH	09/01/2015	A Personal had elective mastoid surgery undertaken in Sept 2013 in SHSCT. He was subsequently readmitted to SHSCT OM 03/10/13 with a left temporal lobe abscess. He was transferred to the Royal Victoria Hospital ICU on the same day.	No	3	SEC	**Recommendation 1 -** Where mastoid surgery is undertaken the operation notes should comment on the integrity or otherwise of the dura and the size of any bone defect as well as the absence or presence of CSF leak.
Perso	Personal	Theatres CAH	Theatres CAH	09/01/2015	Whilst a patient in the Royal Victoria Hospital the patient has required significant further surgery and prolonged antibiotic treatment of the abscess followed by a craniotomy and repair of the skull defect. The patient also developed post-operative meningitis requiring further antibiotics.	No	3	SEC	**Recommendation 2 -** In view of the potential for long term morbidity associated with intracranial infection the Review Team suggests all otologists should consider including the discussion of this potential complication within the consent process for atticoantrostomy.
Perso	Personal	Community	ICU CAH	09/01/2015	A Personal Information redacted by who was involved with the Trust's Home Treatment / Crisis Response Team and previously been admitted to Silverwood Ward, Bluestone Unit Personal Information redacted by the USI was admitted to the Intensive Care Unit.	No	2	ALL	**Recommendation 1 -** For patients requiring onward referral to mental health services at time of discharge from an acute ward, this should be clearly noted within the discharge checklist of the patients chart, including how and when to make this referral.
Pers	Personal	Community	ICU CAH	09/01/2015	The patient was admitted to Silverwood Ward on 2 occasions: • 26/12/2013 - 08/01/2014 after receiving input from the Home Treatment / Crisis Response Team from 11/12/2013 - 26/12/2013	No	2	ALL	**Recommendation 2 -** For patients requiring HTCR input at time of discharge, the mental health services team should obtain the patients expected date of discharge to allow prompt follow up with the ward by the HTCR team on the predicted day of discharge.
Pers	Personal	Community	ICU CAH	09/01/2015	• 11/01/2014 - 11/02/2014 (which included home leave 08/02/2014 - 10/02/2014) after receiving input from the Home Treatment / Crisis Response Team from 08/01/2014 - 11/01/2014 She was admitted back to Home Treatment on discharge from hospital from 11/02/2014 – 20/02/2014 Personal Information	No	2	ALL	**Recommendation 3 -** Ward managers should be given information for dissemination to ward staff on the immediate risk post discharge of patients where there are risks of self-harm and/or patients whose mental health has been an influencing factor in their admission to an acute ward, and how this makes the timely referral to mental health services essential.
Perso	Personal	Male Medical DHH	Male Medical DHH	06/03/2015	Personal Information admitted 16/6/2014. Found on floor at bottom of bed on 27/6/2014. The patient sustained a head injury and had a CT carried out which showed subarachnoid haemorrhage. Tragically the patient died on 30/6/2014.	Yes	1	MUC	**Recommendation 1 -** Ward managers should be given information for dissemination to ward staff on the immediate risk post discharge of patients where there are risks of self-harm and/or patients whose mental health has been an influencing factor in their admission to an acute ward, and how this makes the timely referral to mental health services essential.Nursing staff to be provided with an Update in the Falls Management Policy which now asks staff to record and link episodes of confusion or any other changes in condition in both the narrative notes as well as updating the Falls Assessment and Bed Rails Assessment,
Perso	Personal	Male Medical DHH	Male Medical DHH	06/03/2015		Yes	1	MUC	**Recommendation 2 -** The Falls Management Update will also revisit and stress the critical element of observing and recording CNS observations in relation to patients who have falls which are not witnessed by staff. Audit of CNS recording compliance will be included in the investigation of every fall by the Lead Nurses for Acute Governance,
Perso	Personal	Male Medical DHH	Male Medical DHH	06/03/2015		Yes	1	MUC	**Recommendation 3 - T**he Intentional Rounding template is utilized to record the type and level of supervision provided for the patient on an hourly basis,
Perso	Personal	Male Medical DHH	Male Medical DHH	06/03/2015		Yes	1	MUC	**Recommendation 4 -** Ward safety briefings are now recorded and filed. Falls management to be included in every safety briefing and ward meeting.
Perso	Personal	Male Medical DHH	Male Medical DHH	06/03/2015		Yes	1	MUC	**Recommendation 5 -** Training in relation to the reporting of a SAI has commenced and work is ongoing to streamline the notification and circulation element of the reporting system to reduce the delay in the notification of any SAI's
Perso	Personal	Orthopaedic Ward CAH	Orthopaedic Ward CAH	06/03/2015	A Personal who had a number of drug allergies, one of which was allergy to penicillin. The patient received a dose of IV penicillin which resulted in an anaphylaxis reaction.	No	1	SEC	**Recommendation 1 -** The prescribing doctor should get an update on medication safety
Perso	Personal	Orthopaedic Ward CAH	Orthopaedic Ward CAH	06/03/2015	Treatment for the anaphylaxis was carried out immediately and was successful.	No	1	SEC	**Recommendation 2 -** Staff nurses involved must receive a training update on Administration of Medications.
Perso	Personal	Orthopaedic Ward CAH	Orthopaedic Ward CAH	06/03/2015		No	1	SEC	**Recommendation 3 -** Nursing staff to be reminded of adherence to Trust Medicine Code.
Perso	Personal	Theatres/2 Nth CAH	Theatres CAH	06/03/2015	The patient was admitted to CAH on the 03/04/14 to a medical ward. On the 08/04/14 the patient developed abdominal pain and was taken to theatre on the 10/04/14 where he tragically died prior to surgery commencing.	No	2	MUC/SEC	**Recommendation 1 -** medical patients who require a surgical opinion should be included in the surgical handover for the surgeon of the week.
Perso	Personal	Theatres/2 Nth CAH	Theatres CAH	06/03/2015		No	2	MUC/SEC	**Recommendation 2 -** The referral process which has been agreed with the General Surgeons, which includes the level of doctor to which a referral is escalated and the response timescales. This process will form part of the Acute Directorate escalation process.
Perso	Personal	Theatres/2 Nth CAH	Theatres CAH	06/03/2015		No	2	MUC/SEC	**Recommendation 3 -** The Trust Guidelines on Verification of life extinct and protocol for actions after death have been updated and are awaiting final approval. The guidance regarding completion of the Medical Certificate of Cause of Death remains unchanged in that abbreviations are not to be used. This guidance will be cascaded to the relevant staff.
Perso	Personal	Theatres/2 Nth CAH	Theatres CAH	06/03/2015		No	2	MUC/SEC	**Recommendation 4 -** implement the revised regional DHSSPS guidance (18 April 2014) regarding reporting deaths to the Coroner.

Perso	Personal	Theatres/2 Nth CAH	Theatres CAH	06/03/2015		No	2	MUC/SEC	**Recommendation 5 -** All patients who are identified as ill should be discussed at the appropriate handover times, and a record of attendees and the discussion which took place should be retained. Processes should also be in place to ensure appropriate and timely escalation to the patient's consultant / another consultant when patients are ill.							
Perso	Personal	Theatres/2 Nth CAH	Theatres CAH	06/03/2015		No	2	MUC/SEC	**Recommendation 6 -** National Early Warning Scores (NEWS) observations, escalation process and the specific actions required should be undertaken in accordance with the Trusts guidance. News Trigger Reset should be, where appropriate, be discussed and recorded as part of the patient's management plan.							
Perso	Personal	CYP ED CAH	CYP ED CAH	06/03/2015	Per admittied to CAH ED on 8.12.13 @ 15:50hrs, died 8.12.13 @ 17:00 hrs.	Yes	2	MUC/CYP	**Recommendation 1 -** Nursing staff should record contemporaneously their assessment/care delivered/analysis/action in the notes. (as per NMC record keeping guidance).							
Perso	Personal	CYP ED CAH	CYP ED CAH	06/03/2015		Yes	2	MUC/CYP	**Recommendation 2 -** Nursing & Medical staff should analyse the Daily Fluid Balance Charts in line with the Department of Health guidelines (May 2014) and use this analysis to inform their assessment and treatment plan							
Perso	Personal	CYP ED CAH	CYP ED CAH	06/03/2015		Yes	2	MUC/CYP	**Recommendation 3 -** All nursing and medical staff treating children should be trained in the application and analysis of PEWS. Application of SHSCT PEWS guidance should be audited to ensure compliance							
Perso	Personal	CYP ED CAH	CYP ED CAH	06/03/2015		Yes	2	MUC/CYP	**Recommendation 4 -** Scenario Training regarding the resuscitation of children in ED's to take place in the ED's and to involve the staff from ED and Paediatrics who would be involved in such resuscitation events.							
Perso	Personal	1 West CAH	1 West CAH	03/04/2015	Patient booked electively for theatre on 29/12/14, procedure abandoned due to uterine perforation. Outlied to 4 north post-operatively and transferred back to gynae as became unwell 30/12/14. CT scan 31/12/14 nil of note. Condition deteriorated	Yes	1	IMWH	**Recommendation 1 -** When the decision is made for a day case patient to be kept in hospital overnight, the VTE assessment and drug kardex are to be completed.				21 .03.17 P Kingsnorth has forwarded recommendations to Dr McCormick (cc V Webb) for update			
Perso	Personal	1 West CAH	1 West CAH	03/04/2015	2/1/15, returned to theatre with surgical input. Laparotomy revealed infarcted small bowel along entire length, incompatable with life. Sent back to ward at 23:45 for palliative	Yes	1	IMWH	**Recommendation 2 -** Admitting medical staff should ensure that the pre-operative assessment is reviewed.							
Perso	Personal	1 West CAH	1 West CAH	03/04/2015	care. Death confirmed at 0230hrs.	Yes	1	IMWH	**Recommendation 3 -** Where doubt remains about a patient's anticoagulation strategy or if the planned strategy requires modification because of clinical events, input from the consultant in charge is required.							
Perso	Personal	MIU STH	ED CAH	01/05/2015	Patient on warfarin attended emergency department and diagnosed with intra cerebral bleed following head injury 2 days previously. Patient had been assessed at Minor Injury Unit on day of fall and discharged.	No	1	MUC	**Recommendation 1 -** The Trusts Emergency Nurse Practitioner Protocols for patients presenting with Head Injuries should be reviewed to ensure they have the latest guidance in relation to head injuries on anti-coagulants.							
Perso	Personal	MIU STH	ED CAH	01/05/2015		No	1	MUC	**Recommendation 2** - All patients on anti-coagulants that present to unscheduled care facilities must be asked have they suffered a head injury and this should be documented in the clinical notes							
Perso	Personal	MIU STH	ED CAH	01/05/2015		No	1	MUC	**Recommendation 3 -** Awareness of the new anti-coagulants should be raised in MIU.							
Perso	Personal	MIU STH	ED CAH	01/05/2015		No	1	MUC	**Recommendation 4 -** Emergency Nurse Practitioners should always check if patients are taking anti-coagulants and record this check and the name of the anti-coagulant in their notes.							
Perso	Personal	MIU STH	ED CAH	01/05/2015		No	1	MUC	**Recommendation 5 -** Learning from this incident should be formally shared with clinical staff in unscheduled care.							
Perso	Personal	Trauma Ward CAH	Trauma Ward CAH	01/05/2015	A Personal had surgery for a left fractured proximal ulnar and displaced radial head on 22/9/2014. Post-op instructions were to monitor for compartment syndrome. A decision was taken at 08:40 to split the backslab. The procedure was not carried out until 11:30 hours. On splitting the	No	1	SEC	**Recommendation 1 -** Guidance for nursing staff in relation to escalation of concerns regarding compartment syndrome/neurovascular compromise should be made available to all nursing staff.							
Perso	Personal	Trauma Ward CAH	Trauma Ward CAH	01/05/2015	backslab there was evidence of fasciitis and the patient had a series of operations in SHSCT and the Ulster Hospital.	No	1	SEC	**Recommendation 2 -** The sensation checking sheet should be amended to give clear advice on frequency of checks, especially if there is neurovascular compromise suspected.							
Perso	Personal	Trauma Ward CAH	Trauma Ward CAH	01/05/2015		No	1	SEC	**Recommendation 3 -** All nursing staff on the trauma ward should attend awareness sessions on compartment syndrome.							
Perso	Personal	Trauma Ward CAH	Trauma Ward CAH	01/05/2015		No	1	SEC	**Recommendation 4 -** Plasters or casts should be removed immediately if neurovascular compromise is suspected and certainly less than 10 minutes of the request for removal.							
Perso	Personal	Urology OPD CAH	Urology OPD CAH	02/03/2015	A Personal patient had a Right radical nephrectomy secondary to renal cell carcinoma in August 2012. The patient was reviewed in February 2013. In August 2014, the patient presented to GP with pain, weight loss and anaemia. A CT	Yes rip 26.1.16	2	SEC	**Recommendation 1 -** The Review Team recommends a robust system for managing overdue Uro-oncology review is established.	Designated Urology Review Clinics with specific Oncology Consultant Codes. Capacity-Nurse led follow-up for stable Urology Oncology patients-advance in conjunction with NICaN	Mr A O'Brien	Complete In Line with Regional progress				
LPP	Personal	Urology OPD CAH	Urology OPD CAH	02/03/2015	was carried out which revealed widespread metatastic disease.	Yes rip 26.1.16	2	SEC	**Recommendation 2 -** a. A handover of patient caseload is required before a consultant leaves the trust. This arrangement must be formalised and robust. B. Each consultant should have an exclusive clinic code.	A. The Southern Trust should develop a Policy for Caseload Transfer. A task and finish group should be convened to advance this. B. All Urology consultants have individual tracking codes.	Assistant Directors	A. 3 months B. Complete				
Perso	Personal	Urology OPD CAH	Urology OPD CAH	02/03/2015		Yes rip 26.1.16	2	SEC	**Recommendation 3 -** All radiology reports must be actioned if required and signed off by an appropriate person.	NIECR sign off is available. A task and finish group to be set up to undertake work list sign off for all results	Karen Weaver Siobhan Hanna					
Perso	Personal	Urology OPD CAH	Urology OPD CAH	02/03/2015		Yes rip 26.1.16	2	SEC	**Recommendation 4 -** A timely discharge letter should be dictated for every Urology patient.	Timeframe for discharge letters to be determined. Barriers, if any to achieving this should be identified and addressed.	Martina Corrigan					
Perso	Personal	Urology OPD CAH	Urology OPD CAH	02/03/2015		Yes rip 26.1.16	2	SEC	**Recommendation 5 -** The review team recommends a communication record is designed and instigated for use with Uro-oncology patients and named Key Worker	a. Advanced Communication Training for those imparting information-Urology Consultants B. A task and finish group to be set up to design and implement a communication record. C. The Trust must continue to work with Northern Ireland Cancer Network (NICaN) to ensure equitable services for all cancer groups.	Mr Tony Glackin	A. Complete B. 6 weeks				
Perso	Personal	4 North CAH	4 North CAH	02/03/2015	On 05/11/07 the patient presented to OPD with history of PR bleeding. A Barium enema was requested following her attendance. The Barium enema was performed on 04/01/08. On 25/2/08 the Consultant contacted the GP confirming that an	No	2	SEC	**Recommendation 1 -** Consideration should be given to developing and introducing an electronic system of request for endoscopy.							
Perso	Personal	4 North CAH	4 North CAH	02/03/2015	outpatient flexible sigmoidoscopy had been arranged following the findings of the Barium enema. On 30/10/13 the patient presented with a history of rectal bleeding and had a colonoscopy carried out. The colonoscopy indicated concerns of malignancy. On 12/11/13 the patient underwent a right	No	2	SEC	**Recommendation 2 -** The current requesting system should be reviewed to incorporate a stringent method for checking that endoscopy requests have been actioned by the secretarial support team.							

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Perso	Personal	4 North CAH	4 North CAH	02/03/2015	hemicolectomy and anterior resection with extensive invasion.	No	2	SEC	**Recommendation 3 -** Currently General Practitioners receive a regular bulletin from the Trust on current waiting times for each specialities' procedures/investigations. The circulation list should be expanded to include all clinicians so that they are aware of these times, so that when they are explaining the plan for a patient's on-going treatment/investigation, they can give the patient an indication of when to expect an appointment.							
Perso	Personal	3 South CAH	3 South CAH	14/09/2015	On the 25th August 2014 the patient was admitted to MAU CAH following a fall at home due to a kidney infection. On the 7th September 2014 the patient had an unwitnessed fall and it subsequently was confirmed that the patient has sustained a fractured humerous following the fall. The patient condition deteriorated and the patient subsequently died on the 14/10/14.	rip 1.10.14	2	ALL	**Recommendation 1 -** Initial assessment of elderly patients should include a screening tool for delirium.							
Perso	Personal	3 South CAH	3 South CAH	14/09/2015		rip 1.10.14	2	ALL	**Recommendation 2 -** Identification of cognitive deficits should result in a more formal cognitive assessment.							
Perso	Personal	3 South CAH	3 South CAH	14/09/2015		rip 1.10.14	2	ALL	**Recommendation 3 -** The Southern Trust should formally implement a delirium pathway.							
Perso	Personal	3 South CAH	3 South CAH	14/09/2015		rip 1.10.14	2	ALL	**Recommendation 4 -** Assessment of mobility needs to be consistent. If a patient fluctuates between independence and supervision the recommendation should be the greater level of dependency							
Perso	Personal	3 South CAH	3 South CAH	14/09/2015		rip 1.10.14	2	ALL	**Recommendation 5 -** Ward transfers for patients with cognitive impairment should be minimised.							
Perso	Personal	3 South CAH	3 South CAH	14/09/2015		rip 1.10.14	2	ALL	**Recommendation 6 -** Formal identification of high risk patients should be implemented and patients with delirium should be identified as being inappropriate for transfer unless clinical need dictates.							
Perso	Personal	3 South CAH	3 South CAH	14/09/2015		rip 1.10.14	2	ALL	**Recommendation 7 -** Transfer of a patient should include completion of the SBAR, but this needs updated to include factors such as type of walking aid required for assisted mobility, level of supervision and toileting pattern							
Perso	Personal	3 South CAH	3 South CAH	14/09/2015		rip 1.10.14	2	ALL	**Recommendation 8 -** The Post Falls Assessment should include documentation of disability. Where warranted investigations to identify/exclude associated fragility fractures should be carried out as soon as clinically possible.							
Perso	Personal	ED DHH	Trauma Ward CAH	13/11/2015	New Patient admitted from DHH via Ambulance. No notes sent with Patient, Ambulance Staff advised myself SN Anderson that the Pts BM was 2.9mmol on leaving DHH and	Yes	1	MUC	**Recommendation 1 -** All unwell patients that present to ED with type 2 diabetes should have their blood glucose checked in triage.							
Perso	Personal	ED DHH	Trauma Ward CAH	13/11/2015	the staff in A&E advised the Ambulance that they had given her a glass of milk and a biscuit and to check the BM on route, Ambulance checked the Bm 2.2mmols. On Admission to ward BM 2.6mmols, Pt was Blue in colour, sats 89%, Temp 33 BP	Yes	1	MUC	**Recommendation 2 -** Patients with hypoglycaemia should be treated according to the Southern Trust's guidelines and stablisied prior to transfer.							
Perso	Personal	ED DHH	Trauma Ward CAH	13/11/2015	104/79 P96 News=10, pt transferred onto bed and her own bedsheet from PNH was still underneath her. Oxygen 5lts via facemask applied, Glucogel given and contacted HAN #1795 and asked for immediate JHO to assess patient. Huggy bear	Yes	1	MUC	**Recommendation 3 -** The safety checks for patients that are to be transferred from ED to inpatient trauma need reviewed to ensure they are fit for purpose.							
Perso	Personal	ED DHH	Trauma Ward CAH	13/11/2015	applied to patient to try and increase temperature. S/B JHO second glucogel given then 10% Glucose given over 15mins, then 500mls Dextrose given over 6hours. News monitored	Yes	1	MUC	**Recommendation 4 -** The journey tiem of blood sampels from ED to the laboratory should be monitored and improved.							
Perso	Personal	ED DHH	Trauma Ward CAH	13/11/2015	1hourly news remains between 4-6. Pt reviewed by Trauma on call #1777 and to be reviewed again in the morning by consultant. Died 28.12.14	Yes	1	MUC	**Recommendation 5 -** Trauma ward staff should be reminded to request repeat urea and electrolyte sampling if the initial sample is haemolysed and to escalate to the night co-ordinator if they are unable to obtain blood sampling.							
Perso	Personal	ED DHH	Trauma Ward CAH	13/11/2015		Yes	1	MUC	**Recommendation 6 -** Operational management of Daisy Hill ED should ensure there is adequate senior staffing in the late evenings.							
Perso	Personal	ED CAH	ED CAH	12/10/2015	A Personal attended Craigavon emergency department on 20th March 2015 with a crush injury to his abdomen caused by a machine. He was assessed and	No	2	SEC	**Recommendation 1 -** Awareness of blunt force trauma needs to be raised in Trusts Emergency departments							
Perso	Personal	ED CAH	ED CAH	12/10/2015	subsequently discharged. He re-attended the next day with worsening pain and was discharged after assessment. He re-attended 24th March (third attendance) and was admitted to a surgical inpatient ward. He required laparotomy where a small bowel mesentery tear, ischemic small bowel, infected haematoma were detected and treated	No	2	SEC	**Recommendation 2 -** Reflection and learning should take place on and individual and team basis and that relevant team members have been involved in the analysis of the event							
Perso	Personal	4 North CAH	4 North CAH	12/10/2015	A Personal was admitted to 4 North following fall at home on 10th May 2015. She had sustained a head injury and was on warfarin. Initial CT showed no intracranial haemorrhage. She had another fall on the ward at 5am the next morning and sustained another head injury. Repeat CT showed intracranial haemorrhage. She sadly died on the 14th May	No	1	SEC	**Recommendation 1 -** Continually raise awareness of risk of patients falling in hospital.							
Perso	Personal	Trauma Ward CAH	Trauma Ward CAH	11/12/2015	A Personal was admitted via ED, CAH on 22/11/14 after a fall. She was diagnosed with # of left neck of femur, which was repaired on 23/1/14. The patient became unwell on 24/11/14 after developing post operative ileus. The patient	Yes	2	SEC	**Recommendation 1 -** Fluid balance must be correctly recorded. The information must be analysed and acted upon as appropriate by both medical and nursing staff.							
Perso	Personal	Trauma Ward CAH	Trauma Ward CAH	11/12/2015	deteriorated in the early hours of 25/11/14. Shortly thereafter the patient had a cardiorespiratory arrest. Tragically	Yes	2	SEC	**Recommendation 2 -** VTE and AKI assessment tools should be completed.							
Perso	Personal Informatic	4 South CAH	4 South CAH	11/12/2015	Personal presented with lower abdominal pain on 11/12/2011. Patient underwent elective open cholecystectomy.on 26/3/2011. On 21/7/2012 the patient presented at BHSCT with jaundice and widespread liver metastases. The BHSCT informed SHSCT of this case.	YES RIP 27.4.15	2	SEC	**Recommendation 1 -** All patients with suspected gallbladder cancer on any form of imaging must be discussed at GIT MDM with view to further management and consideration of liaising with or referring to the Specialist Hepatobiliary Team as appropriate.							
Perso	Personal Informatic	4 South CAH	4 South CAH	11/12/2015		YES RIP 27.4.15	2	SEC	**Recommendation 2 -** All relevant information must be included on radiology requests. This includes possibility of cancer from all sources, clinical, imaging, laboratory.							
Perso	Personal Informatic	4 South CAH	4 South CAH	11/12/2015		YES RIP 27.4.15	2	SEC	**Recommendation 3 -** Review and Record in report significant findings in previous Radiological investigations							
Perso	Personal Informatic	4 South CAH	4 South CAH	11/12/2015		YES RIP 27.4.15	2	SEC	**Recommendation 4 -** The planned modification to the Sectra/Pacs system to highlight urgent reports in red should be advanced and audited. Improvements should be undertaken as part of a continuous cycle of quality improvement and further developed as resources and electronic advances allow.							
Perso	Personal Informatic	4 South CAH	4 South CAH	11/12/2015		YES RIP 27.4.15	2	SEC	**Recommendation 5 -** The appropriate clinician must check all patients' pathology results on receipt post-operatively.							

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Perso	Personal	General Surgery OPD STH	General Surgery OPD STH	11/03/2016	Personal Information seen in Surgical Outpatients on 25 February 2014. There was a suspicion of a colon lesion in mid sigmoid colon. Red Flag colonoscopy to be arranged. 2 polyps removed during colonoscopy on 06 March 2014. Diagnosis: tubular adenoma, high-grade dysplasia. Repeat colonoscopy needed due to difficulties during the first procedure. Second colonoscopy performed on 05 April 2014. Third polyp removed. Diagnosis: Sigmoid polyp-adenocarcinoma. Reviewed in Surgical Outpatients on 26 August 2014. There was an unintentional 14 week delay in informing patient of diagnoses and commencing treatment.	No	1	SEC	**Recommendation 1 -** Creation of Trust-Wide Standard Operating Procedures for the clerical teams in relation to allocation of review appointment following investigative procedures. This will have to include input and support from Clinicians in all specialties to ensure that each procedure reflects each specialty's processes.						
Perso	Personal	General Surgery OPD STH	General Surgery OPD STH	11/03/2016		No	1	SEC	**Recommendation 2 -** Creation of Trust-Wide written guidance in relation to the validation of reports, results and histology by each Consultant-Lead team. This guidance will need to reflect both a Corporate and Consultant response to the governance responsibilities when managing patient results. The Operational Teams responsible for implementation of change will need to seek agreement on a basic minimum standard, as well ensure that Trust-Wide, each specialty produce any variances in writing for inclusion. Consultant and clerical annual leave/sick leave contingency planning needs to be considered.						
Perso	Personal	4 North CAH	4 North CAH	11/03/2016	Personal patient under surgical review from 16/08/13. On 17/06/14 patient was seen in Surgical Outpatients: CT colonoscopy done on 13/05/14- the examination was poor and neoplasia could not be excluded. The patient was to be reviewed in the Outpatient clinic in due course to monitor symptoms. This review did not take place. Patient then presented to CAH ED on 18/04/15 with cecal tumour and liver metastases.	Yes	1	SEC	**Recommendation 1 -** The SHSCT Acute Services continue to monitor and reduce the Surgical Review Backlog and waiting times						
Perso	Personal	4 North CAH	4 North CAH	11/03/2016		Yes	1	SEC	**Recommendation 2 -** The Trust-Wide Outpatient Consultation Rooms are furnished with the waiting times for Review patients for each Consultant on a monthly basis						
Perso	Personal	4 North CAH	4 North CAH	11/03/2016		Yes	1	SEC	**Recommendation 3 -** The Trust-Wide Outpatient Consultation Rooms are furnished with Radiology waiting times for routine procedures						
Perso	Personal	4 North CAH	4 North CAH	11/03/2016		Yes	1	SEC	**Recommendation 4 -** The SHSCT Induction includes instruction that all Doctors are expected to provide clear and precise instruction in relation to patient review. The SHSCT need to consider formally discouraging the term 'in due course' within every specialty.						
Perso	Personal	ED CAH	ED CAH	11/03/2016	Patient presented to ED after Right knee injury. Xray initially read as normal by ED Doctor. Official report available revealing fracture 48 hours later. Patient not recalled for 17 days.	No	1	MUC	**Recommendation 1 -** SHSCT Clinicians to consider making an entry in PACS detailing clinical findings and or management plan. This will support the Radiologists assessment to flag or not to flag any notable findings,						
Perso	Personal	ED CAH	ED CAH	11/03/2016		No	1	MUC	**Recommendation 2 -** Radiology Department to send electronic notification of unexpected abnormal findings to referring clinician,						
Perso	Personal	ED CAH	ED CAH	11/03/2016		No	1	MUC	**Recommendation 3 -** Ensure rapid creation and distribution for Name and Date stamp for each Emergency Department Clinician who are responsible for x-ray audit in the Emergency Department. Each patient record to be stamped by Clinician who undertakes the daily audit,						
Perso	Personal	ED CAH	ED CAH	11/03/2016		No	1	MUC	**Recommendation 4 -** Multi-disciplinary process needs to be formalised and documented in relation to the management and processing of abnormal x-ray findings. This process needs to reflect any amendments made in response to this SAI investigation.						
Perso	Personal	Gynae/Theatres CAH	Theatres CAH	11/03/2016	Personal patient admitted with frequent falls, poor oral intake and shortness of breath. Upon admission, found to have post-menopausal vaginal bleeding, microcytic anemia and acute kidney injury. Patient scheduled for hysteroscopy. Patient had cardiac arrest upon induction of anesthesia prior to	Yes	2	IMWH	**Recommendation 1 -** Acute Inpatient ward staff need update training in relation to the assessment and re-assessment capacity to provide consent on every admission- if there is a requirement for consent.			21.03.17 P Kingsnorth forwarding to Dr McCracken for update			
Perso	Personal	Gynae/Theatres CAH	Theatres CAH	11/03/2016	hysteroscopy and sadly passed away.	Yes	2	IMWH	**Recommendation 2 -** The findings and learning within this Level 2 investigation needs to be circulated to all medical and nursing staff to ensure awareness relating to capacity assessment and to reinforce the requirement for staff to documenting patient and family contact. This will also highlight and remind nurses of the importance to document the initiation of any treatment.						
Perso	Personal	AMU CAH	AMU CAH	15/07/2015	Personal patient with a past history of psychotic depression. Admitted on 22 June 2015 following 3 weeks of bizarre, erratic behaviour, slurred speech- polydipsia and polyuria for 3/7. Had been seen by Mental Health Rapid Treatment for 4 days prior to attendance. Blood sugar on admission 33.3mmol/l. Commenced on Hyperosmolar Hyperglycemic protocol. Over the next 24 hours patients serum sodium level rose to 173mmol/l despite fluid therapy. Patient transferred to ICU. On 3 July 2015, patient sadly passed away.	Yes	2	MUC	**Recommendation 1 -** The Review Panel were not in a position to make recommendations in relation to the primary care aspects of Pers care, however it is hoped that this will be addressed by HSCB governance team	Discussed with HSCB GP advisor	Trudy Reid	Complete			
Perso	Personal	AMU CAH	AMU CAH	15/07/2015		Yes	2	MUC	**Recommendation 2 -** The Regional HHS Guidance is unclear and difficult to follow. There needs to be rapid and comprehensive improvement in the provision and availability of information in relation to Hyperosmolar Hyperglycaemic State.	On the 28/11/2016 the CMO launched Diabetes framework and regional network. Dr Bradly from the SHSCT is co-chair of the inpatient diabetes subgroup and will implement recommendations from this group within the SHSCT as they become available					
Perso	Personal	AMU CAH	AMU CAH	15/07/2015		Yes	2	MUC	**Recommendation 3 -** The Northern Ireland Medical and Dental Training Agency (NIMBTA) need to be informed of training gap in relation to HHS with the view to addressing same						
Perso	Personal	AMU CAH	AMU CAH	15/07/2015		Yes	2	MUC	**Recommendation 4 -** Improve the provision and uptake of information in relation to the recognition and management of Endocrine Emergencies for nurses, including the difference between DKA and HHS	The case was discussed at the physicians meeting and discussed at M&M. An e-learning module has been implemented for nursing staff since this SAI 2 Acute diabetic nurse specialists have been appointed since this SAI The SHSCT implemented UK National Guidelines for Management of HSS On the 28/11/2016 the CMO launched Diabetes framework and regional network. Dr Bradly from the SHSCT is co-chair of the inpatient diabetes subgroup and will implement recommendations from this group within the SHSCT as they become available					
Perso	Personal	AMU CAH	AMU CAH	15/07/2015		Yes	2	MUC	**Recommendation 5 -** In the event of acute illness clinical history with underlying psychiatric conditions must include collateral information from family and the mental health specialists in relation to their baseline behaviour						

Perso	Personal	Theatres CAH	Theatres CAH	22/04/2016	Personal Information had rectal resection 11/02/14 for carcinoma of the rectum. In November 2014, patient booked for a reversal of stoma. Added to elective surgery waiting list. Patient admitted for surgery on 23/03/15 for reversal of stoma. Once anaesthetised, the abnormal CT findings were discovered. Procedure abandoned. Patient informed of rationale and referred for palliative chemotherapy	No	2	SEC	**Recommendation 1 -** Trust-Wide written guidance needs to be created in relation to the validation of reports, results and histology by each Consultant-Lead team. This guidance will need to reflect both a Corporate and Consultant response to the governance responsibilities when managing patient results. The Operational Teams responsible for implementation of change will need to seek agreement on a basic minimum standard, as well ensure that Trust-Wide, each specialty produce any variances in writing for inclusion. Consultant and clerical annual leave/sick leave contingency planning needs to be considered.							
Perso	Personal	Theatres CAH	Theatres CAH	22/04/2016		No	2	SEC	**Recommendation 2 -** There needs to be agreement and documented process that if there is a mis-match between proposed/current management, Radiology will electronically flag the abnormal result to the Clinician making the imaging request. There is a fundamental need to ensure that clinicians provide adequate clinical history in a format suitable to PACS and the Radiologist on submission of Radiology requests.							
Perso	Personal	Theatres CAH	Theatres CAH	22/04/2016		No	2	SEC	**Recommendation 3 -** The SHSCT need to consider implementation of a Pre Op Investigation Pathway or check list which records current and timely information in relation to prepratory investigations (where relevant). This needs to be available on the day of admission to the medical and nursing staff admitting the patient in an easily accessible format. The action plan needs to include investigations done for NHS patients which are done in the private sector.							
Perso	Personal	Theatres CAH	Theatres CAH	22/04/2016		No	2	SEC	**Recommendation 4 -** The SHSCT Radiology team require the current process in relation to the hardcopy circulation of hardcopy x-ray reports to be revised to ensure more timely delivery. Target delivery times for reports, the format of reports need to be agreed and maintained. The action plan needs to include investigations done for NHS patients which are done in the private sector							
Perso	Personal	Theatres CAH	Theatres CAH	22/04/2016		No	2	SEC	**Recommendation 5 -** Acute Services within the SHSCT need to consider training, process map and the utilisation of the 'PACS worklists' option in an effort to support the timely management of radiological requests for clinicians.							
Perso	Personal	Theatres CAH	Theatres CAH	22/04/2016		No	2	SEC	**Recommendation 6 -** The Review Panel recommends that there is regular communication or meetings in relation to clinical and radiological mis-matching on both Acute sites in the first instance. These meetings should be open to all specialties to provide a forum to discuss and address any issues around classifications of referral or clinical mis-matches. The action plan needs to include investigations done for NHS patients which are done in the private sector.							
Perso	Personal	Theatres CAH	Theatres CAH	22/04/2016		No	2	SEC	**Recommendation 7 -** Action plans will be addressed through the operational Governance arrangements and assurance of the implementation of actions will be provided by the operational Assistant Directors and Associate Medical Directors to the Director of Acute Services.							
Perso	Personal	ED DHH	ED DHH	25/04/2016	On Wednesday 4 March 2015 at 18:52 hrs Personal presented to Daisy Hill Hospital ED with abdominal pain. Sudden onset of left lower quadrant pain in the morning. Home with analgesia. Return if any concerns. GP if pain not settling.(Departure time 22:15hrs) On Thursday 5 March 2015 at 12:20hrs, Personal arrived to Daisy Hill Hospital Emergency Department at 12:20 hrs unresponsive after out of hospital arrest team present and sadly passed away.	Yes	2	MUC	**Recommendation 1 -** The standard and consistency of documentation by both medical and nursing staff in the Emergency Departments must be addressed. This work should highlight the importance of recording the outcome/effect of any treatment given in the department, such as pain relief.	a. Case presented at M and M and recommendations shared with both medical and nursing staff. B. An audit of documentation by medical staff has been undertaken in quarter one of 2016/2017 and this will be repeated. C. Nursing records will be audited in November 16.	Dr Hampton Dr D Patton Mary Burke Paul Smith	a. Completed May 2016 B. Nov 2016 C. Nov 2016	Case presented at M&M and recommendations shared with both medical and nursing staff. Nov 2016			
Perso	Personal	ED DHH	ED DHH	25/04/2016		Yes	2	MUC	**Recommendation 2 -** An Audit tool for Emergency Department documentation must be developed and implemented, with the results of the audits being regularly shared throughout the Emergency Department muntidisciplinary team.	An audit tool has been developed, which will monitor record keeping standards. Areas of good practice and areas for development and will be shared at ED M & M	Dr Patton	01/10/2016	AN audit tool for ED documentation must be developed which monitors the standards of the notes. An audit will be undertaken and areas of good pratice/areas for development will be shared with staff and an actionplan put in place to address any non-complience. Dec 16			
Perso	Personal	ED DHH	ED DHH	25/04/2016		Yes	2	MUC	**Recommendation 3 -** Establish a formal shift handover for the 24 hour ED shat shift cycle, with a consistent senior clinical presence. This would allow escalation and management of any clinical concerns. The implimentation and attendance at the handovers should be monitored by the ED Clinical Director and ED manager.	Formal handovers in place at 08:00, 14:00 and 22:00 hours in place. Informal handovers occur at change of shift. This is currently monitored by Clinical Director/Department Sister/Charge Nurse. The Trust is under taking a service improvement project on medical hand over which ED will participate in.	Clinical Director Head of Service	Ongoing, Complete	Formal handovers in place at 08:00, 14:00 and 22:00 hours in place. Informal handovers occur when medical staff commence/go off duty. This is currently monitored by Clinical Director. In Place			
Perso	Personal	ED DHH	ED DHH	25/04/2016		Yes	2	MUC	**Recommendation 4 -** A Consistent method of providing discharge advice given to patients leaving the Emergency Departments and the recording of the discharge advice given must be developed. The review Panel propose that discharge advice must include the following three key components: * Discharge Diagnosis * Medication advice (if applicable) * "Red Flag" symptoms following discharge which requires review and who to contact and/or what to do in event of those symptoms emerging.	We are currently developing an ED patient information leaflet for abdominal pain. This will provide information on diagnosis and mediation as appropriate and the red flag symptoms, with an indication what to do if they occur and who to contact. The ED flimsy will also have a diagnosis and a management plan documented.		Nov-15	The discharge diagnosis will be documented in the ED flimsy. Patients that are discharged on medication are issued with advice leaflets which advises of potential side effects. The name of the medication and dose is issued on the bottle/box. A leaflet is currently being developed for patients that present with abdominal pain and are discharged. The leaflet will advise of red flag symptoms following discharge and who to contact or what to do if those symptoms emerge. Dec 2016			
Perso	Personal	Trauma Ward CAH	Trauma Ward CAH	22/04/2016	On Saturday 2 May 2015 at 12:06 hrs, patient attended Craigavon Area Hospital Emergency Department following fall at home. Fractured Lt subtrochanter confirmed by xray at	Yes	2	ATICS	**Recommendation 1 -** Develop guideline for cancellation of patients on the emergency theatre list.	Develop a Trust Policy or Guidance document for the management of repeated cancellation of an inpatients emergency surgery	Dr Tim Bennett	Aug-16				
Perso	Personal	Trauma Ward CAH	Trauma Ward CAH	22/04/2016	12:30 hrs. Noted to be extracapsular, comminuted and impacted. Insertion of Gamma Nail on 6 May 2015. Patient developed upper GI bleeding due to stress ulcer. Patient sadly	Yes	2	ATICS	**Recommendation 2 -** Develop fasting guidance for patients on the emergency theatre list.	Develop a Trust guidance document on pre-operative fasting	Dr Tim Bennett	Aug-16				
Perso	Personal	Trauma Ward CAH	Trauma Ward CAH	22/04/2016	passed away on 21 May 2015.	Yes	2	ATICS	**Recommendation 3 -** evelop process for documentation of anaesthetic assessment for patients on the emergency theatre list.	Introduce an anaesthetic proforma to be included in the patients' notes, to capture the progress of the anaesthetic plan prior to surgery	Dr Tim Bennett	Aug-16				
Perso	Personal	ED CAH	2N Resp	13/05/2016	Patient admitted with Diabetic ketoacidosis, on admission had urinary catheter inserted in ED 22/09/15. Developed severe paraphimosis - underwent surgical repair on 27/9/15.	No	1	MUC	**Recommendation 1 -** Feedback will be given to the relevant staff in ED and the inpatient wards in relation to this incident.							
Perso	Personal	ED CAH	2N Resp	13/05/2016	Discharged 01/10/15	No	1	MUC	**Recommendation 2 -** The Urinary Catheter Insertion and Monitoring Form should be reviewed and updates considered							
Perso	Personal	ED CAH	2N Resp	13/05/2016		No	1	MUC	**Recommendation 3 -** Learning in relation to identifying and preventing paraphimosis should be shared across the Trust							

Perso	Personal	ED CAH	2N Resp	13/05/2016	Personal presented to ED with chest pain and Shortness of Breath, diagnosed spontaneous pneumothorax. Attempted aspiration done in ED, no improvement, so admitted Clinical Decision Unit overnight. Repeat chest x ray in morning showed complete pneumothorax and pleural effusion. Chest drain inserted and 1400mls of blood was evident in drain. Transferred to inpatient ward Craigavon. A further 1500mls of	No	1	MUC	**Recommendation 1 -** There should be a system to raise awareness of this condition for clinical staff	A. Case will be presented at Joint Emergency Department M&M meeting B. Case to be included in Emergency Department Bulletin	M Feenan (associate Specialist) Conor OToole Consultant Emergency Medicine	A. 25.02.2015 B. October 2016					
Perso	Personal	ED CAH	2N Resp	13/05/2016	blood drained on 12/01/15. Patient transferred to thoracic team in RVH.	No	1	MUC	**Recommendation 2 -** Trust Guidelines need changed to include information on the initial management of spontaneous haemopneumothorax	Trust Guideline is being updated	Associated Medical Director	In progress of being rewritten					
Perso	Personal	ED CAH	2N Resp	13/05/2016		No	1	MUC	**Recommendation 3 -** If following Chest Drain insertion for a seemingly primary pneumothorax 100 mls or more of blood drains, followed by another 100 mls of on-going bleeding over 30minutes (> 200mls/hour) then the patient should be discussed with Thoracic with the expectation that they will be accepted for transfer. If Chest X ray shows pneumothorax and obvious fluid level then intercostal drain should be inserted and referral to Thoracic if above volumes of blood evident.	Recommendation needs communicated to ED medical staff	Lead Clinicians Craigavon and Daisy Hill Emergency Departments	October 2016 Emergency Department Bulletin					
Perso	Personal	ED CAH	2N Resp	13/05/2016		No	1	MUC	**Recommendation 4 -** The absence of NEWS recording in CDU needs to be addressed to improve NEWS recording	The Clinical decision Nurse on duty caring for IB needs feedback on the lack of NEWS recording and the need to total NEWS scores	Ward Sister Sharon Holmes						
Perso	Personal	ED CAH	2N Resp	13/05/2016		No	1	MUC	**Recommendation 5 -** Junior medical staff should escalate promptly patients that are deteriorating	F2 doctors caring for IB should receive feedback on the importance of escalation	R Boyle consultant Acute Medicine						
Perso	Personal	ED CAH	2N Resp	13/05/2016		No	1	MUC	**Recommendation 6 -** Chest x-rays with haemothorax as well as pneumothorax should have accurate reports.	The radiology AMD will be informed of the initial report to feedback to radiologist that made report							
Perso	Personal	ED CAH	CAH ED	13/05/2016	An Personal attended emergency department following a fall in the nursing home with a head injury and neck pain on 12/05/15. She had x rays taken which were reviewed. She was discharged back to the nursing home the next	Yes	2	MUC	**Recommendation 1 -** The report should be shared with operational teams for learning								
Perso	Personal	ED CAH	CAH ED	13/05/2016	morning. She returned to Craigavon ED on the 15/05/15 from the nursing home via emergency ambulance as she had been unwell and off feet.	yes	2	mUC	**Recommendation 2 -** There should be a senior review on vulnerable patients with head/neck injuries .prior to discharge from ED								
Perso	Personal	ED CAH	CAH ED	13/05/2016	She was admitted to an inpatient ward Craigavon with falls, UTI. She suffered cardiac arrest later that morning and was resuscitated, but unfortunately she died on 16/05/15. A fracture of her Cervical spine (C 2) was not identified at her initial attendance on 12/05/15.	Yes	2	MUC	**Recommendation 3 -** When a patient is required to wait for an extended period of time in the ED for return to a Nursing Home they should have a nursing assessment and care documented.								
Perso	Personal	ED CAH	CAH ED	13/05/2016		Yes	2	MUC	**Recommendation 4 -** Patients re-attending following a recent relevant ED attendance should have a thorough review of notes and investigations from the first attendance								
Perso	Personal	ED CAH	CAH ED	13/05/2016		Yes	2	MUC	**Recommendation 5 -** A full assessment and examination should be carried out on all patients admitted to MAU in a timely manner.								
Perso	Personal	ED CAH	CAH ED	13/05/2016		yes	2	MUC	**Recommendation 6 -** The Trust should have appropriate procedures in place for when discharge back to nursing homes is either not appropriate or possible in the out of hour's period.								
Perso	Personal	ED CAH	CAH ED	13/05/2016		Yes	2	MUC	**Recommendation 7 -** The Trust should create a system for the timely reporting of ED X rays								
Perso	Personal	MIU STH & ED DHH	MIU STH & ED DHH	13/05/2016	A Personal presented to the Minor Injury Unit South Tyrone Hospital on 20/10/15 with a history of a fall the previous day and alcohol abuse. She complained of a head injury with facial bruising. The examination noted no cervical spine tenderness and facial bones x ray showed no fractures.	No	1	MUC	**Recommendation 1 -** Feedback should be given to relevant staff as a way of informing practice				Solicitor letter in for compensation				
Perso	Personal	MIU STH & ED DHH	MIU STH & ED DHH	13/05/2016	She was discharged home with head injury advice. She attended Daisy Hill Emergency Department on 22/10/15 with persistent vomiting. In ED the examination stated no tenderness over the cervical spine and a CT brain scan revealed no acute intracranial injury. She was admitted and complained of neck pain. A CT of her cervical spine on the 23/10/15 revealed a cervical spine (C2) fracture. She was discharged on the 09/11/15 for follow up and fracture clinic RVH.	No	1	MUC	**Recommendation 2 -** The Emergency Nurse Practitioner Head Injury protocol needs reviewed to define clearly "Minor Head Injury" and advise on the exclusion of additional neck injury in high risk patients								
Perso	Personal	2N Resp CAH	2N Resp CAH	13/05/2016	Personal patient was transferred from a Nursing home to Craigavon Hospital Emergency Department with shoulder pain/septic arthritis on the 30th July 2015. She was admitted to an inpatient ward. She fell on the ward on the 1st of August and sustained a fractured Right femur. She was transferred to the Trauma ward, and had her surgery on the 3rd August. She is recovering on the Orthopedic ward.	No	1	MUC	**Recommendation 1 -** Feedback will be given to the relevant staff on the inpatient wards in relation to the incident		Ward Sister 2 North Respiratory						
Perso	Personal	ED DHH	ED DHH	13/05/2016	A Personal attended the emergency department on the 10/09/15 by ambulance. Personal Information redacted by the USI	Yes	2	MUC	**Recommendation 1 -** Staff involved in this adverse incident should be given feedback	The RCA report should be shared with staff involved in the incident							
Perso	Personal	ED DHH	ED DHH	13/05/2016	was subsequently found dead the next day at home. The coroner's preliminary post mortem is inconclusive and awaiting toxicology which make take several months.	Yes	2	MUC	**Recommendation 2 -** Methadone should not be prescribed or administered in any of the Trusts Emergency Departments	Memo sent to relevant prescribers in the Trusts Emergency departments stipulating to not prescribe Methadone under any circumstances (sent 16/09/15 by Asssistant Medical Director). The Methadone box stored in pharmacy should have "do not supply to ED" on it and Pharmacy Operational procedures should have this written. The Regional Circular from Health and Social Care Board "Opioid Substitute							
Perso	Personal	ED DHH	ED DHH	13/05/2016		Yes	2	MUC	**Recommendation 3 -** The Trusts Guidelines for the Management of Patients Indicating Opiate Dependency Syndrome, within an Acute Setting section for ED needs updated.	The ED section should state clearly that Methadone should not be administered in the Emergency Departments in the Trust							
Perso	Personal	Community	Community CYP	13/05/2016	A Personal was brought by ambulance to the Emergency Department on the 09/01/16 in cardiac arrest. Pers was back seat passenger in a car in a motor vehicle accident and CPR was in progress on route to ED. Resuscitation was unfortunately unsuccessful.	Yes	1	MUC	**Recommendation 1 -** Feedback should be given to relevant staff								
Perso	Personal	Delivery Suite CAH	Delivery Suite CAH	13/05/2016	Personal Information redacted by the USI	Yes	1	IMWH	None, as extreme premature	None, as extreme premature							
Perso	Personal	Delivery Suite CAH	Delivery Suite CAH	13/05/2016	PARA 0 AT 26+2/40 transferred to CAH from AAH with PPROM from 19/40 due to no neonatal cots in AAH.To Delivery Suite 27/11/15. Personal Information redacted by the USI	Yes	1	IMWH	None, as extreme premature	None, as extreme premature							
Perso	Personal Informati	Neonatal Unit CAH	Neonatal Unit CAH	10/06/2016	Personal Information redacted by the USI	Yes	3	IMWH	**Recommendation 1 -** Staff to use antenatal and intrapartum CTG evaluation stickers when interpreting CTGs				21.03.17 P Kingsnorth advises this is now complete				
Perso	Personal Informati	Neonatal Unit CAH	Neonatal Unit CAH	10/06/2016	.Possible working diagnosis ---over whelming sepsis at birth	Yes	3	IMWH	**Recommendation 2 -** Re-emphasise the importance of CTG training for all doctors and midwives annually.								
Perso	Personal Informati	Neonatal Unit CAH	Neonatal Unit CAH	10/06/2016		Yes	3	IMWH	**Recommendation 3 -** Re-emphasise the importance of the "Buddy system" to ensure a second opinion is sought on all CTGs to reduce the risk of misinterpretation.								
Perso	Personal Informati	Neonatal Unit CAH	Neonatal Unit CAH	10/06/2016		Yes	3	IMWH	**Recommendation 4 -** Trust must emphasise the importance of regular handover meetings								

Perso	Personal Informati	Neonatal Unit CAH	Neonatal Unit CAH	10/06/2016		Yes	3	IMWH	**Recommendation 5 -** A robust system for handover of patient care from one clinical area to another							
Perso	Personal Informati	Neonatal Unit CAH	Neonatal Unit CAH	10/06/2016		Yes	3	IMWH	**Recommendation 6 -** Escalation guidelines are available to all staff. Trust to emphasise the importance of same to staff.							
Perso	Personal	Delivery Suite CAH	Delivery Suite CAH	10/06/2016	23-24+2 weeks baby delivered at 2107hrs. Apgars 3@1 8@5 8@10 however sats never went above 60%.Care Personal	Yes	1	IMWH	None, as extreme premature	None, as extreme premature						
Perso	Personal	Orthopaedic Ward CAH	Orthopaedic Ward CAH	10/06/2016	This Personal Information was admitted to the Trauma Ward on 07/01/15 following a fall at home. Past hx of AF, pulmonary fibrosis, chronic kidney disease, and gallbladder perforation. On Dibigitran. Confirmed comminuted unstable fractured Rt shoulder. Conservative management was decided as treatment. Over the next 7 days, this patient had a number of episodes of shortness of breath, low oxygen saturation, and transient confusion. The Dibigitran was recommenced on 09/01/15 after confirmation of no neurological aetiology after his fall at home. It was noted that there were 2 doses of	Yes	1	MUC	**Recommendation 1 -** It is inappropriate to reset a NEWS trigger in a patient without confirmation of their underlying comorbidities. It should be highlighted through induction to junior staff that patients should not have their oxygen level adjusted to levels felt appropriate for with patients with COPD without confirming that condition either through review of notes or patient examination.							
Perso	Personal	Orthopaedic Ward CAH	Orthopaedic Ward CAH	10/06/2016	Dibigitran omitted on the 9/10/11 January 2015. On 14 January 2015, at 15:00 NEWS were noted to be 5. There are no further NEWs recorded until 20:30 when the patient was found breathless and cyanosed. After full resuscitation efforts for 20	Yes	1	MUC	**Recommendation 2 -** Protocol for assessment and escalation to medical staff needs to be enforced and audited on a regular basis to ensure compliance.							
Perso	Personal	Orthopaedic Ward CAH	Orthopaedic Ward CAH	10/06/2016	minutes, this patient was pronounced dead.	Yes	1	MUC	**Recommendation 3 -** Clear instructions should exist in relation to the ward for which cardiac arrest has occurred. Staff should be inducted at the start and provided with a hospital map layout to aid familiarisation							
Perso	Personal	Orthopaedic Ward CAH	Orthopaedic Ward CAH	10/06/2016		Yes	1	MUC	**Recommendation 4 -** When a patient's condition is clinically unstable and deemed peri-arrest and urgent medical response is required it is felt appropriate to activate the cardiac arrest protocol. This will allow immediate medical attention and management plan.							
Perso	Personal	Orthopaedic Ward CAH	Orthopaedic Ward CAH	10/06/2016		Yes	1	MUC	**Recommendation 5 -** Training, education and monitoring omitted and delayed doses of critical medicines must continue and remain a key priority in the safe administration of medicine.							
Perso	Personal	ED CAH	ED CAH	10/06/2016	7/7/15 at 05:00 hrs patient presented to Emergency Department with acute onset of epigastric pain and vomiting and diarrhoea. Discharged home from the Emergency Department with treatment for gastroenteritis at 12:15 hrs. 9/7/15 at 13:42 hrs with severe abdominal pain. Diagnosed with thrombus in superior mesenteric artery at 18:00 hrs.	No	2	MUC	**Recommendation 1 -** The Review Panel would recommend that any patient in the department at the time of medical staff change-over, should be medically assessed prior to discharge. Any assessment or advice should be recorded in the notes.							
Perso	Personal	ED CAH	ED CAH	10/06/2016	Patient transferred to RVH as an emergency and underwent small bowel resection for bowel necrosis.	No	2	mUC	**Recommendation 2 -** Consideration should be given to giving patients who have been assessed after presenting with abdominal pain and are being discharged an advice sheet advising for example, ' this assessment is valid based on the signs, symptoms and investigations at the time of presentation. Patients should be advised it return for re-assessment if their symptoms worsen over the next 24-48 hours.' The provision of verbal and written advice must be recorded in the patient's notes.							
Perso	Personal	3 South CAH	3 South CAH	10/06/2016	A Personal patient was admitted on 19/12/2013 with a leaking nephrostomy tube. The patient had an unwitnessed fall on 20/12/2013. The patient sustained a # femur. Surgery was performed on 24/12/2013. Following his surgery, the patient was transferred to Lurgan Hospital on 3/1/2014 for a period of rehabilitation. Tragically the patient died on 27/2/2014.	No	1	SEC	**Recommendation 1 -** 3 South nursing staff require education and support in relation to consistently and systematically updating the Falls Risk Assessment and intervention care plans. In this instance, Pers falls assessment was incomplete in relation to falls history prior to admission. Changes in clinical condition or the provision of new information was not reflected in Pers risk assessments or care planning. This issue needs to be highlighted within the 3S ward Safety Briefing- this needs to be circulated in multiple formats and repeated in agreed intervals.							
Perso	Personal	3 South CAH	3 South CAH	10/06/2016		No	1	SEC	**Recommendation 2 -** The Review Panel agreed that consistent re-assessment and chronological recording would have provided reassurance every measure was taken to acknowledge and manage Pers risk of falls.							
Perso	Personal	Female Medical DHH	Female Medical DHH	10/06/2016	Personal Patient admitted to Daisy Hill Female Medical Ward on 28 August 2014 with infective exacerbation of COPD. Past medical history of Chronic Obstructive Airway Disease (COPD), Falls, depression, osteoporosis, and weight loss. On Sunday the 14 September 2014 at 03:20 hours Pe had an un-witnessed fall. Complaining of severe weakness and pain in Right leg. X-rays hip, pelvis, lumbar, thoracic and CT of Brain ordered and completed. X-ray report at 11:20 hours reveals confirmed fracture of Right neck of femur. Pe was accepted for transfer and management in RVH. Ct of Brain result at 14:50 hours was, Nothing Abnormal Detected. Right hemi arthroplasty performed on 17 September 2014. Per was returned to Daisy Hill on 23 September 2014. Pe made slow, steady progress in relation to her fracture and the infective exacerbation of COPD and was discharged home on 23 October 2014.	No	1	MUC	None.	No Action Plan required.						
Perso	Personal	Theatres DHH	Theatres DHH	10/06/2016	Personal admitted to High Dependency Unit in Daisy Hill Hospital 07/12/14 with collapse and vomiting. Past history includes anemia, depression, asthma, codeine dependence, renal abscess, duodenal ulcer, learning difficulties and? Wilkies Syndrome.	No	2	MUC	**Recommendation 1 -** Patients with this clinical profile should have urine testing for the presence of Ibuprofen as part of initial assessment and further management planning.							
Perso	Personal	Theatres DHH	Theatres DHH	10/06/2016	OGD done 10/12/14 which revealed gross ulceration and erythema.	No	2	MUC	**Recommendation 2 -** Early referral to the addition service for patients for patient where clinicians diagnoses of NSAID or other OTC drugs are being considered as part of a differential diagnosis.							
Perso	Personal	Theatres DHH	Theatres DHH	10/06/2016	On 14/12/14, patient complained of severe abdominal pain. General condition continued to deteriorate and laparotomy was performed at 13:00hrs. While patient was being prepared for transfer to CAH ICU post-operatively, the patient went into asystole. CPR was carried out but there was no response to treatment. This patient died at 20:30 hours in the Daisy Hill Theatre Recovery Ward.	No	2	mUC	**Recommendation 3 -** The Review Team recommend that the learning from this investigation is shared Regionally with both gastroenterology and surgical teams to highlight this clinical issue.							
Perso	Personal	Female Medical DHH	Female Medical DHH	10/06/2016	Personal admitted to medical ward with cough and shortness of breath. Long-standing history of Chronic Obstructive Airway Disease. Unwitnessed fall on 12/10/15 at 05:30 hrs. Xray confirmed fractured Left femur. Fracture repaired on 14 October 2015 after maximum efforts to	No	1	MUC	**Recommendation 1 -** Assessment of the levels of supervision patients require is to be considered on a daily basis. If supervision is required this must be documented in the nursing notes.							
Perso	Personal	Female Medical DHH	Female Medical DHH	10/06/2016	optimize and prepare this patient for theatre. Patient discharged home on 27 October 2015.	No	1	MUC	**Recommendation 2 -** If assistance with supervision is provided by family this needs to be agreed with family members and recorded in the nursing documentation.							
Perso	Personal	Female Medical DHH	Female Medical DHH	10/06/2016		No	1	MUC	**Recommendation 3 -** All staff must consistently and systematically update patient assessments and care plans. Nursing Quality Indicator audits do include Fall Safe Bundles, but frequency of re-assessment needs to be included into SHSCT data monitoring.							

Perso	Personal	Female Medical DHH	Female Medical DHH	10/06/2016		No	1	MUC	**Recommendation 4 -** Implementation of a delirium care pathway, with appropriate action plan and auditing.							
Perso	Personal	Female Medical DHH	Female Medical DHH	10/06/2016		No	1	mUC	**Recommendation 5 -** Implement and disseminate regional delirium leaflets to patients and familys when they become available							
Perso	Personal Inform	Home of client	ED CYP DHH	10/06/2016	Personal Information redacted by the USI	No	2	MUC	**Recommendation 1 -** All areas where arterial lines are inserted and managed should review existing procedures and protocols to reflect the following guidance: Arterial line blood sampling: Preventing Hypoglycaemic Brain Injury (AAGBI Guideline September 2014)							
Perso	Personal Inform	Home of client	ED CYP DHH	10/06/2016		No	2	MUC	**Recommendation 2 -** All transfer documentation should be reviewed to include a trigger for checking and documenting the type of fluid used to maintain patency of arterial lines							
Perso	Personal Inform	Home of client	ED CYP DHH	10/06/2016		No	2	MUC	**Recommendation 3 -** Where fluids are kept for arterial line use to ensure that storage is complaint with Arterial line blood sampling: Preventing Hypoglycaemic Brain Injury (AAGBI Guideline September 2014)							
Perso	Personal Inform	Home of client	ED CYP DHH	10/06/2016		No	2	MUC	**Recommendation 4 -** Consideration of current adult safeguarding process within ED and the documentation to support same.							
Perso	Personal	4 North CAH	4 North CAH	08/07/2016	On 22/07/14 a Personal admitted with haematemesis and PR bleeding. The patient had an OGD/Laparotomy carried out on 22/07/14. A 5-lumen CVC line was inserted during surgery. The patient was transferred to ICU post-operatively	No	1	SEC	**Recommendation 1 -** SHSCT CVP bundle/proforma is amended to include the assessment of patency and presence of lumen caps							
Perso	Personal	4 North CAH	4 North CAH	08/07/2016	and was transferred to the ward on 25/7/2014. On removal of the patient's NG tube on 27/7/2014, the patient appeared to	No	1	SEC	**Recommendation 2-** CVP proforma should prescribe minimum frequency of monitoring							
Perso	Personal	4 North CAH	4 North CAH	08/07/2016	take a seizure and lose consciousness. Whilst being clinically assessed, it was noted that the brown lumen was open to air.	No	1	SEC	**Recommendation 3 -** There should be creation of guidelines that include CVP assessment on receipt of patient							
Perso	Personal	Gastroenterology Clinic DHH	Gastroenterology Clinic DHH	08/07/2016	Personal Information with history of Crohn's Disease admitted with pancytopenia on 11/12/15. Pt commenced on Azathioprine 200mg on 16/10/15. TPMT result from 2011 not available in hardcopy within patient charts. TPMT in 2011 indicated this patient should not receive Azathioprine. Patient was not re-screened prior to prescription and commencing	No	1	MUC	**Recommendation 1 -** The SHSCT adopts a policy which advocates mandatory TPMT testing prior to commencing azathioprine within all SHSCT specialist teams. This includes SHSCT Dermatology and Rheumatology.							
Perso	Personal	Gastroenterology Clinic DHH	Gastroenterology Clinic DHH	08/07/2016	Azathioprine in 2015.	No	1	MUC	**Recommendation 2 -** The SHSCT implements an agreed azathioprine 'pre-start' checklist for prescribers to complete when initiating azathioprine treatment by all specialist teams using this medicine. This requires mandatory TPMT testing and review of results prior to commencement.							
Perso	Personal	Gastroenterology Clinic DHH	Gastroenterology Clinic DHH	08/07/2016		No	1	MUC	**Recommendation 3 -** SHSCT NIECR Lead to contribute and ensure the inclusion of TPMT test results in NIECR as part of this SAI action plan. Any hardcopy result, need to be returned to original requester for validation and correct filing.							
Perso	Personal	Gastroenterology Clinic DHH	Gastroenterology Clinic DHH	08/07/2016		No	1	MUC	**Recommendation 4 -** The SHSCT creates and implements an agreed Azathioprine patient information leaflet which meets 'Plain English' standards. The importance of blood monitoring and side effects need to be re-enforced.							
Perso	Personal	Gastroenterology Clinic DHH	Gastroenterology Clinic DHH	08/07/2016		No	1	MUC	**Recommendation 5 -** SHSCT Interface Pharmacist for Specialist Medicines to present this SAI for learning to the SCG working group. Review panel would request that TMPT results are mandatory and that the frequency of monitoring if rephrased to remove confusion.							
Perso	Personal	Gastroenterology Clinic DHH	Gastroenterology Clinic DHH	08/07/2016		No	1	MUC	**Recommendation 6 -** This SAI should be shared with HSCB for investigation and review of monitoring in accordance with Shared Care Guidelines by Primary Care Teams.							
Perso	Personal	Delivery Suite CAH	Delivery Suite CAH	08/08/2016	Prim T +5 transferred to theatre for trial of labour two pulls with mental cup baby delivered by BNF. baby transferred to NNU with ? fractured skull.	No	1	IMWH	None, as recognised complication.	No Action Plan required.						
Perso	Personal	ED DHH	ED DHH	08/08/2016	A Personal presented to the Emergency Department (ED) on the 05/04/16 expressing Personal Info. Following	No	1	MUC	**Recommendation 1 -** A concise procedure that covers the transfer of a psychiatric inpatient with a clinical need to ED should be agreed and shared with staff.							
Perso	Personal	ED DHH	ED DHH	08/08/2016	assessment in ED he was referred to psychiatry. Psychiatry assessed him in ED and decided to admit him to an inpatient psychiatric bed. He had denied taking any drugs to the ED doctor and Psychiatric staff.	No	1	MUC	**Recommendation 2 -** Cooperation and team working between Emergency care and Psychiatry should continue to be enhanced.							
Perso	Personal	Male Surgical DHH	Male Surgical DHH	12/09/2016	The patient presented initially at the Emergency Department on the 23/06/14. On the01/07/2014 the patient collapsed at home and represented at the Emergency Department in a peri- arrest state on admission. Following resuscitation the patient was transferred to theatre and an emergency laparotomy was performed. Postoperatively the patient was transferred to ICU	No	2	MUC	**Recommendation 1 -** Permanent and consistent provision 24 hour Staff Grade cover in DHH ED.		Dr Hampton		We have extended the working hours of Middle Grade Doctors to 02:00 hours in the Emergency Department DHH. This is covered by both permanent and locum staff grades. After 02:00 hours there is an SHO and FY2 cover to 08:00 hours. Completed. June 2016 The Trust has on-going adverts to try and secure middle grade cover. Ongoing.				
Perso	Personal	Male Surgical DHH	Male Surgical DHH	12/09/2016	in CAH. The patient has now been discharged from ICU and remains a patient in DHH.	No	2	MUC	**Recommendation 2 -** If it transpires that Permanent and consistent provision 24 hour Staff Grade cover in DHH ED is not possible in the short-term, consideration needs to be given to protected bed provision for patients needing senior surgical re-assessment. Any actions with rationale need to be included in departmental action plan.		Dr Hampton		There are two observation beds ring-renced in Femaole Surgical whereby patients who require senior review are admitted in the out of hours period and assessed by consultant on the post take ward round. Inplace Sept 2015				
Perso	Personal	Male Surgical DHH	Male Surgical DHH	12/09/2016		No	2	MUC	**Recommendation 3 -** Creation and implementation of retrospective review process to ensure ED Flimsey data quality and clinical validation. The process needs to include a very high level initial glance to ensure the flimsey has been completed and then move on to review the quality of the detail of patient response to both medication received while in ED and impact on pain. Creation and implementation of formal process needs to be established to monitor and manage data non- compliance, or in the event of clinical management challenge.		Dr Hampton		It has been agreed to audit the notes of the patients who present overnight. This will be presented at M&M in December 2016. Nov/Dec 2016				
Personal	Personal	Theatres DHH	Theatres DHH	12/09/2016	Personal Information presented to Daisy Hill ED on Saturday 28 February 2015 at 10:25 hrs via ambulance complaining of severe back pain. On tramadol and paracetamol at home. Know allergy to Codeine. Seen by Dr at 12:55hrs. Analgesia given as prescribed. At 15:45, rash on face, Dr informed. Slight rash ? secondary to drug allergy. Chlorphenamine 10mg given	No	1	MUC	**Recommendation 1 -** Any allergy or allergic reaction recorded within documentation or declared by patient/family must be clarified by medical and nursing staff responsible for patient triage, assessment or admission. These details must be recorded.				Date Completed - December 2017 Action Required - Allergy status is recorded at triage on the ED flimsy. Ad hoc checks undertaken by sister/clinical educator.				

Perso nal	Personal	Theatres DHH	Theatres DHH	12/09/2016	i/v at 16:00 hrs for rash. Discharged home at 16:30 hrs. The rapid discharge after treatment for systemic rash is contrary to the Trust Anaphylaxis Policy. On Saturday 28 February 2015 at 18:46 hrs (2 hrs 16 min later) this gentleman presented to DHH ED via ambulance with allergic reaction with airway compromise. Fibre optic intubation performed and patient was transferred to ICU in Craigavon Hospital. Admitted to CAH ICU at 23:05hrs.	No	1	MUC	**Recommendation 2 -** NICE Guidance regarding anaphylaxis management (Appendix Two) suggests 6 hours of clinical observations after administration of intravenous antihistamine and 12 hours of observation after the administration of adrenaline. This guidance needs to be re-circulated through all SHSCT ED's for learning. Evidence of circulation/presentation needs to be recorded.			Date Completed - November 2017 Action required - NICE Guidelines re-circulated November 17				
Perso nal	Personal	Theatres DHH	Theatres DHH	12/09/2016		No	1	MUC	**Recommendation 3 -** The administration of multi-modal analgesia needs to be prescribed with caution irrespective of allergy status. The effects of each administration should be recorded on every occasion by medical and nursing staff. This learning needs to be presented at the Emergency Medicine M&M meeting for learning. Audit should monitor staff adherence to this recommendation.			Date Completed - October 2015 Action required - Case presented at M and M on 28/10/15 Audit to be completed in January 18. Outcome of audit will be presented at patient safety brief and M and M in January 18.				
	Personal	4 South CAH	4 South CAH	12/09/2016	On Monday 9 February 2015, this Personal Information was admitted for surgery to remove a tumour in the transverse colon. Extended Right hemi-colectomy with partial gastrectomy was done on 09/02/15. On Friday the 13th of February 2015 the patient rapidly derteriorated and sadly passed away.	yes	2	SEC	**Recommendation 1 -** In patients with peritonitis, pneumoperitoneum on CXR and a clinical deterioration, consideration should be given to proceed straight to theatre without the need for a CT scan of abdomen.							
Perso	Personal	4 South CAH	4 South CAH	12/09/2016		Yes	2	SEC	**Recommendation 2 -** NEWS scoring should be performed according to trust policy							
Perso	Personal Inform	ED DHH	ED DHH	Jul-16	Patient attended emergency department Daisy Hill on 7th April with abdominal pain, after assessment was discharged. Patient returned to Daisy hill ED on 8th April and 9th April with vomiting and diarrhea and was reassessed and discharged both occasions. Patient returned on 17th April unwell, diagnosed bowel obstruction and was transferred to theatre for laparotomy and subtotal colectomy.	No	2	MUC	**Recommendation 1 -** Patients that re-attend to ED within 24 hours should always be considered a higher risk and such patients need careful consideration regarding further investigations to determine diagnosis.							
Pers	Personal Inform	ED DHH	ED DHH	13/07/2016		No	2	MUC	**Recommendation 2 -** Persistent symptoms accompanied by abnormal tests with increased inflammatory markers require speciality imaging and speciality referral.							
Pers	Personal Inform	ED DHH	ED DHH	13/07/2016		No	2	MUC	**Recommendation 3 -** Abnormal blood results should be highlighted and commented upon (acknowledge) and the notes explained and acted on.							
Pers	Personal Inform	ED DHH	ED DHH	13/07/2016		No	2	MUC	**Recommendation 4 -** When a patient makes an unscheduled return to the ED with the same condition within 72 hours of discharge from the ED, they should be acknowledged and reviewed by senior doctors							
Pers	Personal Inform	ED DHH	ED DHH	13/07/2016		No	2	MUC	**Recommendation 5 -** Documentation must be complete and to a uniformed standard for each attendance. The clinical notes and discharge advice must be of a high standard in each case.							
Pers	Personal Inform	ED DHH	ED DHH	13/07/2016		No	2	MUC	**Recommendation 6 -** Evidence of further training in acute abdominal pain assessment should be evidenced in e-portfolio or at appraisal for all medical staff involved							
Perso	Personal Infe	AMU CAH	AMU CAH	16/05/2012	Patient attended Emergency Department on the 9/04/12 and the 11/04/12. Following assessment of the patient on the 11/04/12 the patient was admitted for investigation and treatment of a painful left buttock. The patient's condition deteriorated resulting in admission to ICU on the 14/05/12. The patient died on the 15/05/12.	YES	2	SEC	**Recommendation 1 – Senior Review** Patients who continue to manifest signs of severe infection (persistent pyrexia, elevated CRP, worsening NEWS), despite 24hrs of on-going antibiotic therapy should have a Consultant review and discussion with the Microbiology Consultant about broadening and escalation of antibiotic therapy.							
Perso	Personal Infe	AMU CAH	AMU CAH	16/05/2012		YES	2	SEC	**Recommendation 2 –** Escalation of deteriorating patients Since this incident occurred the MEWS system for identification and escalation of deteriorating patients has been superseded by the National Early Warning System (NEWS). The criteria for escalation are clearly stipulated within the NEWS chart and include the grade of doctor to which deterioration in patients' condition should be communicated. It is recommended that the process for escalation of deteriorating patients, as outlined in NEWS chart is followed by all clinical staff.							
Perso	Personal	X-Ray CAH	X-Ray CAH	Feb-14	A Personal presented with abdominal pain and weight loss over a 12 month period. During this time 3 CT scans of the patient's abdomen and an MRI small bowel study were carried out and reported on. It	Yes	2	MUC	**Recommendation 1 -** Multi-disciplinary discussion and case review should be undertaken if there is a clinical concern that imaging findings do not correlate with clinical presentation.							
Perso	Personal	X-Ray CAH	X-Ray CAH	Feb-14	transpired that an abnormality in the patient's upper abdomen was present and not correctly reported. During this time frame the patient was under the care of several specialties Following the outcome of an internal review of the case the SHSCT wish to submit it as a SAI as several areas of learning have been identified. It has been agreed by the SHSCT that the SAI team will include an independent Radiologist, Physician and Surgeon. were carried out and reported up until the 3rd July 2012 did not identify a specific cause for Person symptoms. A laparotomy and coeliac lymph node biopsy was performed by Doctor 4 on the 9th July 2012. The histology report of this biopsy sample confirmed the presence of metastatic carcinoma. Further treatment and care included referral to the Specialist Oncology Service for palliative chemotherapy. Outcome, Consequence	Yes	2	MUC	**"Recommendation 2:** The review team recommend that a process should be established to ensure that distinct episodes of illness are not viewed in isolation; previous episodes must be incorporated into the on-going assessment of the patient in order to reduce fragmented care"							
Perso	Personal	MIU STH	MIU STH	07/07/2015	Pe presented to Minor Injury Unit on 7th September 2015 with a painful left lower leg, diagnosed toddlers fracture and plaster cast applied. Reviewed 16th September at Minor Injury Unit, X ray report stated no fracture. Child transferred to Craigavon Emergency Department for review. Admitted to pediatric ward Craigavon with query of cellulitis/osteomyelitis. Was transferred to RBHSC on 18th September. a CT scan and ultrasound scan	No	1	MUC	**Recommendation 1** Learning and awareness from this SEA should be shared with the relevant teams							

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Perso	Personal	MIU STH	MIU STH	07/07/2015	of his calf showed an abscess. He went to theatre for drainage and returned to theatre 48 hours later for debridement of muscle. He was treated with intravenous antibiotics and splint. of the left leg Pe returned to theatre on the 20th September 2015 and had debridement of a portion of his lateral head of the gastrocnemius muscle which was non-viable. On the 23rd September 2015 Pe again went to theatre. The remainder of the lateral head of his gastrocnemius was debrided. Pe returned to theatre the 25th September 2015. All the remaining muscle appeared to be viable. On Barbour ward Pe continued to receive IV antibiotics and had a prelude splint in place to prevent equinas.	No	1	MUC	**Recommendation 2 -** The existing pathways for paediatric orthopaedic patients need reviewed The Trust should work with the HSCB and the PHA to review Paediatric Trauma and Orthopaedic pathways.							
Perso	Personal	MIU STH	MIU STH	07/07/2015		No	1	MUC	**Recommendation 3 -** An updated limping child protocol will be implemented across the Trusts Minor Injury unit and Emergency Departments							
Perso	Personal	ED DHH	ED DHH	03/02/2014	Presented at ED on 20/10/2012 complaining of a tender left calf. At the time a diagnosis was made of superficial thrombophlebitis. Patient returned to ED on 28/10/2012 and presented in cardiac arrest. Resuscitation was commenced but tragically the patient died.	Yes	1	MUC	**Recommendation 1 -** A Two-level DVT Wells score sheet should be placed in the ED flimsy -by the Triage nurse -of all patients who present with a swollen leg at the point of Triage. v Patients who present via ambulance should also have a Two-level Wells score sheet placed in their record.				The Lead Nurse of both EDs to set up a mechanism for this.			
Perso	Personal	ED DHH	ED DHH	03/02/2014		Yes	1	MUC	**Recommendation 2 -** All patients who have a presenting complaint of thrombophlebitis or DVT must have a medical assessment in keeping with the examination elements of the Wells Score. The findings of this examination must be clearly documented in the ED notes and acted upon accordingly.				ED - Medical staff to review the elements of the assessment which are currently recorded and stipulate the elements which must be documented in the ED notes in order to justify the diagnosis.			
Perso	Personal	ED DHH	ED DHH	03/02/2014		Yes	1	MUC	**Recommendation 3 -** A copy of the Trust's "Diagnostic Algorithm for Suspected Deep Vein Thrombosis" should be laminated and appropriately placed in each ED within the Southern Trust.				ED - Algorithm to be displayed and medical and nursing staff advised of this and rationale for same.			
Perso	Personal	ED DHH	ED DHH	03/02/2014		Yes	1	MUC	**Recommendation 4 -** □ The findings of this report should be shared with the medical and nursing teams in both EDs by the designated medical and nursing leads. □ These leads should also ascertain if any formal learning is required by staff in order that the assessment and diagnostic pathways can be followed for those who present with either thrombophlebitis or/and suspected DVT.				ED - Medical and Nursing Ed leads to share Report findings with Team and identify potential learning needs. Should learning needs be identified a learning needs analysis should be undertaken to determine how best to address this.			
Perso	Personal	ED DHH	ED DHH	03/02/2014		Yes	1	MUC	**Recommendation 5 -** This report should be presented at the Trust's Mortality and Morbidity Meetings to ensure the learning is shared throughout the organisation.				Acute Directorate - Report and Action Plan to be forwarded to M+M Chairs in advance of next M+M Meetings for Tabling.			
Irrele	Assault on Nurse	Carpark CAH	Carpark CAH	09/04/2014	On 8.1.14 at approx 22:00hrs a nurse reporting for her shift at CAH site allegedy asaulted by two males in the carpark at CAH. The PSNI were imediately notified and are currently investigating the incident.	No	1	FSS	**Recommendation 1 -** Processes are reviewed to ensure the staff member's line manager and relevant senior staff are alerted to all incidents of this type in a timely manner.							
Irrele	Assault on Nurse	Carpark CAH	Carpark CAH	09/04/2014		No	1	FSS	**Recommendation 2 -** Risk assessments are up to date at ward level/department level in relation to health and safety/security and staff reminded to report any concerns regarding their personalsafety promptly.							
Irrele	Assault on Nurse	Carpark CAH	Carpark CAH	09/04/2014		No	1	FSS	**Recommendation 3 -** The Trust should ensure following any incident an internal investigation is undertaken.							
Irrele	Assault on Nurse	Carpark CAH	Carpark CAH	09/04/2014		No	1	FSS	**Recommendation 4 -** Safety awareness for Trust staff should be developed in partnership with the PSNI							
Perso	Personal	4 North CAH	Theatres CAH	19/09/2014	Following discharged from ICU on to a Surgical Ward the patients clinical observations (NEWS) scores were recorded from admission. The patient's condition showed signs of deterioration whilst on the ward resulting in re admission to ICU. The Southern Trust wish to submit this incident as an SAI in order to establish areas of learning relating to the recording of NEWS scores and subsequent actions.	No	1	SEC	**Recommendation 1 -** On transfer from ICU a clinical decision as to acceptable baseline NEWS, appropriate escalation and Action Plan must be determined and recorded in Medical notes. This must be reviewed as part of Senior Medical Ward Round and at times of clinical concern. M+M Chairs to advance through M+M meetings.				Progress of implementation to be tabled at Acute Directorate Governance Meeting in December 2014. 1. Complete.			
Perso	Personal	4 North CAH	Theatres CAH	19/09/2014		No	1	SEC	**Recommendation 2 -** Exception to NEWS response criteria must be recorded in the patient's medical notes. M+M Chairs to reinforce. Ward Managers and Lead Nurses to reinforce.				2. Medics have been requested to document NEWS exception baseline value. This will be audited by Ward Sister as part of the regular NEWS audit.			
Perso	Personal	4 North CAH	Theatres CAH	19/09/2014		No	1	SEC	**Recommendation 3 -** News Guidance must be followed and recorded appropriately. Registered Nurse must carry out NEWS on patients with fluctuating NEWS as clinically indicated. Local to Ward - Ward Manager to communicate findings of this Report to all staff. In addition to NQI Audits Ward Manager to undertake spot checks of NEWS Charts and investigate if Guidance has not been followed. Directorate Report findings to be shared at patient safety briefing meetings. M+M Chairs to reinforce Learning to be shared at Senior Nursing Forum and cascaded through all divisions Sign off and dissemination of the Acute Directorate NEWS Draft Guidance which is to be used in conjunction with the guidance contained in the NEWS chart.				3. Findings communicated to ward staff – complete. Ward Sisters auditing escalation as part of NEWS audit. This is supported by the Lead Nurses as part of the NAAS project. Ward Sister discusses findings of audit at ward meetings. Agreed processes in place to ensure SAI findings and associated actions are shared within the directorate and cascading to all staff groups as appropriate. Will be discussed at next Senior Nursing Forum. NEWS Guidance work has commenced but is not yet finalised.			
Perso	Personal	4 North CAH	Theatres CAH	19/09/2014		No	1	SEC	**Recommendation 4 -** Mechanism to ensure senior opinion is available throughout the 24 hour period. A review of current provision to be undertaken and action plan drawn up to address any deficits.				4. In progress- now ongoing + monitored by AD, AMD,+ HoS			
Perso	Personal	4 North CAH	Theatres CAH	19/09/2014		No	1	SEC	**Recommendation 5 -** Attendance at Hospital at Night Nursing staff to communicate patient details to Hospital At Night Handover. Bed Manager to attend meeting and record attendance.				5. In Place			
Perso	Personal	4 North CAH	Theatres CAH	19/09/2014		No	1	SEC	**Recommendation 6 -** Nursing Handover - Reinforce at Ward Manager meetings.				6. In Place			
Perso	Personal	4 North CAH	Theatres CAH	19/09/2014		No	1	SEC	**Recommendation 7 -** Where possible Datix details should be entered by person with first-hand knowledge of event. Reinforce with all staff.				7. In Place			
Perso	Personal	ED CAH	ED CAH	10/10/2014	Personal Information referred to the local Emergency Department (ED) for assessment with a history of heavy vaginal blood loss. A review from the Gynae SHO was requested.		Internal review	MUC	**Recommendation 1 -** Copies of protocol "transfer of miscarriage/products of conseption to laboratory" to be made available to both emergency departments.	Completed 24.10.14 by P Kingsnorth						
Perso	Personal	ED CAH	ED CAH	10/10/2014	Pe passed a large blood clot which was queried to be a gestational sac measuring approximately 20 x 3cms in size. The clots were placed on incontinence pads by nurse. The pad was placed on a silver dressing trolley; this was intended to be left for Gynae SHO for examination. This trolley was wheeled outside the cubicle. The pad could not be found. It is assumed it had been placed in a bin in resuscitation room. The bins were searched and only a blood stained pad could be found.		Internal review	MUC	**Recommendation 2 -** Traceability bood for collection of Products of conception to be left in both emergency departments.	Completed 24.10.14 by P Kingsnorth						
Perso	Personal	ED CAH	ED CAH	10/10/2014			Internal review	MUC	**Recommendation 3 -** Information sessions to raise awareness of protocol for Emergency department staff to be arranged.							

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Perso	Personal	ED CAH	ED CAH	10/10/2014	[redacted]		Internal review	MUC	**Recommendation 4 -** Product containers to be stored iin ED where staff have ready access to them.							
Perso	Personal	1 West CAH	1 West CAH		Personal Information referred to the local Emergency Department (ED) for assessment with a history of heavy vaginal blood loss. A review from the Gynae SHO was requested. Per passed a large blood clot which was queried to be a gestational sac measuring approximately 20 x 3cms in size. The clots were placed on incontinence pads by nurse. The pad was placed on a silver dressing trolley; this was intended to be left for Gynae SHO for examination. This trolley was wheeled outside the cubicle. The pad could not be found. It is assumed it had been placed in a bin in resuscitation room. The bins were searched and only a blood stained pad could be found.		2	IMWH	**Recommendation 1** - Sepsis Recognition and Management within ED "Unrecordable" blood pressure measurements must be accepted as evidence/a sign of hypotension until proved otherwise and managed accordingly Within the ED if patients present with or develop signs or symptoms of sepsis the sepsis bundle must be followed. SHSCT to continue to work in conjunction with the Regional Safety Forum on Sepsis Management						
Perso	Personal	1 West CAH	1 West CAH				2	IMWH	**Recommendation 2** - Blood Pressure Readings A blood pressure cuff of the correct size for the individual patient must be sourced and used to take every blood pressure reading Verification required that all ED nursing staff are aware how to measure and source correctly fitting blood pressure cuff This case history to be used as learning example regarding the importance of obtaining blood pressure readings each time they are required						
	Personal	Cellular Pathology Lab CAH	Cellular Pathology Lab CAH	06/02/2015	The Southern Health and Social Care Trust have identified a delay in the transfer of body tissue from the hospital mortuary to the Department of Neuropathology, Royal Hospitals Belfast, for onward transfer to a Brain Bank. This Tissue was donated by the patient and their family for the purpose of research. The incident will be reported to the Human Tissue Authority within two days.	No	1	CCS	**Recommendation 1 -** Within the ED if patients present with or develop signs or symptoms of sepsis the sepsis bundle must be followed						
Perso	Personal	Cellular Pathology Lab CAH	Cellular Pathology Lab CAH	06/02/2015		No	1	CCS	**Recommendation 2 -** SHSCT to continue to work in conjunction with the Regional Safety Forum on Sepsis Management						
Perso	Personal	Cellular Pathology Lab CAH	Cellular Pathology Lab CAH	06/02/2015		No	1	CCS	**Recommendation 3 -** All tissue which is removed in SHSCT Mortuaries must be recorded on the Laboratory Information Management System. This will create an audit trail to track both the processing and final destination or disposal .						
Perso	Personal	Cellular Pathology Lab CAH	Cellular Pathology Lab CAH	06/02/2015		No	1	CCS	**Recommendation 4 -** A monthly physical inspection of SHSCT Mortuaries must be undertaken to ensure there are no tissue samples retained inappropriately.						
Perso	Personal	Cellular Pathology Lab CAH	Cellular Pathology Lab CAH	06/02/2015		No	1	CCS	**Recommendation 5 -** The Trust should consider establishing a dedicated team for obtaining post mortem consent in cases of children over 28 days old and adults.						
Perso	Personal	X-Ray CAH	Trauma Ward CAH	12/06/2015	Chest x-ray carried out preoperatively prior to a surgery following a fractured neck of femur on the 12/03/14. Patient discharged following surgery and re admitted on the 26th May 2014 with SOB and reduced stats. Further chest x-ray showed right pleural effusion and suspicious lesion. The pre-operative x-ray report suggested possible lung cancer however a delay in the management of the patient occurred due to possible communication and/or process issues.	Yes RIP 19.8.14	1	SEC	**Recommendation 1 -** Further develop the radiology department Protocol, 'Reporting & Communicating of Critical, Urgent & Significant Unexpected Radiological Findings' to ensure cancer findings are reported to the referrer **and/or** the cancer tracker. All reports with a high index of suspicion of cancer must be alerted to both referring clinician and cancer tracker.				The review group have received confirmation that this has been actioned and that onward communication for example from the Emergency Department to the Orthopaedic Surgeon will be sent electronically (scanned).			
Perso	Personal	X-Ray CAH	Trauma Ward CAH	12/06/2015		Yes RIP 19.8.14	1	SEC	**Recommendation 2 -** Set up an Acute Directorate working group to review the current processes of communicating suspected cancer diagnosis to patient's consultants in a timely and consistent fashion.						
Perso	Personal	AMU CAH	AMU CAH	31/03/2015	The patient presented at the ED department on the 04/07/14 with a history of a chest infection and was subsequently admitted to a medical ward. The patient's condition deteriorated following admission and the patient subsequently died on the 04/07/14. The patient had a complicated medical history and was very ill on admission.	No	2	MUC	**Recommendation 1 -** Reinforce that once clerked in for admission, all clinical interventions required such as IV fluids are shared with the Nursing staff responsible for the patients care. Share the learning with ED to reinforce that there are no gaps in clinical care between ED and the wards.						
Perso	Personal	AMU CAH	AMU CAH	31/03/2015		No	2	MUC	**Recommendation 2 -** To reinforce in the junior doctors induction training how to identify the very sick patients and when to seek senior review.						
Perso	Personal	AMU CAH	AMU CAH	31/03/2015		No	2	MUC	**Recommendation 3 -** Ensure ongoing awareness and education of the importance of the NEWS escalation protocol and guidelines among all nursing and medical staff. Consider the audit of current pratice and the provision of regular refresher training for all staff.						
Perso	Personal	AMU CAH	AMU CAH	31/03/2015		No	2	MUC	**Recommendation 4 -** Review handover processes for the "Hospital at Night" team especially in relation to the very ill patients. Consideration could be given to the use of an electronic or traffic light alert system.						
Perso	Personal	AMU CAH	AMU CAH	31/03/2015		No	2	MUC	**Recommendation 5 -** Ensure that the learning points are shared with all relevant staff.						
Perso	Personal	Cath Lab CAH	Cath Lab CAH	20/07/2015	Personal Information was admitted for angiography, which was performed on 14/10/2014. On the basis of angiography, the Consultant proceeded to PCI. The patient suffered a cardiac arrest during the procedure; resuscitation was commenced. A decision was taken to transfer the patient to RVH. Tragically the patient subsequently died.	Yes	1	MUC	**Recommendation 1 -** The ECHO machine is to be placed permanently in catheter lab to facilitate emergency access to electrocardiography						
Irrele	Personal	Cath Lab CAH	Cath Lab CAH	20/07/2015		Yes	1	MUC	**Recommendation 2 -** Internal defibrillation paddles are now kept on the thoracotomy tray						
Perso	Personal	Cath Lab CAH	Cath Lab CAH	20/07/2015		Yes	1	MUC	**Recommendation 3 -** A extra adaptor should be purchased to sit with internal defibrillation paddles on the thoracotomy tray						
Perso	Personal	Cath Lab CAH	Cath Lab CAH	20/07/2015		Yes	1	MUC	**Recommendation 4 -** The Clinical Physiologist for "In patients" should hold an emergency bleep for contact in event of emergencies						
Perso	Personal	ED DHH	ED DHH	10/07/2015	Personal Information attended ED, DHH via ambulance with shortness of breath and "off feet". Ambulance obs showed tachycardia and respiratory rate 26. Patient had a cardio-respiratory arrest in ED. ECG showed myocardial infarction.	Yes	1	MUC	**Recommendation 1 -** All ambulance patients are triaged on arrival in ED regardless whether there are free cubicles for their placement and ED notes created.						
Perso	Personal	ED DHH	ED DHH	10/07/2015	After brief return of circulation, patient suffered a further arrest and resuscitation was unsuccessful. The Coroner was happy that the cause of death was MI and that death certificate could be issued.	Yes	1	MUC	**Recommendation 2 -** If there are no free cubicles for ambulance patients, a patient already in a cubicle will be moved out using the seated area, or in exceptional circumstances a patient will be temporality moved to a corridor on a trolley to facilitate.an empty cubicle for the ambulance patients triage assessment						
Perso	Personal	ED DHH	ED DHH	10/07/2015		Yes	1	MUC	**Recommendation 3 -** The nurse in charge of ED has responsibility for the triage of ambulance patients and ensuring they are appropriately placed.						
Perso	Personal	ED DHH	ED DHH	10/07/2015		Yes	1	MUC	**Recommendation 4 -** An area should be identified with a privacy screen for use to triage NIAS patients when no cubicles are available						

Perso	Personal	ED DHH	ED DHH	10/07/2015		Yes	1	MUC	**Recommendation 5 -** The escalation Performa if ED overcrowded should be reviewed and shared with staff in ED							
Perso	Personal	ED DHH	ED DHH	10/07/2015		Yes	1	MUC	**Recommendation 6 -** Actions by the nurse and doctor in charge of the emergency department to address overcrowding should be recorded in the communication diary together with the escalation to the site coordinator and their subsequent response							
Perso	Personal	ED DHH	ED DHH	10/07/2015		Yes	1	MUC	**Recommendation 7 -** Nurse A to have an update on triage training							
Perso	Personal	2 North CAH	2 North CAH	20/03/2015	Personal Information patient admitted to medical ward on 22 September 2014 with neutropenic sepsis. Patient had an unwitnessed fall. Patient was seen by Doctor. CT performed post fall was performed was abnormal. Neurology, RVH were contacted and advised conservative management.	Yes	1	MUC	None	No Action Plan required.						
Perso	Personal Inform	ED CAH	ED CAH	21/04/2015	Pers presented to ED on 26.10.14 at 10:30am. Cardiac Arrest Standby call from Ambulance Control. Personal CPR commenced by ambulance crew & continued until death pronounced at 10:53am	No	1	MUC	None	No Action Plan required.						
Perso	Personal	AMU CAH	AMU CAH	19/01/2015	Person attended MIU in STH on the 25/4/14 where she was diagnosed with a right inferior ramus following a fall at home and was discharged on the same day. On the 26/04/2014 Pe attended E/D in CAH. Perso was transferred from ED to MAU on the same date and appeared asymptomatic.	Yes	1	MUC/OPPC	**Recommendation 1 -** Peview Health and Social Care Trust's interpretation of Public Health England guidelines for stool sampling and implement through updated training to nursing staff. Regional guidance is awaited on the appropriateness of sampling of type 5 stools in these cases.							
Perso	Personal	AMU CAH	AMU CAH	19/01/2015	On the 27/04/2014 Perso was transferred to ward 1 STH for rehabilitation - she remained asymptomatic. Perso was commenced on Trimethoprim on 27.4.14 @ 0800 whilst in ED for a UTI. On 02/0520/14 @ 10:50hrs Perso was noted to have two type 6 bowel motions and was moved into side room 6. At	Yes	1	MUC/OPPC	**Recommendation 2 -** Provide Clostridium Difficile diagnosis and treatment training across all medical teams within the Trust based on the 2014 Clostridium Difficile guidance. Reinforce the requirement for clear recording of communication between microbiology and clinical staff and appropriate escalation.							
Perso	Personal	AMU CAH	AMU CAH	19/01/2015	18:45hrs Pers had a type 7. On 03//05/14 Perso had a type 6/7 a type 5/6 a type 5 and a type 6.	Yes	1	MUC/OPPC	**Recommendation 3 -** Review routine medical handover and communication within the non-acute wards especially prior to weekends.							
Perso	Personal	ED DHH	ED DHH	11/09/2015	A Personal presented at ED DHH on the 13/07/14. The child had fallen while running and sustained an injury to the left elbow... A 'back slab' was applied and review planned at the	No	1	MUC	**Recommendation 1 -** Awareness of diagnosing elbow injuries should be raised with medical staff	This case will be presented at the Southern Trust joint Emergency Department patient safety meetings						
Perso	Personal	ED DHH	ED DHH	11/09/2015	fracture clinic in 1 weeks' time, subsequently following clinic review of the child's x-ray the review was rescheduled for 3 weeks' time. On the 31.07.14 the child was seen at the fracture outreach clinic SHSCT. On clinical review of x-ray no obvious fracture	No	1	MUC	**Recommendation 2 -** Feedback should be given to the Belfast Trust as one of their staff in the Fracture Clinic reviewed the patient on his first attendance at the clinic before the extent of injury was picked up at a subsequent fracture clinic	Written information should be sent to the Belfast Trust informing them of incident for sharing and follow up with their staff involved.						
Perso	Personal	ED DHH	ED DHH	11/09/2015	was noted. A further review was planned for 3 weeks' time On the 21.08.14 the child was seen at the fracture clinic, X-	No	1	MUC	**Recommendation 3 -** All children's elbow fractures should be referred to fracture clinic for review in 1 week.	Nursing and medical staff informed of this						
Perso	Personal	ED DHH	ED DHH	11/09/2015	rays were reviewed and indicated that the medial epicondyle was trapped in the elbow joint. The Child subsequently underwent surgery on his left elbow.	No	1	MUC	**Recommendation 4 -** The Radiology Department should review this case as part of their discrepancy process as the x-ray was reported and missed.	Feedback has also been given to the Consultant Radiologist involved.						
Perso	Personal	ED CAH	ED CAH	13/11/2015	Personal presented to Craigavon Hospital Emergency Department with abdominal pain and vomiting, diagnosed gastritis and discharged from ED. Two days later patient collapsed at home, re-attended ED emergency via emergency ambulance. ECG showed STEMI, transferred to cath lab for pacing and subsequently intubated	No	1	MUC	**Recommendation 1 -** All patients that present to the Emergency Departments with upper abdominal patient, cardiac ischemia should be considered as part of a differential diagnosis and an ECG requested if appropriate	The list of tests in triage needs updated to add recording ECGS on upper abdominal pains						
Perso	Personal	ED CAH	ED CAH	13/11/2015	and ventilated. Patient eventually discharged to nursing home.	No	1	MUC	**Recommendation 2 -** Doctors should do risk assessments to exclude Acute Coronary syndrome (ACS) on all elderly diabetic patients	The incident to be shared with the multidisciplinary staff in both Emergency Departments during the Patient Safety Meeting						
Perso	Personal	ED CAH	ED CAH	13/11/2015		No	1	MUC	**Recommendation 3 -** Feedback to be given to the staff involved in the incident	Staff to receive Serious Event Audit (SEA) report						
Perso	Persona	AMU CAH	AMU CAH	12/06/2015	Unwitnessed fall on inpatient medical ward. Patient sustained intertrochanteric fracture of his neck of femur. He had DHS fixation on 24/01/15 and is waiting a bed in rehabilitation.		1	MUC	**Recommendation 1 -** Nursing staff in Medical admission Unit should be more aware of potential for patients falling	Completed Nursing Admission Booklets should be reviewed to ensure compliance of risk assessment for falls						
Perso	Persona	AMU CAH	AMU CAH	12/06/2015			1	MUC	**Recommendation 2 -** New admissions to Medical Admission Unit should not be admitted to single room if they have confusion or are unsteady on their feet.	Guidance to be given to all nursing staff in Medical Admission Unit						
Perso	Persona	AMU CAH	AMU CAH	12/06/2015			1	MUC	**Recommendation 3 -** The admitting nurse should receive feedback on the falls risk assessment not being completed correctly.	Sister Cullen to share Level 1 SEA report with the admitting nurse						
Perso	Personal	Community CYP	Community CYP	20/302015	Personal Information redacted by the USI	Yes	1	MUC/CYP	None	No Action Plan required.						
Perso	Personal	ED DHH	ED DHH	01/09/2015	An Personal attended the emergency department at Daisy on 28th March 2015 at 23:52 hours with vomiting and abdominal pain. He was assessed and diagnosed constipation and subsequently discharged. He returned 6 hours later and collapsed in the emergency department, he was carried to the resuscitation room. Resuscitation was commenced but was very sadly unsuccessful	Yes	2	MUC	**Recommendation 1 -** The interim protocol put in place post Person death for patients that attend with abdominal pain should be reviewed with senior medical paediatric input.	Protocol in place. A review of the protocol with paediatric/surgical involvement should take place	AMD	Protocol in place but to be reviewed September 16 with paediatric and surgical medical staff.				
Perso	Personal	ED DHH	ED DHH	01/09/2015		Yes	2	MUC	**Recommendation 2 -** The induction booklet for Emergency Department medical staff should be reviewed to ensure there is up to date reference to the interim protocol for attendees with abdominal pain.	The new version of the ED induction Handbook (August 2016) will contain reference to the interim protocol	Mr McCann	In place				
Perso	Personal	ED DHH	ED DHH	01/09/2015		Yes	2	MUC	**Recommendation 3 -** The induction booklets for Emergency Department medical staff should be made available for all staff including locum staff	An electronic copy is emailed to all medical staff (trainees and locums)	Mr McCann	In place				
Perso	Personal	ED DHH	ED DHH	01/09/2015		Yes	2	MUC	**Recommendation 4 -** The middle grade rota in Daisy Hill Emergency Department should be reviewed as part of a workforce review and a plan to address gaps in middle grade medical cover should be formulated and enacted urgently	This has been largely achieved; middle grade cover has substantially been increased. The middle grade cover will extend to midnight 7 days a week.	AMD/AD/HOS	Ongoing				
Perso	Personal	ED DHH	ED DHH	01/09/2015		Yes	2	MUC	**Recommendation 5 -** A clear protocol for the placement of ill children in cubicles and their prompt assessment should be developed urgently and put in place with a staff communication plan	This protocol is in place	P Sheridan	In place				
Perso	Personal	ED DHH	ED DHH	01/09/2015		Yes	2	MUC	**Recommendation 6 -** A system for ensuring that advice given over the telephone to patients and their relatives is recorded should be adopted in both Emergency Departments in the Southern Trust.	Staff have been advised that all children with abdominal pain that have been assessed in ED and discharged and who telephone for advice should be advised to return for assessment. A system for phone advice enquiries with a contact line for ED is still being explored. A request has been submitted for an automated telephone system.	ED Team					
Perso	Personal	ED DHH	ED DHH	01/09/2015		Yes	2	MUC	**Recommendation 7 -** There should be provision for on-going support for Person family and staff affected by this tragic incident	A meeting was held with the family on the 2nd September 2015. A further meeting took place on 22 July 2016. A family meeting was held on 5th August 2016 and a further meeting with family and ST and NIAS was held on the 30th September 2016	P Smyth	Ongoing family support				
Perso	Personal	1 South CAH	1 South CAH	13/11/2015	Patient admitted 6th March 2015 and was commenced on Sando K supplement for 4 days as initially hypokalaemic. Patient suffered cardiac arrest on 9th March 2015, resuscitation was unsuccessful. Potassium level checked during cardiac	Yes	1	MUC	**Recommendation 1 -** Oral Potassium prescribed to treat acute hypokalaemia should be prescribed for a period of 2-3 days until medical review	Prescribers to ensure they record clear instructions on the Medicine Prescription and Administration Record						

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Pers	Personal	1 South CAH	1 South CAH	13/11/2015	arrest and shown to be 8.1. Urea and Electrolytes last checked 6th March, the patients' blood had not been checked the previous 2 days prior to cardiac arrest.	Yes	1	MUC	**Recommendation 2 -** Consideration should be given to defining the recommended frequency of Potassium blood testing in the Southern Trust Hypokalaemia Guidelines for patients on oral potassium to treat hypokalaemia.	The Southern Trust Hypokalaemia Guidelines should be updated as an update was due in 2013.						
Pers	Personal	1 South CAH	1 South CAH	13/11/2015		Yes	1	MUC	**Recommendation 3 -** Prescribers of potassium supplements should ensure that instructions for blood potassium sampling are recorded	The frequency of urea and electrolytes blood sampling for patients being treated for hypokalaemia should be recorded in the drug Prescription and Administration Chart in the special instructions section beside the drugs prescription.						
Pers	Personal	1 South CAH	1 South CAH	13/11/2015		Yes	1	MUC	**Recommendation 4 -** Blood request books used on medical wards should be kept for a period of 6 months	Ward manager to put a communication, retention and storage system in place to facilitate this						
Perso	Personal	ED CAH	ED CAH	13/05/2016	Personal arrived by ambulance to Craigavon Hospital Emergency Department on 24/04/14 at 01:02 hours Per son al at 02:45 hours with head injury and GCS 6. A subsequent CT showed Subdural haemorrhage and possible # C7.	No	1	MUC	**Recommendation 1 -** Feedback will be given to the relevant staff in ED and the inpatient wards in relation to this incident.	Serious Event Audit report to be shared with relevant staff						
Perso	Personal	ED CAH	ED CAH	13/05/2016		No	1	MUC	**Recommendation 2 -** The Urinary Catheter Insertion and Monitoring Form should be reviewed and updates considered	An amendment should be considered by Urology to the Urinary Catheter Insertion and Monitoring form with reference to retracting the foreskin following insertion as well as information on site monitoring						
Perso	Personal	ED CAH	ED CAH	13/05/2016		No	1	MUC	**Recommendation 3 -** Learning in relation to identifying and preventing paraphimosis should be shared across the Trust	Learning shared through ED safety forum Learning shared through ward safety briefings Learning shared through the Trusts learning letter						
Perso	Personal	Theatres DHH	Theatres DHH	23/11/2016	An Personal Information self-presented to Daisy Hill Emergency Department with a swollen right hand and vomiting on 16th May at 23:47 hours. He had cut his hand the previous day in his green house. He was assessed by the emergency department doctor and administered antibiotics and IV fluids. He was then referred to the medical inpatient team Daisy Hill with an initial diagnosis of cellulitis. He was reassessed by the ED doctor and referred to the surgical inpatient team Daisy Hill with a revised possible diagnosis of necrotizing fasciitis. The surgical team had initially planned to transfer him to Plastics UHD but he was transferred to theatre for stabilization. He subsequently had debridement of the hand wound in theatre and was transferred to the Intensive Care Unit Craigavon on the afternoon of 17th May. He remained quite ill and unfortunately died on 18th May at 09:40 hours with a diagnosis of toxic shock syndrome	Yes	2	CCS	**Recommendation 1 -** All staff in ED should continue to be vigilant for the early identification of septic patients	Feedback to be given to ED staff and this should be emphasised at ward safety briefings and the Southern Trust Joint Emergency Department Patient Safety Meetings	Ward Manager ED/Patient Safety Consultant			October 2016 ED M&M March 2017		
Perso	Personal	Theatres DHH	Theatres DHH	23/11/2016		Yes	2	CCS	**Recommendation 2 -** Feedback to be shared amongst the surgical inpatient team. .	This case will be presented at the Southern Trust Surgical Mortality and morbidity meeting	Chair of M&M			Competed August 2016 M&M Surgical, Anaesthetic, Radiology 15 Sept 15 ED M&M March 2017		
Perso	Personal	Theatres DHH	Theatres DHH	23/11/2016		Yes	2	CCS	**Recommendation 3 -** The Trusts Cellulitis Protocol needs amended to better guide staff.	The Trusts Cellulitis Protocol should state if signs of Cellulitis and septic shock, treat as Necrotising fasciitis.	AD/AMD			01/12/2016 The trust's cellulitis guidelines were updated and uploaded on 21/8/17 In the new guidelines it states that for cellulitis:- Class 3-4: have severe sepsis syndrome with organ failure or severe life threatening infection e.g. necrotising fasciitis (see separate section) For antibiotics advice it says Class 3-4: See severe soft tissue infection		
Perso	Personal	Theatres DHH	Theatres DHH	23/11/2016		Yes	2	CCS	**Recommendation 4 -** There should be early referral to Anaesthetics/ICU of hypotensive patients with skin and soft tissue infections.	Junior staff should have awareness raised of sepsis and necrotising fasciitis and septic and toxic shock	AD/AMD			November 2016 May 2016 2017/2018 work is ongoing in relation to raising awareness of sepsis the Medical director chairs a Trust Sepsis 6 group, raising awareness of sepsis ongoing		
Perso	Personal	Theatres DHH	Theatres DHH	23/11/2016		Yes	2	CCS	**Recommendation 5 -** Measures needs to be put in place so that ill patients that have not stabilised are not transferred to an inappropriate ward.	There should be criteria set for ED to safely discharge patients to ward-level care	AD/AMD			November 2016 May 2018 ED doctor refers patient for admission and patient is transferred when accepted by receiving team. NEWS SCORE is reviewed and escalated if appropriate prior to transfer. Registered Nurse transfers patient to the ward		
Perso	Personal	ED CAH	ED CAH	13/11/2015	A Personal Information had a seizure after being administered Intravenous tramadol as analgesia for abdominal pain. He had been administered 200mgs IV as opposed to the 100mgs prescribed.	No	1	MUC	**Recommendation 1 -** The Emergency Department should take all reasonable steps to prevent an reoccurrence of this type of drug handling error	Tramadol injection has been removed from both emergency departments						
Perso	Personal	ED CAH	ED CAH	13/11/2015		No	1	MUC	**Recommendation 2 -** The ward Manager in the ED should ensure their staff are competent in checking and administering medications as per the Trust's Medicine Code	Nurse 2 has been sent on a training update on the Administration of Medication Nurse 2 has undergone a period of supervision of her medicine checking and administration.						
Perso	Personal	ED CAH	ED CAH	13/11/2015		No	1	MUC	**Recommendation 3 -** The Nurse Bank Manager should ensure their staff are competent in checking and administering medications as per the Trust's Medicine Code	The Nurse Bank Manager should be informed of the Serious Adverse Drug Incident to follow up with training and supervision for Nurse 3						
Perso	Personal	ED CAH	ED CAH	13/11/2015		No	1	MUC	**Recommendation 4 -** Medical staff should be reminded to carry out proper medicine checks before they administer medication	The Consultant on charge in ED on the day of the serious adverse drug incident will give feedback to Doctor 1 on how Doctor 1 can prevent a reoccurrence of such a drug error by adhering to checking procedures.						
Perso	Personal	Dermatology OPD CAH	Dermatology OPD CAH	09/10/2015	Personal Information was assessed at the Dermatology OPD Craigavon Hospital on 19/11/13. A dermatofibroma was diagnosed and a plan to review him in 2 months at the	No	1	MUC	**Recommendation 1 -** Awareness of Desmoplastic Melanoma should be raised within the Trust to enhance learning.	This case was presented at the Dermatology Multidisciplinary Meeting on 30/04/15						
Perso	Personal	Dermatology OPD CAH	Dermatology OPD CAH	09/10/2015	Dermatology Outpatients Clinic was planned.There was a delay in his review, he was actually reviewed 23/12/14, At this review a diagnosis of possible cancerous nodule was made. This was excised on 12/03/15. He has been referred to plastics UHD for possible further surgical excision. He has been referred to oncology.	No	1	MUC	**Recommendation 2 -** Steps should be taken to address delays in Dermatology patients being reviewed at Outpatients.	The Trust should consider a workforce review in relation to medical staffing in Dermatology.						
Perso	Personal	3 South CAH	3 South CAH	23/11/2015	On 2 March 2015, Personal presented to CAH ED with feeling unwell, swollen penis for 24 hours. Commenced on Flucloxacillin 2g given intravenously (i/v) and benzylpenicillin 1.2 g i/v. Then commenced on Tazocin 4.5 g i/v three times daily and Daptomycin 475 mg i/v OD prescribed. Oral	No	1	SEC	**Recommendation 1 -** In the event of suspected Fournier's Gangrene, the Microbiology Team need to engage with the senior clinical manager of the patient, followed by joint assessment.							
Perso	Personal	3 South CAH	3 South CAH	23/11/2015	Clindamycin 300 mg prescribed TID on March 4 2015. On 9th March 4 2015, it was noted by Microbiology Consultant that the dose of clindamycin was too low for the indication and that the intravenous route would have been more appropriate.	No	1	SEC	**Recommendation 2 -** The Review Panel understands that the different mode drug kardex between ICU (electronic) and the ward (paper chart) has existed for some time across hospitals in Northern Ireland. While there is a regional project to progress an electronic prescription and administration (EPMA) record for all in-patients, until this is in place, there remains a requirement for a patient's Kardex to be updated following discharge form ICU. This must be highlighted to FY1 doctors as an important clinical task that must be prioritised to avoid omission or delay of medication.							
Perso	Personal	1 South CAH	1 South CAH	11/12/2015	A Personal Information fell from a chair on ward 1 South Craigavon hospital and sustained a fracture to his right hip.	No	1	MUC	**Recommendation 1 -** Feedback will be given to the relevant staff on the inpatient wards in relation to the incident.	Serious Event Audit report to be shared with relevant staff						
Perso	Personal	1 South CAH	1 South CAH	11/12/2015		No	1	MUC	**Recommendation 2 -** Patients taking medication associated with falls should have a medication review undertaken post inpatient fall	Nursing staff to be reminded to request medication review on patients that have fallen who are taking medication associated with falls.						
Perso	Personal Informati	AMU CAH	AMU CAH	18/11/2016	Monday 5 October this patient was admitted to Medical Admissions Unit with acute exacerbation of asthma and abdominal pain. There was a delay in surgical assessment. There was then a further delay in imaging of abdomen. Following assessment and diagnoses of perforation, patient continued to deteriorate and was taken to theatre for an	Yes	2	MUC	**Recommendation 1 -** Rapid ratification and validation by Acute Services of the General Surgery Inpatient Referral form. Clinicians and registered nursing staff require access to training in conjunction with this process being implemented.							

Registered Nurse transfers patient to the ward

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Perso	Personal Informati	AMU CAH	AMU CAH	18/11/2016	emergency laparotomy on 6 October 2015.Pt is currently in ICU on high dose inotropic support following laparotomy	Yes	2	MUC	**Recommendation 2 -** The creation of a formal recorded medical/surgical attendance log at clinical handover at 17:00, 20:30 and 08:00hrs which captures high level clinical discussions and planning. The presence of the registrars on- call would ensure appropriate and timely management of the requests for cross-specialty opinions in particular.							
Perso	Personal	2 North CAH	2 North CAH	23/11/2016	A Personal Information was admitted to ICU on the 07/01/16 with shortness of breath. CTPA confirmed multiple bilateral pulmonary emboli. Despite treatment Pt. sadly died on the 14/01/16. A CTPA from 2014 was re-examined and pulmonary embolus was retrospectively diagnosed. It had not been picked up in 2014 radiology report.	Yes	2	MUC	**Recommendation 1 -** Direct case review with Dr 1. This meeting will be recorded and included in Dr 1's annual appraisal and form part of the professional revalidation process.							
Perso	Personal	2 North CAH	2 North CAH	23/11/2016		Yes	2	MUC	**Recommendation 2 -** Presentation at the Trust Radiology Department "Learning from Discrepancies Meeting". This case will be included in the Learning from Discrepancies Meeting bi annual report to as a way of discovering recurrent discrepancies and as an alert for colleagues to be particularly vigilant for these sources of error.							
Perso	Personal	2 North CAH	2 North CAH	23/11/2016		Yes	2	MUC	**Recommendation 3 -** Presentation to both SHSCT MUSC M&M							
Perso	Personal	2 North CAH	2 North CAH	23/11/2016		Yes	2	MUC	**Recommendation 4 -** Submission of this incident to the Northern Ireland Modernising Radiology Clinical Network for presentation and learning to the radiology departments throughout Northern Ireland							
Perso	Personal	AMU CAH	AMU CAH	18/11/2016	Personal admitted to sideward with weakness and diarrhoea on 11/11/15. On clopidigrel and i/v fluids. On 15/11/15, patient up to notify nursing staff re i/v fluids running out and fell backwards, hitting head. CT revealed traumatic Rt occipital fracture, sub arachnoid haemorrhage and sub- dural haemorrhage. Patient never recovered neurologically and sadly passed away 17/01/16.	Yes	1	MUC	None	No Action Plan required.							
Perso	Personal Inform	Female Medical DHH	Female Medical DHH	13/12/2013	Patient admitted for an elective ERCP on 13/12/12. Following the procedure the patient complained of pain and was admitted for observation and investigations. The patient's condition deteriorated and the patient subsequently died on the 22/12/12.	Yes	2	MUC	**Recommendation 1 -** The review team recommend therefore that all records are: placed in sequential order; dated, timed and signed; and a list containing stakeholder grade, signatures and printed names is completed appropriately in both Medical and Nursing Records							
Perso	Personal Inform	Female Medical DHH	Female Medical DHH	13/12/2013		Yes	2	MUC	**Recommendation 2 -** The Patient Centred Care Record for ERCP should be revised to include guidance on the frequency of physiogical observations required for patients admitted with suspected complications following ERCP. The existing ERCP Protocol shold also be revised to incorporate this information. The Frequency of recording these observations should be written in the nursing care plan and evaulation record.							
Perso	Personal Inform	Female Medical DHH	Female Medical DHH	13/12/2013		Yes	2	MUC	**Recommendation 3 -** The review team recommended these observations should be written in the nursing coare plan and evaulation record. If prescribed analgesia is not imemediately available it must be sourced and administered in a timely fashion. The Trust process for contacting the Pharmacy Department of if the Out of Hours the on-call Pharmacist should be followed. If this is not possible to source the prescription an alternative analgesic must be prescribed and administered.							
Perso	Personal Inform	Female Medical DHH	Female Medical DHH	13/12/2013		Yes	2	MUC	**Recommendation 4 -** The review team recommend Sepsis Guidelines are followed.							
Perso	Personal Inform	Female Medical DHH	Female Medical DHH	13/12/2013		Yes	2	MUC	**Recommendation 5 -** In cases where NEWS is 7 or above the NEWS escalation framework in place must be adhered to and followed in a timely manner.							
Perso	Personal	3 South CAH	3 South CAH	28/11/2016	This Personal to transferred from South West Area Hospital to Craigavon Area Hospital on 19 January 2015 with renal calculi and sepsis. The patient is a brittle epileptic, with a history of thrombocytopenia, ulcerative colitis, and ureteric colic. A urethroscopy and stenting was done on 22 January 2015 and patient was managed in the Intensive Care Unit until Day 2 post op. On Sunday 25 January 2015 at 16:00hrs , this patient had a prolonged epileptic seizure for approximately	No	1	SEC	**Recommendation 1 -** This report has demonstrated that there is a need for an updated operational strategy to address the prolonged and wide-spread poor performance of the 3S staff nurses in relation to avoiding inappropriately omitted and delayed doses of critical medicines.							
Perso	Personal	3 South CAH	3 South CAH	28/11/2016	30 min which required input from ICU Intensivists. Upon review of the medicine kardex, there were documented omissions of anti-epileptic medication.	No	1	SEC	**Recommendation 2 -** The SHSCT formally implement a Medication Incident Monitoring process relevant to the inappropriate omission of any critical medicine. The Panel recommend that all Acute Ward managers utilise the SHSCT template for review of omitted doses of critical medicines which had been circulated informally in the past (Appendix Three). The Review Team suggest Acute Services provide guidance for Ward Managers on how nursing staff are supported and managed following the inappropriate omission of a critical medicine.							
Perso	Personal	3 South CAH	3 South CAH	28/11/2016		No	1	SEC	**Recommendation 3 -** Acute Service Ward Managers adopt a transparent and robust process which demonstrates and records that all staff receive 'Learning from Medication Incident' monthly reports. This should be in conjunction with any ward-based safety briefings or staff meetings.							
Perso	Personal	Orthopaedic Ward CAH	Orthopaedic Ward CAH	18/01/2017	On 3 February 2015, Personal admitted to Craigavon Area Hospital. after fall at home on 2 February 2015. Past medical history of Hodgkin's Lymphoma, Right (Rt) Cerebral Vascular Accident (CVA), Pancreatitis, alcohol dependence, and fatty liver. Imp: fractured Lt sub-trochantric fracture. During recovery period on 15/02/15, patient fell while mobilising independently. X-rays confirm fractured Right proximal femur. Patient made full recovery and was discharged home on 25/02/15.	No	1	SEC	**Recommendation 1** – All staff must consistently update patient risk assessments according to length of patient stay and changes in condition. Acute Services operational teams need to agree a local programme to embed and monitor compliance in relation to live risk assessments documentation. This should include a regular performance feedback mechanism to all Acute nursing staff.							
Perso	Personal	Orthopaedic Ward CAH	Orthopaedic Ward CAH	18/01/2017		No	1	SEC	**Recommendation 2-** Nursing staff to be reminded of the requirement to review and assess their patients in compliance with the risk assessment guidance							
Perso	Personal	Orthopaedic Ward CAH	Orthopaedic Ward CAH	18/01/2017		No	1	SEC	**Recommendations 3- Falls Bundle compliance –**continue audit and feed back to nursing and medical staff for continuous improvement**.**							

Received from Trudy Reid on 16/05/2023. Annotated by the Urology Services Inquiry.

Perso	Personal	ED DHH	ED DHH	19/12/2014	Patient attended ED DHH on the 23/02/13 complaining of back pain. Following assessment the patient was discharged. Patient presented at ED on the 26/02/13 at 17.39hrs having suffered a cardiac arrest at home. The patient was pronounced dead at 17.50hrs.	Yes	2	MUC	**Recommendation 1 -** The possibility of AAA must always be suspected in those over 50 who have any 2 of the following symptoms: • Abdominal/back pain • Hypotension (+/_ tachycardia) • A pulsatile abdominal mass Doctor induction to ED includes teaching relating to the presentation of a patient with a suspected Abdominal Aortic Aneurysm. This information must be strengthened. It is suggested by the review team that Person case history could be annonomysed and used to enhance learning for medical and nursing staff working in ED. The current radiology pathway for diagnosis of AAA is considered appropriate and should be followed.						
Pers	Personal	ED DHH	ED DHH	19/12/2014		Yes	2	MUC	**Recommendation 2 -** Clinical Observations It is imperative that medical and nursing staff take cognisance of the significance of clinical observations and action appropriately.							
Pers	Personal	ED DHH	ED DHH	19/12/2014		Yes	2	MUC	**Recommendation 3 -** It is imperative that the assessing doctor must consider all signs and symptoms in order to determine a diagnosis. If the assessing doctor cannot ascertain an explanation for the presenting symptoms, advice must be sought from a senior clinician. The review team recommend that the mechanism for this is reviewed and strengthened if necessary.							
Pers	Personal	ED DHH	ED DHH	19/12/2014		Yes	2	MUC	**Recommendation 4 -** Discharge medication must always be checked in accordance with the Trust Medicine Code. Practice within the ED must be reviewed and strengthened if required.							
Pers	Personal	ED DHH	ED DHH	19/12/2014		Yes	2	MUC	**Recommendation 5 -** The review team acknowledge "note audit" as good practice. The review team also recognise that the throughput which the ED Consultants deal with on a daily basis can inhibit their availability to carry out this action. The review team therefore recommend that the Trust should consider how time could be allocated in job plans for this activity.							
Perso	Personal	ED CAH	ED CAH	20/08/2013	Personal attended ED CAH 31.10.12. Patient had chest X-ray carried out and review and followup were requested. Patient presented to ED 5.5.13 following further investigation patient was diagnosed as having a lesion on the lung.	No	2	MUC	**Recommendation 1 -** A standardised Referral Form should be designed for onward referrals which can be used by all Southern Trust Departments. The referral should be clear and state the following: Named Consultant/Department/Speciality/Discipline to which the referral is to be sent; the acuity/urgency of the referral. Ideally the referral should be typed. Abbreviations should not be used on the Referral form. A multi-disciplinary team should be convened to design the form and should include representatives from the Booking Centre and Cancer Services.							
Pers	Personal	ED CAH	ED CAH	20/08/2013		No	2	MUC	**Recommendation 2 -** Consideration should be given to rolling out on-line electronic referrals within Secondary Health Care settings.							
Pers	Personal	ED CAH	ED CAH	20/08/2013		No	2	MUC	**Recommendation 3 -** Referrals relating to suspected cancer should be forwarded to the appropriate Cancer Services team for advancement.							
Pers	Personal	ED CAH	ED CAH	20/08/2013		No	2	MUC	**Recommendation 4 -** Only one request should be sent per referral letter/form. All referrals should be sent separately to prevent the chance of a request being inadvertently missed or overlooked.							
Pers	Personal	ED CAH	ED CAH	20/08/2013		No	2	MUC	**Recommendation 5 -** All necessary personnel must be made aware of the Referral process and how to access this.							
Pers	Personal	ED CAH	ED CAH	20/08/2013		No	2	MUC	**Recommendation 6 -** Patients should be informed if onward referral/s is/are to be made and to whom and for what reason. Patients should be given a timeframe of when to expect referral/s and who to contact if the appointment does not materialise. Verbal and written information regarding this should be given to the patient at point of discharge. Consideration should be given to devising a simple discharge template for this.							
Pers	Personal	ED CAH	ED CAH	20/08/2013		No	2	MUC	**Recommendation 7 -** General Practitioners should be informed of all onward referrals, "Red Flag" /"31 Day Target" referrals should be clearly identified in correspondences.							
Patie	Patient 10	Urology OPD CAH	Urology OPD CAH	15/03/2017	Had a CT scan 24/6/2014 as follow-up of bowel cancer. CT showed an abnormal renal cyst with two further cysts in the right kidney.US performed 24/7/2014 showed solid elements within the anterior lower pole cyst and recommended an MRI to further evaluate. MRI performed 2/9/2014. Referral to Urology was not triaged on receipt Pe sent OP appointment for 6/1/2016 Per was seen in clinic on 6/1/16. The sequence of events was outlined and surgical treatment of a suspected cystic renal cancer recommended after completion of up to date staging with a further CT scan. There has been a resultant 18 month delay in OP review and recommendation of treatment for a suspected kidney cancer.	No	2	SEC	**Recommendation 1 -** This SAI has demonstrated that patients will be at an increased risk of harm when the opportunity for early intervention at Triage is omitted. The Review Panel recommend that the Trust reviews the process which enables the clinical triaging and escalation of triage non-compliance in accordance with IEAP	This is monitored through ETriage on a weekly basis and through recording paper copy referrals received on a database that is also monitored on a weekly basis for Urgent and Routine and daily for red flags Yes through weekly monitoring by Head of Service, Red Flag Team and Booking Centre Team and appropriate timely escalation if required						
Patie	Patient 10	Urology OPD CAH	Urology OPD CAH	15/03/2017		No	2	SEC	**Recommendation 2 -** In particular the fundamental issue of triaging GP referral letters remains a challenge within Urology. The urology operational and medical management teams immediately need to address the issue of un-triaged referrals not being processed in accordance with IEAP.	As above. Monitored by HOS, Red Flag Team and Booking Centre Team Yes through weekly monitoring by Head of Service, Red Flag Team and Booking Centre Team and appropriate timely escalation if required						
Perso	Personal	4 North CAH	4 North CAH	09/10/2015	Personal was admitted to 4 North following fall at home on 10th May 2015. She had sustained a head injury and was on warfarin. Initial CT showed no intracranial haemorrhage. She had another fall on the ward at 5am the next morning and sustained another head injury. Repeat CT showed intracranial haemorrhage. She sadly died on the 14th May	Yes	1	SEC	**Recommendation 1 -** Continually raise awareness of the risk of patients falling in hospital							
Perso	Per son	1 South CAH	1 South CAH	4.4.17	Personal presented on 16/12/14with a history of right leg weakness and feeling lethargic. Past history of recurrent Urinary Tract infections (UTI). Working diagnoses, UTI. On 20/12/14 at 13:25, pt became hypotensive and required i/v fluid therapy. NEWs scores were between 2-8. This was managed by FY1. On 21/12/14 at 01:40 hrs, pt became short of breath and coughed up blood stained sputum and had difficulty	No	1	MUC	**Recommendation 1 -** Present SAI findings at M&M to ensure learning is disseminated- staff will understand the importance of escalation and documentation · staff will understand there are different Clostridium species							
Perso	Per son	1 South CAH	1 South CAH	4.4.17	swallowing. NEWS scores between 5-7. The FY1 and FY2 notified Registrar of deterioration at 04:00 hrs. Patient transferred to ICU at 06:20 hrs. This patient had a gastric bleed	No	1	MUC	**Recommendation 2 -** This SAI report is to be shared with ward staff involved in Pe care to ensure learning is disseminated							

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Perso	Per son	1 South CAH	1 South CAH	4.4.17	and melena on admission to ICU. Patients condition did not improved despite maximum inotrope support. On 2/01/15 patient had a distended abdomen. CT scan reveal large areas of bowel ischema. The patient passed away on 3/01/15.	No	1	MUC	**Recommendation 3 -** The Trust will implement the 'Sepsis 6 Bundle' • staff will understand the importance of identification and early treatment of sepsis.							
Perso	Per son	1 South CAH	1 South CAH	4.4.17		No	1	MUC	**Recommendation 4 -** Implement Regional News Chart which includes sepsis 6 with associated training • staff will understand the importance of escalation and documentation • staff will understand the importance of identification and early treatment of sepsis.							
Perso	Personal	Orthopaedic Ward CAH	Orthopaedic Ward CAH	14.4.17	Personal Information admitted from Nursing Home with suspected cellulitis of left ankle. X-ray of ankle taken on 02/02/16. Patient transferred to Orthopaedic Ward and had an un-witnessed fall on 17/02/16 and sustained fractured Lt neck of femur.	No	1	SEC	**Recommendation 1.** This SEA report will be shared with medical, nursing and radiography staff for learning							
Perso	Personal	Orthopaedic Ward CAH	Orthopaedic Ward CAH	14.4.17		No	1	SEC	**Recommendation 2.** Medical Staff who request an X-ray must review and record the findings in the medical notes.							
Perso	Personal	Orthopaedic Ward CAH	Orthopaedic Ward CAH	14.4.17		No	1	SEC	**Recommendation 3.** Pain scores must be regularly recorded, documented and if required analgesia prescribed, administered and effect recorded.							
Perso	Personal	Orthopaedic Ward CAH	Orthopaedic Ward CAH	14.4.17		No	1	SEC	**Recommendation 4.** Trust guidance will be reviewed to guide staff on frequency of falls risk assessments and documented of same.							
Perso	Personal	Orthopaedic Ward CAH	Orthopaedic Ward CAH	14.4.17		No	1	SEC	**Recommendation 5.** Mobility care plans must be completed for patients where there is a falls risk or mobility is affected due to treatment e.g. non-weight bearing.							
Perso	Personal	Orthopaedic Ward CAH	Orthopaedic Ward CAH	14.4.17		No	1	SEC	**Recommendation 6.** Written guidance will be developed for patients whose mobility is restricted as part of their treatment plan e.g. non-weight bearing.							
Perso	Personal	Delivery Suite CAH	Delivery Suite CAH	29.9.17	Personal Information who attended CAH at 33+2 weeks gestation on the 19/8/16 with spontaneous onset of labour and spontaneous rupture of membranes P was	Yes	2	IMWH	**Recommendation 1.** The review team recommend the Trust to update their guidelines on management of breech births.							
Perso	Personal	Delivery Suite CAH	Delivery Suite CAH	29.9.17	counselled by the obstetric registrar and consultant regarding mode of delivery. P wished to proceed with vaginal delivery. P progressed to a vaginal breech delivery of Person at 21:59 hrs on 19/08/16. Person was delivered with Apgar scores of 0 at 1 minute, 0 at 5 minutes and 0 at 10 minutes of life.	Yes	2	IMWH	**Recommendation 2.** Professional communication should be practiced through multidisciplinary staff training including PROMPT (Practical Obstetric Multi-Professional Training) and simulated drills.							
Perso	Personal	Delivery Suite CAH	Delivery Suite CAH	29.9.17	Emergency resuscitation was performed by paediatric staff and Person was admitted to the NNU. Person required ventilation and administration of anticonvulsant medication; Person remained critically unwell requiring maximum intensive neonatal support. The decision was made to withdraw treatment and Person sadly passed away on 25/08/16 at 03:00 hrs	Yes	2	IMWH	**Recommendation 3.** Adoption and promotion of clinical team knowledge of communication aides such as the 'CCUSS'* acronym is proposed, modified from the Aviation Industry acronym 'CUS' (Concerned Uncomfortable Stop). 'CCUSS' stands for 'Clarity' , 'Concerned', 'Uncomfortable', 'Safety', 'Stop'. Any member of a clinical team may use these key words if they wish the team leader to pause and/or stop to allow review of management, and these key words are suggested as 'red alert' words for professionals to acknowledge and act upon whilst avoiding ambiguous or emotive communication during potentially tense clinical scenarios.							
Perso	Personal	1 North Cardiology CAH	I North Cardiology CAH		Personal admitted to 1 North via ED 12/01/16 with NSTEMI. Went to Cath Lab CAH 19/01/16, showed vein graft aneurysm had significantly increased in size. Transferred RVH 21/01/16 for day case closure of vein graft aneurysm. Returned to I North 17:45 hours 21/01/16, felt unwell 19:00, cardiac arrest 21:30. Unsuccessful resuscitation.	Yes	1	MUC	**Recommendation 1.** When a patient is admitted to 1North following a Cardiac procedure, the following must be assessed within 15 minutes of admission and recorded contemporaneously. · NEWS- record on NEWS chart · Wound Check · Attach to cardiac monitor and record rhythm							
Perso	Personal	1 North Cardiology CAH	I North Cardiology CAH			yes	1	MUC	**Recommendation 2.** Any transportation incidents must be reported to medical staff on admission							
Perso	Personal	1 North Cardiology CAH	1 North Cardiology CAH			yes	1	MUC	**Recommendation 3.** ECGs must be recorded with patient identifiable information logged on the ECG machine- ECG printed and filed in patient medical notes							
Perso	Personal	1 North Cardiology CAH	1 North Cardiology CAH			yes	1	MUC	**Recommendation 4.** Nursing staff have been reminded that patient records must be managed to ensure they are securely stored to ensure a complete patient record							
Perso	Personal	Day Surgical Unit CAH	Day Surgical Unit CAH		A patient was admitted to the Day Surgical Unit 09/02/2016 for an OGD. Following the procedure the patient was discharged back to PNH. The patient presented to ED in CAH with total stroke syndrome on 16/02/16 and passed away peacefully on 17/02/2016. The case was discussed with the Coroner. Following an initial review of the case it has become apparent that omission of Enoxaparin medication took place post procedure and that there were issues pertaining to the instructions regarding anti coagulation therapy.	Yes	1	SEC	**Recommendation 1.** Endoscopists must include written instructions for post-procedure management of anticoagulant and antiplatelet medicines for all patints and ensure these are communicated to the in-patient team or GP as appropiate. These must also be communicated in writing to the GP, patient and/or carer on discharge from the Acute Directorate.							
Perso	Personal	Day Surgical Unit CAH	Day Surgical Unit CAH			YES	1	SEC	**Reccomendation 2.** The Trust yellow "addition to the waiting list endoscopy form" and the "Pre-operative Management of Warfarin for Endoscopy Patients Who Are Required to Stop Warfarin Prior to the Procedure" meed to be completed for all at risk patients.							
Perso	Personal	ED DHH	ED DHH	26.5.2016	A Personal Information presented to the ED DHH by ambulance on the 28.4.2016 with palpitations. He had a cardiac history and had stents inserted in the Cath Lab on 18.4.2016. Following examination and tests in ED he was discharged home after 6 hours in ED. He was found dead in	YES	2	MUC	**Recommendation 1.** All POC devices installed in the Trust should have the reference range of results available and operational on printout of results before they are declared operational	POC committee to review existing blood gas machines to ensure the reference ranges are operational and audit monthly to ensure this does not reoccur.						
Perso	Personal	ED DHH	ED DHH	26.5.2016	his house on 29.4.2016. The fire service advised that there was a positive carbon mononixide reading in the house.	YES	2	MUC	**Recommendation 2.** The report should be shared with the operational teams for learning.	Case to be discussed at the emergency Departments Mortality and Morbility Meeting. Feedback to be given to staff involved in the incident Case to be discussed at POC forum.						
Perso	Personal	ED CAH	ED CAH		Patient Per attended Craigavon Hospital Emergency Department with chest pain on 12th April 2012 and was subsequently discharged. He had a chest x ray which was reported as a soft opacity projected over the right lower zone and further assessment was advised. He had a further chest x ray on the 21st April 2013 that did not mention opacity. On the 16th June 2015 a further chest x ray report recorded suspicions of lung neoplasm. A CT chest on the 10th July 2015 confirmed a bronchogenic carcinoma.	NO	1	MUC	**Recommendation 1 -** The current system for follow up of patients that have suspicious chest X rays needs reviewed and improved.	The PACS systems already available feature to identify patients that need follow up should be used in all cases by reporting radiologists. The PACS system could then be interrogated at intervals to identify patients that have been suggested as needing a follow up. A checking process needs to be created to confirm if these patients have had a follow up.		3.8.17 DRO advised The Trust continues to consider the implementation of this recommendation and is in discussion with clinical and operational teams to work out the practicalities of implementing this recommendation considering that last month 4772 patients had 7325 radiographs performed in ED in CAH, in the last 2 weeks 1665 patients had 2203 radiographs performed in ED in DHH, and in the last 2 weeks 50 patients had 52 radiographs performed in MIU in STH. 8202 patients per month, 11835 radiographs - extrapolated to approximately 100,000 patients and 140,000 radiographs per year. Following meetings with operational teams and clinical teams in September the Trust will update the DRO again			
Perso	Personal	ED CAH	ED CAH			NO	1	MUC	**Recommendation 2 -** Relevant staff and teams should receive feedback to raise awareness of this problem and case.	The case will be fed back through the radiology discrepancy process. The case will be fed back at the Joint Emergency Department Safety Meetings (M&M)						
Perso	Personal	ED CAH	ED CAH			NO	1	MUC	**Recommendation 2 -** Relevant staff and teams should receive feedback to raise awareness of this problem and case.	The case will be fed back through the radiology discrepancy process. The case will be fed back at the Joint Emergency Department Safety Meetings (M&M)						
Perso	Personal	ED CAH	ED CAH			NO	1	MUC	**Recommendation 3 -** More clinical information should be available on NIPACS	Consideration should be given to ED notes being scanned onto the PACS system for patients that have been X rayed.						

Perso	Personal	2 North Haematology CAH	2 North Haematology CAH	Sep-17	Personal patient admitted for Chemotheraphy on 7 January 2016. During course of treatment patient acquired Norovirus while an in-patient on 13/01/2016. Patient admitted to Intensive Care and sadly passed away on 24/01/2016.	YES	1	MUC	**Recommendation 1 -** SEA findings to be shared with clinical teams and patient flow teams to ensure alertness of risks of norovirus and other simular transmissible infections.							
Perso	Personal	2 North Haematology CAH	2 North Haematology CAH	Sep-17		YES	1	MUC	**Recommendation 2 -** Side room with en-suite facilities for patients receiving chemotherapy.							
Perso	Personal	2 North Haematology CAH	2 North Haematology CAH	Sep-17		YES	1	MUC	**Recommendation 3 -** Update and recirculate guidelines of admissions to haematology ward.							
Perso	Personal	ED CAH	ED CAH	21.10.2015	A patient Pe was admitted and managed with diagnosis newly diagnosed diabetic in dka, having presented via ED earlier with abdo pain. Given appropriate fluid therapy but became worse. Given opiate analgesia and had cardiorespiratory arrest requiring resuscitation. Post resuscitation showed persistent shock and severe lactic acidosis without ketosis, and developed anaemia. Diagnosis reappraised and intestinal volvulus/abdominal pathology suspected after emergency resuscitation and during prolonged post-arrest phase/ pending transfer to PICU Pers needed emergency laparotomy and suffered gut ischaemia needing resection.	NO	2	MUC	**Recommendation 1 -** All nursing and medical staff should be made aware that serum blood ketones are checked on all patients that have raised blood sugar.	Medical and Nursing Staff adhere to guidelines If blood sugar above 11 or clinical suspicion of DKA serum blood ketones are checked	Dr McCormick HOS					NO
Perso	Personal	ED CAH	ED CAH	21.10.2015		NO	2	MUC	**Recommendation 2 -** BP should be measured on all seriously ill children that present to the ED	All seriously ill children are taken to resus and their BP is monitored Currently in place. Adhoc audit to be completed to ensure compliance.	HOS Lead Nurse Sister Holmes					
Perso	Personal	ED CAH	ED CAH	21.10.2015		NO	2	MUC	**Recommendation 3 -** Within the ED education programme training should take place in relation to the diagnosis, and management of patients with DKA in line with the BSPED guideline.	Simulation with Paeds in place for ED medical and nursing staff Specific sessions on the management of children with DKA to be rolled out	Dr McCormick Lead Nurse Education Facilitator					
Perso	Personal	ED CAH	ED CAH	21.10.2015		NO	2	MUC	**Recommendation 4 -** Staff within ED should be reminded that if a reading is missing on a blood gas report that they should repeat the gas after the machine has been calibrated or use another machine.	Staff are aware that blood gas is repeated if a reading is missing or patients clinical condition indicates blood gas required. This is completed after the machine has been calibrated if ongoing issues with blood gas machine a repeat sample is sent to the lab. Reinforced at patient safety briefing and M&M In Place	Dr McCormick HOS Sr Holmes					
Perso	Personal	AMU CAH	AMU CAH	29.9.2017	A female patient died tragically following a fall within Craigavon Hospital. The patient attended the emergency department on 17th May 2016 and was admitted to the Acute Medical Admission ward on 18th May 2016. The Patient left the ward following which the fall occurred. The patient was also known to the SHSCT mental health services support and recovery team. The Coroner, Health and Safety Executive and the PSNI have been informed of the incident. The Trust received a PSNI "Incidents of Sudden Death SD1" form on 19th May 2016.	YES	3	MUC	**Recommendation 1 -** Patients who present to an Acute Hospital with mental health concerns/risks should have a risk assessment completed by acute staff and this should be documented with any other clinical conditions that resulted in their presentation to hospital. This should be documented: a. In any emergency department assessment b. In the documentation on admission to hospital.							
Perso	Personal	AMU CAH	AMU CAH	29.9.2017		YES	3	MUC	**Recommendation 2 -** Trust healthcare professionals must work together to eradicate terms such as 'medically fit' or 'medical clearance'. The terms 'fit for assessment', 'fit for review' or 'fit for discharge' should be used instead to ensure parallel working.							
Perso	Personal	AMU CAH	AMU CAH	29.9.2017		YES	3	MUC	**Recommendation 3 -** The review team recommend as per NCEPOD that Regional guidelines should be developed outlining the role/responsibilities of general hospital staff in relation to the treatment and care of patients who present with mental health concerns/risks. Any Regional Guidelines should include a recommendation on the use of one-to-one observation support, when following assessment, there is an assessed need for observation in a general hospital setting. The Trust should develop an interim guideline, pending regional guidance, outlining the role/responsibilities of general hospital and mental health staff in the provision of a service to patients who present to an acute hospital with mental health conditions. These should include: a. The point at which a referral to liaison psychiatry should be made b. What should trigger a referral to liaison psychiatry and c. What relevant information a referral should contain d. staff training roles and responsibilities (including guidance on the requirement following mental health assessment for enhanced observation) e. The function of interface meetings between the							
Pers	Personal	IMWH	IMWH	2011	Personal Information redacted by the USI	NO		IMWH	**Recommendation 1 -** A. The review team conclude that it can be very difficult to differentiate between the maternal pulse and foetal heart rate on a CTG tracing, and therefore they cannot conclude that the CTG tracing in this case was not a recording of the maternal pulse. In order to prevent this possibility in the future, the following recommendations are made. These recommendations are consistent with the Trusts Electronic Foetal Monitoring Policy (2008) • Maternal pulse should be recorded ½ hourly in 2nd stage of labour B. • A sonicaid should always be used to identify the foetal heart rate prior to the commencement of a CTG in a labouring mother and the maternal pulse recorded simultaneously. This should be recorded in the chart. If both heart rates are very similar consideration should be given to a foetal scalp electrode or ultrasound scan. C. • If a foetal heart rate appears to be accelerating in response to a contraction the possibility of inadvertent monitoring of the maternal pulse should be considered.	A. These recommendations are consistent with the Trusts Electronic Foetal Monitoring Policy (2008) B. Separate guidance will be developed to clearly highlight the maternal observations that require to be checked during labour and the importance of recording these on the partogram. C. All midwives in Delivery Suite in both Daisy Hill Hospital and Craigavon Area Hospital will attend an awareness session on maternal monitoring.	Patricia Mc Stay Head of Midwifery	31/01/2012				
Pers	Personal	IMWH	IMWH	2011		NO		IMWH	**Recommendation 2 -** At present there is no grading tool in place to grade meconium within the Trust. . The review group propose that a literature review should be completed and presented to the Trusts Consultants of Obstetrics and Gynaecology and Lead Midwives, on the benefits of introducing a tool to provide a robust and consistent mechanism for grading meconium trust wide in the future. If the weight of opinion is that this would be useful, a short life working group should be convened to take this forward.	A short life working group will be convened to review the evidence, develop and implement a meconium grading tool.	Mr David Sim Consultant Obstetrician/Lead Clinician	31/01/2012				

Pers	Personal	IMWH	IMWH	2011		NO		IMWH	**Recommendation 3 -** The review team acknowledge that in this case a senior doctor was present and appropriate treatment and care was provided, when the risk factor of meconium staining was identified. However the timely documentation and transfer from Midwifery Led care to Consultant Led care should be evidenced by the completion of the HART document. Therefore the review team would recommend the following: • When a woman no longer meets the inclusion criteria for midwifery led care a HART document must be completed to ensure that a named Consultant is identified to continue care.	All midwives in Delivery Suite in Daisy Hill Hospital and Craigavon Area Hospital will attend an awareness session regarding the importance of clearly recording the transfer from Midwifery Led Care to Consultant led Care using the HART proforma.	Brenda Kelly Lead Midwife	31/01/2012				
Pers	Personal	IMWH	IMWH	2011		NO		IMWH	**Recommendation 4 -** In view of the valuable information that can be obtained from the analysis of placenta the review team recommend: • The existing policy and procedure should be updated to indicate clear parameters of when the retention of a placenta is required.	A short life working group will be convened to review the guidance on retention of placenta.	Dr Harmini Sidhu Consultant Obstetrician	31/01/2012				
Perso	Personal	MUC/CYP	MUC/CYP	2012	A Personal admitted to ED DHH on 22 December 2012 with abdominal pain and vomiting with a past history of asthma. A review was taken by the Emergency Department and surgery. The child was transferred to the care of the paedritician, and admitted as an inpatient. A CT scan was requested on 23rd evening for further investigation of abdominal pain and during this procedure the patient's condition acutely deteriorated. Prolonged resuscition was carried out however tragically the child subsequently died.	YES		MUC/CYP	**Recommendation 1 - ED -** All paediatric patients require a review by a senior clinician prior to admission. The notes should reflect this assessment and should include a differential diagnosis and a working management plan.							
Perso	Personal	MUC/CYP	MUC/CYP	2012		YES		MUC/CYP	**Recommendation 2 - ED -** Staff must complete all PEWS parameters and adhere to standard as required by the Trust for managing Paediatric Patients. Staff should attend refresher training as required.							
Perso	Personal	MUC/CYP	MUC/CYP	2012		YES		MUC/CYP	**Recommendation 3 - ED -** All children should be allocated a Paediatric Nurse on admission to Emergency Department.							
Perso	Personal	MUC/CYP	MUC/CYP	2012		YES		MUC/CYP	**Recommendation 4 - Access to CT -** The need to strengthen processes to ensure requests for CT scans are taken in a timely manner and full consideration is given to the expertise of speciality doctors involved.							
Perso	Personal	MUC/CYP	MUC/CYP	2012		YES		MUC/CYP	**Recommendation 5 - Access to CT -** All CT/X-ray rooms should be adequately equipped with paediatric resuscitation equipment given the acuity of illnesses seen in these settings and the potential for patients deterioration.							
Perso	Personal	MUC/CYP	MUC/CYP	2012		YES		MUC/CYP	**Recommendation 6 - Access to CT -** Staff in CT/X-ray departments need to be are familiar with and trained in the use of this paediatric equipment.							
Perso	Personal	MUC/CYP	MUC/CYP	2012		YES		MUC/CYP	**Recommendation 7 - Access to CT -** All areas in CT/x-ray that are administering contrast solutions are required to have an anaphylaxis box available (ideally wall mounted). This will also require awareness training to support.							
Perso	Personal	MUC/CYP	MUC/CYP	2012		YES		MUC/CYP	**Recommendation 8 - record Keeping -** All staff recording should be improved in patient records and staff must ensure all entries are legible, dated, timed and signed.							
Perso	Personal	IMWH	IMWH	2014	Perso was admitted in spontaneous labour on 26th April 2013 at Term +5. Perso progressed well in labour, but at 9 cms dilated she developed acute fetal bradycardia which subsequently started to recover but then reverted back to prolonged fetal bradycardia. An emergency Caesarean section was performed under general anaesthetic. The general anaesthetic was complicated by significant regurgitation and aspiration of stomach contents with a subsequent degree of maternal hypoxia. Perso was transferred to the Area Hospital's Intensive Care Unit for further management following delivery. Following maternal intubation Personal was delivered with Apgar's of 0 @ 1minute and 0 @ 5 minutes. Personal was resuscitated and transferred to the local hospital's Special Care Baby Unit and then on to the Regional Hospital's Neonatal intensive care unit (NICU) in Belfast. Personal transferred to back to the Area Hospital's Neonatal Unit (NNU) on 29th April 2013 where Per sadly passed away on the 4th May 2013.	YES	2	IMWH	**Recommendation 1 -** A formal VBAC guideline should be implemented as soon as possible. This should include advice regarding discussion of risk factors during the antenatal period, consistent documentation and intrapartum care.							
Perso	Personal	IMWH	IMWH	2014		yes	2	IMWH	**Recommendation 2 -** The middle grade obstetric staff should be informed at the time of admission in order to ensure timely review and documentation and plan of care.							
Perso	Personal	IMWH	IMWH	2014		yes	2	IMWH	**Recommendation 3 -** There should be a formal guideline for management of acute bradycardia with clear recommendations regarding Decision –to-Delivery Interval (DDI) for a Category 1/blue light caesarean section. PROMPT training every two years should be mandatory for all midwifery and obstetric medical staff throughout the trust.							
Perso	Personal	IMWH	IMWH	2014		yes	2	IMWH	**Recommendation 4 -** The provision of a dedicated ultrasound machine for each delivery suite throughout the Trust.							
Perso	Personal	IMWH	IMWH	2014		yes	2	IMWH	**Recommendation 5 -** The review team recommend a voice over baton bleep emergency system is introduced immediately, to include all team members necessary for delivery and resuscitation of mother and baby.							
Perso	Personal	IMWH	IMWH	2014		yes	2	IMWH	**Recommendation 6 -** An automated electronic anaesthetic record system is required as soon as possible.							
Perso	Personal	IMWH	IMWH	2014		yes	2	IMWH	**Recommendation 7 -** Consider submission of tissue samples from the placenta for urgent culture in the microbiology labs in cases of unexplained fetal bradycardia with a baby delivered with Apgar score less than 3 at 1 minute.							
Perso	Personal	IMWH	IMWH	2014		yes	2	IMWH	**Recommendation 8 -** The Trust should consider offering more specific information regarding the benefit of post mortem examination in similar circumstances. As health care professionals we are obligated to try to establish a cause of death. In the event of parents declining post-mortem consideration should be given to discussion with the coroner.							
Perso	Personal	IMWH	IMWH	2014		yes	2	IMWH	**Recommendation 9 -** The Trust has commissioned a working group to explore any possible explanation and learning from sepsis in labour							
Perso	Personal	ED CAH	ED CAH	27.10.17	Delayed diagnosis of Thoracic Aortic Aneurysm and subsequent death of patient at induction of anesthesia. Patient attended ED in CAH on 13/05/2016 with chest pain following investigation patient was discharged home from ED at 04:50	YES	2	MUC	**Recommendation 1 -** The learning from this case will be shared with staff involved and at ED and medical Morbidity and Mortality meetings and reported in the ED newsletter.							
Perso	Personal	ED CAH	ED CAH	27.10.17	14/05/2016. Re- attended ED in CAH 15/05/2016 and was admitted with infectious exacerbation of COPD. Diagnosed with Thoracic aortic dissection on 16/05/2016. Patient was transferred to RVH, Cardiac Theatres, where her systolic Blood Pressure was 80, and was given half a milligram of Metaraminol, subsequently her blood pressure drifted up to	YES	2	MUC	**Recommendation 2 -** Trust should develop guidance within the acute directorate, systems and processes to endeavour to meet the recommendations in relation to time scale for patient assessment in the Manchester triage tool.							

Perso	Personal	ED CAH	ED CAH	27.10.17	188 systolic, then started to lose her Cardiac output, arrested with Pulseless Electrical Activity. CPR was started immediately, Adrenaline was given, however due to no sufficient Cardiac Output and Saturation, the decision was made to stop CPR and patient passed away at 14:04 on	YES	2	MUC	**Recommendation 3 -** Trust should develop guidance outlining the expectations of ED staff in the identification and management of Aortic Dissection in the ED department, including updating the ED handbook.							
Perso	Personal	ED CAH	ED CAH	27.10.17	16/05/2016.	YES	2	MUC	**Recommendation 4 -** The Trust should consider implementing guidance/systems for patient representations at ED with the same condition as a previous recent attendance and processes e.g. the completion of the Consultant box on eEMS to support the Royal College of Emergency medicine Guidance							
Perso	Personal	ED CAH	ED CAH	27.10.17		YES	2	MUC	**Recommendation 5 -** Staff in AMU will be reminded of the importance of recording and escalation of NEWS as per Trust Guidelines.							
Perso	Personal	AMU CAH	AMU CAH	13.10.17	Personal patient who presented to ED on 29/08/2016 with chest pain and subsequently admitted to AMU. Patient was discharged home on the 30/8/2016 without referral to Cardiology for review. Per died on 19/11/2016 from myocardial infarction.	YES	2	MUC	**Recommendation 1 -** The case should be presented at the medical morbidity and mortality meeting for general learning							
Perso	Personal	Coronary Care DHH	Coronary Care DHH	13.10.17	Personal Information redacted who presented to Daisy Hill Hospital (DHH) emergency department (ED) at 11:31 on 24th November 2016 with a 24hr history of chest pain and a week-long history of shortness of breath. Per was diagnosed with	YES	Internal review	MUC	**Recommendation 1 -** This SEA report should be shared with staff involved and the wider cardiology teams for learning & the Case should be presented at M&M							No
Perso	Personal	Coronary Care DHH	Coronary Care DHH	13.10.17	Non ST elevation Myocardial Infarction (NSTEMI), Troponin level was 3039. Pe was admitted to the Coronary Care Unit (CCU) at 17:30 24th November 2016. At 23:10 Pe was found collapsed in hospital reception area. Cardiac arrest team called. Pe did not respond to resuscitation efforts and passed away at 00:10 hrs on Friday 25th November 2016. The coroner was notified and permitted a	YES	Internal review	MUC	**Recommendation 2 -** Staff should fully risk assess patients clinical presentation, clinical history and haemodynamic stability regarding their safety to move from the bed side. The current recommendations of cardiac monitoring, and clinical observations dependent on condition but minimum 4 hourly following admission should be reinforced.							No
Perso	Personal	Coronary Care DHH	Coronary Care DHH	13.10.17	death certificate to be issued.	YES	Internal review	MUC	**Recommendation 3 -** If cardiac monitoring required there should be nurse monitoring screen 24/7							No
Perso	Personal	Coronary Care DHH	Coronary Care DHH	13.10.17			Internal review	MUC	**Recommendation 4 -** Patients should be advised they should ask or alert staff before leaving any hospital ward. If a patient does wish to leave a ward, against staff advice, the risks should be explained to the patient and same documented. Patient s should be encouraged to comply with advice							No
	Power Cut	CAH	CAH	13.10.17	There were two separate incidences on the night of the 30 March 2017; the CT scanner down time was not a pre cursor to the power failure incident.	NO	Internal review		**Recommendation 1 -** Trust should formally assess risks of further equipment failure and thus power cuts associated with the electrical system including the AAB switches and consider implementing a proactive maintenance program to minimise the risk of further power failures caused by the electrical circuits.							No
	Power Cut	CAH	CAH	13.10.17		NO	Internal review		**Recommendation 2 -** Until risks associated with the power system are resolved contingencies should be put in place							No
	Power Cut	CAH	CAH	13.10.17		NO	Internal review		**Recommendation 3 -** Update and circulate the on call escalation template							No
	Power Cut	CAH	CAH	13.10.17		NO	Internal review		**Recommendation 4 -** Re-issue the CT Divert protocol to all HoS and AD on call for their information.							No
Perso	Personal	ED CAH	ED CAH	15.11.17	On 4 January 2017 Personal patient presented to CAH ED at 09:40 after waking with chest pain and vomiting at 06:00. ECG's done at 10:05 which indicated anterior ST elevation. No action was taken. AT11:17 ECG was repeated and patient referred and accepted by RVH PCI team at 11:25. Time of	NO	1	MUC	**Recommendation 1 -** Circulate SAI report/finding to all medical and nursing staff within SHSCT Emergency Departments and record date of same. Action by: Dr Gareth Hampton and Mary Burke by 31 July 2017.	To be actioned by Dr Gareth Hampton and Mary Burke by 31.7.17						No
Perso	Personal	ED CAH	ED CAH	15.11.17	arrival to RVH was estimated as 12:15. Patient did not leave CAH until 12:30 hrs and arrived to RVH in cardiogenic shock. It is the view of the RVH Cardiology senior cardiology team that the delay in decision making by CAH coupled with delay in patient transfer requires further investigation.	No	1	MUC	**Recommendation 2 -** Trust should continue to develop guidelines within the acute directorate, systems and processes to endeavour to meet the recommendations in relation to time scale for patient assessment, management and transfer							
Perso	Personal	ED DHH	ED DHH	15.11.17	On 20 November 2016 at 00:22 hrs, Personal arrived via NIAS to DHH ED following a fall from bar stool and hitting head on shelf while intoxicated (no spinal immobilisation in situ)	Yes	2	MUC	**Recommendation 1 -** Share the learning from this report with ED staff via M&M, staff briefings and ED news letter							Yes
Perso	Personal	ED DHH	ED DHH	15.11.17	. While in ED at 04:45 Per appeared to have a cardiac arrest for approx. 3 min with return of spontaneous circulation. CT Brain 05:30-NAD. Complained of pain between shoulder blades. CT of c-spine at 06:30. CT spine: complete subluxation and dislocation fracture of C7/T1.	Yes	2	MUC	**Recommendation 2 -** Consideration should be given to including prompts to encourage staff to consider spinal injury for patients who present with head injury on the Regional Triage tool							yes
Perso	Personal	ED DHH	ED DHH	15.11.17	Imp: spinal fracture, cardiac arrest secondary to spinal shock and aspirate pneumonia. Per was transferred to RVH ED Resus as requested at approx. 09:30. Patient subsequently died in RVH on 26 November 2016.	Yes	2	MUC	**Recommendation 3 -** Trust overarching Head Injury Guidance is being developed to include guidance from NICE Head Injury Guidance GC 176 and The Royal College of Emergency Medicine and Patient Safety Alerts							yes
Perso	Personal	ED DHH	ED DHH	15.11.17		Yes	2	MUC	**Recommendation 4 -** Level 1 trauma training will be implemented in ED, the faculty should include education on elderly patient risk factors in trauma							Yes
Perso	Personal	ED DHH	ED DHH	15.11.17		Yes	2	MUC	**Recommendation 5 -** NIAS will develop regional guidance on when a medical escort is required when transferring a patient by ambulance from one hospital to another							Yes
Perso	Personal	ED DHH	ED DHH	15.11.17		yes	2	MUC	**Recommendation 6 -** NIAS will issue updated guidance to clinical staff highlighting the risks of significant trauma occurring in elderly patients following relatively low energy mechanisms and specifically falls from standing height. This will also remind staff of the full clinical criteria required to dispense with the need for formal spinal immobilisation							Yes
Perso	Personal	ICU CAH	ICU CAH	15.11.17	Personal insulin dependent diabetic admitted with pancreatitis. Pt fasted for scan and insertion of central line. No i/v fluids or insulin erected. No BM testing. Subsequent Diabetic Ketoacidosis requiring readmission to ICU. Difficulty in establishing patient management and support between MUSC/SEC/CYP and ATTICS was a substantive issue throughout inpatient stay.	No	2	CCS	**Recommendation 1 -** Diabetic children and young persons <16 years must be managed in a paediatric ward. For children and young people who have diabetes their diabetic care must be managed by the paediatric physician. Where the child has other conditions the including the need for surgical intervention the admitting consultant retains primacy in relation to the underlying condition. If for any reason a child is being managed outside the paediatric ward there should be an automatic referral of all diabetic children to paediatric diabetic teams							No

Perso	Personal	ICU CAH	ICU CAH	15.11.17		No	2	CCS	**Recommendation 2 -** a) All staff who manage children and young people should be trained on the care of children with diabetes including a. The well child with diabetes b. Management of Type 1 Diabetes Mellitus during illness in children and young people under 18 years (Sick Day Rules) c. BSPED Recommended Guideline for the Management of Children and Young People under the age of 18 years with Diabetic Ketoacidosis 2015 b) The guidance should be easily accessed on the Trust intranet, and regular checks of version control in place to ensure the most up to date guidance are on line c) Medical staff should be made aware of DKA calculator and have training on same d) Training in recognising the need to escalate a rising blood glucose and the process for escalation must be provided to all medical, nursing and AHP staff						no
Perso	Personal	ICU CAH	ICU CAH	15.11.17		No	2	CCS	**Recommendation 3 -** Staff should be reminded to access current guidance in relation to the paediatric patients at the point of treatment at http://www.southernguidelines.hscni.net/						no
Perso	Personal	ICU CAH	ICU CAH	15.11.17		No	2	CCS	**Recommendation 4 -** Children and young persons up to the age of 16 years should have a bespoke insulin prescription chart which should include subcutaneous insulin injections, blood sugar levels pre injections and facility to record correction doses of insulin for both hyperglycaemia and ketosis. To the chair's knowledge such a prescription chart is already being designed by the paediatric diabetes network regionally and awaiting final approval						no
Perso	Personal	ICU CAH	ICU CAH	15.11.17		No	2	CCS	**Recommendation 5 -** Trust POCT equipment must be used as per policy when testing blood glucose and ketones, (patient's own equipment must not to be used) MANAGEMENT OF POINT OF CARE TESTING (POCT) DEVICES POLICY http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/documents/SHSCTPOCTPolicyFormatUpdated.pdf						no
Perso	Personal	ICU CAH	ICU CAH	15.11.17		No	2	CCS	**Recommendation 6 -** Ketone meters to be provided in all areas of the hospital where children or adults with diabetes may be managed						no
Perso	Personal	ICU CAH	ICU CAH	15.11.17		No	2	CCS	**Recommendation 7 -** NEWS & GCS must be completed, recorded and escalated as required to the appropriate level of medical staff as per Trust guidance – nursing staff in 4N to complete on line NEWS module						no
Perso	Personal	ICU CAH	ICU CAH	15.11.17		No	2	CCS	**Recommendation 8 -** Fluids must be prescribed, administered and monitored as per Trust guidelines –The daily fluid balance must be accurately recorded. Daily Fluid Prescription & Balance Chart September 2014 – V0.17- http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/documents/PaediatricDailyFluidPrescriptionandChart.pdf Staff in 4N to complete hyponatraemia training.						no
Perso	Personal	ICU CAH	ICU CAH	15.11.17		No	2	CCS	**Recommendation 9 -** Trust administration of medicines code must be followed for the administration of medicines including appropriate recording of omitted doses, the reason for omission and appropriate escalation and reporting.						no
Perso	Personal	ICU CAH	ICU CAH	15.11.17		No	2	CCS	**Recommendation 10 -** Total parenteral nutrition in children must be managed in consultation with a team specialising in paediatric TPN at the tertiary centre.						no
Perso	Personal	ICU CAH	ICU CAH	15.11.17		No	2	CCS	**Recommendation 11 -** The review group recommends that clarity should be provided on how to manage paediatric patients (14-16 years old) requiring specialist care e.g. paediatric ICU in the interim until HSCB paediatric review recommendations are fully implemented						no
Perso	Personal	Dermatology OPD CAH	Dermatology OPD CAH	18.12.17	Patient Mr A was referred by a Dermatologist in the Southern Health and Social Care Trust (SHSCT) to the Plastic Surgery Department, Belfast Health & Social Care Trust (BHSCT) for a wider excision of a malignant melanoma in May 2013. Mr A	Yes	1	MUC/BHSCT	**Recommendation 1 -** Current Melanoma Guidelines should be highlighted at the upcoming Mortality and Morbidity Meetings for Dermatology and Plastic Surgery.						No
Perso	Personal	Dermatology OPD CAH	Dermatology OPD CAH	18.12.17	attended the Plastic Surgery Outpatient Department post excision surgery for a review appointment on 26 March 2014. Following this appointment a letter was sent to Mr A's General Practitioner (GP) asking them to arrange routine review for Mr	yes	1	MUC/BHSCT	**Recommendation 2 -** The learinging from this report should be presented at the respective audit meetings (Plastic Surgery and Dermatology).						No
Perso	Personal	Dermatology OPD CAH	Dermatology OPD CAH	18.12.17	A at their practice. This letter was not copied to the referring Dermatologist and Mr A was not followed up by a Dermatologist or Plastic Surgeon in either Trust. Mr A attended the Emergency Department (ED) IN SHSCT on 8 March 2016 and was found to have a non – occlusive	Yes	1	MUC/BHSCT	**Recommendation 3 -** the tracking system currently being developed in SHSCT should be discussed at the Regional NICaN meeting and its potential as a regional tracking system should be explored.						No
Perso	Personal	Dermatology OPD CAH	Dermatology OPD CAH	18.12.17	thrombus within the right common femoral vein. Due to Mr A's past medical history a CT of chest, abdomen and pelvis was requested by the ED Department. The radiology report identified small nodules on the lung and recommended a	Yes	1	MUC/BHSCT	**Recommendation 4 -** A regional policy for the follow up of patients with skin cancers across specialities (Plastic Surgery and Dermatology) should be developed.						No
Perso	Personal	Dermatology OPD CAH	Dermatology OPD CAH	18.12.17	repeat CT scan in three months' time. A core biopsy was arranged for Mr A in August 2016 by SHSCT. The pathology report of the right axillary lymph node identified histological features consistent with metastatic melanoma. Mr A sadly died on 22 January 2017.	Yes	1	MUC/BHSCT	**Recommendation 5 -** A learning letter should be written and shared with Clinical and Management teams throughout the BHSCT and SHSCT.						No
Pers	Personal Informa	Theatres DHH	Theatres DHH		Patient had Laparotomy and Ileo caecal resection carried out in DHH on the 05/09/12. Subsequently the patient became unwell and following x ray on the 07/09/12 'a X ray detectable swab' was noted. The patient returned to theatre and a laparotomy was carried out. The patient and relatives have been informed both before and after surgery regarding the retention of the swab. At present the patient's condition is stable.	Yes	1	CCS	**Recommendation 1 -** The use of all swabs being used internally needs to be communicated between the surgeon and the scrub and document on the white board If swabs are in use while the count is taking place, these swabs must be highlighted, acknowledged between surgeon and scrub nurse and accounted for at the end of the procedure						

Perso	Personal Informa	Theatres DHH	Theatres DHH			Yes	1	CCS	**Recommendation 2 -** Swab safe system, if used correctly, throughout the totality of the procedure, will ensure that the final count is complete and correct. The Scrub nurse and circulating nurse are responsible for completion of this process. Although there were no interruptions to the swab count in this case, anecdotal evidence suggests that on occasions interruption to swab counts do occur. The review team recommend that the principle of ensuring no interruptions occur during the swab counts is reinforced with all staff.							
Perso	Personal Informa	Theatres DHH	Theatres DHH			Yes	1	CCS	**Recommendation 3 -** The World Health Organisation (WHO) Surgical Safety Checklist exists to prevent this type of surgical error occurring and must be adhered to by all staff. It must be read aloud and acknowledged by the team. To assist with highlighting this as a key patient safety measure, the review team would recommend that the third phase of WHO checklist is completed before the dressing is being placed on the wound.							
Perso	Personal Informa	Theatres DHH	Theatres DHH			yes	1	CCS	**Recommendation 4 -** The Trust should source medium swabs (36cmx11cm) with tapes for use across the Trust. When these are available all remaining medium swabs (36cmx11cm) without tapes will be withdrawn.							
Perso	Personal Informa	Theatres DHH	Theatres DHH			Yes	1	CCS	**Recommendation 5 -** The Review team recommend that a standardised pre-operative patient identification checklist for invasive procedures is used throughout the Trust. Major care plan for use in theatre should be standardised across all relevant areas within the Trust. The importance of completing all documentation accurately ensuring all entries to nursing records are dated and signed needs to be reinforced with all staff. It is further recommended that documentation of swabs, needles and instruments should be noted in the operation notes and signed by the surgeon at the end of surgery. A revision of Protocol for counting swabs, needles and instruments in Theatre will be disseminated to all Theatre managers and surgeons.							
Perso	Personal	Winter Ward CAH	Winter Ward CAH	5.1.18	Incident reported via Interface Notification BHSCT/II/16/13. SHSCT has screened this incident and will be undertaking a Level One investigation.	No	1	MUC	**Recommendation 1 -** This report will be shared with medical and surgical morbidity and mortality meetings							No
Perso	Personal	Winter Ward CAH	Winter Ward CAH	5.1.18	A male patient was admitted to CAH on 15.11.16 with hypothermia, confusion and acute kidney injury (AKI). He was accepted for transfer to Nephrology, Belfast City Hospital on the norming of 20.11.16 for consideration of haemodialysis. At the time of referral and acceptance for transfer the hand over from the medical team in CAH described progressive AKI, oliguria and some dusky discoloration of the feet.	No	1	MUC	**Recommendation 2 -** All patients on admission and during their stay should have a full body review including peripheries.							
Perso	Personal	Winter Ward CAH	Winter Ward CAH	5.1.18	On arrival at approximately 11.00am to ward 11 North, Neurology, BSH the patient was found to have frank necrosis covering most of the plantar surface of both feet and also involving all toes. There was superficial sloughing of skin bilaterally to mid-calf level. Both lower limbs were cold and pale with absent pulse below femoral level.	No	1	MUC	**Recommendation 3 -** Patients who present with renal failure should be assessed for trauma, cellulitis and skin ulcers							
Perso	Personal	Winter Ward CAH	Winter Ward CAH	5.1.18	Vascular surgery input was immediately sought and CT angiogram performed on the day of transfer (see section 8 for more details). Following transfer to Vascular surgery the patient underwent bilateral above Personal on 22.11.2016.	No	1	MUC	**Recommendation 4 -** The SHSCT is to review referral processes/documentation to ensure prompt referral to appropriate specialties							
Perso	Personal	ED CAH	ED CAH	8.12.17	Personal patient attended CAH ED at 22:36 on 14 August 2016 regarding agitation and hallucinations. Personal In redacted by the There was a delay in completing comprehensive imaging and recognition of multiple trauma.	No	1	MUC	**Recommendation 1 -** Continued implementation and integration of 'Emergency Department Mental Health Risk Assessment Form'							
Perso	Personal	ED CAH	ED CAH	8.12.17		No	1	MUC	**Recommendation 2 -** Agree and implement a 'Major Trauma Trigger List' for triage within ED, create a 24-hour SHSCT Major Trauma Team which includes members from ED, Anesthetics , Trauma and Orthopedics and Surgery							
Perso	Personal	ED CAH	ED CAH	8.12.17		No	1	MUC	**Recommendation 3 -** Agree guidelines in relation to SHSCT Spinal patients in ED who have not been accepted by Trauma Specialty. In the event to this occurring, the patient must stay within the ED pending transfer. Rapid development of a clear written agreement as to where Spinal Injury patients will be admitted regionally							
Perso	Personal	ED CAH	ED CAH	8.12.17		No	1	MUC	**Recommendation 4 -** Circulate the validated SAI report regarding DC to the Medical Director of NIAS for learning							
Perso	Personal	Neonatal Unit CAH	Neonatal Unit CAH	26.1.16	Infant born at 34 weeks gestation .Non immune hydrops , congenital heart disease ,prematurity.	Yes	1	IMWH	**Recommendation 1 -** Appropriate response to a pathological antenatal CTG with good teamwork, multidisciplinary senior input.							
Perso	Personal	Neonatal Unit CAH	Neonatal Unit CAH	26.1.16	Withdrawal of care following maximum intensive care support , input from Regional NISTAR team and consultation over 23 hour period from birth with Regional Specialists in Neonatal and Cardiology . Parents fully involved in decision making	Yes	1	IMWH	**Recommendation 2 -** Not all structural abnormalities are detected antenatally as is already known and accepted.							
Perso	Personal	Neonatal Unit CAH	Neonatal Unit CAH	26.1.16	throughout.	Yes	1	IMWH	**Recommendation 3 -** Develop a guideline for investigation and management of polyhydramnios.							

Perso	Personal	ED/Paeds CAH	ED/Paeds CAH	7.8.17	Personal Information redacted by the USI was admitted to Craigavon Area Hospital (CAH) at 11.30 hours on 9 February 2017 with vomiting and pyrexia. Pers developed overwhelming sepsis (Strep Pneumoniae) and did not respond to resuscitation efforts. Pers died on 9 February 2017 at 23.25 hours in Theatres at Craigavon Area Hospital.	Yes	2	MUC/CYP	**Recommendation 1-** Assessment, analysis and escalation to senior staff (nursing assessment tool, PEWS and response to parental concern) A. • The current PEWS should be reviewed and amended to enable a more comprehensive assessment. The revised tool should include timely escalation to senior nursing and medical staff. B. • Training should be provided in the use of revised assessment and PEWS tool. C. • Acute paediatric staff should undertake ongoing comprehensive assessment and analysis to ensure the changing needs of children/young people are met. This assessment should include recording and response to parental concerns and be fully documented.	C. ED - all ED nursing staff who undertake triage are trained in the Manchester Triage Tool. PEWS Is part of the ED induction programme for Registered Nurses. Children are commenced on PEWS at the point of triage. PAEDs who present with minor injuries are not commenced on PEWS.		Inplace				
Perso	Personal	ED/Paeds CAH	ED/Paeds CAH	7.8.17		Yes	2	MUC/CYP	**Recommendation 2 -** Timely diagnosis and commencement of treatment of sepsis and associated training of paediatric nursing and medical staff The Trust should consider how to usefully implement elements of sepsis 6 i.e. antibiotics, bloods, fluids and inotropes if required within 1 hour without increasing antibiotic usage. Associated training should be developed and cascaded to staff. • Levels of contaminants in blood cultures need to be audited, monitored and addressed as part of a quality improvement project. • A training module should be developed to address how to take bloods from children and neonates to avoid contamination. • A child labelled as 'a watcher' at handover should be reassessed.	Medical Director is chairing a working group to ensure effective systems and processes are in place in SHSCT. To ensure early identification and early identification of sepsis. Flow chart and sepsis 6 pathway developed for paediatric sepsis 6 and is currently being piloted on the paediatric ward. Outcome of Pilot to be presented at ED M&M and agree roll out of same for ED.	Dr Hampton ED Clinical Director. Dr McCormick Mary Burke HOS	April/May 2018				
Perso	Personal	ED/Paeds CAH	ED/Paeds CAH	7.8.17		Yes	2	MUC/CYP	**Recommendation 3 -** Communication with parents • Staff must ensure clarity of understanding when conveying difficult information to parents. • Staff should be trained to respond to difficult situations/have difficult conversations. • Information on how to contact the Patient Liaison Officer should be available on the ward and routinely provided to parents.	ED/Clinical Sister band 7/6 level is on duty 24/7 for staff to escalate any concerns, communication difficulties. Nursing staff encouraged to keep parents and child updated on treatment plan. Medical staff communicate the diagnosis and reinforce the medical management plan. Liaison officer no longer in post	Dr Hampton, ED Clinical Director Dr McCormick Lead Nurse ED Sister					
Perso	Personal	ED/Paeds CAH	ED/Paeds CAH	7.8.17		YES	2	MUC/CYP	**Recommendation 4 -** Documentation and record keeping A. • All medical and nursing records must demonstrate assessment detail which justifies clinical decisions made during assessment and ongoing evaluation. B. • Nursing staff must accurately record fluid intake and output on the fluid balance chart. C. • All nursing records should be recorded according to the standards required by the NMC Record Keeping Guidance for Nurses and Midwives (NMC, 2009).	A. In place. Ad hoc audits to confirm same. B. Monthly audits in place to monitor compliance. C. In place. Ad hoc audits to monitor compliance .nursing staff document children's care/treatment in medical/surgical admission booklet if patient is clerk in by Paeds doctor in ED.	Dr Hampton ED Clinical Director. Dr McCormick Lead Nurse ED Sister	A. In place. B. In place C. In place				
Perso	Personal	ED/Paeds CAH	ED/Paeds CAH	7.8.17		YES	2	MUC/CYP	**Recommendation 5** - Adherence to policies and procedures (prescribing and recording of administration of medicines, fluid balance sheet completion and referral to coroner) A. • Staff should adhere to their responsibilities in relation to the prescribing, administration and recording of administration of medicines as set out in the Medicines Management Policy (SHSCT, 2008), Medicines Management Code (SHSCT, 2015) and the NMC Standards for medicines management (2007). B. • Staff should complete the fluid balance chart as detailed in the Paediatric Intravenous Infusion Policy (SHSCT, 2009). C. • Medical staff should undertake the electronic learning on Coroner's Investigations and Inquests Programme in order to ensure increased awareness of the requirement under Section 7 of the Coroners Act (Northern Ireland) 1959 to report a death to the Coroner if it resulted, directly or indirectly, from any cause other than natural illness or disease for which the deceased had been seen and treated within 28 days of death. D. • Doctors should err on the side of caution and	A. Administration and recording of administration of medicines is a standard which Registered Nurses adhere to in ED. Medical Staff adhere to the GMC standards for prescribing of medications. B. In place, currently the fluid balance chart completed for Paeds who present with DKA has been reviewed and amended as per best practice guidelines for implementation. C. In place D. All unexpected deaths I children are reported to the coroner.	CYP Acute	A. B. In place March 2018 C. In place				
Perso	Personal	ED/Paeds CAH	ED/Paeds CAH	7.8.17		YES	2	MUC/CYP	**Recommendation 6 -** Use of non-Trust equipment • Staff should be reminded that they should only use Trust equipment to take observations from patients as this has been tested and calibrated on a regular basis.	In place (reinforced with staff in light of the recommendation from this SAI)		In place				
Perso	Personal	DS CAH	DS CAH	7.9.15	Personal Information who booked for consultant led shared antenatal care at 11 weeks gestation. P attended the Admission and Assessment Unit (AAU) on 16/10/14 at 34+1 weeks gestation complaining of reduced fetal movements. The first cardiotocograph (CTG) (external continuous fetal monitoring) was reported to be suspicious. Ultrasound scan showed a small baby growing on the 10th centile. The repeat	YES	2	IMWH	**Recommendation 1 -** Re-emphasise the importance of CTG training for all doctors and midwives annually. The "Buddy system" has been introduced to ensure a second opinion is sought on all CTGs to reduce the risk of misinterpretation.							
Perso	Personal	DS CAH	DS CAH	7.9.15	CTG was reassuring with fetal movements. Pe was allowed home and advised to return for a repeat CTG on 20/10/14 and to come to the antenatal clinic on 22/10/14.On the 20/10/14 P returned as arranged for a CTG. The CTG showed one unprovoked deceleration which was classified as suspicious. In	YES	2	IMWH	**Recommendation 2 -** A senior member of staff (Paediatrics or Obstetrics /Midwifery) should be identified to liaise with the parents and the resuscitation team to keep the parents updated.							
Perso	Personal	DS CAH	DS CAH	7.9.15	addition Pe had high blood pressure. Ultrasound scan and Doppler were reassuring as was the following 40 minute CTG. She was admitted for monitoring and management. A further CTG at 22:40 was evaluated and suspicious and later re-	YES	2	IMWH	**Recommendation 3 -** At each patient review, staff should appraise themselves of the whole clinical picture including investigations and all of the CTG s							

Received from Trudy Reid on 16/05/2023. Annotated by the Urology Services Inquiry.

Perso	Personal	DS CAH	DS CAH	7.9.15	evaluated as normal. On the 21/10/14 The CTG was recorded to have a sinusoidal pattern, feto-maternal haemorrhage was suspected and later	YES	2	IMWH	**Recommendation 4 -** All staff to adhere to NMC and GMC guidance regarding record keeping.							
Perso	Personal	DS CAH	DS CAH	7.9.15	confirmed by ultrasound. Perso had an emergency Caesarean section on the 21/10/14 at 15:24 hours Personal . Her Apgar score was 5 at 1 minute of age and 8 at 5 minutes of age. Cord pH was 7.30 and 7.24. Perso was transferred to the Neonatal Unit and commenced on nasal prong continuous positive airway pressure (npcpap). Perso received a packed cell transfusion at approximately 19:00 and then had a sudden deterioration/collapse at 19:42 when Perso was intubated and surfactant administered. Pers continued to deteriorate further on the ventilator requiring numerous attempts at cardio-pulmonary resuscitation (CPR).	YES	2	IMWH	**Recommendation 5 -** Recommendations for future pregnancies. 1. Book early for consultant led care 2. Monitor fetal growth to identify a small baby and monitor placental function. 3. Monitor fetal movements according to Trust Guidelines. 4. Discuss mode of delivery, either planned vaginal birth after caesarean section or elective caesarean section.							
Perso	Personal	Community MHD/Acute	Community MHD/Acute	7.2.18	This case involves the death of Personal Information . On 30/12/2016 the Trust was notified, via a SD1 form, of the Personal Information redacted by the USI was known to/referred to mental health and related services, in the 12 months prior to the incident; She had been known to; Support and Recovery services, the Home Treatment/Crisis Response Team and Psychiatric Liaison. Perso was also known to Trust Obstetric services at the time of her death. Per so	YES	2	MHD/Acute	The review team did not make any recommendations for the improvement of HSC services.								
Perso	Personal	ED/MHD	ED/MHD	3.10.17	The Southern Health and Social Care Trust were advised, via the community, of Personal Information redacted by the was known to Mental Health Services, in the 12 months prior to the incident. The Trust contacted HM Coroner, who advised that the cause of death is undetermined at this time. Per was known and/or referred to; the Primary Mental Health and Care Team (PMHCT), Addiction Services, Liaison Psychiatry and the Home Treatment/Crisis Response Team. Personal last contact with Mental Health Services was on 18/10/2016.	YES	2	MUC/MHD	No Recommendations identified.								
Perso	Personal	ED CAH	ED CAH	8.3.18	Personal presented to ED via ambulance -- initial diagnosis Acute Kidney Injury, while in ED she fell of the ED	NO	1	MUC	**Recommendation 1 -** Share this report with ED staff involved and at ED M&M for learning							
Perso	Personal	ED CAH	ED CAH	8.3.18	trolley rails (over trolley safety rails) onto the floor (unwitnessed fall). Patient sustained C1 burst fracture (Jefferson fracture) and left occipital condyle fracture. Patient was transferred to Royal Victoria Hospital for management of her spinal fracture	NO	1	MUC	**Recommendation 2 -** Supervision requirements of patients at risk must be assessed by ED staff- the Trust should provide Guidelines for nursing staff on measures to implement for inpatients that may require enhanced supervision; this should include guidance for the Emergency Department.							
Perso	Personal	ED CAH	ED CAH	8.3.18		NO	1	MUC	**Recommendation 3 -** Liaison with family members/carers must be considered and family members/ carers invited to remain with patients to assist with supervision with their consent							
Perso	Personal	ED CAH	ED CAH	8.3.18		NO	1	MUC	**Recommendation 4 -** Regionally consideration should be given to producing evidence based guidance on falls prevention and enhanced nursing supervision in Emergency departments.							
Perso	Personal	ED CAH	ED CAH	8.3.18		NO	1	MUC	**Recommendation 5 -** Raise awareness of the risk of falls in elderly confused patients within the emergency department including the need for supervision							
Perso	Personal	ED CAH	ED CAH	8.3.18		NO	1	MUC	**Recommendation 6 -** Regional guidance on ED staffing levels should be supported by commissioning funding.							
Perso	Personal	DS CAH	DS CAH	7.9.15	Personal transferred to delivery suite for emergency c/section with sinusoidal ctg. baby girl delivered pale at birth, unplanned admission to nnu Personal) Neonatal death at 34+6 weeks. Cause of death as documented on death certificate: Multi-organ failure- respiratory/ cardiac Due to prematurity and maternal- fetal haemorrhage	YES		CCS	**Recommendation 1 -** Re-emphasise the importance of CTG training for all doctors and midwives annually. The "Buddy system" has been introduced to ensure a second opinion is sought on all CTGs to reduce the risk of misinterpretation.	**Failure to recognise a pathological CTG** 1. Introduction of the Buddy system- 2. Shared learning with medical and midwifery staff at audit – 20th January 2015 3. Case discussed by Dr Currie at regional quality improvement group for the introduction of the new sticker - 9th November 2015. 4. New CTG co-ordinator in post at band 7 – commenced May 2016.to recognise the significance of the post. – Weekly training for staff. 5. CTG training weekly for all staff – newsletters to advise staff of the recognition of sinusoidal patterns.	1. 25th October 2014 2. January 2015 3. November 2015 4. Ongoing 5. Ongoing					
Perso	Personal	DS CAH	DS CAH	7.9.15		YES		CCS	**Recommendation 2 -** A senior member of staff (Paediatrics or Obstetrics /Midwifery) should be identified to liaise with the parents and the resuscitation team to keep the parents updated.	**Take account of the whole clinical picture** At each patient review, staff should appraise themselves of the whole clinical picture including investigations and all of the CTG. This is emphasised at teaching sessions for all staff.	Ongoing					
Perso	Personal	DS CAH	DS CAH	7.9.15		YES		CCS	**Recommendation 3 -** At each patient review, staff should appraise themselves of the whole clinical picture including investigations and all of the CTG s	**Communication** A senior member of staff (Paediatrics or Obstetrics /Midwifery) should be identified to liaise with the parents and the resuscitation team to keep the parents updated. This is embedded in practice within the delivery suites on both sites.	Ongoing					
Perso	Personal	DS CAH	DS CAH	7.9.15		YES		CCS	**Recommendation 4 -** All staff to adhere to NMC and GMC guidance regarding record keeping.	**Record Keeping** PROMPT training emphasises the necessity for a scribe to be designated in the event of any obstetric emergency. This has become embedded in practice.	Ongoing					
Perso	Personal	DS CAH	DS CAH	7.9.15		YES		CCS	**Recommendation 5 -** Recommendations for future pregnancies. 1. Book early for consultant led care 2. Monitor fetal growth to identify a small baby and monitor placental function. 3. Monitor fetal movements according to Trust Guidelines. 4. Discuss mode of delivery, either planned vaginal birth after caesarean section or elective caesarean section.							
Perso	Personal	1 West CAH	1 West CAH	11.12.14	Patient direct admission from A+e at 02.15 hrs due to bed shortage on medcal ward and patient needin a sideward. News on arrival to ward was 8. No bp recorded in A+e or news score recorded. Wrong information on pink admission slip. Was admitted under wrong consultant.	NO	1	MUC	**Recommendation 1 - Sepsis Recognition and Management within ED** "Unrecordable" blood pressure measurements must be accepted as evidence/a sign of hypotension until proved otherwise and managed accordingly Within the ED if patients present with or develop signs or symptoms of sepsis the sepsis bundle must be followed SHSCT to continue to work in conjunction with the Regional Safety Forum on Sepsis Management							

Perso	Personal	1 West CAH	1 West CAH	11.12.14		NO	1	MUC	**Recommendation 2 - Blood Pressure Readings.** A blood pressure cuff of the correct size for the individual patient must be sourced and used to take every blood pressure reading Verification required that all ED nursing staff are aware how to measure and source correctly fitting blood pressure cuff This case history to be used as learning example regarding the importance of obtaining blood pressure readings each time they are required							
Perso	Personal	DPU CAH	DPU CAH	23.4.18	Personal had a colonoscopy on 01/04/15 after a red flag referral. An abnormality was identified but not realized to be malignant. Biopsies were taken which showed low grade dysplasia.	NO	1	SEC	**Rcommendation 1 -** This report should be shared with the endoscopist for learning							andra
Perso	Personal	DPU CAH	DPU CAH	23.4.18	A review at outpatients was planned and Per presented to a different clinician on 17/08/15. Following this review, a red flag sigmoidoscopy was requested. The Sigmoidoscopy was repeated on the 24/08/15 and cancer was ndiagnosed. Missed cancer and follow up review delay of 2 months.	NO	1	SEC	**Recommendation 2 -** This report should be discussed at morbidity and mortality and Endoscopy Users Group meetings for wider learning							
Perso	Personal	DPU CAH	DPU CAH	23.4.18		NO	1	SEC	**Recommendation 3 -** Lesions should be photographed and the photographs retained in the patient record for reference – the Trust should consider the introduction of image capture on the UNISOFT endoscopy system. Documentation of the procedure should include, evidence of best practice including, identification of 'land marks', withdrawal time and effectiveness of bowel preparation.							
Perso	Personal	DPU CAH	DPU CAH	23.4.18		NO	1	SEC	**Recommendation 4 -** A definitive date/ time for review and instruction to the booking centre regarding escalation if the waiting times cannot be achieved should have been given when organising review appointments.							
Perso	Personal	DPU CAH	DPU CAH	23.4.18		NO	1	SEC	**Recommendation 5 -** The report should be discussed at the Surgical M&M meeting							
Perso	Personal	Delivery Suite DHH	DS DHH	23.5.18	A Personal with a history of 2 previous normal vaginal deliveries at Term, was admitted on 30/07/2017 for Induction of labour by prostin pessary at Term plus 9 days gestation as planned antenatally. She was admitted to delivery suite for epidural analgesia and later required an emergency cesarean section delivery for fetal distress. She sustained a ruptured uterus and required admission to HDU for 7 days and treatment for sepsis. The baby was born in poor condition and was transferred to NNU in CAH for cooling for 72 hours and has possible diagnosis of HIE.	NO	1	IMWH	**Recommendation 1 -** Recognition and management of an abnormal CTG with suspected sepsis has been highlighted at monthly CTG training for all staff and this case will be presented at joint Risk management and CTG teaching to illustrate learning points							
Perso	Personal	Delivery Suite DHH	DS DHH	23.5.18		NO	1	IMWH	**Recommendation 2 -** The NICE 2014 CTG evaluation tool does not give an upper limit for fetal heart rate variability levels. Variability of more than 25 beats for more than 25 minutes will be an abnormal feature on the new intrapartum CTG evaluation tool. This new evaluation has been implemented across the SHSCT from April 2018.							
Perso	Personal	Delivery Suite DHH	DS DHH	23.5.18		NO	1	IMWH	**Recommendation 3 -** A regional CTG masterclass has been held for all midwives and obstetricians in the Trust. This included in depth multidisciplinary discussion around fetal monitoring in high risk labours							
Perso	Personal	Delivery Suite DHH	DS DHH	23.5.18		NO	1	IMWH	**Recommendation 4 -** The review team would recommend that maternal temperature should be recorded using tympanic thermometer for consistency and Tempadots will be removed from delivery suite.							
Perso	Personal	Delivery Suite DHH	DS DHH	23.5.18		NO	1	IMWH	**Recommendation 5 -** The communication aide memoire iSBAR (Situation, Background, Assessment, and Recommendation) has been highlighted and shared to all staff to prompt appropriate escalation within the Team when concerns are raised about labouring woman							
Perso	Personal	ED CAH	ED CAH	8.6.18	Personal Information with a background of recent gastric cancer treatment who was admitted via the Emergency department (ED) in Craigavon Area Hospital (CAH) with haemoptysis and left sided chest pain. She was found to have metastatic cancer and subsequently developed bilateral subdural haetatomas, disseminated intravascular coagulation and thrombocytopenia which were felt to be secondary to her metastatic cancer.	YES	1	MUC	**Recommendation 1 -** Share this SEA report with morbidity and mortality meetings for learning and learning from this incident will be shared in the Trusts Learning from Medication Incidents Acute Services/Non-acute Hospitals							
Perso	Personal	ED CAH	ED CAH	8.6.18	Pe was admitted to CAH on 15 January 2018 with a two or three day history of haemoptysis and left sided chest pain. On admission there was concern about a possible pulmonary embolism (PE) and she received a dose of Enoxaparin 80mg (at this point Pe had platlets of 42). However a Computerised Tomography Pulmonary Angiography (CTPA) did not demonstrate a pulmonary embolism but did demonstrate sketelton metastases. Pe had low platlets and was resuscitated with multiple platelet infusions and cryoprecipitate.. On 16.1.2018 Pe complained of a headache and she had a Computerised Tomography of Brain (CTB) which demonstrated bilateral sudbural haematomas and cerebrial oedema. Her case was discussed with Neurosurgery who felt that intervention at this point was not appropiate.	YES	1	MUC	**Recommendation 2 -** If patient has suspected VTE, bleeding risks must be assessed and carefully considered prior to prescribing anticoagulants							
Perso	Personal	ED CAH	ED CAH	8.6.18		YES	1	MUC	**Recommendation 3 -** CTPA should be performed prior to administration of anticoagulant treatment if there is evidence of bleeding risks in a patient with suspected VTE (on occasions it may be necessary for medical staff to discuss with the radiology department the urgency of the CTPA request)							
Perso	Personal	ED CAH	ED CAH	8.6.18		YES	1	MUC	**Recommendation 4 -** Seek advice from haematology if a patient with VTE has a significant bleeding risk If there is no evidence of bleeding anticoagulant therapy can be administered as per NICE/guidance empirically where PE is suspected							
Perso	Personal	ED CAH	ED CAH	8.6.18	Pe died on 25.1.18 following discussion with the Coroner a Medical Certificate of Death was issued which stated cause of death: 1. a) Bilateral subdural haematomas b) Dissemintated intravascular coagulation and thrombocytopenia c) Metastatic gastric cancer 11. Hypertension; Uterine fibroids.	YES	1	MUC	**Recommendation 5 -** ED department induction – update to include Trust VTE guidance May 2017							
Perso	Personal	ED CAH	ED CAH	8.6.18		YES	1	MUC	**Recommendation 6 -** Trust Thrombosis committee should be re-established							
Irrele	Decontamination Endoscopy	DPU STH	DPU STH	24.7.18	On 16 January 2017 the Southern Health and Socail Care Trust iscovered that machines were used from the 9 January 2019 to 16 January 2017 using incorrect chemicals. It was established the incorrect combination of chemicals were used from the 9 January 2017 to 16 January 2017 in two Endoscopy Washer Distinfectors (EWD's). The EWD's had been used to process endoscopes which had been used on patients during this time.	N/A	1	CCS	**Recommendation 1 -** Early Alert to HSCB		Trudy Reid	Complete 25.1.17				
Irrele	Decontamination Endoscopy	DPU STH	DPU STH	24.7.18		N/A	1	CCS	**Recommendation 2 -** review and amend standard operantional procedures		Marie Wilson	Completed and shared with staff week beginning 10.2.17				
Irrele	Decontamination Endoscopy	DPU STH	DPU STH	24.7.18		N/A	1	CCS	**Recommendation 3 -** Interview and/or obtain statements staff involved to ascertain time line of events leading to incident		Marti McKenna Marie Wilson	Completed 23.1.17				
Irrele	Decontamination Endoscopy	DPU STH	DPU STH	24.7.18		N/A	1	CCS	**Recommendation 4 -** Patient affected to be identified		Mary McGeough and Marie Wilson	Completed 7.1.17				
Irrele	Decontamination Endoscopy	DPU STH	DPU STH	24.7.18		N/A	1	CCS	**Recommendation 5 -** Risk assess affected patients for Blood Bourne Virus, tuberculosis, CJD, C. difficile and immune status etc		Dr Martin Brown Esther Gishkori Ronan Carroll Marie Wilson Referring Consultant					
Irrele	Decontamination Endoscopy	DPU STH	DPU STH	24.7.18		N/A	1	CCS	**Recommendation 6 -** Laboratory Tests to ascertain effectiveness of decontamination (including disinfection efficacy test pseudomonas aeruginosa 106, Staphylococcus aureus 106, Mycobacterium terrae 105, Candida albicans 104)		Paul Marshall	Results anticipated 30.1.17 and 16.2.17 & 21.2.17				
Irrele	Decontamination Endoscopy	DPU STH	DPU STH	24.7.18		N/A	1	CCS	**Recommendation 7 -** Meet with company to discuss company Trust supply and communication interfaces and any issues		Paul Marshall	Complete 10.2.17				

Irrele	Decontamination Endoscopy	DPU STH	DPU STH	24.7.18		N/A	1	CCS	**Recommendation 8 -** Endoscope Washer Disinfector machine and attachments- The Trust is currently scoping available equipment to ascertain if products are available that will provide physical barrier to attaching the incorrect chemicals		Marie Wilson, Sandra McLoughlin & Paul Marshall	Ongoing				
Perso	Personal	AMU CAH	AMU CAH	29.9.17	Personal Information known to mental health services following a manic episode in December 2014.Per was admitted to the Bluestone Psychiatric Inpatient Unit between 26/06/2015 and 11/08/2015 Personal Information redacted by the USI remained under the care of mental health services. Personal Information redacted by the USI	YES	3	MUC	The review team have made recommendations from the learning highlighted in this case and have referenced the NCEPOD report 'Treat As One Bridging The Gap Between Mental And Physical Healthcare In General Hospitals' published in January 2017. The review team are aware that some of the recommendations may require commissioning support. **Recommendation 1.** Patients who present to an Acute Hospital with mental health concerns/risks should have a risk assessment completed by acute staff and this should be documented with any other clinical conditions that resulted in their presentation to hospital. This should be documented: a. In any emergency department assessment b. In the documentation on admission to hospital.	ED and the Mental Health Team have implemented the mental health risk assessment tool.	Clinical Director Head of Service	Jun-18		Jun-18		
Perso	Personal	AMU CAH	AMU CAH	29.9.17	died at 12:10 on the 18/5/2016.	YES	3	MUC	**Recommendation 2**. Trust healthcare professionals must work together to eradicate terms such as 'medically fit' or 'medical clearance'. The terms 'fit for assessment', 'fit for review' or 'fit for discharge' should be used instead to ensure parallel working.	The terms have been amended to eradicate terms such 'Medically Fit' or 'Medical Clearance'. See attached Risk Assessment.	Clinical Director ED and Mental Health	Jun-18				
Perso	Personal	AMU CAH	AMU CAH	29.9.17		YES	3	MUC	**Recommendation 3**. The review team recommend as per NCEPOD that Regional guidelines should be developed outlining the role/responsibilities of general hospital staff in relation to the treatment and care of patients who present with mental health concerns/risks. Any Regional Guidelines should include a recommendation on the use of one-to-one observation support, when following assessment, there is an assessed need for observation in a general hospital setting. The Trust should develop an interim guideline, pending regional guidance, outlining the role/responsibilities of general hospital and mental health staff in the provision of a service to patients who present to an acute hospital with mental health conditions. These should include: a. The point at which a referral to liaison psychiatry should be made b. What should trigger a referral to liaison psychiatry and c. What relevant information a referral should contain d. staff training roles and responsibilities (including guidance on the requirement following mental health assessment for enhanced observation) e. The function of interface meetings between the	Acute and Mental Health Team are working together to develop interim guidelines. Guidelines are currently in draft form. a. Any patient who presents with Mental health issues are referred to the Mental Liaison Team following assessment by Doctor. b. Mental Health Liaison Team are drafting guidance for Acute staff c. Mental Health have provided a prompt sheet for Acute Staff of the information required when referring a patient to a mental health team. See attached Mental Health Risk Assessment						
Perso	Personal	ED DHH	ED DHH	7.9.18	On Wednesday 28 December 2016 Perso presented to DHH ED at 06:15 hrs having pulled out his percutaneous endoscopic gastrostomy (PEG) tube at 01:00 hrs, in the private nursing home (PNH). Perso was reviewed by Dr 1 who could not re-insert the PEG. Perso 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. Perso was discharged back to PNH at 12:50 hrs. Perso re-attended DHH ED on Thursday 29 December 2016 at 15:15 hrs with history of repeated vomiting since change of PEG. The temperature was 37.2o, Pulse 102, Respirations 26, BP 90/69, SpO2 92% on arrival. At 19:40 hrs 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". A do not actively resuscitate (DNAR) was implemented from 20:30 after discussion with the. Perso passed away on 10 January 2017. Dr 6 met with the family 13 March 2017 to discuss patient care and submitted Datix following same in relation to PEG re-insertion and promised an internal investigation.	YES	1	MUC	**Recommendation 1-** Share this report for learning with the ED, medical and surgical morbidity and mortality meetings **Recommendation 2 -** Trust guidelines to be developed for the replacement of late displacement of PEG tubes to include correct positioning checks.							
Perso	Personal	ED DHH	ED DHH	7.9.18	Per attended Daisy Hill Hospital (DHH) Emergency Department (ED) on 07 July 2017 following displacement of a Percutaneous Endoscopic Gastrostomy (PEG) tube. The reinsertion performed by a surgeon after failed attempt by the ED staff. The atient re attended ED on 07 July 2017 at 20:45 and was admitted overnight for observation and discharged back to the Private Nursing Home (PNH) the next morning. Following discharge back to PNH, Pe pulled out his Peg Tube again with the balloon inflated. Pe re attended DHH ED on 08 July 2017 at 16:09. Pe had been unwell and was reported to be sweaty and vomiting coffee ground coloured fluid. A Computer Tomography (CT) scan report states "Mislocated gastrostomy catheter. The catheter should no longer be used and should be withdrawn" …The gastrostomy tube was lying outside the stomach Per had a laparotomy on 09 July 2017and was admitted to ICU and later discharged to HDU in DHH. Pe died on 22 July 2017, the cause of death was documented as Bronchopneumonia, antecedent causes were, intra-abdominal sepsis due to iatrogenic injury, other significant causes were recurrent aspiration pneumonia	YES	1	MUC	Recommendation 1 Share this report for learning with the ED, medical and surgical morbidity and mortality meetings Recommendation 2 Trust guidelines to be developed for the replacement of displaced PEG tubes of prolonged duration to include correct positioning checks.							
Perso	Personal	GMM DHH	GMM DHH	7.9.18	On Wednesday 4 January 2017 Per presented to Daisy Hill Hospital Emergency Department at 19:00 hrs with difficulty breathing and slow Atrial Fibrillation (AF). Past history of AF, mitral stenosis (on digoxin). Initial diagnoses: bradycardia, mitral stenosis, pleural effusions. Notes indicate that at approximately 22:30 Personal was increasingly drowsy and clammy. Personal Information redacted by being	YES	1	MUC	**Recommendation 1 -** The SHSCT should urgently develop and implement a Policy for the Requesting, Processing and Reviewing with Acknowledgement Clinical Tests. Processes for signing off on investigations need audited and embedded.							

Received from Trudy Reid on 16/05/2023. Annotated by the Urology Services Inquiry.

Perso	Personal	GMM DHH	GMM DHH	7.9.18	unresponsive at 00:00- consultant aware, no evidence of action being taken. Pe transferred to Coronary Care unit on Thursday 5 January 2017 at 01:30. GCS 3/15. Anaesthetic team contacted at 02:45hrs. Per passed away at 09:25 hrs.	YES	1	MUC	**Recommendation 2 -** System of concern escalation should be embedded. An example includes the adoption and promotion of clinical team knowledge of communication aides such as the 'CCUSS'* acronym be proposed, modified from the Aviation Industry acronym 'CUS' (Concerned Uncomfortable Stop). 'CCUSS' stands for 'Clarity' , 'Concerned', 'Uncomfortable', 'Safety', 'Stop'. Any member of a clinical team may use these key words if they wish the team leader to pause and/or stop to allow review of management, and these key words are suggested as 'red alert' words for professionals to acknowledge and act upon whilst avoiding ambiguous or emotive communication during potentially tense clinical scenarios.							
Perso	Personal	GMM DHH	GMM DHH	7.9.18		YES	1	MUC	**Recommendation 3-** Clinical responsibility falls to the department in which the clinically deteriorating patient is being treated. Reassessment and an updated management plan needs implemented with recommunication to the accepting team prior to transfer. No patient should be transferred without pre-knowledge of the deterioration as this may influence ward for admission.							
Perso	Personal	GMM DHH	GMM DHH	7.9.18		YES	1	MUC	**Recommendation 4-** Robust documentation of hospital at night communications needs to be ensured with appropriate filing. Consideration should be given to electronic capture of these important documents. There should be robust documentation in the clinical notes of 'hand over' information between clinical teams							
Perso	Personal	CT CAH	CT CAH	7.9.18	Pe attended Craigavon Area Hospital (CAH) Emergency Department (ED) at 14:06 hrs on 30 April 2017, with possible bowel obstruction, investigations included Computed tomography (CT) scan. Pe aspirated in the CT scanner and developed respiratory failure, requiring intubation and ventilation. On 01/05/17 Pe had a subtotal colectomy and ileostomy, and was transferred to ICU post operatively. Despite maximal treatment Pe died at 15:30 on the 1 May 2017.	YES	1	SEC	**Recommendation 1 -** The Clinical supervisor for the trainee doctors/locum agency should meet with them and discuss this case and the review management plan implemented to aid reflection and learning.							
Perso	Personal	CT CAH	CT CAH	7.9.18		YES	1	SEC	**Recommendation 2 -** Present this case at M&M to share learning							
Perso	Personal	CT CAH	CT CAH	7.9.18		YES	1	SEC	**Recommendation 3 -** The Trust should consider producing written guidance on the implementation of the National Emergency Laparotomy Audit (NELA) standard in relation to the active input of a Consultant Surgeon and a Consultant Anaesthetist.							
Perso	Personal	CT CAH	CT CAH	7.9.18		YES	1	SEC	**Recommendation 4 -** The Trust should consider implementing a formal document with agreed language for handover of clinical information, including a clinical risk assessment with morbidity scores, an escalation process and automatic referral to Consultant.							
Perso	Personal	X-Ray CAH	X-Ray CAH	7.9.18	Pe had a Magnetic resonance cholangiopancreatography MRCP on 5 November 2014 showed an abnormality which was misinterpreted and reported as inflammatory change of pancreas.	NO	1	CCS	**Recommendation 1 -** The SHSCT should urgently develop and implement a Policy for Reviewing and Acknowledgement of Clinical Test results by referrers.							
Perso	Personal	X-Ray CAH	X-Ray CAH	7.9.18	On the 27 March 2015 Pe had an inpatient Ultrasound Scan (USS) in Craigavon Area Hospital (CAH). The provisional USS report which was sent up to ward on designated paper form mentioned "Several echo poor solid areas noted at the splenic hilum and at the aorta ? nodes". A Consultant Radiologist confirmed the findings shortly afterwards and issued final report on NIPACS with the conclusion "Peri-splenic and left para-aortic lymphadenopathy - in keeping with malignancy. Pancreas obscured. Red flag computed tomography scan (CT) chest, abdomen and pelvis required". The finalised report was not highlighted to clinicians as it was expected that final authorised reports will be reviewed due to inpatient status of patient at the time. The recommendation to refer for red flag CT was not actioned by clinicians. On 12 June 2015 Pe was admitted for laparoscopic cholecystectomy. There is no record of the previous results being reviewed prior to surgery.	NO	1	CCS	**Recommendation 2 -** The SHSCT should ensure that the WHO check list includes a question regarding all relevant results being signed off							

Personal Information redacted by the USI **SAI Quality Improvement Action Plan** Personal Information redacted by the USI

Reference number	Recommendations	Designated responsible person	Action required	Date for completion/ timescale	Date recommendation completed with evidence
1	All staff in ED should continue to be vigilant for the early identification of septic patients	Ward Manager ED/Patient Safety Consultant	Feedback to be given to ED staff and this should be emphasised at ward safety briefings and the Southern Trust Joint Emergency Department Patient Safety Meetings Completed	October 2016	ED153.docx ED M&M March 2017
2	Feedback to be shared amongst the surgical inpatient team. .	Chair of M&M	This case will be presented at the Southern Trust Surgical Mortality and morbidity meeting	Completed August 2016	M&M Surgical, Anaesthetic, Radiology 15 Sept 15 1431 Minutes of Morbidity & Mortality ED M&M March 2017 ED153.docx

3.	The Trusts Cellulitis Protocol needs amended to better guide staff.	AD/AMD	The Trusts Cellulitis Protocol should state if signs of Cellulitis and septic shock, treat as Necrotising fasciitis. In place as outlined	December 2016	The trust's cellulitis guidelines were updated and uploaded on 21/8/17 In the new guidelines it states that for cellulitis:- **Class 3-4**: have severe sepsis syndrome with organ failure or severe life threatening infection e.g. necrotising fasciitis (**see separate section**) For antibiotics advice it says **Class 3-4:** **See severe soft tissue infection**  http___www.southe rnguidelines.hscni.pdf  Personal Information redacted by the USI Action plan SAI template.do
4.	There should be early referral to Anaesthetics/ICU of hypotensive patients with skin and soft tissue infections.	AD/AMD	Junior staff should have awareness raised of sepsis and necrotising fasciitis and septic and toxic shock	November 2016 May 18	2017/2018 work is ongoing in relation to raising awareness of sepsis the Medical director chairs a Trust Sepsis 6 group, raising awareness of sepsis ongoing
5	Measures needs to be put in place so that ill patients that have not stabilised are not transferred to an	AD/AMD	There should be criteria set for ED to safely	November 2016	ED doctor refers patient for admission

	inappropriate ward.		discharge patients to ward-level care	May 18	and patient is transferred when accepted by receiving team. NEWS SCORE is reviewed and escalated if appropriate prior to transfer. Registered Nurse transfers patient to the ward

Minutes of Emergency Department Morbidity & Mortality Meeting
Wednesday 29th March 2017 at 9:30am in the Consultant Room, ED
(Video linked to ED, DHH)

ED153	**SAI feedback Case no** Personal Information **SAI – Summary** Presented Emergency Department (ED) Daisy Hill Hospital with swollen right hand and vomiting. The patient had cut right hand on greenhouse previous day. Diagnosed as severe cellulitis by ED doctor, commenced on IV antibiotics. Became more unwell with hypotension. Further review by ED doctor ?necrotising fascitis and referred to surgical team. Reviewed by surgical team and ?tendon sheath infection and organised transfer to plastics Ulster Hospital Dundonald. Prior to transfer became more unwell. Taken to theatres and arterial/central lines. Took to theatre locally for debridement of right arm and then transferred to ICU Craigavon Area Hospital. Remained very unwell and died 2 days after admission **SAI – Summary of findings/conclusions** • Patient should have been given higher triage priority and placed in resus on arrival (priority 2 instead of 3) • Patient should have been assessed by ED doctor sooner as they showed signs of severe sepsis (seen 47 minutes after triage) • Sepsis protocol should have been completed promptly (>1 hour before antibiotic given, antibiotics should have priority over IV paracetamol) • Necrotising faciitis is a very rare condition that is difficult to diagnose – felt that presence of septic shock should have warranted earlier senior surgical review (initial diagnosis of ?tendon sheath infection by surgical junior) • The anaesthetic team should have been involved earlier – patient remained hypotensive for prolonged period despite fluid resuscitation • There was a delay in surgical debridement – long delay to surgery (may not have changed outcome but panel felt opportunity missed for earlier surgical intervention) **SAI – recommendations** • All ED staff should continue to be vigilant for the early identification of septic patients • Case to be presented to southern trust surgical M&M meeting • The trusts cellulitis protocol needs amended to better guide staff • There should be early referral to ICU of hypotensive patients with skin/soft tissue infections • Measures need to be put in place so that ill patients that have not been stabilised are not transferred to an appropriate ward **Discussion** Missed diagnosis from surgical point of view. Appropriately managed from ED perspective. Need for appropriate level of surgical Doctor to review.

Minutes of Morbidity & Mortality Surgical, Anaesthetic, Radiology
Tuesday 15th September 2015, at 1:45pm in the Lecture Theatre, MEC

1431	Necrotizing Fasciitis. Minor injury right hand. Two days later admitted Daisy Hill Hospital. Next day died of Toxic Shock Syndrome. **Background** Past medical history: IHD on Ramipril, Bisoprolol, Isosorbide, GTN, CKD Stage 3. Baseline GFR 33, creatinine 173, PMR on maintenance Prednisolone 4mg/day, Prostate Cancer Gleason grade 7. PSA 28.9, conservative treatment. Unwell for 6 weeks. Attending GP with anorexia, weight loss and reduced energy. **Timeline** Injury to right hand. Late next day: Arrived Daisy Hill Hospital ED. Increasing pain and swelling for 24 hours + vomiting. Approximately forty minutes later assessed by ED F2. HR – 119, BP - 82/63, T - 37.4, BM 10.4. Discussed with medics and accepted. IV fluids, antibiotics etc. Around three hours later: Cellulitis tracking up arm (?nec.fasc.) Surgeons contacted and saw patient. ? Tendon sheath infection. Referred to Plastics and accepted (if BP >80). BP 69/41 so Anaesthetist informed. Ninety minutes later: Cellulitis improving. Consultant informed. Transferred to theatre for lines etc. Four hours later: Reassessed in theatre. ?necrotising fasciitis. Haemodynamically unstable and deteriorating despite maximal intervention. Discussed with Microbiology and family. Seventy five minutes later: Extensive debridement. Around two hours later: Transferred to ICU Craigavon Area Hospital. Next day: Died. Pathology necrotising Fasciitis due to Strep Group A. **Toxic shock syndrome** • Lappin & Ferguson *Lancet 2009* • Waldron & McNamara, *The Surgeon 2015* • Acute, multi-system, toxin mediated illness, often resulting in multi-organ failure. • Staph Aureus and Group A strep • Management – Early identification of the illness, source control, administration of antimicrobials and immunoglobulins. • Mortality >60% in patients >60 years old **Discussion** General discussion was held and the following points were noted: On occasion, it may be appropriate to seek the assessment of Plastic Surgeons and they may consider coming to the Trust regarding further management of the case, rather than transferring the case to Belfast. There is a Necrotizing Fasciitis protocol available online however each case merits discussion with Microbiology. Source control / Surgery is <u>THE</u> definitive management. **Learning points** • If cellulitis is noted and falling BP, consider Necrotizing Fasciitis. • There is a Necrotizing Fasciitis protocol available • Consider discussing case with Microbiology regarding management Statement of management: 2 (There were areas for consideration but they made no difference to the eventual outcome.)

Minutes of Emergency Department Morbidity & Mortality Meeting
Wednesday 29th March 2017 at 9:30am in the Consultant Room, ED
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Antibiotic Guidelines for CELLULITIS (Adults)

Mild: no signs of systemic toxicity, and no significant co- morbidity.
Moderate:

- systemically well, but with a co-morbidity e.g. peripheral vascular disease, chronic venous insufficiency or morbid obesity which may complicate or delay resolution of their infection **OR**
- may have a significant systemic upset such as acute confusion, tachycardia, tachypnoea, hypotension or may have unstable co-morbidities that may interfere with a response to therapy or have a limb threatening infection due to vascular compromise.

Severe: have sepsis syndrome or severe life threatening infection e.g. necrotising fasciitis (see separate section).

Panton-Valentine Leukocidin (PVL)-positive S. aureus strains can cause skin and soft tissue infections. It is usually associated with community-acquired infections, generally affecting previously healthy young children and young adults. Clinical infection tends to accompany other risk factors such as:

- Recurrent abscesses
- History of *S.aureus* infection
- Overcrowding
- Engagement in close contact sports (which can cause skin abrasions) e.g. rugby, wrestling
- Being in military, residential home and school settings
- Using contaminated articles: sharing towels, razors
- Poor hand hygiene
- Damaged skin e.g. eczema

CLINICAL GUIDELINES ID TAG	
Title:	**Antibiotic guidelines for cellulitis (Adults)**
Author:	Dr Martin Brown and Mrs A McCorry
Speciality / Division:	Microbiology, Pharmacy
Directorate:	Acute
Date Uploaded:	3rd October 2014
Review Date:	1st October 2016
Clinical Guideline ID	CG0022

Antibiotic Guidelines for CELLULITIS			
CLINICAL CONDITION	**RECOMMENDATIONS**	**ALTERNATIVE (suitable in serious penicillin allergy)**	**COMMENTS**
Cellulitis Contact microbiology immediately if: • Rapidly spreading cellulitis (suggestive of Group A streptococcal infection)contact microbiology for advice immediately. • PVL suspected.	**Mild:** Flucloxacillin 1g 6 hourly PO If streptococcal infection is suspected add: Amoxicillin 500mg 8hourly PO **Moderate to severe:** Flucloxacillin 2g 6 hourly IV *plus* Benzylpenicillin 1.2g 4 hourly IV **Necrotising fasciitis:** See separate section	Doxycycline 100mg 12 hourly PO Clindamycin 900mg 8 hourly IV **For patients ≥65:** If systemically well and stable Daptomycin 4mg/kg 24 hourly IV (if creatinine kinase elevated before treatment contact microbiology for advice) If systemically unwell and/or unstable Daptomycin 6mg/kg 24 hourly IV (if creatinine kinase elevated before treatment contact microbiology for advice)	Take blood culture and wound swab or pus for culture. Duration: As per clinical response, typically 7-14 days. **Daptomycin:** monitor creatinine kinase before treatment and then weekly (more frequently if receiving another drug known to cause myopathy-preferably avoid concomitant use) If on 4mg/kg and weight > 87kg or on 6 mg/kg and weight >83kg confirm dose with pharmacy or microbiology between 9am and 5pm day 1 or 2 of treatment.

Antibiotic Guidelines 2013 (extract)

CLINICAL CONDITION	ANTIBIOTIC THERAPY	COMMENTS
Severe Soft Tissue Infection (necrotizing fasciitis or evidence of toxic shock) **Seek immediate surgical and microbiologist advice**	*Empiric therapy for mixed infection*: Piperacillin/Tazobactam 4.5g 8 hourly IV *plus* Clindamycin 900mg 6 hourly IV. *Group A Streptococcal infection:* Benzylpenicillin 1.2g 2- 4 hourly IV *plus* Clindamycin 900mg 6 hourly IV *Penicillin allergy:* Clindamycin 900mg 6 hourly IV *plus* Ciprofloxacin 400mg 6-8 hourly IV *plus* Metronidazole 500mg 8 hourly IV Note: Treatment includes early surgical debridement and high dose antibiotic therapy directed at the pathogens for 2-3 weeks**.**	Necrotizing fasciitis is an acute, rapidly developing infection of deep fascia. Five clinical features suggest the presence of a deep and severe infection of skin and its deeper tissue: severe, constant pain, bullous lesions, gas in the soft tissues, systemic toxicity, and rapid spread centrally along fascial planes. Take blood culture and send wound swab, debrided tissue/ pus for culture to microbiology lab. This is a life threatening infection.

AGENDA

Acute Audit Committee Meeting

Friday 23rd March 2018

12:30-13:30

Meeting Room 1, Admin floor Craigavon Area Hospital with video-link Daisy Hill Hospital Tutorial Room (1st Floor)

1.	Attendance/Apologies Heather Trouton, Anne Quinn, Terri Harte, Dr Sidu, Dr Harty	
2.	Notes of previous meeting	 Acute Audit Committee notes Sep
3.	Review of Draft Terms of Reference	 Termsof referenceAcute Audit
4.	Audit priorities/programme	 HQIP 2018-19 National Audit list.xlsx  Audit proforma March 18.docx
5.	Audit Feedback processes	
6.	Date of next Meeting	

Southern Health and Social Care Trust

ACUTE CLINICAL AUDIT COMMITTEE

Date: Friday 22nd September 2017
Time: 12:00
Venue: Meeting Room, Admin Floor, CAH with video link to Clanrye House, DHH

NOTES

1.0	**Apologies**: Tracey Boyce, Dr Hogan, Dr Browne, Dr Murphy, Dr Liggett Attendees: Mrs E Gishkori, Mrs H Trouton, Mrs A Quinn, Mrs C Beattie, Dr A Ervine, Dr M Sidhu
2.0	**Welcome and Background** Esther Welcome everyone This meeting is to try to re-establish the Clinical Audit committee building on the excellent work previously undertaken by the committee The vision is that the committee will be clinically led with managerial support to lead service improvement. It is planned that the committee will support focused pieces of audit and service improvement work –the direction being set by identified risks within Acute, identified by trends from SAIs, Complaints, S&G, patient safety alerts and the HQIP national audit requirements, Royal College, NCEPOD
3.0	**Review of Terms of Reference** The Draft Terms of Reference were shared with the group, due to limited attendance they are to be recirculated for comment
4.0	**Audit Report** The SMT 2nd March 2017 National Clinical & Social Care Audits and Clinical Outcome Review Programmes was shared with the group National Audit Programme 2016-17 (HQUIP) was share with the group.
5.0	**Audit Priorities/programme** The group discussed the direction being set by identified risks within Acute, identified by trends from SAIs, Complaints, S&G, patient safety alerts and the HQIP national audit requirements, Royal College, NCEPOD. However further discussion is required with a fuller attendance before setting audit priorities/programme

6.0	**Resources Required** There was discussion regarding the resources required to support the audit committee to ensure robust audit activity leading to service improvement and reduction of clinical risk. Discussions included corporate support and leadership Within acute support requirements included 1. Administrative support 2. Accurate and timely data from the information team 3. IT system to enable a central repository of audit activity to be collected, support reports and production of action plans- Q-Pulse was discussed as already used for audit in laboratory and planning to be used in radiology. 4. Audit champions within clinical and operational teams
7.0	**AOB Applications for funding to support Clinical Audit & Quality Improvement**
11.0	**Date of Next Meeting:** **15th December 2017 at 12:00**

Southern Health and Social Care Trust

Quality Care - for you, with you

Acute Audit Committee, Acute Directorate

Terms of Reference

Introduction

In recent years the volume of standards and guidelines has become increasingly challenging for providers and commissioners to manage within existing risk management and clinical governance arrangements. As a consequence regional discussions have been undertaken to agree the most effective and efficient process for disseminating, implementing and assuring these standards and guidelines.

On 26 September 2011 the Chief Medical Officer issued a circular (reference HSC (SQSD) 04/11) to outline the new processes for the Endorsement, Implementation, Monitoring and Assurance of NICE Guidelines and NICE Technology Appraisals in Northern Ireland. These new processes became effective from 28 September 2011 (*Appendix 1*).

On 28 September 2011 Dr Carolyn Harper, PHA, issued a draft regional consultation paper which outlined the proposed systematic and integrated approach by these external agencies regarding the issue and management of safety alerts.

In response to both of these circulars the Trust has reviewed its arrangements for the management of standards and guidelines and as a consequence of this review the Trust's Standards & Guidelines Review Group was established in April 2012. This group identifies the directorate(s) responsible for disseminating and implementing each of the NICE guidelines, NPSA alerts, NCEPOD and other external reports, etc.

The Acute Directorate has proposed that an Acute Audit Committee now be established to further strengthen the arrangements for providing assurance on compliance with these Standards & Guidelines, as well as acting as an early alert system when difficulties with providing compliance are anticipated or have been identified.

Remit

The remit of the Acute Audit Committee is to:

- Provide a systematic and integrated approach for the identification and prioritisation of risk-related audits arising from:
  - the Corporate Standards & Guidelines Group,
  - trends arising from complaints, incidents, SAIs, litigation etc
  - significant audits identified by Divisions to minimise harm / risk to patients, clients, staff and the Trust.

These projects will form the Committee's Annual Audit Work Programme.

- Identify and prioritise the audit projects which will be supported by the Effectiveness & Evaluation Unit, together with the frequency of reporting the associated findings.

- Develop a 'rolling' Audit Recipe Book, outlining projects which will be delegated to junior medical staff at the commencement of each intake of doctors. These projects will be monitored by the supervising nominated Consultant Audit Lead, who is responsible for ensuring the findings are regularly presented at the Acute Audit Committee (or exception reporting as required).

- Provide assurance on the level of compliance in respect of the risk-related audits identified above, and/or propose recommendations for improvement, and/or act as an early alert system when difficulties with providing compliance are anticipated or have been identified.

- Provide expert advice regarding the development and implementation of an SHSCT IT system to support both the integrated monitoring of Standards & Guidelines and the provision of assurances arising from the Acute Audit Committee's Annual Work Programme. The IT system should include a facility for electronic registration of all audit projects initiated throughout the Directorate, irrespective of whether they are included in the Acute Audit Committee's Annual Audit Work Programme

Committee membership:

The Acute Audit Committee will be composed of the following:

Mrs E Gischori	Director of Acute Services
Mrs Tracey Boyce	Director of Pharmacy
Mr R Carroll	AD for ATICS & SEC
Dr G Browne	ATICS
Mr C Weir	SEC
Mrs H Trouton	AD for IMWH, CCS and laboratory
Dr Hogan	AMD for IMWH, CCS and laboratory
Rohit Sharma	IMWH, DHH
Dr Sidhu / Dr Rebecca Henry	IMWH, CAH
Dr Aaron Ervine	Laboratory
Dr Aaron Ervine	Radiology
Mrs A McVey	AD for MUSC

Dr P Murphy	AMD for MUSC
Dr N Liggett	Physicians, CAH
Neil Liggett,	MUSC, CAH
John Harty	MUSC, DHH
Anthony McClelland	MUSC, cardiology.
Mr C Weir	AMD for Education and Training
Mrs T Reid	Acute Clinical and Social Care Governance Coordinator
Mrs A Quinn	E&E Manager
Mrs C Beattie	S&G Manager

Invitations may be extended to other Directorate members or outside agencies as deemed appropriate. If parameters of the audit are multidisciplinary, then multidisciplinary representatives will be co-opted for that audit.

Responsibilities of Group Members
Each member is responsible for:

- Reviewing the issued standards and guidelines and providing expert opinion from within their division / area of responsibility, to inform the identification and prioritisation of projects to be included in the Committee's Annual Audit Work Programme.
- Reporting and disseminating the outcome and actions within their Division / area of responsibility.
- Taking forward actions arising from Committee meetings
- Ensuring that risk related audits within their Division / area of responsibility are identified and considered.
- Ensuring a departmental audit meeting occurs within their own department on a monthly basis and audits are presented and learning points ascertained.
- Ensure that the Trust is fully informed of any audit work that is presented at Regional, National or International meetings.
- Ensuring the mandatory audit reports assigned to their department have been completed and presented to the Committee.
- Ensure that the junior doctors are fully informed about the process of audit within the SH&SCT and their responsibilities to the process at the commencement of their post at departmental induction.

Quorum

A meeting will be quorate if over 50% of members are present, including the Chair or nominated Deputy.

Frequency of meetings

The Committee will meet on a quarterly basis. Dates will be identified in advance to facilitate diary management.

Reporting arrangements
The Chairperson / AMD S&G will be responsible for providing summary / exception reports to Acute SMT and for producing an Annual Audit Report. It is the responsibility of nominated Consultant Audit Leads to ensure progress reports from their division / area of responsibility are submitted to the Chair, as required.

Each nominated Consultant Audit Lead will provide a written report of the audit activity that has taken place within their department on a yearly basis. All audit activity must be reported, including audits that have not been completed. The audit activity of each Consultant and junior doctor must be included within the report.

The Committee will provide each Consultant/Junior Doctor with a record of their audit activity on a yearly basis for incorporation within their appraisal folder.

Management of the Group Meetings

An agenda and required papers will be issued one week in advance of the meeting, to ensure timely review and preparation.

Review of the Terms of Reference

The terms of reference will be reviewed on an annual basis or earlier if required.

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

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

Audit Proforma

Level	Audit type - Projects identified through	
Level 1 audits, "external must dos" where the service is applicable to SHSCT	• National audits (HQIP), including National Confidential Enquiry into Patient Outcomes and Deaths (NCEPOD) / Other Confidential Inquires	1
Level 2 audits, 'internal must dos'	• National audits not contained within the HQIP list • Clinical risk • Audits arising from: ➢ Serious untoward incidents. internal reviews ➢ National Institute of Clinical Excellence Standards & Guidelines ➢ Complaints ➢ Re-audit • Regional audits initiated by RQIA / GAIN ?Level 2 or 3	2
Level 3 audits, 'divisional priorities'	• Local topics important to the division	3
Level 4 audits	• Clinician / personal interest • Educational audits	4

RQIA Audits/Reviews

- Review - IV Fluids in Adults- NICE Clinical Guideline 174 - Intravenous (IV) Fluid Therapy in Adults in Hospitals - in Northern Ireland.
- Theatre practice
- Management of controlled drugs
- Care of Older People Acute Hospitals
- Mixed gender
- Hospital at night
- Belfast unscheduled care
- NICE CG 142 Dementia
- GAIN Guidelines on Caring for People with a Learning Disability in General Hospital Settings (Published December 2014)
- REVIEW of Brain Injury Services in Northern Ireland (Published September 2015)
- REVIEW of Implementation of the Palliative and End of Life Care Strategy (Published January 2016)
- Review of Perinatal Mental Health Services in NI - January 2017
- REVIEW of SPECIALIST SEXUAL HEALTH SERVICES in NORTHERN IRELAND (Published October 2013)
- REVIEW of the Implementation of the Respiratory Service Framework (Published March 2014)
- REVIEW of Discharge Arrangements from Acute Hospitals (Published November 2014)
- REVIEW of STROKE SERVICES in NORTHERN IRELAND (Published December 2014)
- REVIEW of Discharge Arrangements from Acute Hospitals (Published November 2014)

Patient Safety Audits

- SSI – orthopaedic and C Section
- Ventilator Associated Pneumonias/bundle compliance
- Central Venous Catheter related infections/bundle compliance
- Crash Calls
- Stroke
- VTE
- Sepsis 6
- Neutropenic Sepsis
- WHO check list
- Falls
- NEWS
- Pressure Ulcers
- MUST
- Delirium Tool compliance

Governance Co-ordinators Meeting

Wednesday 28/6/17

Beechfield House, CAH Site

1. Apologies

Claire McNally

Present: Margaret Marshall, Tony Black, Lauren Megahey, Marita Magennis, Trudy Reid, Jilly Redpath, Nicole Evans.

2. Notes of meeting

Agreed to be a true record.

3. Matters arising from minutes of meeting.

None.

4. Adverse Incident Project

- Lauren told the meeting that she had received lots of feedback from staff; staff engagement was very good. Staff had expressed that they do not like the Datix form. They feel that it is too long, that they are unsure of what information to put in it and they do not like the fact that you are unable to save it and come back to it at a later date.
- Lauren was contacted by a Union rep (staff side) called Margaret Devlin. Margaret queried what the project was about and wanted to know if we had consulted with the Union. She wanted to know if staff had been consulted. Margaret sits on the Health and Safety Committee.
- Lauren hoped to have something on paper to show the meeting but unfortunately there had been an issue with the test site and she was unable to access it. IT has the licence keys for Datix but they had not applied them to the test site and it was therefore not working.
- **Action**: Tony is to put together a draft based on what was discussed at the meeting he attended this morning.
- It will most likely be the end of August before the pilot is ready.
- There has been a lot of interest in piloting – CYP, MHD, OPPC, Trauma, Anaesthetics, Clinical and Nursing have all displayed an interest. The plan is to ask them to fill out the real form and the test form and record how long it takes to fill out each form to determine which form takes more time to complete. There is also to be an automated response to staff when they fill in the form to state that the report has been submitted for review. A leaflet will be given to staff to explain the form and the information required.
- Extra features of Datix are to be considered at a later date as it would be unrealistic to include them by October.
- After the test forms have been submitted they will be reviewed to determine if the information that was obtained is sufficient and relevant to purpose.

- Datix Manager/ Administrator – A paper is to be submitted to SMT in September to ask for funding for this post. The evidence from the project will be used to highlight the need for a Datix Manager/ Administrator within Governance.
- **Action:** Nicole is to link in with the Northern Trust to obtain a job description for this post.
- Lauren provided process maps for the meeting, specific to each directorate.
- Incidents that happen outside the Trust – Jilly looks at incidents outside the Trust, for e.g. GP's etc. but she is not the handler for these incidents. She does not feel that it would be right for her to be the handler. If the incident relates to domiciliary, it would need to be a domiciliary manager that is the handler. It should be a member of that team. An initial request from Claire McNally was that Jilly close these off on the system but Jilly feels that the team would then miss out on any learning. Jilly would just advise if it had been passed onto the Board.
- **Action:** Jilly to link with Claire.
- CYP Pilot – Marita provided an update on CYP's reflecting on incidents in Carrickmore Residential. She expressed that there had been very positive staff engagement and a prescriptive model of reflection. It was found to be a positive and effective communication tool that helps people to have difficult conversations. Marita originally agreed to report back to the management team but found this to be ineffective. It was then agreed that one person from each meeting would be the facilitator. It transpired that the management team had been suggesting the outcomes from the pilot for some time. There has been no feedback yet from the young people living there but Marita felt that it was for staff to have a discussion with them to get their opinion.

  In a separate project for CYP, Dr Khan is simulating different situations. The pilot looks at what would you do in the situation? How would you deal with it? This highlights the various situations that can arise and how different people respond to them and from this training can be provided on how to deal with particular situations. Tony said he was very interested in this concept in relation to violence and aggression.
- OPPC Pilot – In the absence of an OPPC representative, Margaret told the meeting that OPPC had hoped to do a piece on administering Insulin (Primo). They are currently putting a team together.
  In residential settings medications are no longer set down in front of residents to take. The Senior Carer now gives the client the medication and witnesses them take it. Initially the residents did not seem to like this but now they feel more supported.
- Acute Pilot – Safety Improvement in Radiology. Trudy stated that someone had been recruited to deal with incident safety. They are to use the same system as the labs to record (Q Pulse). This will also be duplicated onto Datix and will be part of the Radiology accreditation process. Primo did not really get off the ground.
- Margaret concluded that the project needs to be reported on by September so moving forward Dr Khan's simulation, CYP's pilot at Carrickmore and the Adverse Incident Plan will be reported at the meeting.
- Scrutiny of AI at Corporate Level and Learning – the group is to be kept going after September/ October for improvement as it is felt it is very valuable.

Jilly and Lauren left the meeting.

5. Standards and Guidelines

- Directorates are to ensure that the applicability and compliance columns are completed.
- Governance Officers are to complete the database on a weekly basis to ensure compliance.
- Simon Gibson was invited to the meeting today to represent the Medical Directorate but he is on annual leave.
- NG 51 – The Board have said that this Nice Guideline had been sitting for some time. Nicole has sent this to Simon again but as yet has received no feedback.
- CYP – the work is being done but they are not getting the chance to update the database.
- If someone goes into the database and someone from Corporate Governance is in it, just pick up the phone and speak to the staff member and ask to have access.
- If there is any query with regards to which directorate is going to deal with the standard or guideline, the directorates are to communicate with each other in order to determine this information for definite and then record it on the database.
- The Change Lead is to be written in after the designated directorate, eg. Acute (Lead). (After the meeting Trudy emailed asking if it would be better to use 'Co-ordinating' – this is to be discussed within the directorate teams and an opinion to be given at the next meeting).
- E Proforma for diabetes – anything that is cross directorate is to be initiated by the lead directorate, sent to the smaller directorate and then the final E Proforma is to be sent to Corporate Governance. They have not to be sent to Corporate Governance until final and ready for submission.
- Regional Line Labelling Policy – Lines are generally fine in acute and CYP but the policy is being redone and is with Simon to be signed off.

6. SAI

- Directorates are to monitor those that have been completed and not completed and extract the learning.
- How we record SAI's and hold details needs to be looked at. The database held in Corporate Governance is to be moved onto Datix. Therefore all information relating to the dealing of SAI's needs to be forwarded onto Corporate Governance so that they can ensure that their database holds all the information. Family engagement and the area of service failure need to be recorded on Datix.
- The Corporate Governance office hopes that by 1st January 18 all information relating to SAI's will be held on Datix. The Governance Officers are to lead to ensure that this can progress.
- Tony is to look at Datix in relation to the learning codes.
- Nicole explained the new structure of the Governance Officers meetings – they will consider S&G, complaints, SAI's, Ombudsman Cases etc.

7. Ombudsman Cases

- Responses to the Ombudsman have to be back with the Ombudsman by the date specified in the letter. Therefore they need to be sent to the Corporate Governance in enough time to allow for postage to Ombudsman by the date specified.
- (At the meeting it was decided that Directorates have to apply to the Ombudsman directly for an extension if the response is not likely to be back with the Ombudsman by the date given. However, the Ombudsman has now said that they will not communicate with anyone other than the Corporate Governance office. Therefore, as discussed at Corporate Officers meeting, if a directorate requires an extension, they are to draft an email at least 3 working days before the response is due back to the Ombudsman and send it to the corporate office to be forwarded onto the Ombudsman.)
- Letters for signature by the CX are to be sent to Elaine Wright and Elaine will then leave in the postal tray for the attention of the corporate office for posting. The signed letter will be scanned and sent to the directorate for their records. Supporting documents are not to be sent to Elaine. Please notify the corporate office, in the email sent to Elaine for signature, that there are supporting documents to accompany the letter and arrange for their delivery to the corporate office.

8. CH8 Reporting

- The Trust response field cannot be left blank.
- Quarter 4, year-end report to be re-run to report for the whole year.
- The report will be shown at all future coordinators meetings.
- The closed complaint summary will also be shown at future coordinators meetings.

9. AOB

- E Proformas – Trudy asked how we as a group manage the risks now sitting within the guideline, for e.g. if 2 more podiatrist are needed for the service. The directorate are to decide internally on the level of risk and escalate to SMT. (There was previously a business case for funding in this situation)

Marita gave her apologies for the next meeting. Denise will come in her place.

Stinson, Emma M

From: Carroll, Ronan [redacted]
Sent: 16 June 2017 14:03
To: Weir, Colin; Haynes, Mark
Cc: Reid, Trudy
Subject: FW: Screening
Attachments: Time line [redacted].xlsx; Time line [redacted].xlsx; Time [redacted].xlsx; Time line [redacted].xlsx; Time line [redacted].xlsx; Time line [redacted].xlsx; Time line [redacted].xlsx; Time line [redacted].xlsx; Time line [redacted].xlsx

Importance: High

Colin/mark
When could we meet next week to screen – I will be in ACH mon, tues & thurs

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From: Reid, Trudy
Sent: 16 June 2017 10:31
To: Carroll, Ronan
Subject: FW: Screening

Ronan please see attached time lines for screening

SEC	[redacted]	CT showed PE not actioned - Mark
SEC	[redacted]	Delay in diagnosis and treatment of prostate cancer - Colin
sec	[redacted]	Delay in diagnosis and management of prostate cancer -Colin
SEC	[redacted]	Delay in diagnosis and treatment of prostate cancer - Colin
SEC	[redacted]	Delay in tumour management - Mark
SEC	[redacted]	Not preped for CT scan - aspirated –Mark
SEC	[redacted]	Not referred from urology MDM to endocrine - colin

Regards,

Trudy

Trudy Reid
Acute Clinical and Social Care Governance Coordinator
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ
Telephone [redacted]

Mobile Personal Information redacted by the USI

Patient 11

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
NICER	17/07/2016		GP	GP referral to urology	Reason for Referral/ History of Presenting Complaint Description: overactive bladder Comment: This Patient 11 is having increased problems in recent months with storage and voiding LUTS. I have commenced him on Oxybutinon, but would value a full bladder assessment from the Continence Service in SWAH, whom he has attended in the past. Many thanks.		IEAP					
NICER	28/07/2016		GP	GP referral to urology	Reason for Referral/ History of Presenting Complaint Description: Elevated PSA. Comment: This Patient 11 man has mixed symptoms of overactive bladder and prostatism. Recent MSU and urinalysis were normal, but PSA was 5.6. On examination he has a moderately enlarged smooth prostate. I have commenced him on Oxybutynin recently and he has felt some improvement in his LUTS. Please see and advise regarding further management of his elevated PSA. I have also referred this man to the Continence Service for bladder studies.		IEAP					
NICER	18/01/2017		Consultant Urologist	Letter to patient	Dear Patient 11 I am following up a referral your GP sent in July 2016. At the time of this referral your prostate blood test was elevated slightly above normal range. I would be grateful if you could arrange to have repeat of this blood test checked with your GP at your earliest convenience using the enclosed blood test request form. Once a result is available I will be making arrangements to review in clinic.							
NICER	21/01/2017 reported 27/01/2017			Histology report	REPORT CLINICAL_DETAILS Right colonic biopsies - diarrhoea PATHOLOGISTS_REPORT Sections of the 3 white tissue fragments received show normal colonic mucosa with no evidence of inflammation, dysplasia or malignancy. DIAGNOSIS: COLONIC MUCOSA NO PATHOLOGIC DIAGNOSIS							
NICER	20/02/2017		Consultant Urologist	Letter to GP	Diagnosis: Elevated PSA with LUTS Outcome: MRI prostate and TRUS biopsy Trial of Tamsulosin I reviewed Patient 11 today who has had a two year history of frequency of urination and some stinging inside which is relieved by urination. He also feels he has intermittent incomplete emptying. He previously had marked symptoms of urgency which have improved since starting Oxybutynin and this was on the background of having previous urodynamics several years ago that did describe an overactive bladder however I could not find these results today, this information was from the patient. He describes no haematuria but does have nocturia up to 6 times at night, some hesitancy and terminal dribbling. There is no history of incontinence. His weight is stable and his appetite is good. His PSA in July 2016 was 5.6 and January 2017 5.5 ng/ml. On PR examination the base was smooth but I was unable to access the top of the prostate. He underwent flow and post void residual today which showed a post void residual of 7mls and a maximum flow of 16.2mls. His urinalysis was negative. His kidneys were normal. His prostate was identified as having a volume of 31cc with some areas of focal calcification. In view of his elevated PSA and smaller prostate and evidence of calcification this gentleman would benefit from further investigation to rule out any malignancy of his prostate and in light of this I have arranged an MRI of his prostate then TRUS biopsies. I have given him a trial of Tamsulosin today to see if this will improve some of his symptoms and have suggested that should he not see symptom PETER							
NICER	20/02/2017		Consultant Urologist	Letter to Pt	Dear Patient 11 Further to your recent clinic attendance I have seen the result of your MRI scan. As you are aware this was performed to further assess the raised prostate blood test. The MRI scan does show a small area of abnormality in the left side of the prostate. I believe arrangements have been made for you to have biopsies of the prostate and this will include some additional biopsies of this area of abnormality on the left side.							
NICER	27/02/2017	16:10			MRI pelvis and prostate							

NICER	06/03/2017	09:21	Radiology	Urology MRI report	27/02/2017 17:10 MRI Pelvis prostate, Author: RRO, Regional Admin MRI PROSTATE CLINICAL HISTORY PSA 5.5. 30 cc. Calcification on ultrasound.? Prostatic malignancy FINDINGS Prostate volume 28 mL. There is an area of decreased T2 W signal in the left peripheral zone measuring 17 x 14 x 25 mm (PI-RADS 5). DWI is been degraded by the THRs. Normal seminal vesicles. No enlarged pelvic lymph nodes. Small focus of decreased T1 W signal in the left ilium of equivocal significance. No other bony lesions. CONCLUSION T2, N0, M0 left peripheral zone carcinoma. (Assumed ilial lesion to be benign but bone scintigraphy recommended). This report of an unexpected significant finding has been notified to the imaging department using the agreed protocol.							
	04/04/2017 reported 11/04/2017			Histology report	CLINICAL DETAILS Recent MRI - area of abnormality left side. PSA: 5.5. Prostate Vol: 27.8 cc. Specimen - Prostate. PATHOLOGIST'S REPORT GROSS DESCRIPTION NATURE OF SPECIMEN: Needle core biopsy SITE: 1. Right base - Three cores measuring 5 mm, 6 and 5 mm along with fragments. (Clinically two cores, on slides fragmented) SITE: 2. Right mid - Three cores easuring 17, 9 and 7 mm along with fragment. (Clinically two cores, on slides fragmented) SITE: 3. Right apex - Two cores measuring 16 and 15 mm. SITE: 4. Left base - Three cores measuring 19, 18 and 12 mm. SITE: 5. Left mid - Four cores measuring 16, 5, 12 and 7 mm alongwith fragment. (Clinically three cores on slides fragmented) SITE: 6. Left apex - Four cores measuring 10, 6, 9 and 4 mm along with fragment. (Clinically two cores on slides fragmented) HISTOLOGY HISTOLOGICAL TYPE: Adenocarcinoma DIFFERENTIATION/GLEASON SUM SCORE: Overall 3+3 = 6 NUMBER OF CORES/CHIPS INVOLVED: 7 of 19 Right base - No tumour identified. Right mid - No tumour identified. Right apex - No tumour identified. Left base - 3 of 3 cores, Gleason 3+3, 11.2 mm max length, 75-80% of tissue. Left mid - 3 of 4 cores, Gleason 3+3, 35-40% of tissue. Left apex -1 of 4 cores, Gleason 3+3, <5% of tissue. INVASION INTO: Seminal vesicle: No Extracapsular fat: No PERINEURAL INVASION: Yes LYMPHOVASCULAR INVASION: No FURTHER COMMENTS: Within 7 of the 19 prostatic core biopsies there are infiltrates of Gleason 3+3 adenocarcinoma. This occupies approximately 20% of the overall tissue examined. There is perineural invasion but no lymphovascular invasion of extracapsular extension. DIAGNOSIS: PROSTATE CORE BIOPSIES							
NICER	04/04/2017		Nurse specialist	Letter to GP	Patient 11 attended Thorndale Unit on 4th April. Written consent was obtained. Local anaesthetic inserted and following guidance from his recent MRI scan a total of 14 core biopsies of prostate were collected. Personal Information found the procedure somewhat uncomfortable but recovered quickly when the probe was removed. He was provided with a 3 day course of prophylactic antibiotics and discharged home care of a family member. His histology results will be discussed at urology MDM and reviewed by Mr Haynes thereafter. Yours sincerely dictated but not signed							
NICER	04/04/2017			US Guided biopsy prostate transrectal	Report 04/04/2017 09:46 US Guided biopsy prostate transrectal, Author: Radiology, Admin This examination was performed by the Urologist. Please see patient notes.							
NICER	10/04/2017		Medical	SWAH discharge letter for admission 6/4/17 to 10/4/17	This Patient 11 was admitted with pyrexia following a recent prostate biopsy two days previous. He reported feeling generally unwell with aches as well as complaining of ongoing urinary frequency and hesitancy. Patient continued to spike temperatures while in hospital and blood cultures were taken. This gentleman was discussed with urology in CAH where he underwent the biopsy who advised starting Patient 11 on Ciprofloxacin and Gentamicin to which he responded well. CRP peaked at 221.1 but is now improving. Patient 11 is feeling well, he is apyrexic and is surgically fit for discharge with further 7 days of oral Ciprofloxacin. Many thanks for your ongoing care of this gentleman.							

NICER	03/05/2017		Consultant Urologist	Letter to GP	Diagnosis: Low risk prostate cancer Outcome: Bone scan and subsequent outpatient review Personal Information prostate biopsies have shown a gleason 3+3=6 prostate cancer. His presenting PSA is 5.5 and on MRI scan his local staging would be T2 N0. A bone scan has been arranged to complete his staging. I would anticipate this to be satisfactory given the low risk nature of his disease. His treatment options are either proceeding to treatment with curative intent with either radical surgery, external beam radiotherapy or brachytherapy or alternatively proceeding to active surveillance. He has been given written information regarding prostate cancer and information regarding each of these treatment options. I plan to review him in clinic after his bone scan to discuss these further. Yours sincerely							
NICER	18/05/2017	12:00 reported 18 :26	Radiology	NM bone whole body	Report 18/05/2017 16:14 NM Bone whole body, Author: Vallely, Stephen No evidence of bony metastatic disease. Bilateral hip replacements noted							

Received from Trudy Reid on 16/05/2023. Annotated by the Urology Services Inquiry.

Personal Information redacted by the USI

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
NICER	10/03/2016		Medical	Discharge letter post hip replacement	Principle Discharge Diagnosis :-Right total hip replacement. Operations/Procedures/Radiology -Right total hip replacement. Additional Information for GP -Past Medical/Surgical History -TIA, Heart failure, Cardiac valve: tricuspid valve repair, Left THR, Multiple gallstones, Pancreatitis, C5-C6 spondylotic myelopathy with nerve root entrapment, Left THR, Fibrotic lung disease Changes to Medications - Start/Stop Analgesia: PRN CLEXANE: FOR 5 WEEKS POST OP. SURGERY ON 24/2/2016. Furosemide: was held during admission as patient had AKI. This resolved and patients furosemide was restarted. **Clinical Information/Comments** Patient underwent Right total hip replacement under Mr Patton on 24/2/2016. Post operative instructions included: Routine observations, 24 Hours flucloxicillin, Clexane for 5 weeks, Mobilise Full weight bearing, Avoid Abduction exercises 6/52, Check XRays, AP pelvis and lateral hip, Review 6/52 OPD. Patient made good post operative progress with physiotherapy. During admission patients inguinal hernia became problematic, as patient found it slightly more difficult to reduce. An urgernt referral to Mr Hewitt Consultant general surgeon was sent to surgeons secretary. His discharge was delayed solely due to delays with implementing social input. Patient was deemed fit for discharge on 10/3/2016.						
NICER	23/06/2017			Referral from GP	Reason for Referral/ History of Presenting Complaint Description: gallstones Comment: Thank you for seeing this gentleman who had pancreatitis in 2013 as a result of gall stones. He was told at the time he would be reviewed in 3 mth but that has not yet happened. He had been well but recently he has had vomiting and nausea off and on since 5 days since ate cheese. no diarrhoea.bitter taste in mouth. His main concern is when he had pancreatits due to gall stones surgeon warned him about something leaking out and eroding stomach. I told him this happens in pancreatitis if bad but he no longer has pancreatitis. I am grateful for rv re gall stones.						
NICER	11/07/2016			Referral from GP	Reason for Referral/ History of Presenting Complaint Description: Vascular surgery Comment: severe v veins...has developed phlebitis on L side....previous bleeding DU on oral nsaids....topical nsaid given...referral for advice re ? further management of varicose veins Many thanks. Personal						
NICER	21/07/2016		Consultant	OP letter to GP	I assessed Personal today. He has had trouble in the past relating to his gallbladder and gallstone pancreatitis although he has a lot of medical co-morbidities. I note though recently that he has got a new iron deficiency anaemia and I think before we consider doing anything with his gallbladder that needs to be investigated. I have talked to him about an OGD and colonoscopy today which I think he is fit for and I have booked these procedures on a red flag basis.						
NICER	27/07/2016		Specialty doctor	Letter to Consultant	Personal is under investigation for microcytic anaemia. He underwent an OGD which demonstrated polyps within the stomach. There is no dysplasia or malignancy. The morphological features were non-diagnostic of the gastric polyps. Duodenal biopsies have shown no evidence of coeliac disease. Within the colon there is evidence of diverticulosis and also colonic polyps within the ascending colon. Biopsies of these have showed a tubular adenoma with low grade dysplasia. There is no obvious cause for his anaemia demonstrated on CT of his chest abdomen and pelvis performed. There were no malignant features within the scan however sub-segmental and segmental embolus seen in the right lung which will require further follow up. From a colonoscopy view he will require a repeat colonoscopy in 5 years' time due to the 2 polyps on the ascending colon. I will leave further follow up with						
NICER	02/08/2016	13:50	Consultant Surgeon		CT performed Chest and abdomen						
NICER	07/08/2016	08:09	Radiology	CT report	Requested by Consultant surgeon :- Clinical Info From Order Personal with iron def anaemia. OGD and colonoscopy no cause found. Diverticular disease. **02/08/2016 15:06** CT Chest and abdo and pelvis with contrast Hx: Fe def aenaemia. No cause on OGD and colonoscopy. **Technique:** Spiral imaging of the chest and abdo/pelvis **Findings:** Chest: No overt lymphadenopathy. Cardiomegaly. Midline sternotomy and tricuspid valve replacement. No pericardial effusion or central PE. However segmental PE is seen in the lat seg ML image 148 and posterobasal RLL image 187. Subsegmental embolus ML image 176. No pleural lesion or effusion. No central endobronchial lesion. The lungs show some mild reticulations, small airways changes and atelectatic bands without any significant nodule or mass to suggest malignancy. Triangular intrapulmonary node LLL image 175. Abdo/pelvis: No liver lesion. Small cysts noted. Gallstones no biliary dilatation. Unremarkable spleen, pancreas and adrenals. Renal cysts no mass or hydronephrosis. Pelvic viscera obscured by artefact. No bowel dilatation. No overt fat stranding. Paucity of fat limits assessment but reassuring results from endoscopies. L inguinal hernia containing sigmoid. Diverticulosis noted. No adenopathy, ascites or omental disease. Normal calibre aorta. Bilateral THRs. Spondylotic changes no overt destructive skeletal lesion. **Conclusion:** No malignant features within scan limits. However subsegmental and segmental emboli seen in the R lung. **Message to referring clinicians via medica.** Dr A Wallis Consultant Radiologist GMC 6102974 Medica Reporting Ltd	Audit trail of CT result Request date 27.7.16 Examination CT chest abdomen and pelvis – Red Flag Exam performed 2.8.16 Reported 7.8.16 by Medica Reporting Radiologist Reported communicated urgently emailed D McKay re urgent report on 08/08/2016 10:13 Ruth Gribben					
Email	08/08/2016			Audit trail	Reported communicated urgently emailed D McKay re urgent report on 08/08/2016						
NICER	30/08/2016				OP review by orthopaedics						
NICER	24/01/2017				RVH cardiology review						
NICER	24/02/2017				1 year review post hip surgery						

NICER	03/03/2017		ED consultant	chest Xray	03/03/2017 16:17 XR Chest, Author: RRO, Regional Admin X-RAY chest FINDINGS:CTR 160/325. Sternotomy sutures are in situ. No signs of heart failure or pleural effusion. Some shadowing in the right base extending down from the right hilum. It is most likely to be inflammatory. A followup chest x-ray after course of antibiotics is recommended in 4-6 weeks							
NICER	04/03/2017		Requested by Consultant physician reported radiology	CT result	04/03/2017 13:18 CT Angiogram pulmonary, Author: Johnston, Norlinda Technique: Enhanced volume scan of the chest as per CTPA protocol. Comparison study: CT chest dated 2 August 2016. Findings: Previous median sternotomy and tricuspid annuloplasty. No evidence of central or segmental pulmonary embolism. Two tiny filling defects are noted within the subsegmental left lower lobe pulmonary arteries (image 195) in keeping with a small volume pulmonary embolism. No pericardial effusion. The pleural spaces are clear. Dependent changes at the lung bases. No focal area of collapse or consolidation. No skeletal infiltration. Summary: Tiny subsegmental pulmonary embolism of the left lower lobe. No central PE.							
NICER	06/03/2017	13:45 performed reported 13:54		Discharge letter CAH	Admission Reason Increasing shortness of breath ?PE Patient Receiving Palliative Care? No Principle Discharge Diagnosis Pulmonary embolus Operations/Procedures/Radiology CTPA Additional Information for GP Past Medical/Surgical History Previus PE 2016, tricuspid valve repair 2013 (severe TR), pancreatitis, hernia repair, CCF, BPH, OA, R THR (2016), L THR (1997). iron deficinecy anaemia - polyps and diverticulosis on OGD Changes to Medications - Start/Stop Started Apixaban and Laxido Clinical Information/Comments This Personal Information was admitted with increasing shortness of breath over the past 3-4 weeks. Started on a course of Amoxicillin and Prednisolone by GP 1 week prior to admission. When there was no improvement, Furosemide was added. As still no imrpovement, Personal attended ED. Chronic dry cough. O/E bilateral ankle oedema Personal was initally treated with therapeutic Enoxaparin, IV fluids, and furosemide held. CTPA showed tiny subsegmental PE in left lower lobe. Started Apixaban during admission - initially 10 mg BD then switching to 5mg BD on 10/03/2017. Reviewed by the Medical Team today - Personal is feeling well, keen for home and up and mobilising freely. Observations remain stable and Personal is now medically fit for discharge home.							

Data Source	Date	Time	Professional Group	Key Facts	Patient 14 Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
NICER	03/06/2016		GP	GP referral	Reason for Referral/ History of Presenting Complaint Description: Raised PSA Comment: Many thanks for seeing this patient - Small rise in PSA noted on routine testing earlier in year - had returned to Normal on repeat testing but mot recent test raised again (5.63) . Few LUTS and nil overt on clinical examination . Please see and advise regards further investigation .		IEAP					
NICER	07/02/2017		Consultant urologist	letter to pt	Dear Patient 14 I am writing to you with the results of your recent MRI. I am pleased to say there are no significant abnormalities of your prostate. There are however some changes within a small area of the prostate so we cannot completely exclude a tumour. Given that your PSA remains raised for your age I would like to offer you a prostate biopsy that is performed under local anaesthetic in the Thorndale outpatients. I will arrange for you to have biopsies and you will be sent an appointment in due course, however if you don't wish to proceed with biopsies at the present time or wish to discuss this further we would be more than happy to hear from you. If you have any queries please contact us on the number above, otherwise I will see you with your biopsy results						
NICER	07/02/2017		Consultant urologist	letter toGP	Thank you for referring this Patient 14 who has a raised PSA of 5.63. Prior to that it had been 4.4 and 5.5. On questioning Patient 14 reports no troublesome lower urinary tract symptoms. He has some occasional hesitancy however he is very happy with his waterworks at present. On examination his abdomen was soft and non-tender and he has a non-palpable bladder. The area revealed moderately enlarged and generally firm but benign feeling prostate. Given that it has been 8 months since his last PSA I have repeated this today at clinic. If it remains elevated or has risen further I will proceed with an MRI of his prostate as he has no contra-indications to this. If however his PSA remains stable I think it is reasonable to continue with 6 monthly surveillance PSA. I will be in touch with his results when they are available. Yours sincerelyThank you for referring this Patient 14 who has a raised PSA of 5.63. Prior to that it had been 4.4 and 5.5. On questioning Patient 14 reports no troublesome lower urinary tract symptoms. He has some occasional hesitancy however he is very happy with his waterworks at present.						
NICER	07/02/2017		Consultant urologist	letter to pt	Dear Patient 14 I am writing to inform you of your latest PSA prostate blood test result. Your PSA has dropped slightly to 5.5 from 5.6 last year. Overall this is reassuring. Given that it remains slightly elevated for your age I will proceed with booking an MRI scan of your prostate as discussed at clinic. You will receive an appointment in due course.							
NICER	24/02/2017	08:20			MRI Pelvis prostate							
NICER	06/03/2017	19:21	Radiology	MRI report	Report 24/02/2017 09:05 MRI Pelvis prostate, Author: Williams, Marc Prostate volume of 37cc. There is a small volume of reduced T2 and ADC signal change related to the posterolateral peripheral zone of the left apex to mid gland. No overt restricted diffusion. The appearances are therefore of equivocal significance and may represent a small focus of tumour. Extension to but not definitively beyond the prostatic capsule. Non specific minor reduced T2 and ADC signal changes within the posterolateral and peripheral zones of both sides of the mid gland to base. Within the limitations of transition zone assessment, no definite transition zone tumour is identified. The seminal vesicles appear unremarkable.5mm utricular cyst. No pelvic lymphadenopathy. Probable degenerative change at L5/S1. An 11mm low T1 signal focus within the right femoral neck is not thought to be significant. CONCLUSION: There is no definite radiological evidence of significant prostate tumour. A small volume of signal change within the posterolateral peripheral zone of the left apex to mid gland is regarded as suspicious. Mild signal change elsewhere within the peripheral zone as described is equivocal. If biopsies are being considered, you may wish to consider additional biopsies of the left apex to mid gland peripheral zone. If tumour should be present, the appearances are thought to represent organ confined disease.						
NICER	28/03/2017			US Guided biopsy prostate transrectal	Report Final 28/03/2017 10:36 US Guided biopsy prostate transrectal, Author: Newell, Denise This examination was performed by the Urologist. Please see patient notes.							
NICER	28/03/2017		Nurse specialist	letter toGP	Patient 14 attended Thorndale Unit today. Written consent was obtained, local anaesthetic inserted and following guidance from his recent MRI scan a total of 15 core biopsies of prostate were obtained. He was provided with a 3 day course of prophylactic antibiotics and discharged home care of a family member. His histology results will be discussed at the urology MDM and he will be reviewed by Mr O'Donoghue thereafter.							

NICER	28/03/2017 reported 5/4/2017			Histology report	CLINICAL DETAILS Recent MRI. SPECIMEN - Prostate. PATHOLOGIST'S REPORT GROSS DESCRIPTION : NATURE OF SPECIMEN: needle core biopsy. SITE: 1. Right base - 2 cores and fragments the longest measuring 18 mm. SITE: 2. Right mid - 2 cores the longest measuring 20 mm. SITE: 3. Right apex - 4 cores the longest measuring 8 mm. SITE: 4. Left base - 2 cores the longest measuring 16 mm. SITE: 5. Left mid - 4 cores the longest measuring 20 mm. SITE: 6. Left apex - 3 cores the longest measuring 19 mm. HISTOLOGY HISTOLOGICAL TYPE: Adenocarcinoma. DIFFERENTIATION/GLEASON SUM SCORE: 3+3=6 NUMBER OF CORES/CHIPS INVOLVED: Right base - Not involved. Right mid -Not involved. Right apex - 1 of 2 cores involved. Gleason 3+3. 40% tissue. Left base - 2 of 2 cores involved. Gleason 3+3. 50% tissue. 6.5mm max length Left mid - 1 of 4 cores. Gleason 3+3. 1% tissue Left apex - 3 of 3 cores involved. Gleason 3+3. 20% tissue. INVASION INTO: Seminal vesicle: No. Extracapsular fat: No. PERINEURAL INVASION: No. LYMPHOVASCULAR INVASION: No. Prostatic adenocarcinoma of overall Gleason sum score 3 + 3 = 6 is present in 7 of 17 cores with a maximum tumour length of 6.5 mm. The tumour occupies approximately 15% of the total tissue volume. DIAGNOSIS PROSTATE NEEDLE CORE BIOPSY ADENOCARCINOMA						
NICER	06/04/2017		Chair MDM	MDM letter to GP	This patient was discussed at the Urology MDM @ The Southern Trust On 06/04/2017. Diagnosis: Prostate cancer Gleason Score 3 + 3 MDM Update: CONSULTANT MR O'DONOGHUE: This Patient 14 who has a raised PSA of 5.63ng/ml. Prior to that it had been 4.4ng/ml and 5.5ng/ml. He reports no troublesome lower urinary tract symptoms, he has some occasional hesitancy. The area revealed moderately enlarged and generally firm but benign feeling prostate. MRI, 24.02.17 - There is no definite radiological evidence of significant prostate tumour. A small volume of signal change within the posterolateral peripheral zone of the left apex to mid gland is regarded as suspicious. Transrectal prostatic biopsy, 28.03.17 - Prostatic adenocarcinoma of Gleason score 3 + 3 = 6, is present in 7 of 17 cores with a maximum tumour length of 6.5mm. The tumour occupies approximately 15% of the total tissue volume. MDM Plan: Discussed at Urology MDM 06.04.17, Patient 14 has low risk, organ confined prostate cancer. For review with Mr O'Donoghue to discuss all treatment options. Signee: If you have any queries or require further information, please do not hesitate to contact us.						
NICER	19/04/2017		Consultant urologist	letter toGP	This gentleman as you know recently had prostate biopsies for a PSA of 5.63ng/ml. The histology has come back showing adenocarcinoma of the prostate Gleason score 3+3=6 in 7 of 17 cores. The tumour occupied approximately 15% of the total tissue. His MRI showed no definite radiological evidence of a significant prostate tumour. There was a small volume of signal change within the posterolateral peripheral zone of the left apex to mid-gland which was regarded as suspicious. As per MDT I have went through the various options for treatment with this low risk organ confined prostate cancer with Patient 14. We discussed radical radiotherapy, radical surgery and active surveillance and he wishes to pursue a period of active surveillance. I will see him in 4 months' time with a PSA 1 week beforehand and in 1 years' time I will re-biopsy his prostate. Yours sincerely						

Patient 12

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
NICER	08/09/2016		GP	Referral to urology	Reason for Referral/ History of Presenting Complaint Description: lower urinary tract symptoms and elevated PSA. Comment: Dear Urologist Please may I have your advice on this Patient 12 with lower urinary tract symptoms and elevated PSA. This man has previously been reviewed in regards to an elevated PSA. He complains of increasing lower urinary tract symptoms of frequency and nocturia. He denies any haematuria or dysuria. He decided to stop his combodart due to erectile dysfunction. He denies any erectile dysfunction while taking Contiflo. His PSA has had a slow general increase over the last number of years and is now 7.34. I would appreciate your opinion on biopsy of his prostate.		IEAP					
NICER	30/01/2017		GP	Referral to urology	Reason for Referral/ History of Presenting Complaint Description: elevated PSA Comment: Please find attached my previous referral in regards to this Patient 12 . I have repeated his PSA at a reasonable interval and it has elevated to 9.43. I would appreciate it if you could upgrade his referral to red flag.		IEAP					
NICER	06/02/2017		LAT3 in Urology	Letter to GP	Diagnosis: Raised PSA Plan: MRI prostate Thank you for referring this Patient 12 who has a rising PSA. Over the last 12 months it has gone from 7.3 to 6.9 and subsequently 9.43 in January 2017. I note that he has had previous investigations including a TRUS biopsy in 2008 which was benign. He reports some urgency and occasional dribbling but is not overly troubled with his lower urinary tract symptoms. He has had no haematuria, UTIs or weight loss. Of note he had previously been on Combodart however he discontinued this due to erectile dysfunction. He is now only on Contiflo. On examination this gentleman has a moderately enlarged but benign feeling prostate. There is a nodule present just left of the midline however I note that this was present in 2007 as documented in an outpatient letter at that time. I have discussed the options with Patient 12 and we have agreed to proceed with an MRI of his prostate. If this shows any abnormalities we will carry out a TRUS biopsy. I will be in touch with the result of his scan in due course.							
NICER	14/02/2017				MRI performed							
NICER	01/03/2017			MRI report	14/02/2017 09:42 MRI Pelvis prostate, Author: RRO, Regional Admin. MRI prostate Oncology report CLINICAL HISTORY Rising PSA 9.4 from 6.9 last year, left lobe nodule on rectal examination FINDINGS Prostate volume 60 mL. There is a 1 cm nodule seen in the left posterior peripheral zone bulge in the capsule, with restricted diffusion (PIRADS 5) and also a possible lesion seen in the right anterior lobe and some PIRADS 3 changes in the right peripheral zone posteriorly. The seminal vesicles collapsed but grossly normal. Normal visualised rectum and bladder. No significantly enlarged lymph nodes or bony deposit in the pelvis CONCLUSION If biopsy-proven, at most, T3a N0, MX							
NICER	07/03/2017		Consultant Urologist	Letter to Pt	Dear Patient 12 I am writing to you with results of your recent MRI. The scan has detected some changes within your prostate which require further investigation. As we discussed at clinic, the next step is to perform a biopsy of the prostate. This can be performed under local anaesthetic at our outpatient unit. I will arrange this and will be in touch with appointment details in the near future.							

NICER	11/04/2017			Histology report	REPORT CLINICAL DETAILS Total cores taken 14. ?? abnormality left mid - base on MRI. PSA 9.43 ng/ml. Prostate volume 31.8. Medication Combodart. SPECIMEN - Prostate. PATHOLOGIST'S REPORT GROSS DESCRIPTION NATURE OF SPECIMEN: Needle core biopsy SITE: 1. Right base - 2 cores measuring 15 and 6 mm along with fragment. SITE: 2. Right mid - 2 ragged cores measuring 14 and 13 mm. SITE: 3. Right apex - 1 core measuring 14 mm. SITE: 4. Left base - 2 ragged cores measuring 18 and 12 mm. SITE: 5. Left mid - 6 cores measuring 11, 10, 14, 12, 5 and 3 mm along with fragments. SITE: 6. Left apex - 1 core measuring 10 mm along with fragment. HISTOLOGY HISTOLOGICAL TYPE: Adenocarcinoma OVERALL GLEASON SUM SCORE: 3+4 = 7 (Grade Group 2) NUMBER OF CORES INVOLVED: 8 of 14 Right base - No tumour identified. Right mid - 2 of 2 cores, Gleason 3+3, < 5% of tissue. Right apex - No tumour identified. Left base - No tumour identified. Left mid - 6 of 6 cores, Gleason 3+4, 6.3 mm max length, 20-25% of tissue. Left apex - No tumour identified. INVASION INTO: Seminal vesicle: No Extracapsular fat: No PERINEURAL INVASION: No LYMPHOVASCULAR INVASION: No FURTHER COMMENTS: The macroscopically described 2 cores within the block 5C got fragmented into 5 small bits, two of which show neoplastic glands. It is difficult to be certain but would be best regarded as 2 of 2 cores involved. Within 8 of the 14 prostatic core biopsies there are infiltrates of Gleason 3+3 and 3+4 adenocarcinoma. This occupies approximately 5% of the overall examined material. There is no perineural invasion, lymphovascular invasion or extracapsular extension. Selected slides (5B, 5C) were discussed with Dr G McClean. DIAGNOSIS PROSTATE CORE BIOPSIES ADENOCARCINOMA				
NICER	20/04/2017		Chair of MDM	MDM meeting letter to GP	This patient was discussed at the Urology MDM @ The Southern Trust On 20/04/2017. Diagnosis: Prostate cancer Gleason Score 3 + 4 MDM Update: CONSULTANT MR HAYNES: This Patient 12 has had a rising PSA it had gone from 7.3ng/ml to 6.9ng/ml and subsequently 9.43ng/ml in January 2017. He has had previous investigations including a TRUS biopsy in 2008 which was benign. He reports some urgency and occasional dribbling but is not overly troubled with his lower urinary tract symptoms. On examination he has a moderately enlarged but benign feeling prostate. MRI, 14.02.17 - If biopsy-proven, at most, T3a N0, MX Transrectal prostatic biopsy, 11.04.17 - Adenocarcinoma, Gleason 3+4 = 7. Number of cores involved - 8 of 14. MDM Plan: Discussed at Urology MDM 20.04.17. Patient 12 has high risk prostate cancer. He should be seen in clinic and have a discussion with regard to curative treatment. Signee: If you have any queries or require further information, please do not hesitate to contact us.				
NICER	03/05/2017		Consultant Urologist	Letter to GP	Diagnosis: High risk non metastatic prostate cancer Outcome: Commence Bicalutamide 50mgs once a day, 28 day course Please commence Decapeptyl 11.25mg first dose to be given week commencing 15th May and continued every 12 weeks thereafter Isotope bone scan Refer to Oncology for consideration of radiotherapy in addition to androgen deprivation Patient 12 prostate biopsies have confirmed a high risk prostate cancer and radiologically on his MRI this would appear to be stage T3a with no nodal metastases. Given this the recommended treatment would be hormones and radiotherapy. I have outlined this to him. He does require a bone scan to complete his staging which I have arranged. I have commenced him on his Bicalutamide today and would be grateful if you could arrange his Decapeptyl as above. I have referred him to my Oncology colleagues				

Patient 137

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
NIECR	20/12/2016			CT Chest and abdo and pelvis with contrast	20/12/2016 11:28 CT Chest and abdo and pelvis with contrast At the posterior aspect of the RUL, there is a 42 x 21 x 21 mm irregular soft tissue abnormality with an air bronchogram, adjacent to the oblique fissure present. Minimal linear atelectasis in the right base and mild bilateral basal hypoventilation atelectatic changes. Several accentuated subcarinal lymph nodes measuring up to 12 mm. Normal both kidneys with mildly accentuated collecting system (likely of no clinical significance). In the left perirenal space, anterior to the upper pole of the kidney, there is a large (78 x 68 x 72 mm) well defined fatty tumour with some soft tissue component, abutting mildly thickened adrenal. Enlarged prostate. Normal liver, bile ducts, pancreas, right adrenal, spleen and urinary bladder. No sinister process of the imaged skeleton. Partial lumbarisation of S1. Two small sclerotic lesions within the L3 vertebral body (bony islands?). A small T12 vertebral body haemangioma. **Conclusion:** Right upper lobe pulmonary abnormality suggesting a dense consolidation. Please correlate with clinical features. Follow-up recommended. A large fatty tumour in the left perirenal space which may be in keeping with an angiomyolipoma with extrarenal growth. Differential diagnosis should include liposarcoma, adrenal teratoma or adrenal myelolipoma. Specialist referral is advised. Time Reported 20-Dec-2016 15:42							
NIECR	21/12/2016			Letter from respiratory physician to GP	Diagnosis: 1. Right upper lobe community acquired pneumonia. - CT chest 20/12/16, right upper lobe consolidation. 2. Left perirenal mass. - CT chest abdomen 20/12/16, large fatty tumour (78 mm) left perirenal space. 3. Left hydrocele repair 2012. 4. Hypertension. 5. Recurrent episodes of hiccups. Comment: This Personal Information redacted by the USI was reviewed at the Respiratory Clinic today following his recent discharge from hospital. His CT imaging is as detailed above. I reviewed the patient's CT imaging with Dr Clarke, Consultant Radiologist today. The left perirenal mass differential diagnosis includes an adrenal myelolipoma, atypical lipoma or a liposarcoma. Action: 1. I have explained the CT results and further management plan to the patient. 2. I would be grateful if you could provide this patient with 7 days of Amoxicillin and Clarithromycin as per handwritten note and telephone call to your surgery today. 3. Red flag referral to Urology Team, Craigavon Area Hospital has been arranged. 4. Repeat chest x-ray has been booked for 6 weeks' time. 5. No review is planned at the Respiratory Clinic.							
NIECR	21/12/2016			Red flag referral from respiratory physician to Urologist	I would be grateful for your urgent assessment of this Personal Information redacted by the USI who has been found to have a 78 mm left perirenal mass. Please find a copy of the most recent correspondence attached. Thank you for your help.							
NIECR	23/12/2016			MDT letter to chair of MDT from Consultant Urologist 2	We have received communication from the chest physician colleagues in the Erne re this Personal Information redacted by the USI with pneumonia, but has had an incidental finding of a mass lesion in the left perirenal area. I don't think that this is renal in origin; I would agree with their sentiments that this could either be of adrenal origin, I suspect it would be difficult to biopsy. I would be grateful if his films could be reviewed. This would probably be beneficial before speaking to [redacted] Patient 137 himself							
NIECR	12/05/2017			GP letter	Reason for Referral/ History of Presenting Complaint Description: L renal mass Comment: Patient 137 has never had an appointment re this matter-- ? has referral been made and what are the rv arrangements							
NIECR	18/05/2017			OPD letter to GP from Consultant	Many thanks for your letter Patient 137. Unfortunately it would appear that the referral to the Endocrine Team has not happened. I have done a referral which is attached and I would anticipate Patient 137 will hear from the Endocrine Team in due course.							

NIECR	18/05/2017			OPD letter to Endocrine consultant from Urology Consultant	I would be grateful if you could arrange for review of Patient 137 's imaging and clinical review with yourself. He was referred following a CT scan which was performed in December 2016 following an admission under the care of the General Physicians in South West Acute Hospital. Incidentally the CT scan showed an abnormality in the left peri-renal space. This was reviewed at the Urology MDM in Craigavon Hospital on 12th January where it was felt to represent an adrenal abnormality and referral to yourself was recommended. Unfortunately this referral does not appear to have occurred and a new letter was sent by Patient 137 's GP today. The view of the Urology MDT was given that it would appear to be an adrenal abnormality and further management would be appropriate under your care. I would be grateful if you could arrange for review of your imaging at MDT and subsequent clinic review with yourself regarding further managem							

Received from Trudy Reid on 16/05/2023. Annotated by the Urology Services Inquiry.

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ED record	30/04/2017	14:06		Arrival at ED	Arrived ED by ambulance - alone							
ED record	30/04/2017	14:06	Nursing Hannah Donnelly	Triage	Shortness of Breath adults New abnormal pulse SOBAR today, denies CP feels otherwise well Pulse 109 BP 92/55, RR 28 temp 36.7 SaO2 94 Location resus							
ED record	30/04/2017	OA	Medical Gilbert Rice	Assessment	Personal Information generally unwell x2 episode vomit yesterday SOB, Øpyrexia, Ø cough BO 1/7 ago Sister stated vomiting ++ for 1/52 mild cognitive impairment 2o to stroke **PMH** DM type 2 ↑chol prev ICH HTN O/E HS 1+11+0 calves SNT Chest ↓A/E L base. Abdomen distended ++ non tender BS↓ Na 126, K5.7 Cl78, ur 14.4,cr 178 eGFR 25 (41) trop 43 (29) LFT N, wcc 14.3 CRP 39.3							
ED record	30/04/2017			Diagnosis	1. Acute Bowel obstruction 2. Hyperkalaemia 3. AKI							
NIECR	30/04/2017	15:42		Abdominal X-ray	30/04/2017 16:21 XR Abdomen, Author: McReynolds, Andrew There is marked dilatation of multiple small and large bowel loops. The colon appears oedematous and there is subtle intramural pneumatosis in the ascending colon. I note the subsequent CT report. AMcR/PFR							
NIECR	30/04/2017	15:42		Chest X-ray	30/04/2017 16:21 XR Chest, Author: Fourways, 4W Admin Radiology Report Date: 08/06/2017 19:10 Date: 30 April 2017 Examination: Chest x-ray Technique: AP Clinical Indications: Query bowel obstruction or lung lesion Findings: The heart size is normal both lungs are of normal volume. There is minimal subsegmental collapse at the left base but there is no free air under the hemidiaphragms to suggest perforation. There is no focal consolidation or collapse. No change is seen compared to previous films of February 2017.							
ED record	30/04/2017	16:00			Referred to surgical team							
ED record	30/04/2017		Nursing Hannah Donnelly		Prioritised in resus							
ED record					CXR→consolidation L Base AXR → Large dilated bowel loop							
NIECR		17:37		CT abdomen	NB! This is a change of a previously given preliminary report 30/04/2017 17:57 CT Abdomen and pelvis, Author: Hutchinson, Christopher Subsequently contrast was administered per rectum in an attempt to delineate the possible calibre change further. There is a 40mm long apple core tumour present in the recto sigmoid region. This is causing almost complete obstruction however a small amount of contrast has passed beyond it. No significant local or regional lymphadenopathy has been identified. Again pneumatosis intestinalis is present in the ascending and transverse colon. There is no evidence of portal venous gas. **Conclusions:** Obstructing lesion in the recto sigmoid region has appearances highly suspicious for malignancy. I am now informed the patient has had previous pelvic radiotherapy. A stricture secondary to this is possible but thought less likely given the degree of shouldering of the lesion. The continued lack of portal venous gas leads me to suspect that the pneumatosis intestinal is is secondary to obstruction rather than ischaemia. **Findings discussed directly with the referring team Reported on call by C Hutchinson St5** 30/04/2017 17:57 CT Abdomen and pelvis, Author: Hutchinson, Christopher **Indication:** Personal Information redacted by the USI with PMHx traumatic brain injury. A/w 1/52 intermittent vomiting, 1/7 of acute abdo distension and 1/7 no BO. On presentation to ED hypotensive, abdomen tense and distended. lactate 13.2. WCC 14, CRP 40 **Technique:** Due to renal function, non contrast CT abdomen and pelvis. **Findings**: The large bowel is distended and filled with fluid and faeces until an abrupt calibre change in the recto sigmoid region. This is adjacent to the suture material from the frevious hysterectomy. The is significant pneumatosis in the ascending and transverse colon to the splenic flexure. There is no portal venous gas. Being non contrast, it has not been possible to assess the mesenteric arteries. There is some calcification of the aorta but non of the mesenteric vessels. The small bowel and stomach is distended and fluid filled. Within the limitations of this non contrast study, there is no significant abnormality of the liver, pancreas spleen or adrenals. Gallstones noted. There is no free fluid or gas.							
ED record		19:30	J Anderson		Urinary catheter inserted aseptically							
ED record		18:45	E Jones		Attended for CT abdo. Placed in 4 North but returned to Resus after scan ABG repeated							
NIECR		19:37			Clinical Info From Order 1/7 distended abdomen + No BO. Vomitting 1/52. Lactate 13. CTAP - distended LB loops ?adhesional LBO ?pseudoobstruction Time Reported 04-May-2017 10:31							
ED record		20:10	E Jones		For further CT scan with contrast. Surgical Dr to acompany. Not for wrd until result of scan as may need to go to theatre							
ED record					Admit to ward - Theatre							
ED record				Discharge obs	P 120, BP 121/56, resp 18, tmp 36, SPO2 99% intubated							

ED record		22:10			Left department							
ED record continuation		22:10	E Jones		Retrospective note Pt brought to CT scan for further CT abdo with rectal contrast. Accompaied by surgical Dr IV access tissued on route to scan. IV fluids stopped. When on scanner pt had rectal catheter inserted and Dr began to give contract. Monitored throughout. Obs stable. Shortly after contract started pt began to vomit profusely. Suctioned while on scanner, became very cyanosed. O2 therapy applied. Assisted airway. Colour remained poor and became more unresponsive crash team called as peri arrest call. Anaesthetic team also contacated. NG tube inserted and pt intubated and ventilated. Proceeded with CT scan as planned. Taken to theatre to await report may need laparotomy tonight. Surgical reg spoke with sister and updated her. Family decided to go home phone numbers given. I will hand over to theatre staff to update family as and when needed							
Medical notes		22:15	I Soric Surgical reg		Pt waas taken to CT ???rectal contrast. Vomited during the procedure and became very hypoxic and unresponsive. Anaesthetic team got involved. Pt was intubated in CT. CT verbal report→Stricturing lesion upper rectum- most likely neoplastic →large bowel obstruction D/W with Personal Information redacted by the USI the situation. Explained the situation deteriorated dramatically and our expectations are very guarded. Personal Information redacted by the USI aware very understanding and they saw a decline in Persona l condition over latst 2/52 and news was not entirely unexpected to them. Explained that after conversation with consultant on call Mr Hewitt and anaesthetic team we feel the best next step is surgery to remove the obstructed large bowel. Personal Information redacted by the USI agreed with the plan and totally understood that Perso nal may not survive the operation or immediate postoperative period. Family ???? to be informed of further changed in Personal Informati condition							
Southern Trust Acute Surgical Admission			HO/Soric		**Presenting Complaint** Abdominal distension **History of presenting complaint** Vague historian. Patient states that she had an episode of collapse yesterday Sister states patient had been vomiting for 1/52 Last BO yest. Abdomen ↑distension over 1/7 Denise any abdo pain **Past medical/surgical history** TBI →SAH 1997 T2BM, HTN, Endometrial CA - TAH 2006 **Abdomina**l Grossly distended & tense. Non peritonitis **Bloods** HB 127, WBC 14.3, PLT 639, CRP 39, NA 126, K 5.7, CL 78, Urea 14.4, Creat 128, eGFR 25 TP 69, ALb 43, Bili 13.2, ALP 83, AST 22, ALT 20 GGT 33 **Imaging** CTAP dilated LB ? pneumatosis ? adhesions LBO ? pseudo-obstruction **Problem list/differentials** Adhesional LBO vs pseudo-obstruction AKI **Management plan** Resuscitation Gastrografin n enema with CTAP →if contrast pass throught →conservative management v caecum flex sig →if blockage of contradt → ? laparotomy Waiting **Senior Review** Personal Information redacted by the USI . Very unwell. Abod distension ? large bowel obstruction on CT ? pneumatosis caecum and ascending colon D/W Mr Hewitt →suggested to do a CT with Gastrografin enema to confirm the presentation of large bowel obstruction. Mr Hewitt happy with the plan							
Southern Trust Acute Surgical Admission			Anaesthetist		Neurological Diwson, Moore, ST anaes 2116 30/4/17 Fast asleep to CT @20:44 on immediate arrival A -? copious vomit B -SpO2 ~60%/cyanosed partially obstructed RR ~18 C -P144 no BP possible no IV access D -AV P U Actions 10 Access tibia (2 failed ???in side) M'son C NGT - 500mls drained RSI ??50 ? ROC 100mg McGrath CT pass 7.5 coexPropofol 100mls/hr 16# ESR Handed over to the night team and D?W R McKee							
Medical notes			CT 2		Written in retrospect Patient transferred to CT scanner by myself, ED nurse and porter at 20:20. Stable pre-transfer, normotensive, communicative X comfortable. Platient lay on right lateral position for insertionof catheter PR & contract injection. During instillation of PR contract patient aspirated with acute destauration. Mouth suction but unable to protect the airway. Cardiac arrest team & anaesthetics fast bleeped to CT scanner. Patient cnscious throughout with no loss of output. NG inserted by SPR Soric. 10 access obtained. Patient intubated via RSI, Following discussion between surgical & anaesthetic team, dicision made to perform CT scan as anaesthetic team in attendance. CT scan R/V by SpR Soric & D/W on call radiologist & Mr Hewitt. Given CT findings, blood results & patients clinical stable, decision made to perform laparotomy. Anaesthetic team in agreement. Family informed of events							
Operative notes			Soric & Crawford		Midline laparotomy **Finding**- Grossly distended large bowel. Impeding perforation caecum and transverse colon. Obstructing lesion upper rectum ……..							
NIECR	01/05/2017			Chest X-ray	Date: 1 May 2017 Examination: Chest x-ray Technique: AP Clinical Indications: Query line placement query pneumothorax query aspiration **Findings:** The heart size is within normal limits. The ET tube and right internal jugular line are in a good position with no pneumothorax. There is marked consolidation within the right lung compatible with infection. These changes have markedly worsened compared to 30 April 2017.							
NIECR	01/05/2017			Letter to GP	I regret to inform you of the death of Personal Information redacted . She attended Craigavon ED on 30/4/17 with vomiting and abdominal distension. CT showed bowel. obstruction due to a rectosigmoid tumour and she proceeded to laparotomy for a subtotal colectomy. She was transferred to ICU post-op and had high inotrope and ventilator requirements. She also had haemodialysis. However, despite maximal treatment, she continued to deteriorate. After discussions with her family, care was withdrawn on the afternoon of 1/5/17 and she passed away peacefully at 15:50. Her MCCD was completed as follows: 1) a) Multi-organ failure b) Small bowel obstruction c) Recto-sigmoid tumour 2) Chronic Kidney disease, Diabetes Mellitus							

Received from Trudy Reid on 16/05/2023. Annotated by the Urology Services Inquiry.

Personal Information redacted by the USI

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
ED record	19/11/2015	11:23			Presented to ED with GP letter							
ED record	19/11/2015	11:24		Triage	Abdominal pain in adults Mod pain Abdo pain for 4/7 no D/V treated fro UTI HX kidney stones BP 137/89 RR18 temp 36 SaO2 97 ALert Pain score 6							
ED record	19/11/2015	11:30	Doctor 1	Assessment	Personal HX pain RIF Gradual onset. Constant pain worse on movement 6/10 severity. Associated anorexia. No nausea/vomiting . Sweating at night no temps. No bowel movement from Sunday until this morning - usually regular. No urinary symptoms O?E Pt looks well RR 18, SpO2 97%RA Temp 36.0 BP 137/89 HR 90 HS 1+11+0 Chest clear CRP 324, WCC 15.6 neut 84.4 PLT 341 Amylase 36 LFTs N U&E N RIF tenderness with guarding fullness R side Plan AXR, urinalysis Bloods							
NIECR	19/11/2015	12:46		XR Abdomen	No abnormal bowel dilatation seen. Calcific opacity seen in the right lumbar region. Degenerative changes seen in the spine. Vascular calcification noted. Time Reported 20-Nov-2015 10:18							
NIECR	19/11/2015	16:00		CT Abdomen and pelvis with contrast	Technique: Volume scan of the abdomen and pelvis following IV and oral contrast. **Findings:** A tubular structure exits the posterior aspect of the caecum, believed to represent a retrocaecal appendix. This is significantly enlarged with a maximum axial diameter of approximately 1.7 cm and it displays mural thickening and hyperenhancement. A small bleb of extraluminal gas is noted posterior to the appendix and there is a focal collection of fluid measuring approximately 5 cm in maximum axial diameter adjacent to this. Inflammatory stranding and subcentimeter lymphadenopathy is present in the surrounding fat of the right iliac fossa. Overall appearances are thought to represent acute retrocaecal appendicitis with localised perforation and formation of a focal fluid collection. The collection is thin walled but displays some peripheral rim enhancement. Of note, there is soft tissue thickening present at the base of the appendix/tip of the caecum. Further assessment is advised in this area. Scattered diverticula are noted throughout the entire colon. Within the limitations of an unenhanced study, the small and large bowel are otherwise unremarkable. No other intraperitoneal air or fluid. Two sub centimetre foci of ill-defined low attenuation are present within the right lobe of liver. These are essentially too small to categorise accurately. No other significant liver pathology demonstrated. A cortical cyst is present within the lower pole of each kidney, larger on the right side than the left. Both display foci of peripheral calcification and will require follow-up. A 1 cm calculus is present in the upper pole of the right kidney. The kidneys are otherwise unremarkable. The gallbladder, pancreas, spleen and adrenal glands are normal. Calcified mesenteric abdominal lymph nodes are present which may represent previous granulomatous disease. The visualised lung bases are clear. Degenerative changes are present in the visualised thoracolumbar spine. Lucent lesions within the L2-L5 vertebral bodies are fat attenuation and are most likely to represent incidental haemangiomas. **Conclusion: 1.** Appearances in the right iliac fossa are thought to represent an acute retrocaecal appendicitis with localised perforation and formation of a focal fluid collection. The collection is thin walled but diplays peripheral enhancement. Soft tissue thickening is present at the base of the appendix/tip of the caecum and evaluation of this region is advised in due course to exclude other pathology. **2.** Sub-centimetre foci of low attenuation in the right lobe of liver are essentially too small to characterise. A 3 month interval US scan is advised to ensure no progression. In the presence of a known sinister pathology these might be viewed with more suspicion and MRI should then be considered. **3.** Bilateral renal cysts which display peripheral calcification and require follow-up. A repeat CT of kidneys is advised in 1 year. **4**. Other incidental findings as discussed. Result discussed with surgical registrar on call at time of report. Time Reported 20-Nov-2015 10:18							
ED record	19/11/2015	16:00			Discharge observations P 86 HR 153/74, resp 18, temp 37.8 SpO2 96% GCS 15/15 Left dept at 15:05 to ward							
Person Cenred Nursing Assessment and Plan of Care	19/11/2015				Admitted to MSW Abdominal Pain							
NIECR	27/11/2015			Medical Hospital Discharge letter	RIF pain Initial Diagnosis ?appendicitis ?walled-off appendix ?malignancy Method of Admission Emergency Patient Receiving Palliative Care? No Principle Discharge Diagnosis Perforated appendix - conservatively managed Investigations Bloods on admission: Hb 129, WCC 15.6, Plt 9.8, Na 137, K 4.9, Urea 9, Creat 100, eGFR >60. CRP 324. LFTs normal. Amylase 36. Urine MSSU - no growth (16/11/15) ECG - AF with old RBBB Echo - sinus rhythm. LVF is low normal with EF approx 55%. Mild bi-latrial dilation. Mild aortic valve stenosis. AVA 1.9m2 Operations/Procedures/Radiology CT A/P - acute retrocaecal appendicitis with localised perforation and formation of a fluid collection. Collection thin walled with peripheral enhancement. Soft tissue thickening at base of appendix/tip of caecum. Evaluation of this region advised to exclude other pathology. Suc-centimetre foci of low attentuation in right lobe of liver too small to characterise. 3 month interval US scan advised to ensure no progression. Additional Information for GP Past Medical/Surgical History CVA Drinks alcohol socially - 1 glass wine per day Non smoker. Walks 6 miles/week. Changes to Medications - Start/Stop To complete a total of 14 days of antibiotics Started on Apixaban for AF Clinical Information/Comments Personal . Presented to ED with RIF pain. No other symptoms. 1/52 hx of pain on the right side. Pain unchanged during that week. No urinary symptoms. Last BO the same morning of presentation. No diarrhoea, no PR bleeding. No weight loss. No temperatures. OE, fullness and tenderness in RIF. No guarding. BS present. Patient was admitted for CT abdomen, kept fasting, given IV fluids. CT AP performed. CT findings - as above. Decision made to treat conservatively with antibiotics. Inflammatory markers continued to improve during treatment with antibiotics. During admission, new onset AF discovered on ECG. Patient asymptomatic of same. Impression was of AF secondary to sepsis. Reviewed by medical team - echo performed (result as above), advised to treat AF with apixaban due to CHADS score of 4 (for age and hx of CVA). Clinical impression on 27/11/2015 was that Pers was improving and fit for discharge with completion of a 14 day course of antibiotics (switched to co-amoxiclav). Had 9 days IV Abx. He is for repeat CT in 3/52. Colonoscopy in 8-10/52. To attend SAU level 3 DHH on Monday 7th Dec at 10am for repeat routine bloods. He is to be given the telephone number of Mr Gilpin's secretary in case of problems and has been strongly advised to seek medical advice should he feel unwell. Did the patient receive a blood transfusion? No							
Person Cenred Nursing Assessment and Plan of Care	01/12/2015				Patient had appointment at SAU today. Was admitted to ward query appendix abscess/mass							
NIECR	02/12/2015	16:15		CT Abdomen and pelvis	CT abdomen and pelvis performed following oral and intravenous contrast. Comparison made with previous CT scan examination of 19/11/2015. **Findings** 10x10 x 5.5 cm collection seen in the right iliac fossa. The posterior wall of the cecum is markedly thick walled. Two illdefined hypodense lesion seen in the segment V of the liver meauring upto 8.8mm. Gallbladder, spleen and pancreas appear normal. 8.3 mm calculus seen in the right kidney with no obstructive changes. 4.3 cm cyst also seen in the right kidney anteriorly. 13 mm hypodense lesions seen in the left kidney. Normal urinary bladder. Atherosclerotic calcification of the aorta and its branches seen. Degenerative changes are seen in the spine. There is suggestion of haemangioma in L3 vertebral body. **Conclusion** 10x10 cm collection in the right iliac fossa region. Thickening of the posterior ceacal wall which is highly concerning for neoplastic lesion. Two ill-defined hypodense lesion in the liver. These are too small to characterise however the differential diagnosis include metastasis. Ultrasound/MRI suggested for further evaluation. 13mm hypodense lesion in the left kidney. Follow up suggested. Time Reported 03-Dec-2015 10:18							

NIECR	04/12/2015	11:00		CT Guided drainage abdomen	04/12/2015 14:23 CT Guided drainage abdomen Procedure: Written informed consent obtained. Using CT guidance and aseptic technique a 12-French pigtail catheter was positioned within the previously described right-sided collection. Sample provided for microbiology. No immediate complication. The patient was returned to the ward for post procedural observations.Time reported 04-Dec-2015 15:18							
NIECR	04/12/2015			Medical hand over	Admitted recently with acute appendicitis and a mass. He was already on Plavix at that time so was treated conservatively. He was readmitted with further sepsis. CT scan confirms an abscess which is for radiological drainage today. The CT scan also suggests that there may be an underlying lower pole caecal carcinoma.							
NIECR	08/12/2015	10:11		CT Abdomen and pelvis	08/12/2015 11:14 CT Abdomen and pelvis Comparison made with previous examinations. **Findings** Mild right-sided pleural effusion with posterior basal consolidation. The collection in the right iliac fossa now measure 9.5x9.7x 6.2 cm and show septation/loculation. The drain tube is in the superolateral part of the collection. Rest of the abdominal findings reported on the previous examinations are unchanged. Time Reported 09-Dec-2015 08:54							
Medical notes	09/12/2015				Open drainage of appendix abscess							
Medical notes	10/12/2015			Ward round	Day 1 post I+D Δ appendix abcess NEWS 2 score on O2 Patient off 02 currently, pain improved from yesterday BO Plan Dietician, Bloods Switch to antibiotics- septrin + metronidazole							
NIECR	16/12/2015			Medical Hospital Discharge letter	Patient's Description of Their Complaint Abdominal pain Initial Diagnosis Appendiceal mass Method of Admission Emergency Patient Receiving Palliative Care? No Principle Discharge Diagnosis Appendiceal abscess Investigations Comparison with CT 19/11/2015: 10x10 cm collection in the right iliac fossa region. Thickening of the posterior ceacal wall which is highly concerning for neoplastic lesion. Two ill-defined hypodense lesion in the liver. These are too small to characterise however the differential diagnosis include metastasis. Ultrasound/MRI suggested for further evaluation. 13mm hypodense lesion in the left kidney. Follow up suggested. Operations/Procedures/Radiology CT-guided drain insertion Incision and drainage of appendiceal abscess: E coli and bacteriodes from wound culture Additional Information for GP Past Medical/Surgical History AF (apixaban) Stroke 2014 (right basal ganglia infarct) Hypercholesterolaemia Ex-smoker Changes to Medications - Start/Stop Start fortisip compact, pro-cal shots and forceval Clinical Information/Comments This Personal Information presented with abdominal pain and general malaise. Recently discharged following conservative treatment of perforated appendix. Is a/w Colonoscopy with Mr Gilpin as thickened caecum noted on previous CT. Commenced on antibiotics and analgesia. Underwent CT-guided drainage of appendiceal mass. Underwent incision and drainage of same. Seen by physio, OT and dietician. Reviewed by cardiology for AF. Currently bloods and symptoms improved. Obs stable. Surgically fit for discharge. Many thanks for continuing this patient's care. Did the patient receive a blood transfusion? No							
NIECR	18/12/2015			OPD letter surgical to GP	This Personal Information presented at the unit for review. He is presently systemically well and apyrexic. He has a history of open drainage of an appendix abscess on the 9 December 2015. On examination the wound site is healing satisfactorily the staples have been removed today from the main wound. No dehiscence of wound following removal of staples. There is no evidence of any surrounding overt erythema underlying collection or discharge. The wound has been redressed and we will review him again in the Surgical Assessment Unit on the 23 December 2015. Bloods for FBP, U&E and CRP have been sent off.							
NIECR	23/12/2015			SAU letter to GP	This Personal Information presented at the unit for review. He is presently systemically well, apyrexic and is feeling a lot better than before. His appetite is improving, bowels are moving, waterworks NAD. He has a history of appendix abscess with open drainage on the 9 December 2015. On examination the abdomen was soft and non-tender. RIF wounds are healing satisfactorily. Superior larger wound is healing well by primary intention. Infer lateral smaller wound shows some scant serous discharge but is otherwise healthy. The wound site has been redressed and he is to have regular dressings via the district nurse. He is presently awaiting a colonoscopy via the DPU. No further review has been planned in the Surgical Assessment Unit but if the need arises we shall be more than happy to see him again.							
ED record	30/01/2016	11:04			Self referral to ED @11:04							
ED record	30/01/2016	11:10		Triage	Wounds ? Infection Had appendectomy 6/52 ago drain in place prior pain and redness overnight lower abdomen Hand written note IVF 957/0(35 On amoxicillin form yesterday . ???red around old drain site BP137/71, RR16, temp 36 SaO2 97 A Pain score 6 65.5kg							
ED record	30/01/2016			Assessment	Appendectomy ?? RIF→???..... Tazocin 4.5g IV prescribed 14:15 administered 14:30							
Person Cenred Nursing Assessment and Plan of Care	30/01/2016				Admitted to FSW ward Pelvic abscess							
NICER	31/01/2016	09:00		CT Abdomen and pelvis with contrast	31/01/2016 12:11 CT Abdomen and pelvis with contrast The clinical history was noted. The history states the patient has had an appendicectomy. I see no evidence of appendicular histopathology in "lab centre". Please clarify clinical history. **Comparison** was made to the CT from 8 December 2015. There has been considerable reduction in the amount of abscess present in the right iliac fossa. A small right iliac fossa collection remained between the lateral aspect of the psoas muscle, anterior to the iliac muscle and extending to and involving the anterior abdominal wall with a low density tract seen extending to the skin. On maximal axial dimensions the liquefied portion of the intra-abdominal component to the abscess measures only 4.2 cm x 1.5 cm. This area was adjacent to an enlarged and abnormal looking appendix. Excess cecal pole mass was also present. Has the patient had a colonoscopy to exclude cecal pole mass? No small bowel dilatation. Elsewhere, the remainder of the abdominal findings were as described on the recent CT reports (particular reference was made to the CT report from the 2/12/15) . **Conclusion**. Ongoing right iliac fossa inflammatory abnormality with appendicitis. Overall there has been considerable reduction in size of the abscess when directly compared to initial CT scans. A small residual abscess communicating with the base of the appendix and extending laterally to the anterior abdominal wall with an associated entero-cutaneous fistula remained. Comment. At some stage colonoscopy of the cecal pole will be required in order to exclude cecal pole mass/tumour (if not already performed). Possible caecal pole mass may be contributing to the ongoing inflammatory process as the appendix does appear distended and may be obstructed at the base. A prominant ileocaecal valve area is considered and is possible but there is not much fat in this abnormal area. Please see selected images.Time Reported 31-Jan-2016 13:07							
Endoscopy day cae person centred nursing record	04/02/2016				Colonoscopy							
NIECR	04/02/2016				CLINICAL DETAILS Appendix/ caecal mass on CT. Biopsied irregular mucosa in caecum. Caecal pole biopsies PATHOLOGIST'S REPORT The specimen consists of multiple pieces of tissue processed in two cassettes (A & B) Histology show colonic mucosa with a villous architecture. There is a spectrum of low grade and high grade dysplasia. In one fragment dysplastic glands elicit a desmoplastic response and there is disruption of the muscularis mucosa and dysplastic glands adjacent to large sub-mucosal type blood vessels. A few small fragments of detached non-dysplastic mucosa are present. The appearances are those of an adenocarcinoma. There is a background of low and high grade dysplasia CAECAL MUCOUS MEMBRANE ADENOCARCINOMA Reported 12-Feb-2016 16:42							
NIECR	05/02/2016			Medical hand over	This man was admitted a couple of months ago with right iliac fossa pain and CT scan shows an appendix mass. It was initially treated conservatively. He then developed an appendix abscess which was drained percutaneously. Then he was taken to theatre for open drainage without an appendectomy. His sepsis settled after draining of the abscess and IV antibiotics. He was readmitted again last weekend with discharging sinus in his anterior abdominal wall and small abscess which was drained in theatre. He had a repeat CT scan which showed a small collection around his cecum and possible cecal lesion. I done a colonoscopy today down to his cecum and there is a small lesion in his cecal pole. This was biopsied today and he remains on IV antibiotics and we are awaiting results of his cecal biopsies. I have explained the likelihood of cecal carcinoma to him and his wife and he will need to be discussed at MDT.							

NIECR	07/02/2016			Medical Hospital Discharge letter	Initial Diagnosis Deep abdominal collection Method of Admission Emergency Patient Receiving Palliative Care? No Principle Discharge Diagnosis Discharging anterior abdominal wall sinus and small abscess Small collection at caecum and ?small lesion at caecal pole ?caecal malignancy Operations/Procedures/Radiology CT abdomen : Ongoing right iliac fossa inflammatory abnormality with appendicitis. Overall there has been considerable reduction in size of the abscess when directly compared to initial CT scans. A small residual abscess communicating with the base of the appendix and extending laterally to the anterior abdominal wall with an associated entero-cutaneous fistula remained. Possible caecal pole mass may be contributing to the ongoing inflammatory process as the appendix does appear distended and may be obstructed at the base. A prominant ileocaecal valve area is considered and is possible but there is not much fat in this abnormal area. Colonoscopy: diverticula around the sigmoid, caecal lesion, ?neoplastic ?inflammatory. Biopsies taken. Additional Information for GP Past Medical/Surgical History AF - on apixaban CVA Changes to Medications - Start/Stop No change Clinical Information/Comments This gentleman was recently discharged from Daisy Hill with abdominal pain. CT scan showed an appendix mass which was initially treated conservatively but later required drainage. He was readmitted with a three day history of exudate from his wound and feeling sweaty. He had no respiratory or urinary symptoms and his bowels were opening normally. On examination he was apyrexic, obs stable, abdomen soft and non-tender with a small superficial fluctuant swelling in the RIF with surrounding erythema. WCC 10 and CRP 56. Impression was of an abdominal abscess or collection. He was commenced on IV tazocin and gentamicin and the wound was opened and drained. A CT scan was carried out which showed a reduction in size of the collection, enlarged and abnormal appendix, caecal pole mass and entero-cutaneous fistula. An eakin bag was in place which drained serrous fluid. Colonscopy showed a caecal lesion which has been biopsied ?malignancy. Coloscopy findings have been discussed with the patient and family. For discussion at MDM next week.							
NIECR	07/02/2016			Consultant 4 to Consultant 3 referral	Many thanks for agreeing to see this Personal Information for consideration of right hemicolectomy as per the outcome of the MDT today. Personal as you know has caecal cancer proven on biopsy and on CT scan. He initially presented with an appendix abscess which was drained percutaneously back in December. This was followed by open drainage under general anaesthetic of the abscess as it had reoccurred. His op note states that his appendix was removed at the same time, but on checking his chart his appendix is still intact. I have contacted him today via the phone and explained to him the diagnosis and the fact that he will require a right hemicolectomy. He is on Apixaban for previous stroke and he will need to stop this prior to his surgery. I will leave that in your hands. Yours sincerely							
NIECR	07/02/2016			Consultant 4 to GP letter	Further to this gentleman's recent colonoscopy as an inpatient, caecal biopsies have confirmed the diagnosis of adenocarcinoma of the caecum. He was recently discussed at our colorectal MDT, and the plan is to proceed to a right hemicolectomy under Mr McKay. I have contacted the patient and informed him of the results of the biopsy and the outcome of the MDT discussion.							
NICER	11/02/2016	10:40		US Abdomen	11/02/2016 11:06 US Abdomen There are two small echogenic areas in the right lobe of liver which appear similar in size to previous CT (31/1/16). They measure 8.1mm and 8.2mm and are suggestive of haemangiomas. Due to patient history it is recommended to repeat scan of liver in 3 months to check for stability. Right kidney BPD measures 9.8 cm. There is a calculus in the upper pole and a cyst with fine septation in the lower pole(3.4cm) Left kidney BPD measures 10.5 cm. No hydronephrosis. The spleen is normal in size and texture. The pancreas is obscured with bowel gas. The aorta and IVC are normal in calibre. Time Reported 11-Feb-2016 11:13							
NIECR	18/02/2016			MDM Update:	Mr 1 Personal Information h/o appendix abscess which was drained on 4/12/2015; 3 day h/o tenderness at drain site - noted to have small fluctuant abscess. This was incised and drained; however pus noted to be emerging through wound from deeper abscess. ?deeper collection. CT 31/01/16 Abd/Pel 31/01/16 - At some stage colonoscopy of the cecal pole will be required in order to exclude cecal pole mass/tumour (if not already performed). Possible caecal pole mass may be contributing to the ongoing inflammatory process as the appendix does appear distended and may be obstructed at the base. A prominant ileocaecal valve area is considered and is possible but there is not much fat in this abnormal area. Colonoscopy 04/02/16. Pathology - adenocarcinoma. Dear Dr XX On 18/02/2016. This patient was discussed at the Lower GI MDM @ The Southern Trust Consultant Surgeon Mr 2Yours sincerely, Discussed at Colorectal MDM 18/02/16. Patient to be referred to Mr 3 for surgery. If you have any queries or require further information, please do not hesitate to contact us.							
NIECR	29/02/2016			OPD letter consultant 3 to GP	I assessed Pers today. Pers has got a caecal cancer he unfortunately presented with perforation, either of the caecum itself or more likely a perforated obstructed appendix secondary to the tumour. He has had a difficult time with multiple trips in and out of hospital and his family were somewhat unhappy today with the care that he has received. In any case he has now been referred to the colorectal team. He requires a right hemicolectomy. He has not yet had a CT chest and we will book this for him a couple of weeks post-surgery given that he is for theatre on Wednesday. I have explained the risks and benefits of the procedure to him including the risks of infection, bleeding, DVT, PE, anastomotic leak rate, risk of mortality and so on. He is keen to proceed and we will admit him on Wednesday morning. He is off his Apixaban and we will restart it when it is safe post-operatively. He previously had a stroke but his exercise tolerance is excellent with approximately 3 miles he can walk at present. He is not diabetic and I hope he will do well.							
Medical notes	02/03/2017				Admitted for Right hemicolectomy							
NIECR	02/03/2017			Histology result	Final REPORT CLINICAL DETAILS Right hemicolectomy, perforated caecal cancer, extended resection - right hemicolectomy+abdominal wall+roof of abscess cavity. Macroscopic R0 PATHOLOGIST'S REPORT GROSS DESCRIPTION Specimen dissected by: Dr Karel Dedic Type of specimen: right hemicolectomy Site of tumour: caecum Length of specimen: terminal ileum 35 mm, caecum and ascending colon 150 mm Maximum tumour diameter: 35 mm Nature of tumour: Polypoid Tumour perforation: Yes - retroperitoneal Distance of tumour from nearest cut end: 50 mm from proximal limit HISTOLOGY Histological type: Adenocarcinoma Differentiation: Moderate Local invasion: pT4b (in colonic carcinoma, involvement of abdominal wall or adjacent loops of bowel equates to pT4b) Maximum distance of spread beyond muscularis propria: 4 mm Lymphovascular invasion: No Venous invasion: Extramural Lymph nodes: Number of lymph nodes identified = 20 Number infiltrated by tumour = 0 Apical node: Not involved Peritoneal involvement: None Proximal margin: Not involved Distal margin: Not involved Non-peritonealised circumferential margin: Not involved Histological measurement from tumour to non-peritonealised margin 5 mm pathology: None Pre-operative therapy given: Unknown Histologically confirmed metastatic disease: No Pathological staging: Dukes' B (growth beyond m. propria, nodes negative) pTNM staging: pT4bN0 Complete resection: Yes (R0) Mismatch repair IHC and KRAS: not performed; if required, couldbe performed on block C Diagnosis: Colon Adenocarcinoma lymph node negative for tumor cells							
NIECR	08/03/2016			Medical Hospital Discharge letter	Admission Reason Elective Admission for Right Hemicolectomy Patient Receiving Palliative Care? No Principle Discharge Diagnosis Caecal Adenocarcinoma Operations/Procedures/Radiology Right hemicolectomy Additional Information for GP Changes to Medications - Start/Stop as below Clinical Information/Comments Personal admitted for Right hemicolectomy following diagnosis of caecal adenocarcinoma. Well post op. On one occasion HR increased to 136. Treated with a stat of oral bisoprolol. Discussed with Cardiology. As HR usually 70-80 bpm, advised OP 24hour tape to assess whether or not rate control is suitable. Fit for discharge 08/03/2016.							
NIECR	09/03/2016			Letter from consultant 3 to patient	Your follow up CT chest has not shown any increase in the size of this little lung nodule, whch is good news, and means it is very unikely to be of any concern whatsoever. I will review you in outpatients.							
NIECR	10/03/2016			MDM Update:	Diagnosis: Carcinoma of caecum CONSULTANT: MR 3 Personal Information , h/o appendix abscess which was drained on 4/12/2015; 3 day h/o tenderness at drain site - noted to have small fluctuant abscess. This was incised and drained; however pus noted to be emerging through wound from deeper abscess. ?deeper collection. CT 31/01/16 Abd/Pel 31/01/16 - At some stage colonoscopy of the cecal pole will be required in order to exclude cecal pole mass/tumour (if not already performed). Possible caecal pole mass may be contributing to the ongoing inflammatory process as the appendix does appear distended and may be obstructed at the base. A prominant ileocaecal valve area is considered and is possible but there is not much fat in this abnormal area. Colonoscopy 04/02/16. Pathology - adenocarcinoma. Right Hemi 02/03/16. Pathology - adenocarcinoma, pT4b N0 R0, no LVI, Extramural Venous Invasion present, 0/20 nodes involved, Dukes B. MDM Update: Dear Dr On 10/03/2016. This patient was discussed at the Lower GI MDM @ The Southern Trust MDM Plan: Yours sincerely, Discussed at Colorectal MDM 10/03/16. Consultant to discuss chemotherapy with patient. If you have any queries or require further information, please do not hesitate to contact us.							
NICER	18/03/2016	13:45		CT Chest with contrast	18/03/2016 13:45CT chest with contrast. **Findings** Lung emphysema. 6mm pleural base triangular opacity seen in the right base laterally. Band opacity seen in the anterior segment of the right upper lobe. There is no hilar or mediastinal lymphadenopathy. Multiple thoracic vertebrae show slight anterior wedging. **Conclusion** No thoracic metastasis seen. Nonspecific small pleural based triangular opacity in the right base laterally. Follow up noncontrast CT of the chest in six months time suggested. Time Reported 20-Mar-2016 10:11							

NIECR	25/04/2016			Letter from consultant 3 to patient	I reviewed Pers today. He is keeping very well. He is getting back to pretty much all normal activities since his open right hemicolectomy for a T4b N0 adenocarcinoma of the caecum, which had previously locally perforated. He is still on iron tablets. I see his last haemoglobin is still on 95, so we have rechecked his full blood count and iron studies today, he certainly should continue on iron until these have improved. He is going to start playing golf again. There is no strong indication for adjuvant chemotherapy in his case and we will adopt a watchful waiting approach. I have checked his CEA today and we will see him again in four months' time							
	12/09/2016	13:30		CT Chest	12/09/2016 13:21 CT Chest CT chest without contrast. Comparison made with previous examination 18/03/2016. **Findings** The pleural based opacity in the right base laterally show no inerval increase in size. Time Reported 28-Sep-2016 20:02							
				OPD letter consultant 3 to GP	I reviewed Pers today. He is keeping really very well. He had a right hemi colectomy with abdominal wall resection of perforated caecal cancer in March of this year of this year. He has made a very good recovery. He is back playing gold. He does have a bit of a new facial twitch but I think he has been referred for a CT scan of brain and neurology opinion. From my point of view he is doing very well. I have booked a CT scan of his chest, abdomen and pelvis for follow up. I have also organised a follow up colonoscopy for him and checked his CEA today.							
	19/12/2016	10:00		CT Chest and abdo and pelvis with contrast	19/12/2016 10:05 CT Chest and abdo and pelvis with contrast **Indication**: Perforated caecal cancer operated in March 2016. Query metastasis. Technique: Arterial phase chest and portal venous phase abdomen pelvis volume scans with oral contrast. Comparison is made to the previous recent CT scans. **Findings**: The thoracic findings are stable with no convincing evidence of metastatic disease. A sub centimetre hypodensity inferiorly in the right lobe of the liver is also stable. Postinflammatory / surgical change in the right iliac fossa appears be resolving with no definite evidence of local recurrence. The right kidney has a 12 mm caliceal stone and an unchanged (4 cm diameter) slightly complex Bosniak class two cyst. A 10 mm low density lesion arising from the inter polar region of the left kidney has attenuation higher than a simple cyst, and although too small to accurately characterise is suggestive of at least a complex cyst and should be kept under surveillance with subsequent routine CTs. The adrenal glands, spleen and pancreas are unremarkable. The aorta has normal calibre, and there is no significant lymphadenopathy or destructive osseous lesion. **Conclusion**: No convincing evidence of disease recurrence. Time Reported 29-Dec-2016 18:13							
Endoscopy day care person centred nursing record	27/01/2017				Colonoscopy							
NIECR	22/05/2017			OPD letter consultant 3 to GP	I reviewed Pers today. He has been keeping well apart from some discomfort in the right iliac fossa. I had a look back at his CT scan that was performed earlier in December and just asked radiology to review the images from it to see if there was any concern. They certainly did not report any significant thickening of the anastomosis and he has had a subsequent colonoscopy to the anastomosis which was okay. I have rechecked his CEA today. We will wait until we hear back from radiology and if the CEA is raised we will rebook a quicker CT than we previously planned. Otherwise he himself looks well and is getting on with his life as normal. We will see how he gets on from here. Yours sincerely							