Subject: FW: Memo please send out
From: McVeigh, Elizabeth [Personal Information redacted by the USI]
To: McFadden, Paul [Personal Information redacted by the USI], Graham, Simon [Personal Information redacted by the USI], Cromie, Lynn [Personal Information redacted by the USI], Magowan +40 More
Cc: Holmes, Sharon [Personal Information redacted by the USI], Sheridan, Paul [Personal Information redacted by the USI], Fearon, Pauline [Personal Information redacted by the USI], Conway +5 More
Sent: 16/09/2015 15:27:11

FYI

Brenda – could you please circulate to your roistered junior doctors.

Pauline – Could you please distribute in DHH

Thanks

Elizabeth

From: Seamus O'Reilly [Personal Information redacted by the USI]
Sent: 16 September 2015 14:38
To: McVeigh, Elizabeth
Subject: Memo please send out

- Methadone (For all doctors in both ED's, Sharon, Paul Sheridan, Barry Conway and Mary Burke)
-
    - The prescription and dispensing of methadone from ED is not supported by any policy in the UK. It is recommended that it only to be done on the advice of specialists in addictions. Therefore if a patient presents to the ED requesting methadone it **must not be prescribed or dispensed.** Guidance on the management of mild withdrawal suggests that diazepam etc can be used and if severe symptoms the patient should be admitted medically whereby the trust policy on opioid detoxification should be followed.
    - References include - Guidelines for the management of patients indicating opiate dependency syndrome, within an acute setting (on the trust intranet), NICE guidelines - Drug misuse: opioid detoxification (CG52) and Drug Misuse and Dependence - UK guidelines on Clinical Management DOH NTA. The DOH guidance gives very good advice on symptom control: http://www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf .
- SPA update (consultants in CAH)
-
    - Dear Colleague As you know I am presently putting our job plans onto Zircadian. The auditors are due to inspect these soon and from experience they have required

Southern Trust

06/10/15

Volume 6
Issue 06 October 2015

EDC news

Southern Trust

Emergency Department

Craigavon Area Hospital
68 Lurgan Road
PORTADOWN
BT63 5QQ

Phone: Personal Information redacted by the USI
Fax: Personal Information redacted by the USI
E-mail: Personal Information redacted by the USI

Any items to be included please contact

Editor: Dr Justin McCormick, Associate Specialist

If you have anything of interest that you would like to be included in this monthly newsletter please forward to Personal Information redacted by the USI

Is anyone doing anything for charity let us know

Is anyone moving on let us know

Is anyone joining us let us know

Is anyone getting engaged/married/babies etc. let us know

Has anyone passed exams let us know

If there is anything going on that would be of interest to us all LET US KNOW

N.B.

Apologies for the delay in the publication of this newsletter. As you probably can appreciate it does take a period of undisturbed office time. Also please remember that as editor I should not be submitting/writing all the articles (this is very time consuming)

If you wish this newsletter to continue please submit interesting articles for publication to Elizabeth.

I fear that this newsletter is unsustainable without staff support.

Announcements:

Congratulations:

Personal Information redacted by the USI is due to get married this weekend.

Congrats also to Personal Information redacted by the USI on sustaining non life threating injuries which results in considerable periods of time off work!
Bubble wrap will be provided by Personal Information for any further potential dangerous activities!

Great to have our permanent secretary Personal Information redacted by the USI back after her prolonged absence.

Au Revoir

Personal Information redacted by the USI is soon leaving to go into the community we wish her all the best. It has been lovely working with you.

Personal Information redacted by the USI has left more to follow in the spotlight section

Case of the month

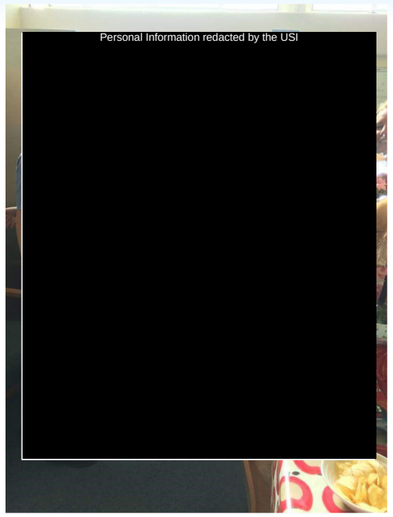
Inside this issue:

Alerts/Information

Due to a recent case a Memo has been circulated from Personal Information re: Methadone. **This is not to be prescribed by the Emergency Department.** There are community based addiction teams with stringent protocols for the administration for this much sought after and dangerous drug.

Talking to Personal Information this morning there has been a recent case of a pregnant lady in another Trust in whom Domestic Violence was not considered. UNOCINI's should be filled out in all patients who have children at home with special consideration of the unborn child who remains at risk.

SPOTLIGHT



Personal Information redacted by the USI was with us for five years and in that time she became a valuable member of the ED team always ready with a smile and willing to go that extra mile for her patients. She was easy to work and you could certainly see the influence of her mum Personal Information redacted by the USI on her nursing style. (Personal Information redacted was a senior staff nurse with us for many years who was the embodiment of good nursing standards) But Personal Information felt the need for more challenges in her life and hence moved to midwifery training.

We will all miss her from the Emergency Department and she is of course welcome back at any stage (as is her mum).

Nurses

Congratulations to all our new Band 6's needless to say we will be very sad to lose Personal Information redacted by the USI to DHH. There will be a definite gap in our band 5/6 tier now. These were all very experienced nurses and excellent at teaching and in the smooth running of the Department.

Personal Information redacted by the USI ex of Antrim ED who has now trained as a midwife will be one of our new band 6's. She should be starting with us shortly and naturally we welcome her to the team.

Suggestion box!

More good suggestions have come through many thanks keep me coming...

- Put ED achievements and targets including anonymised thank you letter onto the TV screen in patients waiting room
- Increased frequency of staff meetings to improve communication
- Please consider an antibiotic drawer in Resus
- Up to date discharge information sheets which are evidence based to assist patient eduction
- Could we get a 2nd phone for M2
- 7 suggestions for consideration of a rolling rota for nursing staff
- Staff training—need for supervised sessions with multi-disciplinary input
- Free WiFi for patients waiting room/CDU

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

NEW STAFF

Personal Information redacted by the USI are all with us at the moment as pre-registration and will be starting as nurses with us soon.

Personal Information redacted by the USI is back from maternity leave soon.

Personal Information redacted by the USI has returned after her 18th child!

Nice Personal Information redacted by the USI is back.

Students

Personal Information redacted by the USI are our Fourth year medical students all of them are very keen.

Also Personal Information redacted by the USI are our Fifth years

M+M learning from August/September2015

Mortality(Aug)

2 OOH arrests no learning associated with these

CAH Morbidity, inability to get Doppler ultrasounds at weekend

Further discussion about risk of not being able to get Doppler ultrasound scans for ?DVT within 24 hours of request. Known risk ?on trust's risk register. For now, senior review and decision/ communication on a case by case basis

CAH Abdo pain

Too many CT KUBs? Ultrasound's role, see BMJ 18 months ago; home if no hydronephrosis or ureteric jets, EH.

Previous agreement; CTKUB for first presentation, ultrasound if recent CTKUB

Agreement should have senior review of CTKUB decisions

CAH Case, Child with abdo pain

AXR soft tissue mass Ultrasound done and missed mass, not documented and comments criticized by parents of child

Lesson: governance of use of ultrasound machine in the ED. Should be for specific indications

FAST/AAA/Venous access/Other indications by 'arrangement' e.g. bladder volume

Should be documented clearly (including a copy of the scans – **press print button**)

Audit, Personal Information redacted by the USI leading on departmental audit, see his document. Based on CEM audits

Chest pain pathway, Personal Information

Feedback from some juniors to Personal Information redacted by the USI who passed it and some of his own to Personal Information redacted by the USI

Feedback = include RVH's fax number, make it less wordy, score makes it too complicated, and don't want senior review for so many patients.

Personal Information redacted by the USI: not sure Score can just be dropped as significant numbers do want it, with recognition that it works alongside clinical judgement. Am looking to reduce the number of patients where senior review is advised by encouraging admission for high scorers and senior review for intermediate (the group with most uncertainty) and low scorers (the group most likely to be safe for home). Further delay reforming pathway to include HEART score itself and pending further discussion with stakeholders.

CT in Sepsis, Personal Information redacted by the USI

Case series of 3 patients who presented with septic shock (failure to clear lactate and inotrope dependence for whom CT scanning enabled diagnosis and altered management (hydonephrosis and liver abscess). Discussion around whether that would be for the emergency physician to intiate or to recommend to specialty (medicine/ICU urology)

Art lines, Personal Information redacted by the USI Suggestion that a proforma may be required for any Art line placement in the EDs

Mortality(Sept)

5 deaths at CAH in the month incl one trauma case - 90 year old fallen down stairs, sub-dural haemorrhage, GCS 3, fixed dilated pupil.

Importance of seniors involved in end of life care.

Morbidity

Missed SUFE: not xrayed despite GP referring for XR. Doctor involved given feedback. Discussion around SHO teaching importance of imaging possible SUFE. Missed soft tissue infection of lower leg of toddler; seen at MIU, misdiagnosed as ?Toddler's fracture.Swelling means not Toddler's fracture.High index of suspicion for osteomyelitis/musculo-skeletal infection Should ENP's be seeing under 5s?Difficulties with Ortho/RHSCB interface...

Case at DHH of patient with COPD who presented critically unwell with sepsis, not suitable for ICU, no HDU bed. Suggestion from medics that CT abdomen would have been useful earlier, though wasn't well enough.

Involve critical care early (if available); that and other specialty support might enable decision to provide end of life care earlier

Early non-contrast CT abdomen in sepsis may help management (as per Personal Information redacted by the USI presentation e.g. urosepsis)

Sedation: RCEM standard is proforma use in 100% procedures requiring sedation

Procedure book is back in resus, sits on top of the filing cabinet by door to resus at the staff room end. H&C number essential for auditing purposes please. If you put the procedure in the book before it takes place, it can remind you to use the proforma too.

...PHA learning letter...

Vascular referrals, issue mirrors that with orthopaedics; Belfast specialties want local specialties to involve themselves. Local specialties want ED to manage patients independent of them. Might even include direct referral by GPs of some things Need for referrals policy (vascular and orthopaedics)

Southern Health and Social Care Trust

Guidelines for the Management of Patients Indicating Opiate Dependency Syndrome, within an Acute Setting

Ownership – SH&SCT

Status – Current

Next Review – 2015

Publication Date – 12/10/12

Authors – Addiction Service Opiate Management Working Group

Evidence Base –Approved by-

1. Clinical Protocols for Detoxification in Hospitals and Detoxification Facilities John B. Saunders and Junie Yang Royal Brisbane Hospital and The Prince Charles Hospital Health Service Districts (2002) ISBN: 0-9578860-1-2
2. Cochrane Reviews. Alpha2 adrenergic agonists for the management of opioid withdrawal.
3. http://www.cochrane.org/reviews/en/ab002024.html
4. NICE guidelines. Drug misuse: opioid detoxification**.** http://guidance.nice.org.uk/CG52
5. Drug Misuse and Dependence – UK Guidelines on Clinical Management DOH NTA 2007.

Approved by – Mental Health Interface Group. Acute / Mental Health Liaison *Group*

It is the responsibility of relevant staff to familiarize themselves with, and adhere to the contents of these guidelines

Persons who use prescribed or non-prescribed opiates will attend the Emergency Department on occasions when in need of acute or emergency treatment. This guideline has been devised by the SCHSCT Addiction Team as below;

Dr Iqbal Consultant Psychiatrist (Locum Addictions)

Dr Hanna Speciality Doctor for Addictions

Ann O'Neil & John McGarvey Addiction Liaison Practitioners

Theresa Hamilton & Anne Marie Harvey Opiate Treatment Practitioners

Kevin Morton Addictions Services Coordinator

In Consultation with:

Dr U. Bradley Consultant physician MAU Craigavon hospital

Mr O'Reilly Consultant in Emergency medicine, Craigavon Area Hospital

Dr K. Ritchie Consultant Physician MAU Craigavon Hospital

The aim of this guideline is to outline managing opiate dependence syndrome in a patient who is receiving treatment for other health needs, within the general hospital setting. The main possible scenarios are outlined below;-

Patient presenting to A&E

Emergency treatment to be carried out according to patient need. Where dependant opiate use is identified, but emergency treatment issue resolved, the patient can be issued with a copy of Appendix I detailing their local Addiction Service and the required pathways to access treatment (see appendix I). During office hours, Addictions Liaison professionals can offer assessment and signposting, or onward referral to Addiction Service, if required.

Patient being admitted to Acute Wards CAH, DHH or Bluestone Hospital

When admission is required for treatment, opiate withdrawal symptoms may become apparent within 8-12 hours of last opioid usage for heroin, 24 hours or more with methadone & buprenorphine.

The pattern of withdrawal symptoms from different types of opioids (e.g. heroin, morphine, codeine, and methadone) are similar, although the severity and duration of symptoms vary according to the type of opioids being used. Longer acting opioids (e.g. codeine, methadone) are associated with more protracted withdrawal symptoms than short-acting opiates (e.g. heroin). A sudden cessation of heroin use produces withdrawal symptoms of greater severity, but shorter duration than withdrawal symptoms associated with a cessation of methadone.

The common signs and symptoms of opioid withdrawal are: lacrimation (running eyes), rhinorrhoea (running nose), perspiration, mydriasis (dilated pupils) piloerection (gooseflesh) hot and cold flushes, fatigue, yawning , restlessness, insomnia, muscle aches, leg cramps, joint pain (particularly backache), abdominal cramps, diarrhoea, nausea, vomiting, anorexia. Drug seeking behaviour becomes prominent, through requests for medication or attempts to self-medicate. The physical syndrome of opioid withdrawal resembles a severe bout of influenza. Unlike withdrawals from alcohol or benzodiazepines, opiate withdrawals are not considered life threatening.

Severity of Opiate withdrawal symptoms can be assessed using the COWS scale (Appendix II) and urine drug screen to detect opiate metabolites (near site testing with laboratory analysis request afterwards).

Less severe withdrawal symptoms (more common with OTC or prescribed opioid medications and where heroin use is smoked and less established), can be managed symptomatically (see Appendix III).

More severe opiate withdrawals, seen with both chronic opioid medication & heroin dependency, (smoked and IV use), may require a planned detoxification using Lofexidine (See Appendix IV). As this detox regimen requires a loading & reducing schedule of prescribing over a period of at least 7 days, this should only be initiated if the patient will be staying in-patient for this length of time, for their co-existing medical treatment needs. Transfer to The Addiction Unit may be an option, when patient is medically and psychiatrically stable, to ensure continued detoxification treatment. Addictions Liaison Practitioners, will assist with this assessment, recommend treatment and arrange referral to the Addiction Unit, if appropriate.

In the event that Lofexidine and symptomatic treatment does not manage opiate withdrawal symptoms, consultation should occur between treating hospital doctor and Addiction Team doctor. Opiate Substitution Treatment (OST) with either buprenorphine or methadone may be required, but should **NOT** be initiated without recommendation and guidance from the on call doctor. Further management advice may be available from Liaison Mental Health Practitioners in Out Of Hours situations.

Patients already receiving OST

For patients already maintained on Opiate Substitution Treatment (OST), please contact OST keyworker, or the dispensing community Pharmacist, to confirm dose and dispensing arrangements. (Refer to Appendix I) Continue prescribing, as a maintenance dose, unless Addictions Clinician advises otherwise.

When analgesia is required, NSAID's should be considered first, if not contraindicated. If acute pain indicates stronger analgesia, opioids may be required, taking into consideration potential for CNS depression (including any benzodiazepine Rx). Patients complying with prescribed buprenorphine may be at risk of precipitated withdrawal, if given additional opioids. Consideration should be taken of higher doses (above 10-12mg OD) and time of last dose, to assess potential risk of precipitated withdrawal.

Discharge Arrangements for Patients receiving OST

When a patient is being discharged on OST, liaison with Addiction Team Opiate Treatment Practitioner should occur, regarding handing back OST prescribing responsibility. A prescription will then be arranged for dispensing in the Community Pharmacy, with prompt follow up review in Out-Patient clinic.

Blood Borne Virus

When assessment indicates a history of current or past injecting drug use, check with patient if they are aware of their virology status. It would be good practice to carry out virology testing for Hepatitis B & C and HIV, if same not recorded as having been done recently. In patient admission would also be an opportunity to commence Hepatitis B vaccination, with further doses being given by Patients GP, as per recommended schedule.

NI Take Home Naloxone Initiative

From July 2012, Addiction Teams in Northern Ireland will be issuing kits of Naloxone to service users or their representatives, after being trained how to administer the medication IM, in opiate overdose situations. It may be the case that such persons attend A&E for further management of overdose.

Amended 12-10-12

Appendix I

CONTACT DETAILS FOR OPIATE ADDICTION SERVICES IN NORTHERN IRELAND

Contact local service for referral requirements.

Southern Trust

Community Addiction Service
St Luke's Hospital
Loughgall Road
Armagh
02837412878

Dr J Anderson Consultant
Dr Hanna Staff Grade Doctor

Theresa Hamilton *Opiate substitution Nurse*
Anne Marie Harvey *Opiate substitution Nurse*

In Patient Addictions Unit
02837412502

Belfast Trust

SPT Office
First floor Dunluce Health Centre
1 Dunluce Avenue
Belfast
BT9 7HR
02890204334
Dr Toal Consultant
Dr B Boggs Staff Grade Doctor
Trudie Coyne Opiate Substitution Team Leader

Western Trust

TNF Hospital
1 Donaghanie Road
Omagh
BT79 ONS
02882835443

Dr Payne Consultant

Dr Hegarty
Josephine Mullan
Opiate substitution Nurse

Woodley House
Gransha Park
Derry
BT47 6TF
02871865237

Lorna Forest
Opiate substitution Nurse

Northern Trust

Opiate Substitution Team
105a Railway Street
Ballymena
BT42 2Af
02825631970
Dr Gregg Consultant
Dr Sarwar Staff Grade Doctor
Des Flanagan *Opiate Substitution Co-Ordinator*

South Eastern Trust

Consultant Dr S Flanagan
Opiate Substitution Nurse Team lead Mr Noel Taggart

Shimna House
Downshire Hospital
Adglass Road
Downpatrick
BT30 6RA
Tel 0284513922

Newtownards
3 church street
Newtownards
BT23 4AN
Tel 028 91816666

Down and Lisburn Area
TSL House
38 Bachelor Walk
Lisburn
Bt28 1X2
Tel - 02892668607

Amended 12-10-12

Appendix II **Assessment of Opiate Withdrawals**

Clinical Opiate Withdrawal Scale (COWS)

Score Chart for measuring symptoms over a period of time.

For each item, write in the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to ***opiate withdrawal***. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Resting Pulse Rate: (record beats per minute) Measured after patient is sitting or lying for one minute 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120				
Blood Pressure (Lying Standing for lofexidine)				
Sweating: over past ½ hour not accounted for by room temperature or patient activity. 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face				
Restlessness Observation during assessment 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds				
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible				
Bone or Joint aches If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/ muscles				

Amended 12-10-12

4 patient is rubbing joints or muscles and is unable to sit still because of discomfort				
Time				
Runny nose or tearing Not accounted for by cold symptoms or allergies 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks				
GI Upset: over last ½ hour 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhoea 5 Multiple episodes of diarrhoea or vomiting				
Tremor observation of outstretched hands 0 No tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching				
Yawning Observation during assessment 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute				
Anxiety or Irritability 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable anxious 4 patient so irritable or anxious that participation in the assessment is difficult				
Gooseflesh skin 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection				
Total scores **with observer's initials**				

Score:

Score:

5-12 = mild; measure COWS 4-6 hourly

13-24 = moderate; score measure COWS 2 hourly

25-36 = moderately severe; measure COWS hourly

More than 36 = severe withdrawal measure COWS every 30mins.

Appendix III

Simple Symptomatic Relief for Opiate Withdrawals

Medicating for symptomatic relief is suitable for those patients who have features of low or mild opiate dependence with current low level use of heroin (below 0.5 gram daily), or opioid medications, preferably with short history (less than 12 months) of use. Patients would also require good motivation to remain abstinent from opioids use.

Contra-indications

- Pregnancy (withdrawal could cause spontaneous abortion

  Injecting 3-4 times daily or more, of heroin daily
- Heroin use for over 18 months (unless only has features of mild dependence, and low level of use – that is, smoking less than 0.5g daily) (See Appendix IV)
- Poly drug use and/or alcohol misuse

Symptomatic relief medications

- Zopliclone 7.5-10mg or Temazepam 10-20mg, at night for insomnia
- Metoclopramide is prescribed orally or IM at a dose of 10mg every 8 hours as required for nausea and/or vomiting
- An antacid 15-20ml orally is given every 6 hours as required for heartburn or indigestion
- Buscopan orally every 8 hours as required for abdominal cramps (common in the middle phase of opioid withdrawal)
- Loperamide 2mg po after loose stool to a maximum of 16mg daily.
- Quinine sulphate 300mg PO BD as required for muscle cramps (common in opioid withdrawal). CAUTION - excess quinine sulphate is toxic to the heart
- Paracetamol 1g PO every 4-6 hours as required for headaches and other minor pains.
- More severe aches and pains can be treated with NSAIDs, such as Ibuprofen 400mg PO every 8 hours as required, where not contraindicated (history of ulcers, gastritis, asthma, renal impairment)

Appendix IV LOFEXIDINE DETOXIFICATION (requires medical consensus)

Lofexidine

Specific exclusion criteria

- A history of sensitivity to Lofexidine or other Imidazole derivatives (e.g. clotrimazole).
- A history of cardiovascular disease.
- A history of cerebrovascular disease.
- A history of renal impairment.
- Concurrent pregnancy or breast feeding.
- Concomitant prescription of medication other than described in this protocol.
- Concomitant use of illicit substances or any CNS depressant drug (including alcohol) during detoxification

General exclusion criteria.

- A history of repeated failure to complete community detoxification.
- Severe concurrent medical or psychiatric illness, or potential for detoxification-induced relapse of such illness.
- Concurrent suicidal risk.
- Cognitive deficits.

Patients that fulfil any of the exclusion criteria above may be unsuitable for lofexidine detoxification.

For these patients experiencing opiate withdrawal, they should be managed symptomatically with benzodiazepines and other medications as listed in Appendix III. Lofexidine still may be considered but only after discussion with senior medical or Addictions Service staff.

Low prescribing regimen - For patients detoxifying from dosages of street heroin <1/4g daily or dependent level of OTC/ Unprescribed opioid medications, where objective withdrawals apparent

Lofexidine PO	Mane	12 noon	6pm	10pm	Total dose	prn
Day 1	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	
Day 2	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	
Day 3	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	0.2mg BD
Day 4	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	0.2mg BD
Day5	0.2mg			0.2mg	0.4mg	0.2mg BD
Day 6				0.2mg	0.2mg	0.2mg BD
Day 7						0.2mg BD
Day 8						0.2mg BD

Moderate prescribing regimen for patients detoxifying from moderate dosages of street heroin 1/4g - 3/4g daily

Lofexidine PO	Mane	12 noon	6pm	10pm	Total dose	prn
Day 1	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	
Day 2	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	
Day 3	0.4mg	0.4mg	0.4mg	0.4mg	1.6mg	
Day 4	0.4mg	0.2mg	0.2mg	0.4mg	1.2mg	0.2mg QDS
Day5	0.2mg	0.2mg	0.2mg	0.2mg	0.8mg	0.2mg QDS
Day 6	0.2mg				0.4mg	0.2mg QDS
Day 7					0.2mg	0.2mg TDS
Day 8						0.2mg BD
Day 9						0.2mg BD

ADJUNCTIVE MEDICATION

To be prescribed as prn medication for all regimes.

Ibuprofen 400mg tds po prn for duration of detoxification

Metoclopramide 10mg tds po prn for duration of detoxification

Loperamide 2mg po after loose stool to a maximum of 16mg daily for 1 week

Zopiclone 7.5-15mg nocte po prn for a maximum of 2 week

Clinical Observations during Lofexidine detoxification

All patients experiencing opiate withdrawal should have their Clinical Opiate Withdrawal Scale (COWS) measured. All patients in a general hospital setting within the Southern Trust should have their National Early Warning Scores (NEWS) measured and recorded. The NEWS will guide staff regarding frequency of clinical monitoring required and when to alert medical staff to review the patient.

Loxfedinine can cause hypotension, postural hypotension and bradycardia. In addition to the observations recorded above, all patients should have lying and standing blood pressures recorded. Lofexidine should be withheld and medical staff notified if:

1. There is evidence of postural hypotension
2. Blood pressure is recorded at less than 80/50
3. Heart rate is recorded at less than 50 beats per minute

Opiate Withdrawal in Pregnancy

In pregnancy, Methadone is used to treat opiate withdrawal. In an acute setting when a pregnant patient is experiencing opiate withdrawal, methadone 20mg daily should be prescribed and titrated by 5mg daily. Urgent advice for further management must be sought from medical staff in the Addictions Team. Also senior medical/obstetric staff responsible for the patient's care must be made aware of the patient's admission and be involved in on-going care.

For further reading please reference

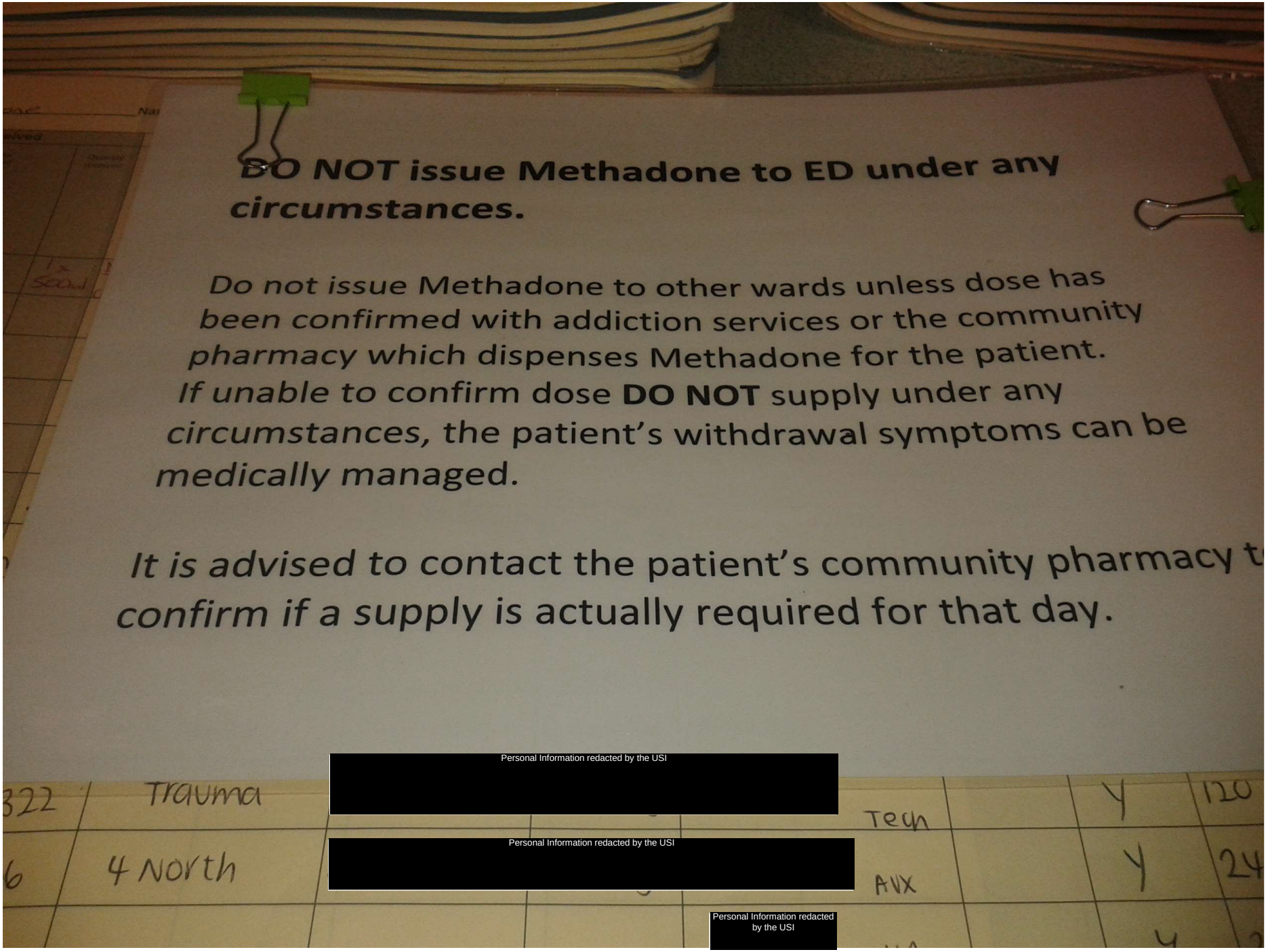
Clinical Protocols for Detoxification in Hospitals and Detoxification Facilities John B. Saunders and Junie Yang Royal Brisbane Hospital and The Prince Charles Hospital Health Service Districts (2002) ISBN: 0-9578860-1-2

Cochrane Reviews. **Alpha2 adrenergic agonists for the management of opioid withdrawal.**

http://www.cochrane.org/reviews/en/ab002024.html

NICE guidelines. **Drug misuse: opioid detoxification.** http://guidance.nice.org.uk/CG52

Drug Misuse and Dependence – UK Guidelines on Clinical Management DOH NTA 2007.



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

DO NOT issue Methadone to ED under any circumstances.

Do not issue Methadone to other wards unless dose has been confirmed with addiction services or the community pharmacy which dispenses Methadone for the patient.
If unable to confirm dose **DO NOT** supply under any circumstances, the patient's withdrawal symptoms can be medically managed.

It is advised to contact the patient's community pharmacy to confirm if a supply is actually required for that day.

SOUTHERN HEALTH AND SOCIAL SERVICES BOARD
AREA PHARMACEUTICAL SERVICE

TITLE:	CONTROLLED DRUGS PART 15: SUPPLY OF OPIOID SUBSTITUTION THERAPY		
NUMBER: **1 (o)**	VERSION/EDITION NO: **New**	REPLACES:	
WRITTEN BY **Frances McKenna** UPDATED BY:	SIGNATURE: :	AUTHORISED BY: **Tracey Boyce** DIRECTOR OF PHARMACEUTICAL SERVICES	SIGNATURE:
PAGE COUNT: **1 of 2**	COPY NO: **Master**	DATE OF ISSUE: **September 2016** UPDATED:	NEXT REVIEW DATE: **September 2018**

Objective:

To ensure all controlled drug (CD) requisitions and prescriptions received by pharmacy for Opioid Substitution Therapy are handled appropriately and are recorded in the controlled drug register in accordance with the Misuse of Drugs Regulations (Northern Ireland) 2002 and with any guidance issued by DHSSPSNI.

Scope:

To be applied to all CD requisitions and prescriptions for Opioid Substitution Therapy which are received by pharmacy.

Responsibilities:

It is the responsibility of the Pharmacy Patient Services Manager/Dispensary Manager to ensure all CD requisitions that need to be recorded are recorded in a CD register in accordance with the Misuse of Drugs Regulations (Northern Ireland) 2002 and with guidance issued by DHSSPSNI.

Process:

When dealing with requests for Opioid Substitution Therapy (herein referred to as OST) the following points should be noted:

- The prescribing and dispensing OST from ED is not supported by any policy in the UK. It is recommended that it only be done on the advice of specialists in addictions. Therefore if the patient presents in ED requesting OST it **must not be prescribed or dispensed.** Guidance on the management of mild withdrawal suggests that diazepam etc. can be used and if symptoms are severe the patient should be admitted medically whereby the Trust policy on Opioid Detoxification should be followed:
  http://vsrintranet.southerntrust.local/SHSCT/HTML/documents/GUIDELINESforthemanagementofpatientsindicatingopiatedependencysyndrome.pdf
  Other references include – Guidelines for the management of patients indicating opiate dependency syndrome within an acute setting (on the Trust Intranet), NICE Guidelines – Drug Misuse: Opioid Detoxification (CG52) and Drug Misuse

.

SOUTHERN HEALTH AND SOCIAL SERVICES BOARD
AREA PHARMACEUTICAL SERVICE

TITLE:	**CONTROLLED DRUGS** **PART 15: SUPPLY OF OPIOID SUBSTITUTION THERAPY**		
NUMBER: **1 (o)**	VERSION/EDITION NO: **New**	REPLACES:	
WRITTEN BY **Frances McKenna** UPDATED BY:	SIGNATURE: :	AUTHORISED BY: **Tracey Boyce** DIRECTOR OF PHARMACEUTICAL SERVICES	SIGNATURE:
PAGE COUNT: **2 of 2**	COPY NO: **Master**	DATE OF ISSUE: **September 2016** UPDATED:	NEXT REVIEW DATE: **September 2018**

and Dependence – UK Guidelines on Clinical Management DOH NTA. The DOH guidance gives very good advice on symptom control:
http://www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf

- If a request (Requisition) is received from a ward for OST and the ward has a pharmacist, contact should be made with them to ensure that the patient's dose has been confirmed. If there is no pharmacist on the ward, from which a request is received, before the dose can be supplied the dose should be confirmed with the community pharmacy that usually supplies the patient or with a member of the community addictions team responsible for the patient. If unable to confirm dose **DO NOT** supply under any circumstances, the patient's withdrawal symptoms can be medically managed. It is advised to contact the patient's community pharmacy to confirm if a supply is actually required for that day.

- If a ward makes a request for OST that will run into a weekend or Bank Holiday and the patient is going to be on the ward over the weekend or Bank Holiday the supply for those days should also be issued as long as the dose has been confirmed as above.

- **OST must not be issued on discharge** for any patients. The community pharmacy that usually supplies the patient should be contacted to inform them that the patient has been discharged and when the patient's last dose had been administered in hospital

Audit:

The dispensary manager/pharmacy patient services manager will observe the operation of this procedure and will review and make amendments as appropriate.

If new legislation, new guidance or a critical incident (which may trigger a review) occurs, this SOP will be reviewed prior to the recommended review date.

Controlled Drugs Part 15

I, the undersigned have read the above Policy Procedure and fully understand the points detailed. I am also fully aware of what my responsibilities and those of my colleagues are as a result of this Policy Procedure.

NAME	GRADE	SIGNATURE	DATE

Southern Health and Social Care Trust

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

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

Date of Incident/Event: 10/09/15

HSCB Unique Case Identifier: Personal Information redacted by the USI

Service User Details: D.O.B: Personal Information redacted by the USI
Gender: Personal Information redacted by the USI) Age: Personal Information redacted by the USI)

Responsible Lead Officer: Cathy Daly
Designation: Consultant Emergency Medicine

Report Author: Review Team: Jayne Agnew, Clinical Services Pharmacist, Paul Sheridan, Ward Manager Daisy Hill ED,

Facilitator: Paul Smyth

Date report signed off: 13 May 2016

Date submitted to HSCB: 23 May 2016

1.0 EXECUTIVE SUMMARY

Irrelevant information redacted by the USI

2.0 THE REVIEW TEAM

Names	Titles
Cathy Daly (Chair)	Consultant Emergency Medicine Southern HSCT
Jayne Agnew	Clinical Services Pharmacist, Southern HSCT
Paul Sheridan	Ward Manager Daisy Hill ED, Southern HSCT
Facilitator - Paul Smyth	Lead Nurse Governance, Southern HSCT

3.0 SAI REVIEW TERMS OF REFERENCE

Irrelevant information redacted by the USI

[redacted]

This investigation will adhere to the principles contained within the National Patient Safety Agency (NPSA) Policy documents on “Being Open – Communicating Patient Safety Incidents with Patients and their Carers”. (Appendix 2)

http://www.npsa.nhs.uk/site/media/documents/1456_Beingopenpolicy111.pdf

Roles and responsibilities

The Chair will lead the Review Team and will provide the final written report to the Director of Acute Services.

The review team will provide information to the Chair to ensure the review is complete and the review team will contribute to the development and review of the report for factual accuracy and thorough analysis.

4.0 REVIEW METHODOLOGY

Irrelevant information redacted by the USI

[redacted]

5.0 DESCRIPTION OF INCIDENT/CASE

Background

Irrelevant information redacted by the USI

[redacted]

5.0 DESCRIPTION OF INCIDENT/CASE

Irrelevant information redacted by the USI

[redacted]

5.0 DESCRIPTION OF INCIDENT/CASE

Irrelevant information redacted by the USI

[redacted]

5.0 DESCRIPTION OF INCIDENT/CASE

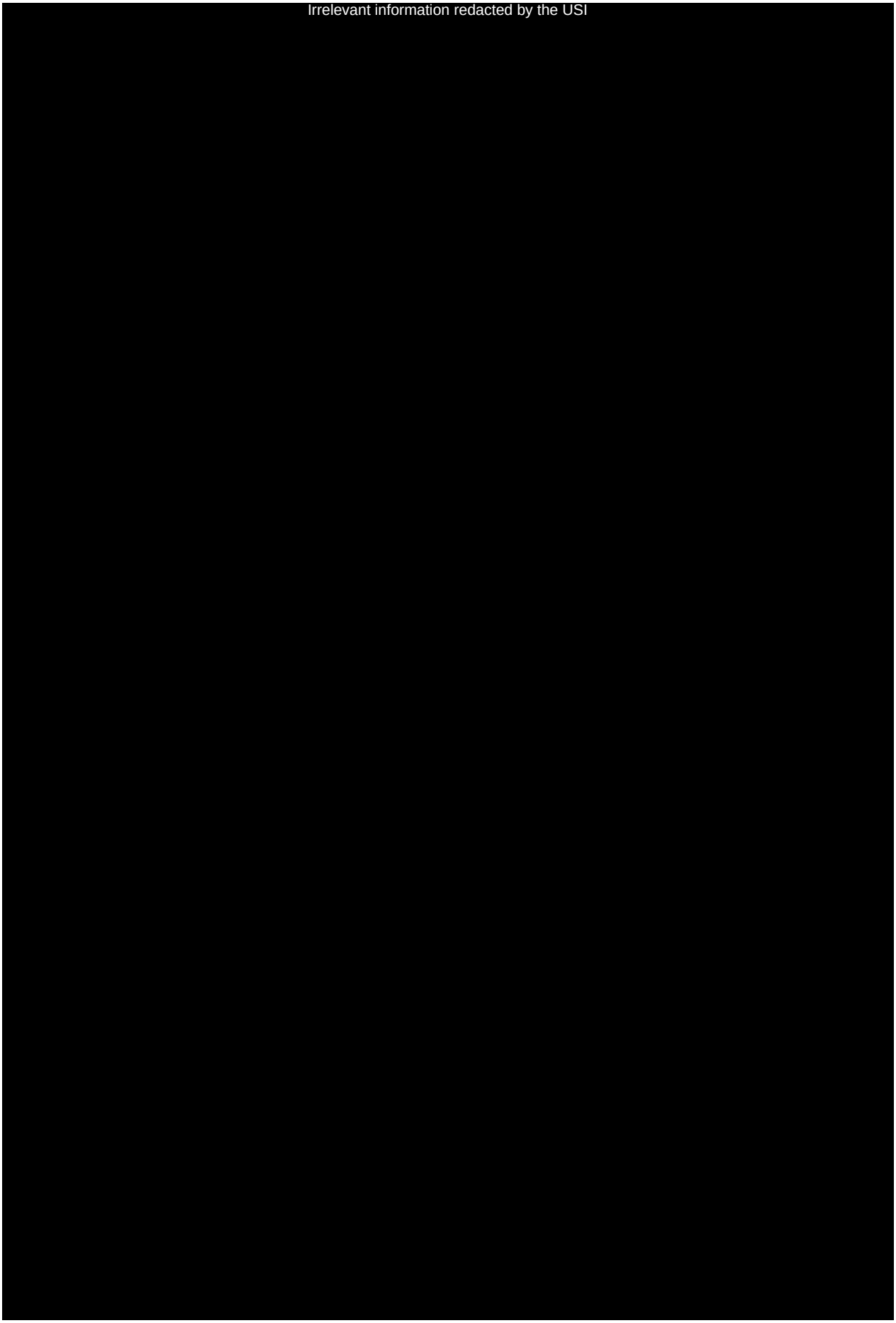
Irrelevant information redacted by the USI

[redacted]

6.0 ANALYSIS/FINDINGS

Irrelevant information redacted by the USI

[redacted]



6.0 ANALYSIS/FINDINGS

Irrelevant information redacted by the USI

[redacted]

6.0 ANALYSIS/FINDINGS

Irrelevant information redacted by the USI

[redacted]

6.0 ANALYSIS/FINDINGS

Personal Information redacted by the USI

[redacted]

7.0 CONCLUSIONS

Irrelevant information redacted by the USI

[redacted]

- **Emergency Department staff were not informed SV was taking other**
- Irrelevant information redacted by the USI

8.0 LESSONS LEARNED

- Irrelevant information redacted by the USI

9.0 RECOMMENDATIONS AND ACTION PLANNING

Recommendation 1

Staff involved in this adverse incident should be given feedback

Action

The RCA report should be shared with staff involved in the incident

Lead

AD/AMD

Timeframe

May 2016

Recommendation 2

Methadone should not be prescribed or administered in any of the Trusts Emergency Departments

9.0 RECOMMENDATIONS AND ACTION PLANNING

Action

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 Therapy on Discharge From Secondary Care” to be shared with relevant staff.

Lead

AD/AMD

Timeframe

May 2016

Recommendation 3

The Trusts Guidelines for the Management of Patients Indicating Opiate Dependency Syndrome, within an Acute Setting section for ED needs updated.

Action

The ED section should state clearly that Methadone should not be administered in the Emergency Departments in the Trust

Lead

AD/AMD

Timeframe

May 2016

10.0 DISTRIBUTION LIST

- Family of Personal
- HSCB
- Staff involved in Personal’s care

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

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

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

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, a number of service users or if the SAI relates **only** to a HSC Child Death notification *(SAI criterion 4.2.2)* **Please select as appropriate (✓)**	**Single Service User**	(✓)	**Multiple Service Users***		**HSC Child Death Notification only**		
	Comment: ****If multiple service users involved please indicate the number involved***						
2) Was the Service User[1] / Family / Carer informed the incident was being investigated as a SAI? **Please select as appropriate (✓)**	**YES**	(✓)	**NO**				
	If **YES**, insert **date informed**:18/01/16						
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being investigated as a SAI						
	a) No contact or Next of Kin details or Unable to contact						
	b) Not applicable as this SAI is not 'patient/service user' related						
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user						
	d) Case involved suspected or actual abuse by family						
	e) Case identified as a result of review exercise						
	f) Case is environmental or infrastructure related with no harm to patient/service user						
	g) Other rationale						
	If you selected c), d), e), f) or g) above please provide further details:						
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**							
Content with rationale?	**YES**		**NO**				

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

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

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

[1]*Service User or their nominated representative*

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

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

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being investigated as a SAI)*		
Continued overleaf	**e)** No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

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

SECTION 2

INFORMING THE CORONER'S OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) *(complete this section for all death related SAIs)*				
1) Was there a Statutory Duty to notify the Coroner at the time of death? **Please select as appropriate** (✓)	**YES**	(✓)	**NO**	
	If **YES**, insert **date informed**: 11/09/15			
	If **NO**, please provide details:			
2) Following or during the review of the SAI was there a Statutory Duty to notify the Coroner? **Please select as appropriate** (✓)	**YES**		**NO**	(✓)
	If **YES**, insert **date informed**:			
	If **NO**, please provide details: Cornoor was already aware of SAI review			
3) If you have selected 'YES' to any of the above **'1' or '2'** has the review report been shared with the Coroner? **Please select as appropriate** (✓)	**YES**		**NO**	(✓)
	If **YES**, insert **date report shared**:			
	If **NO**, please provide details: **Report to be forwarded to coroner by Corporate governance**			

DATE CHECKLIST COMPLETED	**20/05/16**

[1]*Service User or their nominated representative*

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

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

Complaints by Loc (Exact) and Date Received grouped by Site
Communication

	2016 04	2016 05	2016 06	2016 07	2016 08	2016 09	2016 10	2016 11	Total
Craigavon Area Hospital	**14**	**5**	**9**	**0**	**25**	**5**	**10**	**14**	**82**
1 East Maternity Antenatal	3	0	0	0	0	0	0	0	3
1 West Gynae	0	0	0	0	1	0	0	0	1
2 North Haematology	0	0	0	0	1	0	1	0	2
2 North Resp/Medical	0	0	0	0	4	0	4	0	8
2 South Medical	0	0	0	0	2	0	0	0	2
2 South Stroke	2	0	0	0	0	0	0	0	2
3 South	0	0	0	0	0	2	2	0	4
4 North	0	0	1	0	0	0	0	3	4
4 South	0	1	1	0	0	0	0	1	3
Admissions/Assessment Unit	3	0	0	0	0	0	0	0	3
Emergency Department	1	0	2	0	0	0	0	0	3
Antenatal Clinic	0	0	0	0	0	0	0	1	1
Booking Centre	2	0	0	0	0	0	1	0	3
Colposcopy Clinic	0	0	3	0	3	0	0	0	6
Delivery Suite, CAH	0	0	0	0	4	0	0	6	10
Fertility Clinic	0	0	0	0	0	0	0	1	1
Gastroenterology Clinic	0	0	0	0	0	1	0	0	1
General Surgery Clinic	1	0	0	0	0	0	0	0	1
Gynae Clinic	0	2	0	0	1	0	0	1	4
ICU (HDU)	1	0	0	0	0	0	0	0	1
Kitchen	0	0	0	0	0	0	1	0	1
The Maples	0	0	1	0	0	0	0	0	1
Oncology Clinic, Mandeville Unit	0	2	0	0	0	0	0	0	2
Orthopaedic Clinic	0	0	0	0	2	0	0	0	2
Orthopaedic Ward	0	0	0	0	2	0	0	0	2
Pain Management Clinic	0	0	0	0	1	0	0	0	1
Physiotherapy Inpatient	0	0	0	0	1	0	0	0	1
Pre-operative Assessment Clinic	0	0	0	0	2	0	0	0	2
Rheumatology Clinic	0	0	0	0	0	0	0	1	1
Switchboard	0	0	1	0	0	0	0	0	1
Theatre	1	0	0	0	0	0	0	0	1
Urology Clinic	0	0	0	0	1	0	0	0	1
X-ray Dept (Radiology)	0	0	0	0	0	2	1	0	3
Community	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**1**
John Mitchel Place, HSSC	0	0	0	0	1	0	0	0	1
Daisy Hill Hospital	**0**	**3**	**2**	**3**	**8**	**7**	**0**	**0**	**23**
Emergency Department	0	0	0	0	2	0	0	0	2
Antenatal Clinic	0	0	2	0	0	0	0	0	2
Day Clinical Centre	0	0	0	0	1	0	0	0	1
Discharge Lounge	0	0	0	0	1	0	0	0	1
Early Pregnancy Problem Clinic	0	0	0	0	0	2	0	0	2
Female Medical, Level 5	0	0	0	0	1	0	0	0	1
General Male Medical, Level 5	0	0	0	0	2	0	0	0	2
Male Surgical/HDU	0	3	0	3	0	0	0	0	6
Stroke / Rehab	0	0	0	0	1	3	0	0	4
Theatre	0	0	0	0	0	2	0	0	2
Totals:	14	8	11	3	34	12	10	14	106

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

Ref	Date Received (Complainants - All dates)	Division	Site	Loc (Exact)	Subjects (Subjects)	Staff types (Subjects)	Description	Outcome	Replied done (Complainants - All dates)	Response time
AS208.16/17	21/09/2016	SEC	Craigavon Area Hospital	Gastroenterology Clinic	Communication/Information	Non Staff	Irrelevant information redacted by the USI		26/09/2016	3
AS192.16/17	13/09/2016	SEC	Daisy Hill Hospital	Theatre	Communication/Information	Medical and Dental				51
AS160.16/17	23/08/2016	IMWH	Craigavon Area Hospital	Delivery Suite, CAH	Communication/Information	Nursing and Midwifery			26/09/2016	23
AS39.16/17	06/05/2016	IMWH	Craigavon Area Hospital	Gynae Clinic	Communication/Information	Medical and Dental			18/05/2016	8
AS143.16/17	10/08/2016	MUC	Daisy Hill Hospital	Female Medical, Level 5	Communication/Information	Nursing and Midwifery			18/10/2016	48
AS159.16/17	23/08/2016	IMWH	Craigavon Area Hospital	Delivery Suite, CAH	Communication/Information	Nursing and Midwifery			20/09/2016	19
AS168.16/17	25/08/2016	MUC	Craigavon Area Hospital	2 South Medical	Communication/Information	Nursing and Midwifery			07/10/2016	30
AS156.16/17	24/08/2016	IMWH	Community	John Mitchel Place, HSSC	Communication/Information	Non Staff			12/09/2016	12
AS99.16/17	27/06/2016	SEC	Craigavon Area Hospital	4 North	Communication/Information	Medical and Dental			17/08/2016	36
AS99.16/17	07/11/2016	SEC		4 North	Communication/Information	Medical and Dental				36

Ref	Date Received (Complainants - All dates)	Division	Site	Loc (Exact)	Subjects (Subjects)	Staff types (Subjects)	Description	Outcome	Replied done (Complainants - All dates)	Response time
AS35.16/17	05/05/2016	SEC	Craigavon Area Hospital	Oncology Clinic, Mandeville Unit	Communication/Information	Medical and Dental	Irrelevant information redacted by the USI		11/07/2016	46
AS246.16/17	02/11/2016	IMWH	Craigavon Area Hospital	Fertility Clinic	Communication/Information					0
AS246.16/17	02/11/2016	IMWH	Craigavon Area Hospital	Antenatal Clinic	Communication/Information	Administrative and Clerical				0
AS274.16/17	25/11/2016	IMWH	Craigavon Area Hospital	Delivery Suite, CAH	Communication/Information	Medical and Dental				0
AS88.16/17	08/06/2016	CSCG	Craigavon Area Hospital	The Maples	Communication/Information	Administrative and Clerical			05/07/2016	19
AS24.16/17	22/04/2016	IMWH	Craigavon Area Hospital	Admissions/ Assessment Unit	Communication/Information	Nursing and Midwifery			18/07/2016	58
AS148.16/17	11/08/2016	SEC	Craigavon Area Hospital	Orthopaedic Clinic	Communication/Information	Nursing and Midwifery			16/09/2016	25
AS182.16/17	07/09/2016	CCS	Craigavon Area Hospital	X-ray Dept (Radiology)	Communication/Information	Nursing and Midwifery			14/10/2016	27
AS182.16/17	07/09/2016	CCS	Craigavon Area Hospital	X-ray Dept (Radiology)	Communication/Information	Administrative and Clerical			14/10/2016	27
AS240.16/17	25/10/2016	SEC	Craigavon Area Hospital	3 South	Communication/Information	Medical and Dental				0
AS217.16/17	29/09/2016	IMWH	Daisy Hill Hospital	Early Pregnancy Problem Clinic	Communication/Information	Medical and Dental				0
AS131.16/14	02/08/2016	SEC	Craigavon Area Hospital	Orthopaedic Clinic	Communication/Information	Nursing and Midwifery			15/08/2016	9
AS81.16/17	14/06/2016	FSS	Craigavon Area Hospital	Switchboard	Communication/Information	Non Staff			28/06/2016	10

Ref	Date Received (Complainants - All dates)	Division	Site	Loc (Exact)	Subjects (Subjects)	Staff types (Subjects)	Description	Outcome	Replied done (Complainants - All dates)	Response time
AS194.16/17	14/09/2016	MUC	Daisy Hill Hospital	Stroke / Rehab	Communication/Information	Social Services	Irrelevant information redacted by the USI		13/10/2016	21
AS134.16/17	02/08/2016	MUC	Craigavon Area Hospital	2 North Resp/Medical	Communication/Information	Nursing and Midwifery			22/09/2016	35
AS134.16/17	25/10/2016	MUC		2 North Resp/Medical	Communication/Information	Nursing and Midwifery				35
AS67.16/17	08/06/2016	IMWH	Craigavon Area Hospital	Colposcopy Clinic	Communication/Information	Administrative and Clerical			01/08/2016	81
AS67.16/17	08/08/2016	IMWH		Colposcopy Clinic	Communication/Information	Administrative and Clerical			03/10/2016	81
AS256.16/17	10/11/2016	MUC	Craigavon Area Hospital	Rheumatology Clinic	Communication/Information	Medical and Dental				0
AS206.16/17	20/09/2016	SEC	Craigavon Area Hospital	3 South	Communication/Information	Medical and Dental	Complainant unhappy with standard of communication in relation to his come in date for insertion of urinary stent. Also concerned at the length of time it took to remove the stent during which he had two severe infections which resulted in two hospital admissions. Complainant suggests that communication between administrative staff and consultants needs improved upon.			0
AS139.16/17	09/08/2016	MUC	Daisy Hill Hospital	General Male Medical, Level 5	Communication/Information	Medical and Dental	Irrelevant information redacted by the USI		04/11/2016	62
AS227.16/17	10/10/2016	CCS	Craigavon Area Hospital	X-ray Dept (Radiology)	Communication/Information	Medical and Dental				0

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

Ref	Date Received (Complainants - All dates)	Division	Site	Loc (Exact)	Subjects (Subjects)	Staff types (Subjects)	Description	Outcome	Replied done (Complainants - All dates)	Response time
AS20.16/17	18/04/2016	CCS	Craigavon Area Hospital	ICU (HDU)	Communication/Information	Medical and Dental	Irrelevant information redacted by the USI		11/05/2016	16
AS172.16/17	30/08/2016	MUC	Craigavon Area Hospital	2 North Haematology	Communication/Information	Non Staff			19/09/2016	41
AS172.16/17	19/10/2016	MUC		2 North Haematology	Communication/Information	Non Staff			26/10/2016	41
AS221.16/17	04/10/2016	FSS	Craigavon Area Hospital	Booking Centre	Communication/Information	Administrative and Clerical			19/10/2016	11
AS276.16/17	28/11/2016	IMWH	Craigavon Area Hospital	Delivery Suite, CAH	Communication/Information	Nursing and Midwifery				0
AS09.16/17	12/04/2016	IMWH	Craigavon Area Hospital	1 East Maternity Antenatal	Communication/Information	Nursing and Midwifery			16/05/2016	23
AS167.16/17	24/08/2016	IMWH	Craigavon Area Hospital	Pre-operative Assessment Clinic	Communication/Information	Medical and Dental				0
AS34.16/17	29/04/2016	FSS	Craigavon Area Hospital	Booking Centre	Communication/Information	Non Staff			18/05/2016	10
AS147.16/17	10/08/2016	FSS	Craigavon Area Hospital	Pain Management Clinic	Communication/Information	Administrative and Clerical			30/08/2016	13
AS243.16/17	01/11/2016	SEC	Independent /Voluntary Sector Locations		Communication/Information	Administrative and Clerical				0
AS155.16/17	18/08/2016	SEC	Craigavon Area Hospital	Pre-operative Assessment Clinic	Communication/Information	Nursing and Midwifery			31/08/2016	8
AS25.16/17	22/04/2016	SEC	Craigavon Area Hospital	General Surgery Clinic	Communication/Information	Nursing and Midwifery			17/05/2016	16

Ref	Date Received (Complainants - All dates)	Division	Site	Loc (Exact)	Subjects (Subjects)	Staff types (Subjects)	Description	Outcome	Replied done (Complainants - All dates)	Response time
AS27.16/17	28/04/2016	MUC	Craigavon Area Hospital	2 South Stroke	Communication/Information	Medical and Dental	[redacted]	Irrelevant information redacted by the USI	21/06/2016	36
AS266.16/17	21/11/2016	IMWH	Craigavon Area Hospital	Gynae Clinic	Communication/Information	Medical and Dental				0
AS96.16/17	23/06/2016	IMWH	Daisy Hill Hospital	Antenatal Clinic	Communication/Information	Medical and Dental			26/09/2016	65
AS261.16/17	17/11/2016	SEC	Craigavon Area Hospital	4 North	Communication/Information	Nursing and Midwifery				0
AS72.16/17	10/06/2016	MUC	Craigavon Area Hospital	Emergency Department	Communication/Information	Medical and Dental			27/07/2016	32
AS234.16/17	19/10/2016	SEC	Craigavon Area Hospital	3 South	Communication/Information	Nursing and Midwifery			28/11/2016	28

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

Acute Services Complaints by Ward/Department and Date Received grouped by Site
Quality of Treatment and Care

	2016 04	2016 05	2016 06	2016 07	2016 08	2016 09	2016 10	2016 11	Total
Craigavon Area Hospital	**8**	**2**	**16**	**3**	**23**	**18**	**6**	**15**	**91**
1 North Cardiology	0	0	0	0	0	0	1	0	1
1 South Medical	0	0	1	0	0	1	0	2	4
CEAW	0	0	0	0	0	1	0	0	1
1 West Gynae	0	0	0	0	1	0	0	0	1
2 North Haematology	1	0	0	0	0	0	0	0	1
2 North Resp/Medical	1	0	0	0	4	0	4	0	9
2 South Medical	0	0	1	0	2	0	0	0	3
2 South Stroke	2	0	2	0	0	0	0	1	5
3 South	0	0	0	0	1	5	0	0	6
4 North	0	2	0	0	0	2	0	2	6
4 South	0	0	1	0	0	3	0	0	4
Admissions/Assessment Unit	3	0	0	0	2	0	0	0	5
Emergency Department	1	0	5	0	3	1	0	3	13
Antenatal Clinic	0	0	1	0	1	0	0	0	2
Dermatology Clinic	0	0	0	0	0	1	0	0	1
Delivery Suite, CAH	0	0	1	0	5	0	0	4	10
ENT Clinic	0	0	0	0	0	1	0	0	1
Gynae Clinic	0	0	1	0	1	0	0	0	2
MAU	0	0	0	2	0	1	1	0	4
Non Trust premises	0	0	2	0	0	0	0	0	2
Orthopaedic Clinic	0	0	0	0	0	1	0	0	1
Orthopaedic Ward	0	0	0	0	0	0	0	1	1
Physiotherapy Inpatient	0	0	0	0	1	0	0	0	1
Pre-operative Assessment Clinic	0	0	0	0	1	0	0	0	1
Theatre	0	0	0	1	0	0	0	1	2
Trauma Ward	0	0	0	0	0	0	0	1	1
Urology Clinic	0	0	0	0	1	0	0	0	1
X-ray Dept (Radiology)	0	0	1	0	0	1	0	0	2
Daisy Hill Hospital	**1**	**0**	**3**	**6**	**9**	**3**	**5**	**1**	**28**
Emergency Department	0	0	1	2	3	1	1	0	8
Day Clinical Centre	0	0	0	1	1	0	0	0	2
Discharge Lounge	0	0	0	0	1	0	0	0	1
Day Procedure/Day Surgery Unit	0	0	0	0	0	0	1	0	1
Delivery Suite, DHH	0	0	0	1	0	0	0	0	1
Female Medical, Level 5	0	0	0	0	1	0	0	0	1
Fracture Clinic	0	0	0	1	0	0	0	0	1
General Surgery Clinic	0	0	0	1	0	0	0	0	1
General Male Medical, Level 5	0	0	2	0	2	0	3	0	7
Menopause Clinic	1	0	0	0	0	0	0	0	1
Paediatric Ward	0	0	0	0	0	0	0	1	1
Stroke / Rehab	0	0	0	0	1	0	0	0	1
Theatre	0	0	0	0	0	2	0	0	2
South Tyrone Hospital	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**1**
Day Procedure/Day Surgery Unit	0	0	0	0	0	0	0	1	1
Totals:	9	2	19	9	32	21	11	17	120

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

Ref	Date Received	Division	Site	Loc (Exact)	Subjects (Subjects)	Staff types (Subjects)	Description	Outcome	Replied	Response time
AS07.16/17	08/04/2016	MUC	Craigavon Area Hospital	2 North Haematology	Quality of Treatment & Care	Nursing and Midwifery	Personal Information redacted by the USI		10/05/2016	21
AS24.16/17	22/04/2016	IMWH	Craigavon Area Hospital	Admissions/Assessment Unit	Quality of Treatment & Care	Nursing and Midwifery			18/07/2016	58
AS27.16/17	28/04/2016	MUC	Craigavon Area Hospital	2 South Stroke	Quality of Treatment & Care	Nursing and Midwifery			21/06/2016	36
AS30.16/17	29/04/2016	IMWH	Daisy Hill Hospital	Menopause Clinic	Quality of Treatment & Care	Non Staff			16/05/2016	10
AS33.16/17	04/05/2016	SEC	Craigavon Area Hospital	4 North	Quality of Treatment & Care	Nursing and Midwifery			23/06/2016	35
AS68.16/17	08/06/2016	IMWH	Craigavon Area Hospital	Emergency Department	Quality of Treatment & Care	Medical and Dental			22/07/2016	31
AS68.16/17	08/06/2016	IMWH	Craigavon Area Hospital	Gynae Clinic	Quality of Treatment & Care	Medical and Dental			22/07/2016	31
AS69.16/17	10/06/2016	IMWH	Craigavon Area Hospital	Delivery Suite, CAH	Quality of Treatment & Care	Medical and Dental			05/09/2016	59
AS75.16/17	13/06/2016	MUC	Craigavon Area Hospital	1 South Medical	Quality of Treatment & Care	Nursing and Midwifery			11/07/2016	20
AS85.16/17	16/06/2016	IMWH	Craigavon Area Hospital	Emergency Department	Quality of Treatment & Care	Medical and Dental			18/07/2016	21
AS89.16/17	21/06/2016	SEC	Craigavon Area Hospital	4 South	Quality of Treatment & Care	Nursing and Midwifery			04/08/2016	31
AS87.16/17	21/06/2016	MUC	Craigavon Area Hospital	2 South Medical	Quality of Treatment & Care	Nursing and Midwifery			24/06/2016	3
AS100.16/17	27/06/2016	MUC	Craigavon Area Hospital	2 South Stroke	Quality of Treatment & Care	Nursing and Midwifery			11/07/2016	10

Ref	Date Received	Division	Site	Loc (Exact)	Subjects (Subjects)	Staff types (Subjects)	Description	Outcome	Replied	Response time
AS100.16/17	27/06/2016	MUC		2 South Stroke	Quality of Treatment & Care	Nursing and Midwifery	Irrelevant information redacted by the USI			10
AS105.16/17	30/06/2016	MUC	Daisy Hill Hospital	General Male Medical, Level 5	Quality of Treatment & Care	Nursing and Midwifery			14/09/2016	52
AS102.16/17	30/06/2016	CCS	Craigavon Area Hospital	Non Trust premises	Quality of Treatment & Care	Non Staff			25/07/2016	16
AS115.16/17	11/07/2016	MUC	Craigavon Area Hospital	MAU	Quality of Treatment & Care	Nursing and Midwifery			03/10/2016	58
AS119.16/17	18/07/2016	SEC	Daisy Hill Hospital	General Surgery Clinic	Quality of Treatment & Care	Medical and Dental			16/09/2016	43
AS117.16/17	18/07/2016	MUC	Daisy Hill Hospital	Emergency Department	Quality of Treatment & Care	Nursing and Midwifery			19/09/2016	44
AS120.16/17	20/07/2016	SEC	Craigavon Area Hospital	Theatre	Quality of Treatment & Care	Medical and Dental			28/10/2016	71
AS121.16/17	20/07/2016	MUC	Daisy Hill Hospital	Day Clinical Centre	Quality of Treatment & Care	Nursing and Midwifery			15/09/2016	40
AS129.16/17	29/07/2016	IMWH	Daisy Hill Hospital	Delivery Suite, DHH	Quality of Treatment & Care	Nursing and Midwifery			05/09/2016	25
AS134.16/17	02/08/2016	MUC	Craigavon Area Hospital	2 North Resp/Medical	Quality of Treatment & Care	Nursing and Midwifery			22/09/2016	35
AS133.16/17	02/08/2016	IMWH	Craigavon Area Hospital	Delivery Suite, CAH	Quality of Treatment & Care	Medical and Dental			27/09/2016	39
AS139.16/17	09/08/2016	MUC	Daisy Hill Hospital	General Male Medical, Level 5	Quality of Treatment & Care	Nursing and Midwifery			04/11/2016	62

Ref	Date Received	Division	Site	Loc (Exact)	Subjects (Subjects)	Staff types (Subjects)	Description	Outcome	Replied	Response time
AS139.16/17	09/08/2016	MUC	Daisy Hill Hospital	Stroke / Rehab	Quality of Treatment & Care	Nursing and Midwifery	Irrelevant information redacted by the USI		04/11/2016	62
AS141.16/17	09/08/2016	SEC	Craigavon Area Hospital	3 South	Quality of Treatment & Care	Nursing and Midwifery	Complainant advises that the side effects of a urology procedure were not explained to him and that he felt embarrassed and humiliated by the way in which the member of staff made him feel.	Head of Urology and Ward Managers to ensure appropriately trained nurses are available to provide stent removal service. Patient due review towards the end of this year.	16/09/2016	27
AS143.16/17	10/08/2016	MUC	Daisy Hill Hospital	Day Clinical Centre	Quality of Treatment & Care	Nursing and Midwifery	Irrelevant information redacted by the USI		18/10/2016	48
AS149.16/17	11/08/2016	MUC	Craigavon Area Hospital	Emergency Department	Quality of Treatment & Care	Medical and Dental			22/09/2016	29
AS154.16/17	15/08/2016	MUC	Daisy Hill Hospital	Emergency Department	Quality of Treatment & Care	Medical and Dental			22/09/2016	27
AS85.16/17	17/08/2016	IMWH		Emergency Department	Quality of Treatment & Care	Medical and Dental				21
AS160.16/17	23/08/2016	IMWH	Craigavon Area Hospital	Delivery Suite, CAH	Quality of Treatment & Care	Nursing and Midwifery			26/09/2016	23
AS159.16/17	23/08/2016	IMWH	Craigavon Area Hospital	Delivery Suite, CAH	Quality of Treatment & Care	Medical and Dental			20/09/2016	19
AS167.16/17	24/08/2016	IMWH	Craigavon Area Hospital	1 West Gynae	Quality of Treatment & Care	Medical and Dental				0
AS167.16/17	24/08/2016	IMWH	Craigavon Area Hospital	Urology Clinic	Quality of Treatment & Care	Medical and Dental				0

Ref	Date Received	Division	Site	Loc (Exact)	Subjects (Subjects)	Staff types (Subjects)	Description	Outcome	Replied	Response time
AS168.16/17	25/08/2016	MUC	Craigavon Area Hospital	2 South Medical	Quality of Treatment & Care	Nursing and Midwifery	Irrelevant information redacted by the USI		07/10/2016	30
AS165.16/17	25/08/2016	IMWH	Craigavon Area Hospital	Admissions/Assessment Unit	Quality of Treatment & Care	Medical and Dental			27/09/2016	22
AS188.16/17	03/09/2016	SEC	Craigavon Area Hospital	Orthopaedic Clinic	Quality of Treatment & Care	Nursing and Midwifery			21/10/2016	35
AS184.16/17	07/09/2016	SEC	Craigavon Area Hospital	CEAW	Quality of Treatment & Care	Nursing and Midwifery				0
AS185.16/17	08/09/2016	SEC	Craigavon Area Hospital	3 South	Quality of Treatment & Care	Medical and Dental				0
AS185.16/17	08/09/2016	SEC	Craigavon Area Hospital	3 South	Quality of Treatment & Care	Nursing and Midwifery				0
AS189.16/17	08/09/2016	SEC	Craigavon Area Hospital	Emergency Department	Quality of Treatment & Care	Medical and Dental				0
AS189.16/17	08/09/2016	SEC	Craigavon Area Hospital	3 South	Quality of Treatment & Care	Medical and Dental				0
AS192.16/17	13/09/2016	SEC	Daisy Hill Hospital	Theatre	Quality of Treatment & Care	Medical and Dental				51
AS193.16/17	14/09/2016	MUC	Craigavon Area Hospital	Dermatology Clinic	Quality of Treatment & Care	Medical and Dental			26/10/2016	30
AS195.16/17	15/09/2016	MUC	Craigavon Area Hospital	MAU	Quality of Treatment & Care	Medical and Dental			11/10/2016	18
AS197.16/17	15/09/2016	MUC	Daisy Hill Hospital	Emergency Department	Quality of Treatment & Care	Nursing and Midwifery			10/10/2016	17

Ref	Date Received	Division	Site	Loc (Exact)	Subjects (Subjects)	Staff types (Subjects)	Description	Outcome	Replied	Response time
AS204.16/17	20/09/2016	MUC	Craigavon Area Hospital	1 South Medical	Quality of Treatment & Care	Nursing and Midwifery	Irrelevant information redacted by the USI		17/10/2016	19
AS204.16/17	20/09/2016	MUC	Craigavon Area Hospital	4 North	Quality of Treatment & Care	Nursing and Midwifery			17/10/2016	19
AS206.16/17	20/09/2016	SEC	Craigavon Area Hospital	3 South	Quality of Treatment & Care	Medical and Dental	Complainant unhappy with standard of communication in relation to his come in date for insertion of urinary stent. Also concerned at the length of time it took to remove the stent during which he had two severe infections which resulted in two hospital admissions. Complainant suggests that communication between administrative staff and consultants needs improved upon.			0
AS205.16/17	20/09/2016	SEC	Craigavon Area Hospital	4 South	Quality of Treatment & Care	Medical and Dental	Irrelevant information redacted by the USI			0
AS205.16/17	20/09/2016	SEC	Craigavon Area Hospital	4 South	Quality of Treatment & Care	Nursing and Midwifery				0
AS211.16/17	23/09/2016	SEC	Craigavon Area Hospital	ENT Clinic	Quality of Treatment & Care	Medical and Dental			06/10/2016	9
AS212.16/17	27/09/2016	CCS	Craigavon Area Hospital	X-ray Dept (Radiology)	Quality of Treatment & Care	Medical and Dental			28/10/2016	24
AS218.16/17	30/09/2016	CCS	Independent/Voluntary Sector Locations		Quality of Treatment & Care	Non Staff			24/10/2016	16
AS222.16/17	05/10/2016	MUC	Craigavon Area Hospital	1 North Cardiology	Quality of Treatment & Care	Medical and Dental			08/11/2016	24
AS226.16/17	10/10/2016	SEC	Daisy Hill Hospital	Day Procedure/Day Surgery Unit	Quality of Treatment & Care	Medical and Dental				0
AS238.16/17	20/10/2016	SEC	Daisy Hill Hospital	General Male Medical, Level 5	Quality of Treatment & Care	Nursing and Midwifery				0
AS195.16/17	20/10/2016	MUC		MAU	Quality of Treatment & Care	Medical and Dental				18
AS105.16/17	24/10/2016	MUC		General Male Medical, Level 5	Quality of Treatment & Care	Nursing and Midwifery				52

Ref	Date Received	Division	Site	Loc (Exact)	Subjects (Subjects)	Staff types (Subjects)	Description	Outcome	Replied	Response time
AS134.16/17	25/10/2016	MUC		2 North Resp/Medical	Quality of Treatment & Care	Nursing and Midwifery	[redacted]			35
AS249.16/17	02/11/2016	SEC	South Tyrone Hospital	Day Procedure/Day Surgery Unit	Quality of Treatment & Care	Non Staff			21/11/2016	13
AS244.16/17	02/11/2016	IMWH	Craigavon Area Hospital	Delivery Suite, CAH	Quality of Treatment & Care	Medical and Dental				0
AS255.16/17	10/11/2016	MUC	Craigavon Area Hospital	2 South Stroke	Quality of Treatment & Care	Nursing and Midwifery				0
6950/1116	11/11/2016		Daisy Hill Hospital	Paediatric Ward	Quality of Treatment & Care	Medical and Dental				0
AS120.16/17	17/11/2016	SEC		Theatre	Quality of Treatment & Care	Medical and Dental			25/11/2016	71
AS261.16/17	17/11/2016	SEC	Craigavon Area Hospital	4 North	Quality of Treatment & Care	Nursing and Midwifery				0
AS267.16/17	22/11/2016	MUC	Craigavon Area Hospital	Trauma Ward	Quality of Treatment & Care	Nursing and Midwifery				0
AS269.16/17	22/11/2016	SEC	Craigavon Area Hospital	Orthopaedic Ward	Quality of Treatment & Care	Nursing and Midwifery				0
AS270.16/17	24/11/2016	MUC	Craigavon Area Hospital	1 South Medical	Quality of Treatment & Care	Nursing and Midwifery				0
AS276.16/17	28/11/2016	IMWH	Craigavon Area Hospital	Delivery Suite, CAH	Quality of Treatment & Care	Medical and Dental				0

Irrelevant information redacted by the USI

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

Directorate of Acute Services
Patient Falls by Site, Location and Month - 01 April 2016 to 30 November 2016

	2016 04	2016 05	2016 06	2016 07	2016 08	2016 09	2016 10	2016 11	Total
Craigavon Area Hospital	**60**	**60**	**56**	**59**	**57**	**46**	**50**	**52**	**440**
1 North Cardiology	3	2	2	4	5	2	4	2	24
1 South Medical	10	13	7	6	15	8	10	2	71
1 West Gynae	1	2	0	0	0	0	1	0	4
2 Medical	0	0	1	0	1	1	1	2	6
2 North Haematology	3	2	1	3	3	2	1	2	17
2 North Resp/Medical	2	3	0	1	0	3	1	0	10
2 South Medical	3	6	4	4	1	3	3	1	25
2 South Stroke	4	3	6	1	4	2	2	2	24
2 West Maternity Post Natal	1	0	0	0	2	1	1	1	6
3 South	5	0	5	1	3	4	2	4	24
4 North	5	5	6	2	1	2	1	6	28
4 South	2	4	1	5	2	0	4	6	24
Admissions/Assessment Unit	0	0	0	0	0	0	0	1	1
Emergency Department	2	6	5	7	3	5	8	5	41
Breast Screening Unit	0	0	0	0	0	0	0	1	1
Car Park/Grounds	0	0	0	0	0	1	0	0	1
Cardiac Catheterisation Lab	1	0	0	0	0	0	0	0	1
Corridor/Stairs	0	0	0	0	0	1	0	0	1
Dermatology Clinic	1	0	0	1	0	0	0	0	2
Day Procedure/Day Surgery Unit	0	0	0	0	0	1	0	0	1
Delivery Suite, CAH	0	0	0	1	0	0	0	0	1
ICU (HDU)	0	0	1	0	0	0	2	0	3
MAU	5	6	12	14	11	6	5	5	64
MRI Unit	0	0	0	0	1	0	0	0	1
General Outpatients Reception/Waiting Area	0	0	0	0	1	0	0	0	1
Orthopaedic Ward	4	3	2	4	1	0	2	2	18
Recovery Unit	1	0	2	0	0	0	0	0	3
Public Toilets	0	0	0	1	0	0	0	0	1
Trauma Ward	3	1	0	3	0	0	0	5	12
Winter Pressures Ward(Ramone)	3	4	0	1	3	4	2	5	22
X-ray Dept (Radiology)	1	0	1	0	0	0	0	0	2
Daisy Hill Hospital	**24**	**17**	**22**	**13**	**10**	**16**	**15**	**16**	**133**
Emergency Department	**0**	**2**	**3**	**0**	**0**	**0**	**0**	**1**	**6**
Coronary Care Ward, Level 5	0	1	2	1	0	0	0	1	5
DEAW	1	1	0	0	0	0	0	0	2
Female Medical, Level 5	3	1	2	2	1	5	3	3	20
Female Surgical/Gynae	4	1	4	2	2	3	0	1	17
General Male Medical, Level 5	3	5	3	3	0	4	4	4	26
Maternity Ward	1	0	0	0	0	0	1	0	2
Male Surgical/HDU	1	3	5	0	3	0	3	0	15
Physiotherapy Outpatients Department	1	0	0	0	0	0	0	0	1
Reception/Waiting Area	0	0	0	0	0	0	0	1	1
Renal Unit	0	0	0	0	0	1	1	1	3
Renal Clinic	1	0	1	0	0	0	0	0	2
Stroke / Rehab	9	3	2	5	4	3	3	4	33
South Tyrone Hospital	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**2**
Minor Injuries Unit	1	0	1	0	0	0	0	0	2
Totals:	85	78	79	72	68	62	65	68	577

Live SAI's under investigation as at 7.12.16

Handler	Level	Datix no	Initials	Div	Incident date	Date screened	Description	Current Stage	Details
PS	1	Personal Information redacted by the USI		MUC	12.4.12	22.7.15	Delay in follow up suspicious X ray Tumour	Under investigation	
PS	1			MUC	22.12.14	11.08.15	IP fall head injury	Needs new chair [redacted] left Trust	Being reviewed for de-escalation
PS	1			SEC	3.4.15	30.9.15	Delay follow up colonoscopy	Not started	for further consideration re possible descalation awaiting image presentation at M&M
CYP	1			MUC	21.1.16	CYP	Out of hopital cardiac arrest	CYP taking lead.	
CC	1			SEC	17.2.16	15.3.16	Missed fracture	Under investigation	Meeting arranged for 20.9.16 @ 9am - going to ACG October 2016 or November 2016
CC	1			MUC	22.1.16	14.3.16	Norovirus in haematology	Meeting being arranged.	Report being drafted
PS	2			MUC	19.5.15	8.6.15	inpatient fall with # NOF, died 2 days later	Report not started	To Be De-escalated
CC	2			MUC	20.12.14	19.1.15 & 26.2.15	Inpatient fall #	Under investigation	RV complete report to be drafted ? Descalation following discussion with [redacted] - report to be written regarding de-escalation.
CC	2			SEC	6.1.16	15.3.16	Missed renal cancer	Under investigation	Not started - time line complete Meeting 10am Tutorial Rm 3
CC	2			SEC	23.12.15		Diabetic adolescent	Meeting being arranged.	It is anticipated report completed by Feb ACG meeting
PS	2			MUC	29.4.16	11.5.16	Carbon monoxide poisoning.	Under investigation	First RCA meeting 22.6.16
	1			MUC	21.1.16	16.5.16	Cardiac arrest post transfer from Belfast	Under investigation	Needs discussion with Dr [redacted]
TR	3			MUC	18.05.16	23.05.16	Fall from stairwell	Under investigation	Letter to be issued to Family. Meeting with family to be arranged. Further meeting to be arranged for Feb
	2			MUC	15.5.16		Thoracic aneurysm - link with RVH	Under investigation	Meeting being arranged
PK	2			IMWH	19.8.16		Unexpected death of baby following breech delivery	Under investigation	
CC	2			OPPC/ Acute	16.2.16		CVA - anticoagulant issues	Under investigation	

Southern Health and Social Care Trust

REPORT SUMMARY SHEET

Meeting: Date:	Governance Committee 8th December 2016
Title:	Clinical & Social Care Governance Report to Governance Committee
Lead Director:	Dr Richard Wright – Medical Director
Corporate Objective:	Safe, high quality care
Purpose:	To provide assurance to Trust Governance Committee regarding directorate management of: • Adverse Incidents • Complaints

Summary of Key Issues for Governance Committee

High level context:

- Overview of trends in adverse incident reporting YTD 23rd November 2016
- Overview of trends in complaints management including regional peer comparison data
- Update on key patient safety initiatives that support governance data YTD 30th September 2016

Key issues/risks for discussion:

- Update on Regional Patient Safety Programme
- Trust review of Adverse Incident Processes
- Trust Complaints Categorisation

Summary of SMT challenge/discussion:

SMT requested the following in future reports:

Section 1: Incident Management – Incidents relating to Verbal abuse and Physical abuse should include a breakdown of those affected ie: staff or service user.

Governance Committee requested the following in future reports:

A high level summary of the SAIs reported in 2016/17 i.e. what these were; where they occurred and learning / improvements as a result for assurance.

Number of outstanding SAIs and contributory factors preventing compliance with timescales.

Internal/External Engagement:

- Senior Management Team
- Directorate Governance Coordinators

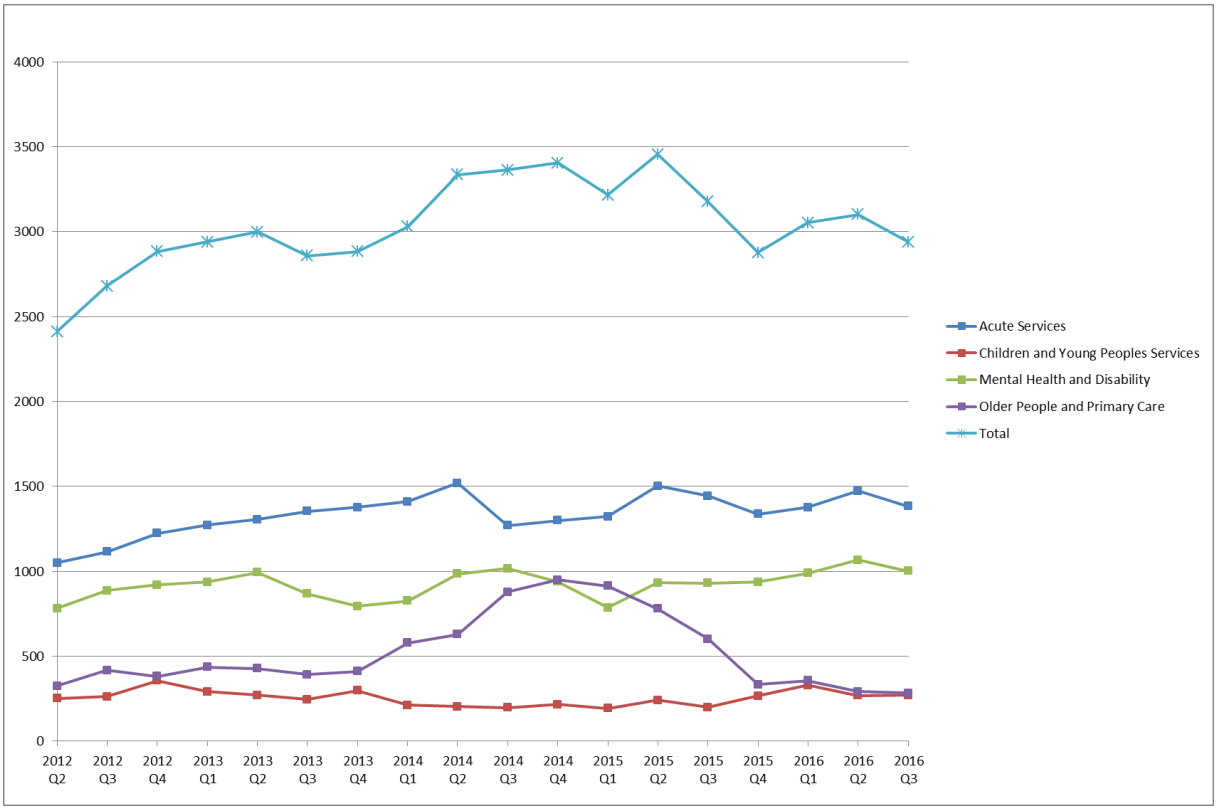
Section 1 Incident Management

1.1 Trust Overall Incident Figures

The consistent identification, monitoring and review of incidents is central to the Trust's strategic and operational processes to ensure it can achieve its vision for safe and effective care. During the period April 2012 – September 2016 there have been a total of 54,830 incidents reported throughout all directorates. The Trust has promoted the importance of incident reporting to staff as a means of learning and quality improvement.

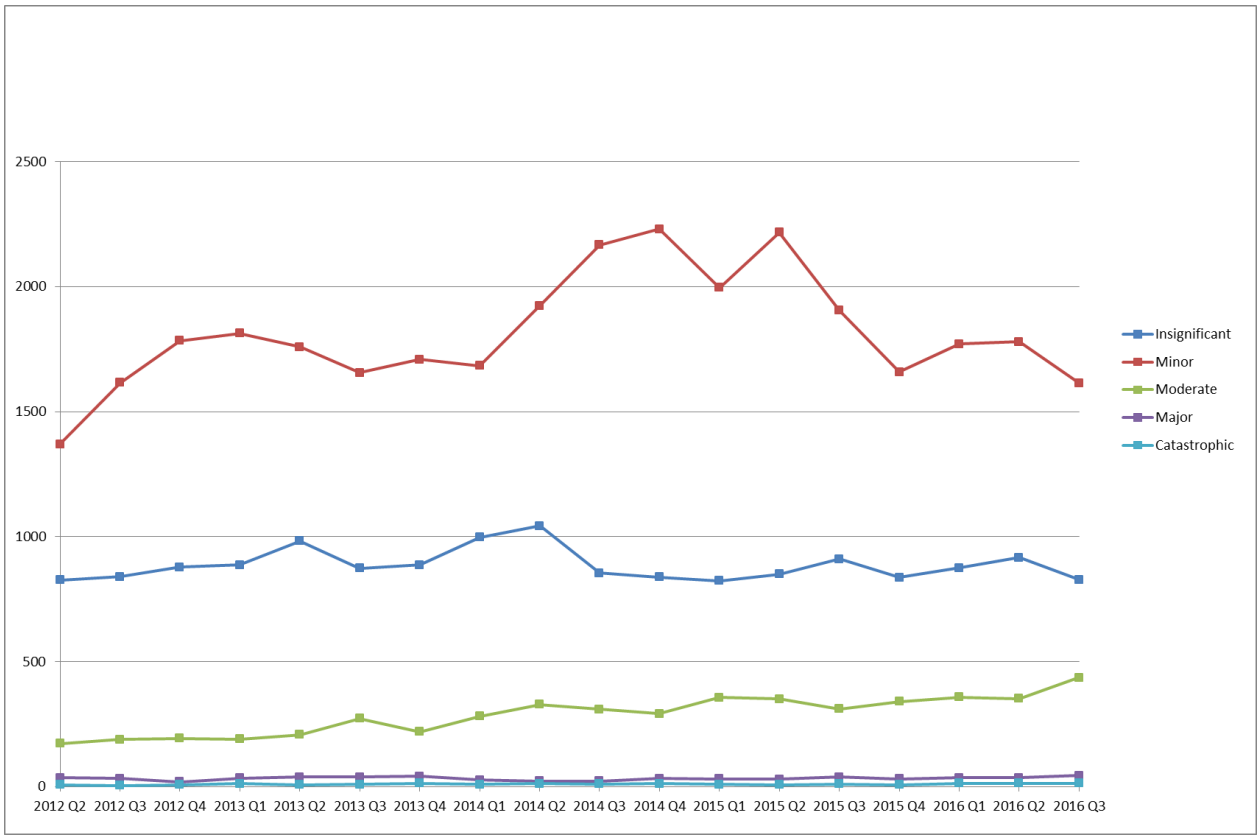
Figure 1.1.1 demonstrates a slight increase in incident reporting over the period (Q2 2012 – Q3 2016). Figure 1.1.2 shows that the increase in reporting can be attributed to incidents that fall within minor severity grading.

1.1.1 Total No of Incidents Reported Over Time by Care Directorates for Time Period: 01 April 2012 – 30 September 2016



**Quarter April - September 2016 has not shown any significant change in the profile of Incidents*

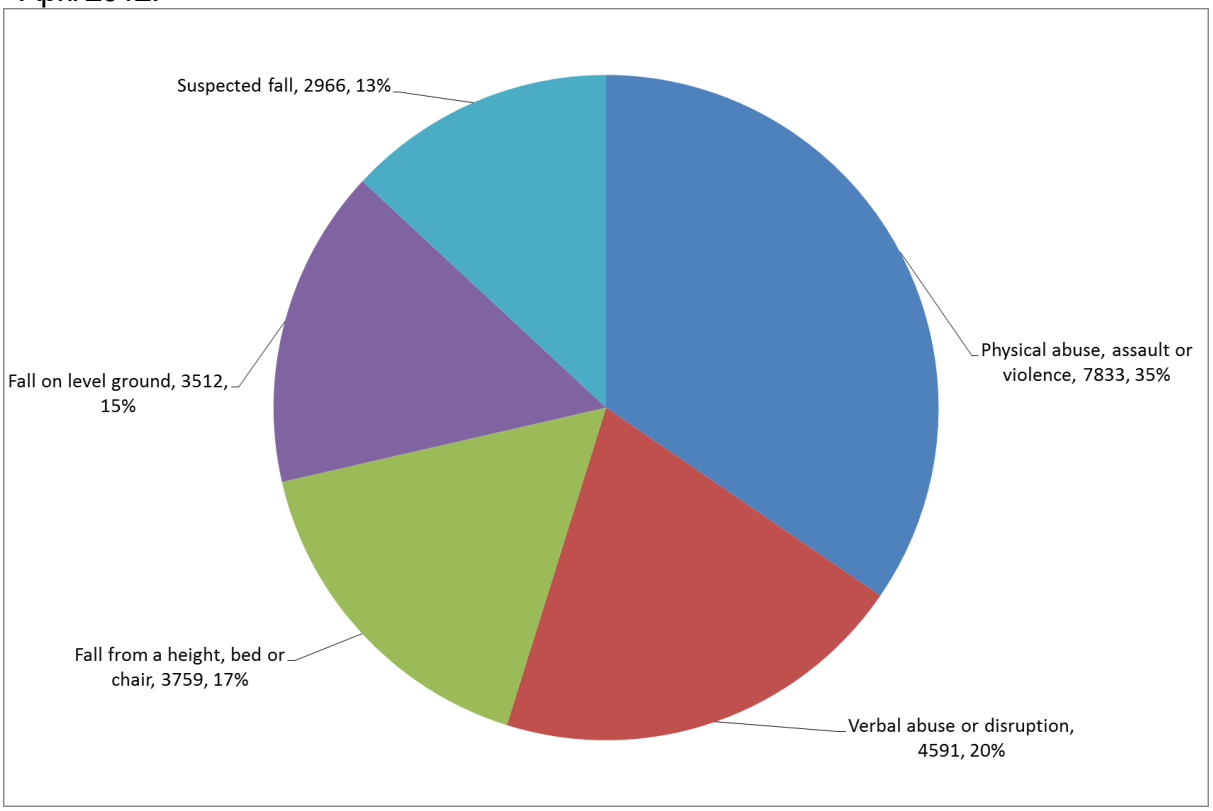
1.1.2 Total No. of Incidents by Severity Grading (Actual Harm) Over Time for Time Period: 01 April 2012 – 30 September 2016



**Quarter April - September 2016 has not shown any significant change in the severity of Incidents*

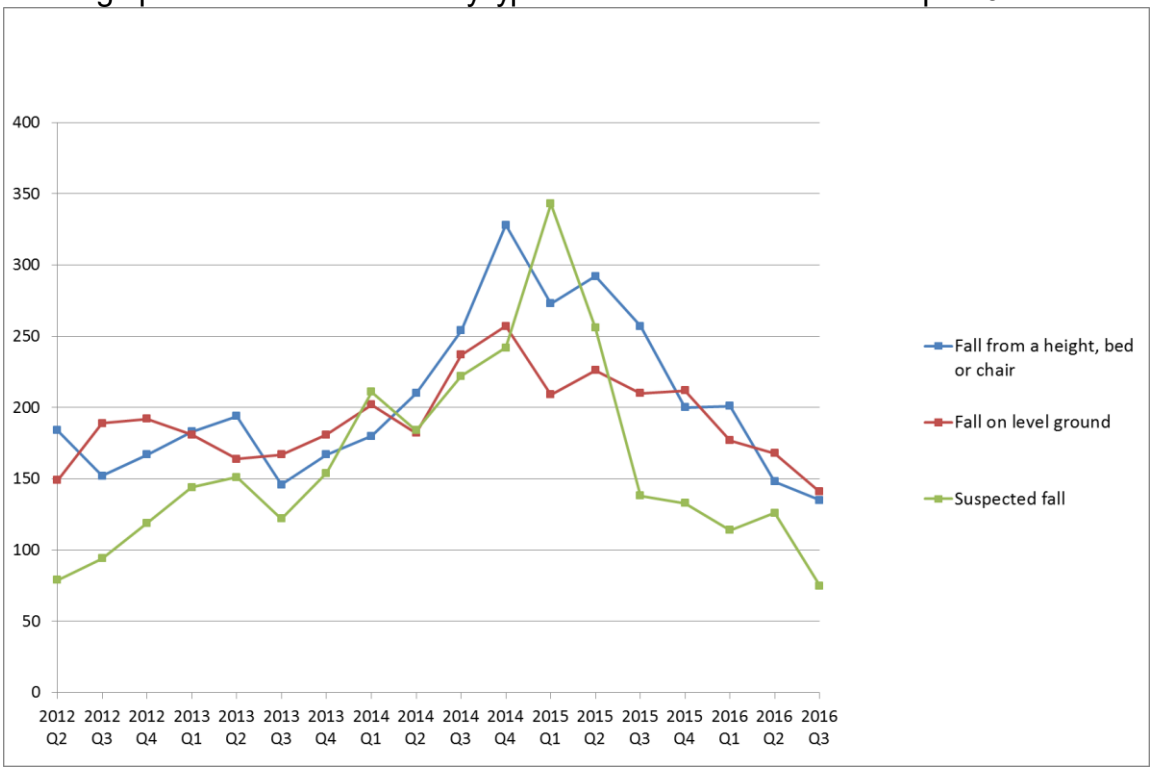
1.1.3 Top 5 Incident Types

The below graph shows a breakdown of the top 5 incident categories recorded on Datix since 1st April 2012.



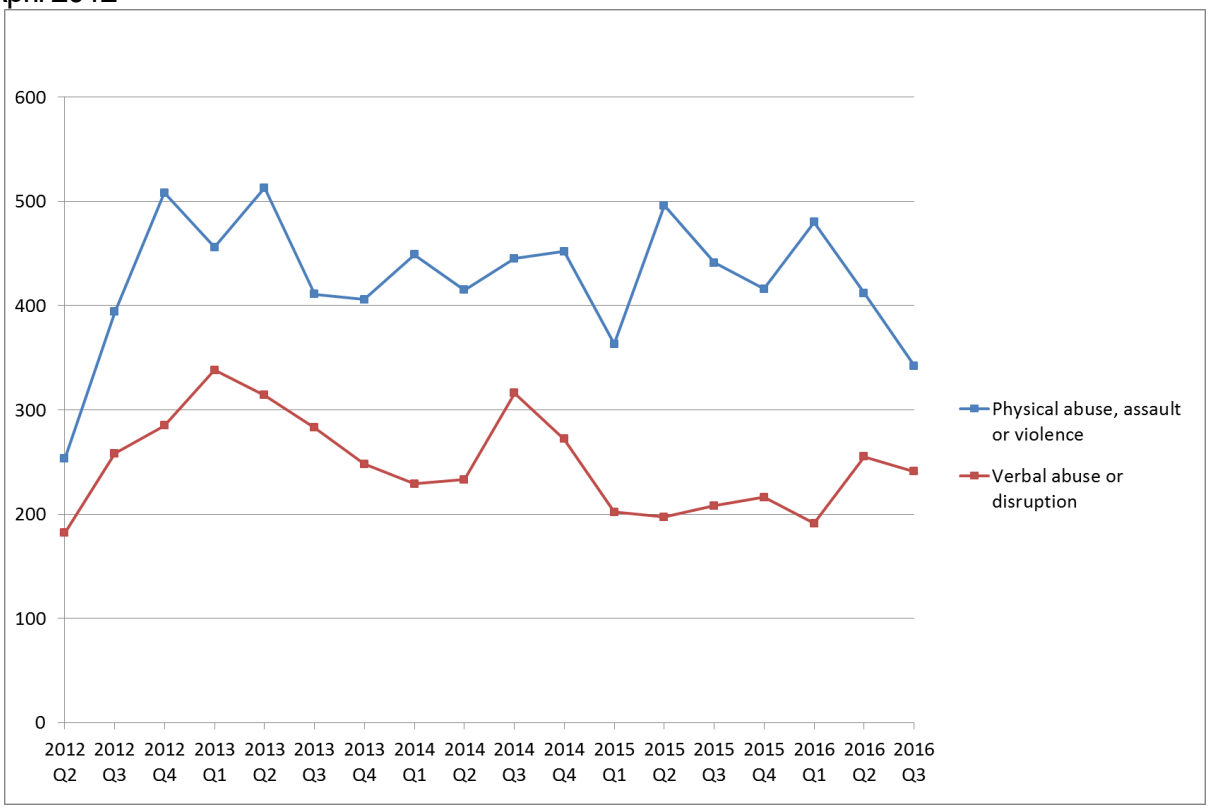
1.1.4 Falls Incidents

The below graph details falls incidents by type recorded on Datix since 1st April 2012



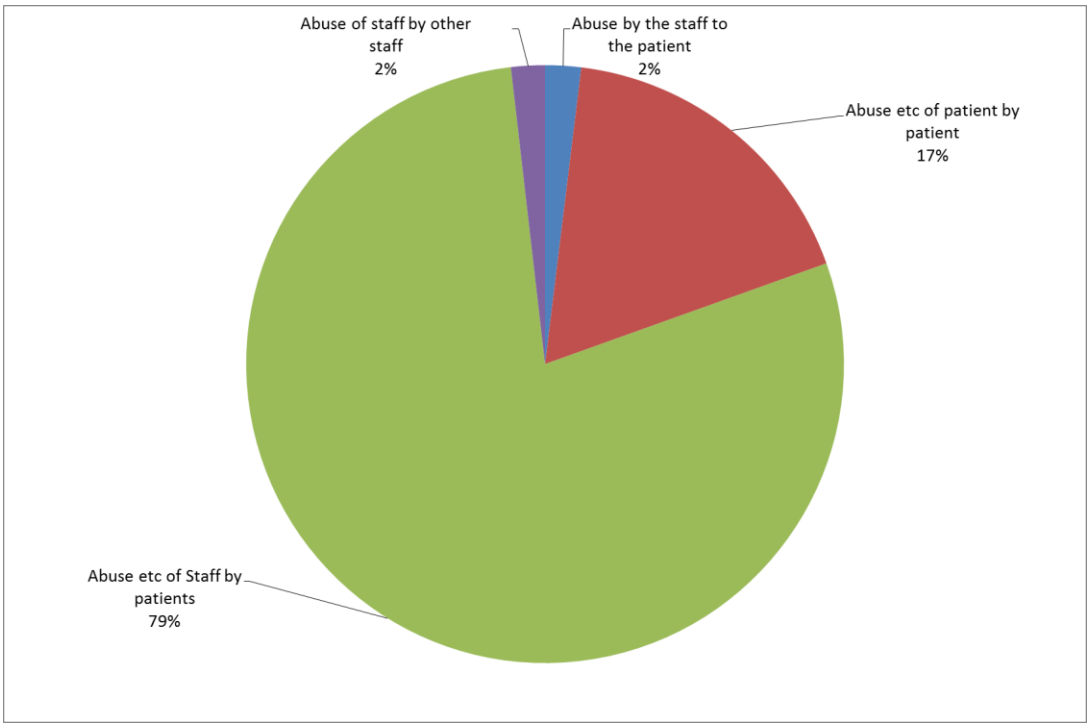
1.1.5 Physical and Verbal Abuse Incidents

The below graph details physical and verbal abuse incidents by type recorded on Datix since 1st April 2012



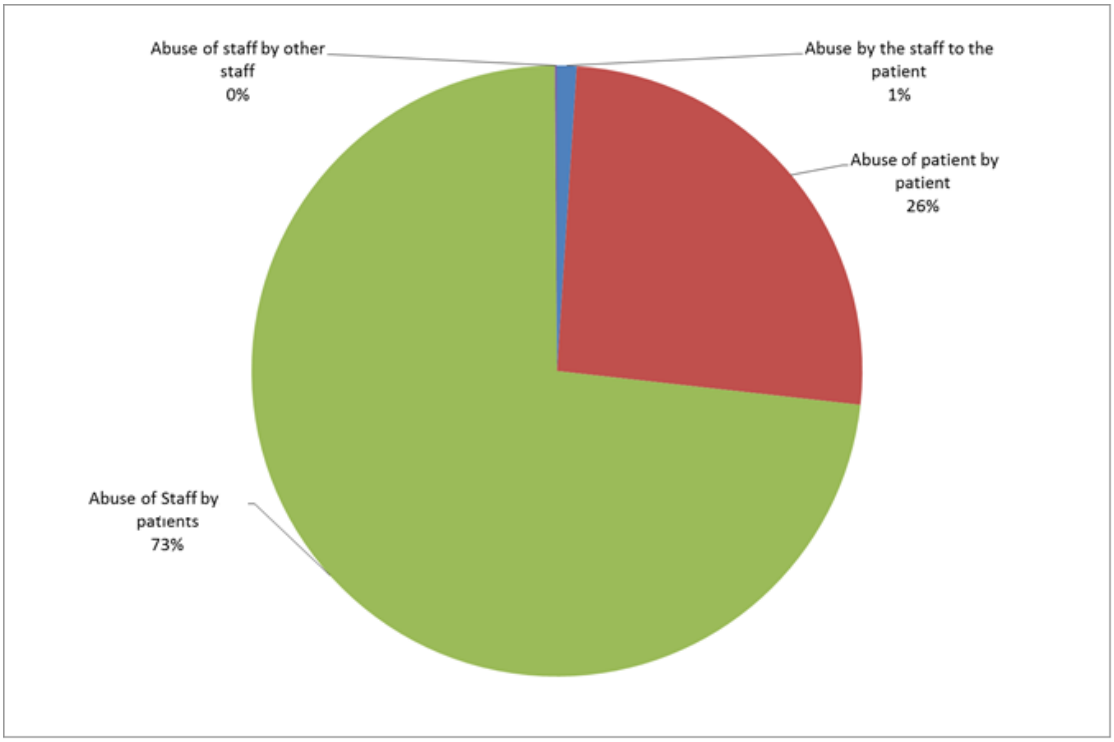
1.1.6 Verbal Abuse Incidents

The below graph details verbal abuse incidents by type recorded on Datix since 1st April 2012



1.1.7 Physical Abuse Incidents

The below graph details physical abuse incidents by type recorded on Datix since 1st April 2012



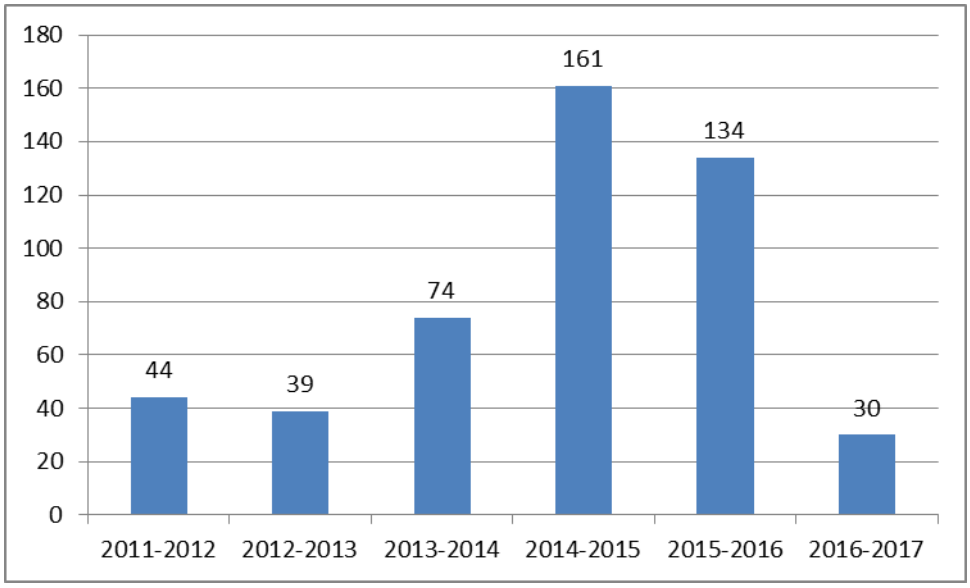
1.2 Serious Adverse Incidents

Since 1st April 2012 – 30th September 2016 the Trust has reported 54,830 incidents. Since 1st April 2012 – YTD 23rd November 2016 some **482** adverse incidents have met the Serious Adverse Incident (SAI) criteria as the set by the HSCB. This number equates to (0.9%) of all adverse incidents reported via the Trust Incident Management system.

1.2.1 Breakdown of number of SAIs reported by directorate by Financial Year (YTD 23rd November 2016)

Directorate	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	Grand Total
Acute	12	8	18	45	54	10	147
CYPS	9	6	9	19	21	2	66
MH&LD*	20	21	28	35	17	17	138
OPPC	3	4	19	62	42	1	131
Grand Total	**44**	**39**	**74**	**161**	**134**	**30**	**482**

1.2.2 Breakdown of SAIs Reported by Financial Year (2011/12 to 2016/17 YTD 23rd November 2016)



Timescales for the completion of Serious Adverse Incidents

These are set out by the HSCB as follows:

Level 1 SAI investigations - 6 weeks

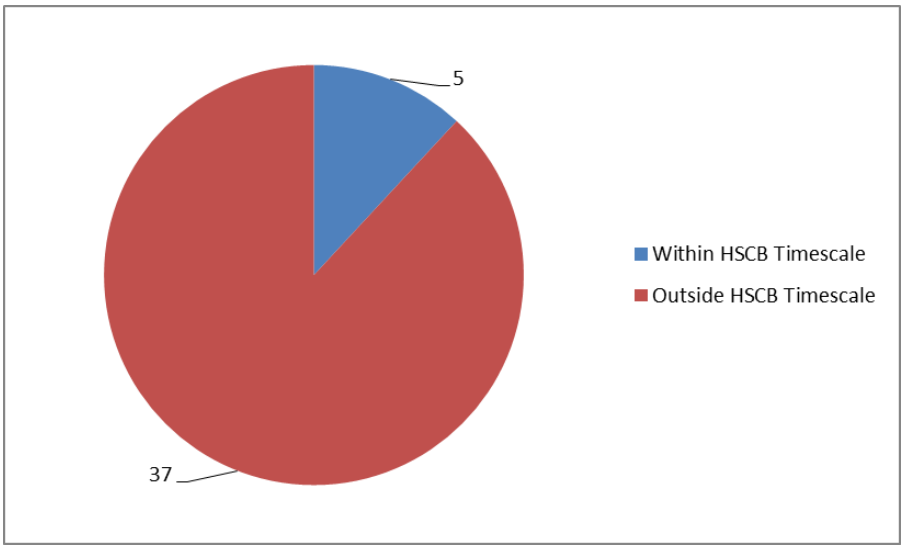
Levels 2 & 3 investigations – 12 weeks

Presently there are 42 SAI investigations currently being progressed within SHSCT, of which 5 are within the HSCB timescales for submission as outlined in figure 1.2.3. There are a number of contributory factors set out below which influence the timescales of completion of SAI reports within the timescales identified in the HSCB Serious Adverse Incident Procedures.

- Appropriate Team configuration to ensure appropriate level of clinical independence and expertise
- The prioritisation of SAI investigations within existing workloads
- Necessary engagement with service users and their families, particularly where a death has occurred
- Where the SAI investigation spans across 2 or more Trusts

In order to minimise the risk of delay in implementing immediate learning due to investigations not being completed within HSCB timescales, all adverse incidents that meet or have the potential to meet the SAI criteria are subject to an internal screening process. Incidents are screened by the appropriate Assistant Director, Associate Medical Director and Governance Co-ordinator. This process ensures areas of immediate learning resulting from incidents are identified and acted on immediately and shared with Service Users, the DHSSPSNI and HSCB through the Early Alert system as appropriate.

1.2.3 Numbers of SAI Investigations - Completed v Non Completed within HSCB timescales (YTD 23rd November)



1.2.4 Categorisation of SAIs 1st April 2011 – 23rd November 2016*

SAIs have been categorised according to a framework presented by Donaldson et al (2012). The use of this reporting framework will allow for trend analysis over time and identification of areas for service improvement.

Area of Service	Incident Type	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	Total
Checking and oversight	Medication	0	0	1	1	0	0	2
	Test results	0	0	2	9	4	0	15
Equipment Related	Necessary Equipment Misused or misread by practitioner	4	0	2	1	0	0	7
	Necessary equipment not available	0	0	0	1	0	0	1
Prevention	Inpatient falls	0	1	3	6	5	0	15
Management of deterioration	Acting on or recognising deterioration	6	6	7	12	9	0	40
	Giving ordered treatment/support in a timely way	0	1	0	0	2	0	3
	Observe / review	0	0	0	6	6	1	13
No Area of Service Failure	No Area of service failure (a large number of these investigations were of expected child deaths and suicides)	29	26	39	58	50	8	210
Other	Other	4	5	9	16	4	0	38
SAI investigation in progress	SAI investigation in progress	0	0	0	2	19	21	42
N Home Falls	Not yet included in categorisation	1	0	11	49	35	0	96
Grand Total		**44**	**39**	**74**	**161**	**134**	**30**	**482**

**Classified according to Donaldson, Liam J., Sukhmeet S. Panesar, and Ara Darzi. "Patient-safety-related hospital deaths in England: thematic analysis of incidents reported to a national database, 2010–2012." (2014): e1001667.*

Section 2 Patient Safety

There are a number of work streams that are in progress to implement the recommendations of SAIs as categorised in the previous section. Two key patient safety programmes that focus on improving practice in the management of falls and the use of early warning scores for deteriorating patients are progressed through the Trust as part of the Regional Patient Safety Programme. It should be noted that there is variation on how each Trust undertakes audit, therefore any regional comparisons should be guarded. It has not been possible to present Regional Quarter 3 Comparisons in this quarter's report, as regional data is not yet available to the Trust.

2.1 Falls

2.1.1 Falls Prevention Programme

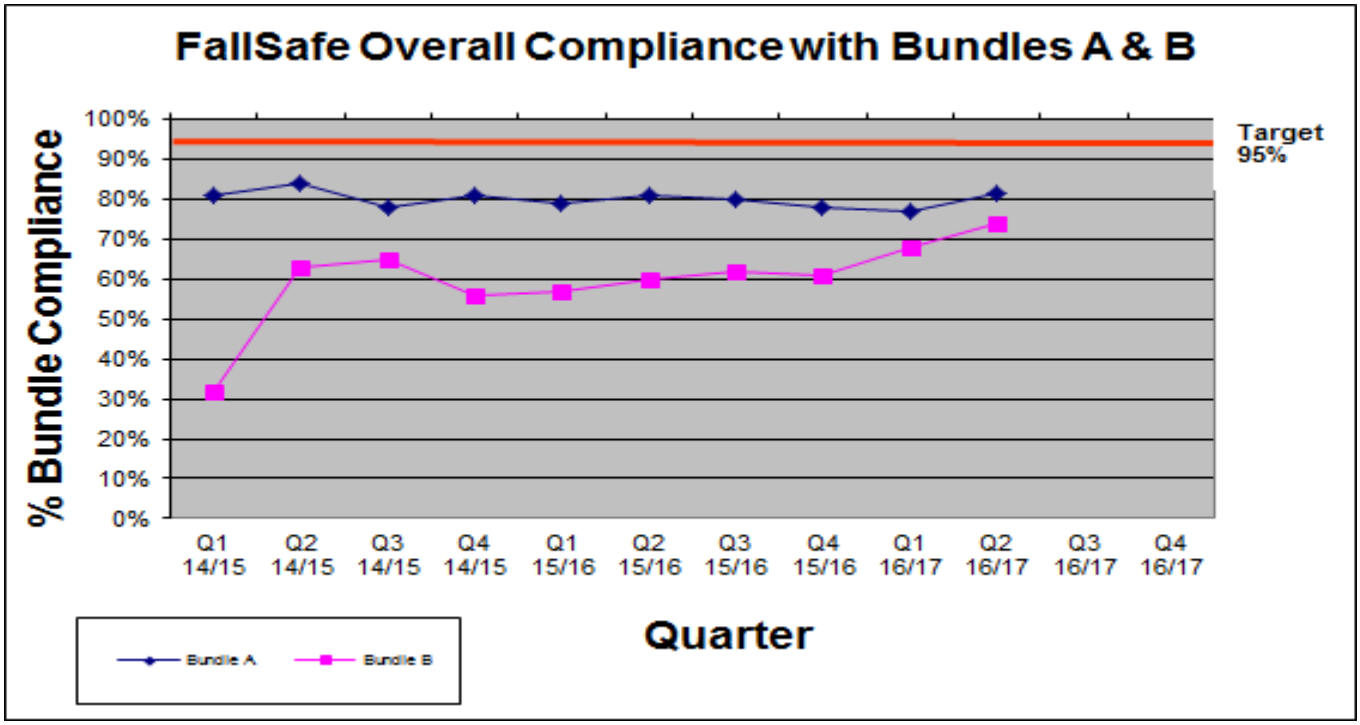
The regional falls prevention work is ongoing and focuses on compliance with seven elements of the Royal College of Physicians FallSafe Bundle A (for all patients) and three elements of FallSafe Bundle B (for patients over 65 years).

2.1.2 Outcome Measures

The outcome measure of this work is to monitor falls incidents rate per 1,000 Occupied Bed Days and those which cause moderate or more severe harm. Table 2.1.3 sets out the Trust's overall compliance with FallSafe Bundles A & B and the associated falls and injury rates in the same period based on 26 wards across the Trust.

.

2.1.3 Trust Data Quarter 2 2016/17:



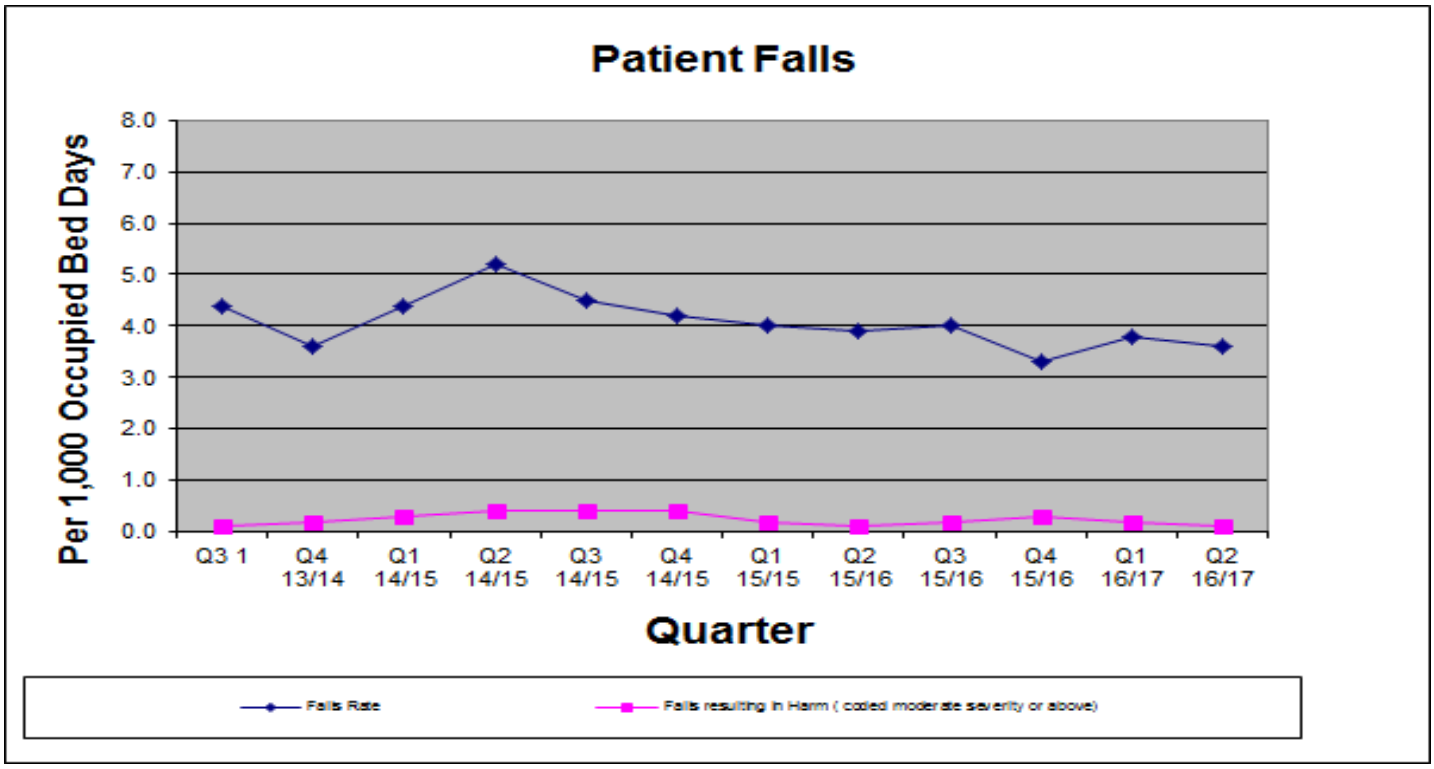
2.1.3 Regional Comparison of Bundle Compliance Quarter 1 2016/17

Falls Bundle A

Southern Trust	**77%**
Western Trust	95%
South Eastern Trust	82%
Northern Trust	71%
Belfast Trust	39%

Falls Bundle B

Southern Trust	**68%**
Western Trust	94%
South Eastern Trust	80%
Northern Trust	66%
Belfast Trust	48%



2.1.4 Regional Comparison of Patient Falls Quarter 1 2016/17

Total Falls per 1,000 Bed Days

Southern Trust	**3.8**
Western Trust	5.2
South Eastern Trust	6.3
Northern Trust	6.7
Belfast Trust	3.7

Falls resulting in harm (moderate severity or above) per 1,000 Occupied Bed Days

Southern Trust	**0.2**
Western Trust	0.1
South Eastern Trust	0.1
Northern Trust	0.2
Belfast Trust	0.1

Summary:

All elements of FallSafe Bundle A, with the exception of urinalysis have achieved compliance of 99% or greater in Q2 2016/17. In line with other Trusts, undertaking urinalysis or documentation of contraindication when urinalysis is not done, is still proving to be challenging.

- Overall Compliance with the three elements of Bundle B has shown a steady increase over the past 3 quarters.
- The Trust's Falls Rate has declined since Q2 2014/15.

2.2 National Early Warning Scores (NEWS)

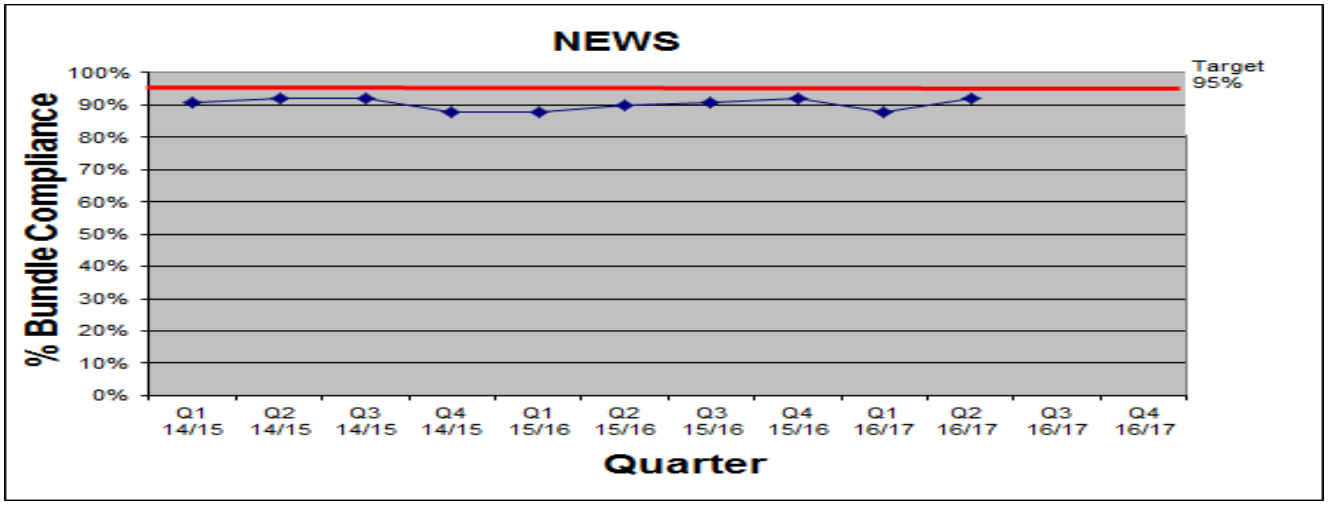
2.2.1 Regional NEWS Compliance

Early Warning Scores have been developed to facilitate early detection of deterioration by categorising a patient's severity of illness and prompting nursing staff to request a medical review at specific trigger points utilising a structured communication tool while following a definitive escalation plan. The Public Health Agency Quality Improvement Plan Framework for 2016/17 requires Trusts to achieve 95% compliance with a Trust NEWS Bundle.

2.2.2 Process Measure

To achieve 95% compliance with the NEWS Bundle on all appropriate wards across the Trust by March 2017.

2.2.3 Trust Data Quarter 2 2016/17:



Regional Comparison Quarter 1 2016/17:

Southern Trust	**88%**
Western Trust	94%
South Eastern Trust	84%
Northern Trust	92%
Belfast Trust	97%

Summary:

- This Quality Improvement initiative remained on the PHA Quality Improvement Plan Framework for 2016/17
- The focus for the Region is on appropriate escalation and a separate audit in respect to same is on-going

2.3 Pressure Ulcers

Regional Improvement Work on Pressure Ulcers began in the summer of 2011 with the introduction of the SKIN Care Bundle.

Commissioning Plan Priorities 2016/17:

2.3.1 Process Measure:

Compliance with SKIN Care Bundle

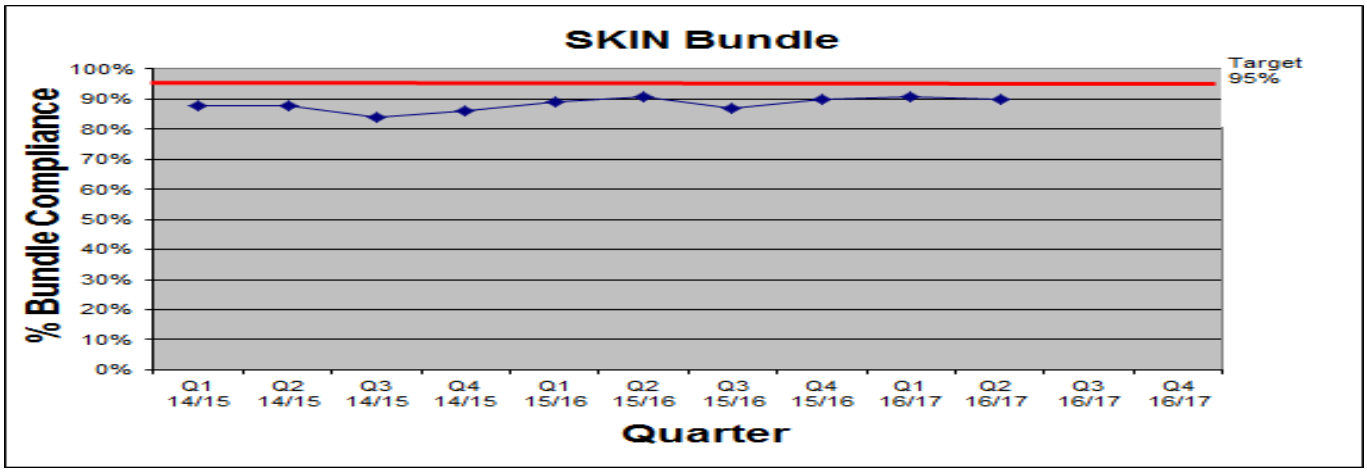
2.3.2 Outcome Measures:

- Number of Grade 2 & above Ward Acquired Pressure Ulcers and Rate per 1,000 Occupied Bed Days

- Number of Grade 3 & 4 Ward Acquired Pressure Ulcers

- Number of Grade 3 & 4 Ward Acquired Pressure Ulcers which were unavoidable

Trust Data Q2 2016/17:



Regional Comparison Q1 2016/17:

- **Bundle Compliance**

Southern Trust	**91%**
Western Trust	95%
South Eastern Trust	80%
Northern Trust	91%
Belfast Trust	96%

- **Rate & Number of Grade 2 and above Pressure Ulcers (per 1,000 Occupied Bed Days)**

Southern Trust	**0.70 (50)**
Western Trust	0.85 (60)
South Eastern Trust	0.44 (33)
Northern Trust	0.58 (44)
Belfast Trust	0.50 (78)

- **Rate & Number of Grade 3 & 4 Pressure Ulcers (per 1,000 Occupied Bed Days)**

Southern Trust	**0.06 (4)**
Western Trust	0.09 (6)
South Eastern Trust	0.15 (11)
Northern Trust	0.17 (13)
Belfast Trust	0.13 (21)

- **Rate & Number of Avoidable Grade 3 & 4 Pressure Ulcers**

Southern Trust	**0.06 (4)**
Western Trust	0.03 (2)
South Eastern Trust	0 (0)
Northern Trust	0.13 (10)
Belfast Trust	0.03 (5)

NB: As the is variation on how each Trust undertakes the RCA, comparisons should be guarded

Summary:

- The focus for the Region is on Grade 3 & 4 Ward Acquired Pressure Ulcers and those which are avoidable.
- From April 2015 an RCA is now carried out on all Grade 3 & 4 Ward Acquired Pressure Ulcers. A review of RCAs is undertaken at the bi-monthly Quality Improvement Team Meeting with Lead Nurses, feeding Learning Points back to colleagues via Ward Manager's Meeting.

2.4 Venous Thromboembolism (VTE)

Regional Improvement Work on VTE began 2009/10.

Commissioning Plan Priority 2016/17:

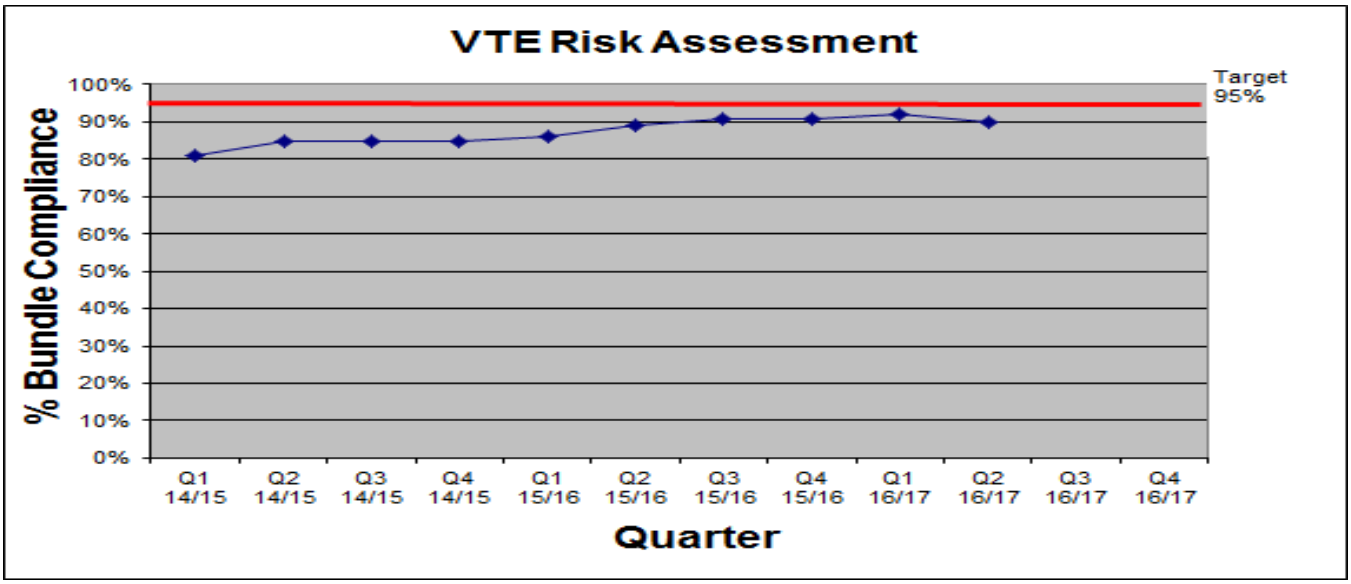
2.4.1 Process Measure:

To improve compliance with VTE Risk Assessment across all inpatient wards to achieve 95% compliance by March 2017

2.4.2 Outcome Measure:

Trust data below

Trust Data Q2 2016/17:



Regional Comparison Q1 2016/17:

Southern Trust	**92%**
Western Trust	85%
South Eastern Trust	93%
Northern Trust	90%
Belfast Trust	91%

Summary:

- The revised Audit commenced on all applicable wards across the Trust during 2014/15
- To aid compliance the Regional agreed VTE Risk Assessment has been included in the new Kardex
- Q2 2016/17 saw first dip in compliance since Q3 2015/16
- Non-Acute Wards saw compliance increase to 99.5% in Q2 2016/17

2.5 Malnutrition Universal Screening Tool MUST

This appeared on the PHA Quality Improvement Plan Framework for the first time last year.

Commissioning Plan Priority 2016/17:

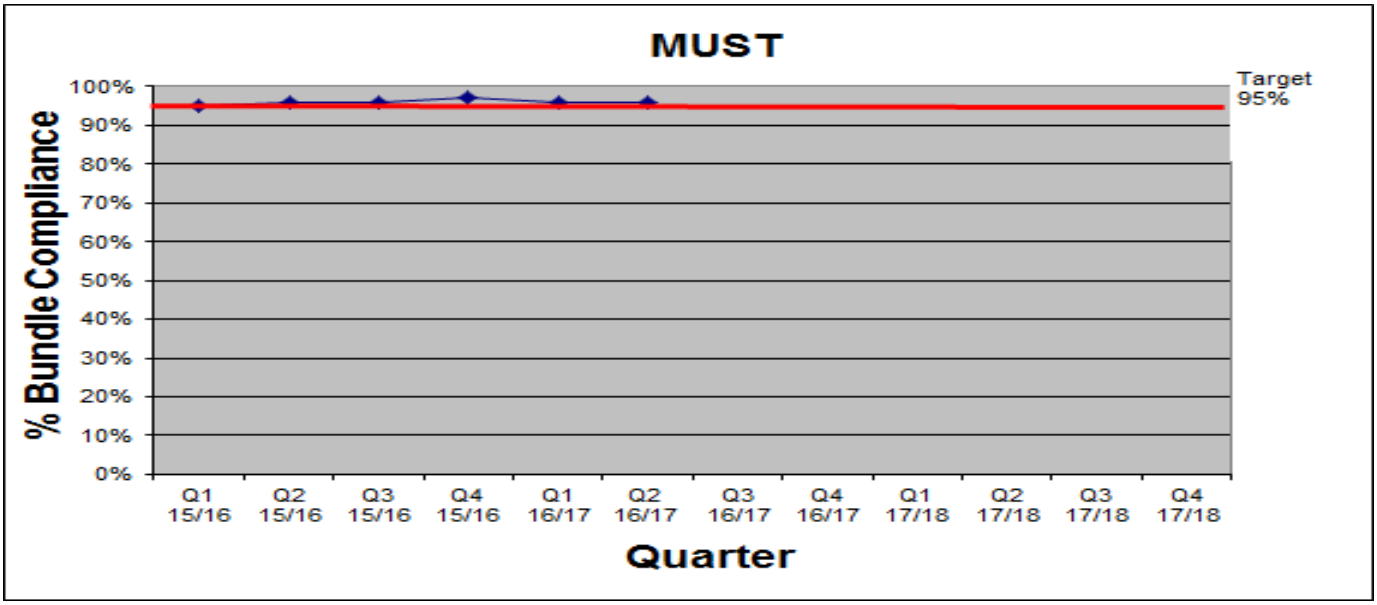
2.5.1 Process Measure:

To achieve 95% compliance with the completion of the MUST Tool within 24 hours of admission on all appropriate wards across the Trust by March 2017

2.5.2 Outcome Measure:

N/A

Trust Data Q2 2016/17:



Regional Comparison Quarter 1 2016/17:

Southern Trust	**96%**
Western Trust	95%
South Eastern Trust	97%
Northern Trust	91%
Belfast Trust	89%

Summary:

- Data collection began in April 2015
- Goal has been achieved in all 6 quarters since measurement commenced

2.6 Omitted & Delayed Medicines

This appeared on the PHA Quality Improvement Plan Framework for the first time last year.

Commissioning Plan Priority 2015/16: (wording for 2016/17 is still be to finalised)

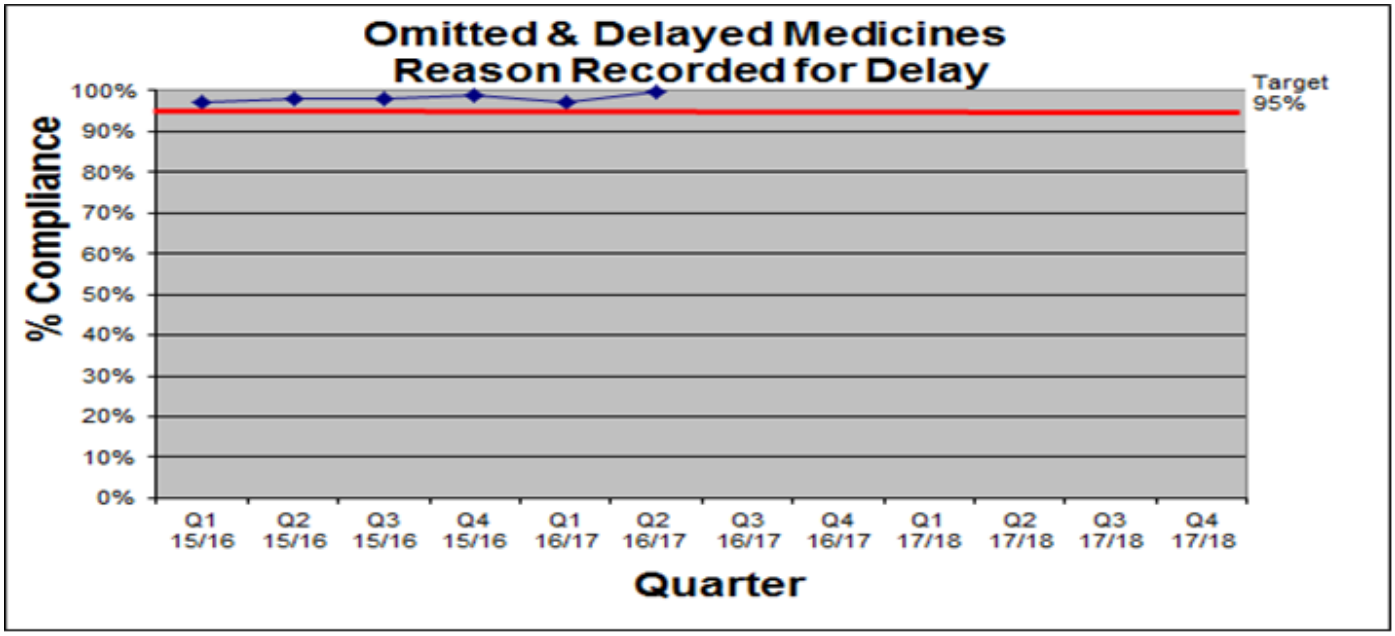
2.6.1 Process Measure:

Trusts should "demonstrate improvement in compliance with the reduction in omission of recording delay, to establish baseline measure by March 2016

2.6.2 Outcome Measure:

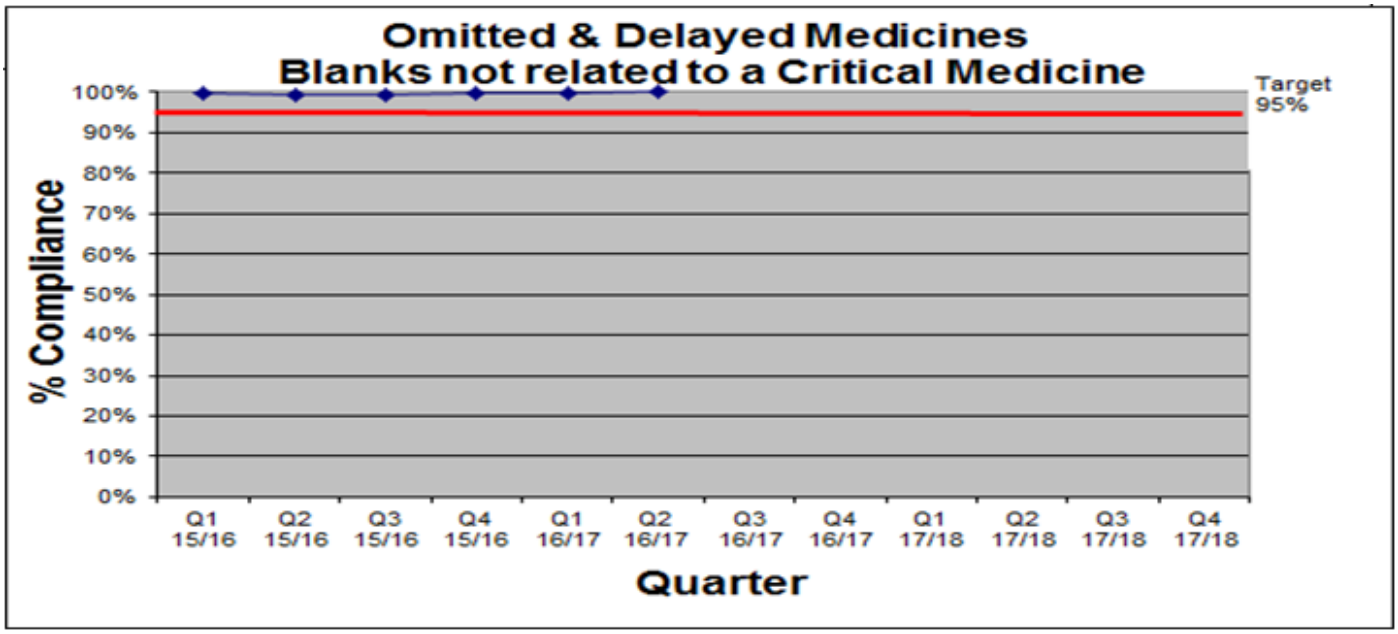
N/A

Trust Data Q2 2016/17:



Regional Comparison Quarter 1 2016/17:

Southern Trust	**97.2%**
Western Trust	92.8%
South Eastern Trust	88.6%
Northern Trust	90.0%
Belfast Trust	87.5%



Regional Comparison Quarter 1 2016/17:

Southern Trust	**99.8%**
Western Trust	99.7%
South Eastern Trust	97.8%
Northern Trust	No data available
Belfast Trust	93.8%

Summary:

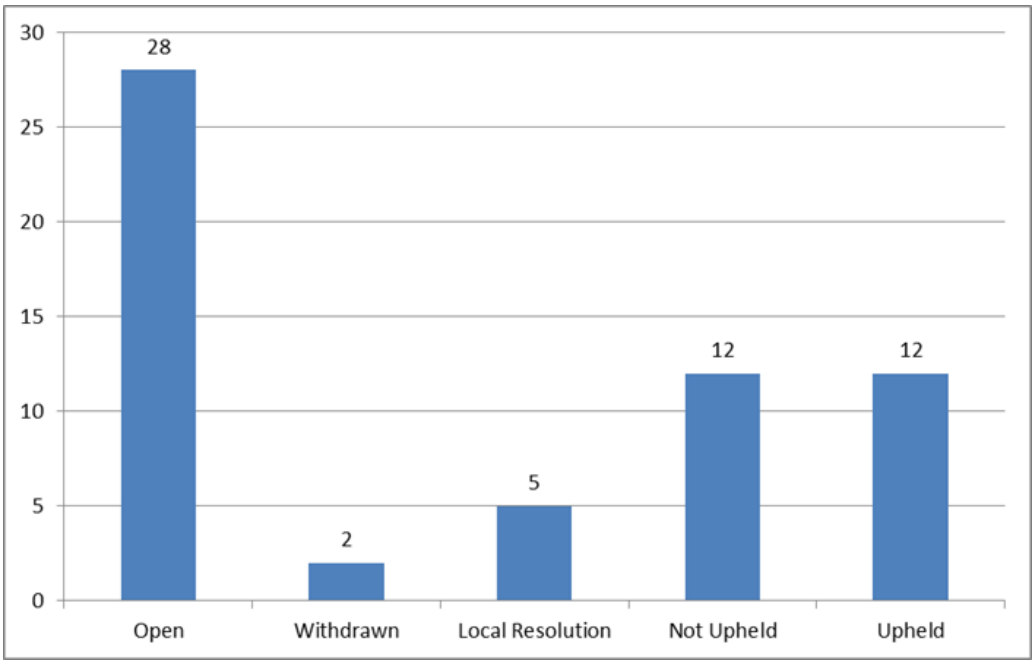
- Data collection only began in April 2015
- Goal has been achieved in all 6 quarters since measurement commenced

Section 3 Complaints & Ombudsman's Complaints

3.1 Complaints referred to the Ombudsman (QE 30th September 2016)

Financial Year	Annual Complaints	Annual Complaints Referred to Ombudsman	%
2011/12	759	10	1.32%
2012/13	864	10	1.16%
2013/14	1055	7	0.66%
2014/15	1135	8	0.70%
2015/16	1163	14	1.20%
2016/17	599	10	1.17%
Total		**59**	

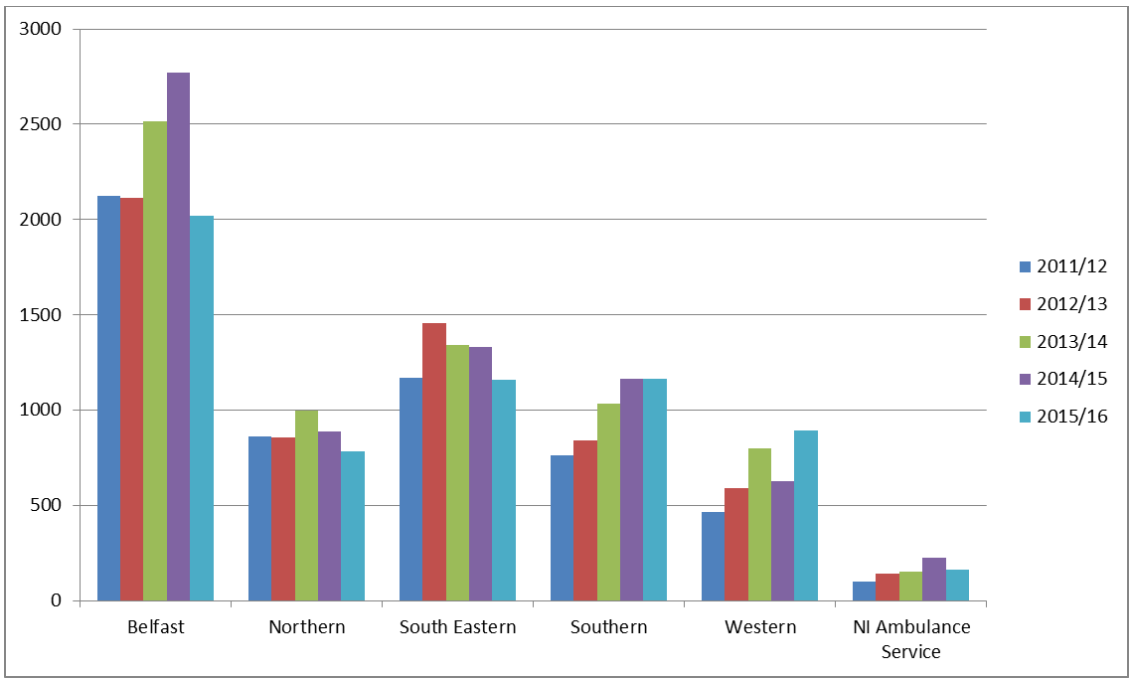
Of the **59 complaints** referred to the Ombudsman since April 2011, the Ombudsman has completed an investigation on **24 of the 59 complaints to date**. A further **7 complaints** were either referred back to the Trust or withdrawn and **28 complaints** remain open.



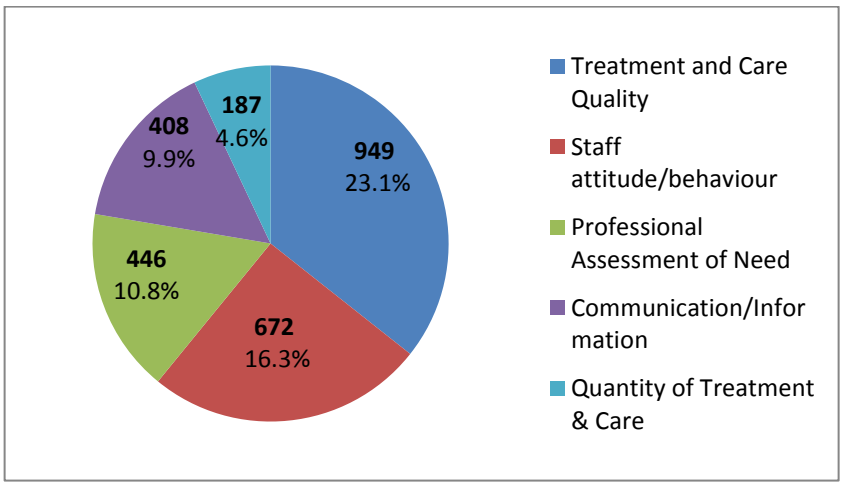
3.2 Complaints Management

3.2.1 Complaints Issues Received by all HSC Trusts 1st April 2011 – 30th September 2016

Below is a profile of the activity of all complaints received across all HSC Trusts from 1st April 2011 – 31st March 2016. *(Source Complaints Received* by *HSC Trusts, Board and Family Practitioner Services in Northern Ireland (2015/16).* It should be noted that returns to both the DHSSPS and the Regional HSC Board are made on the number of ***complaint subjects received as opposed to the number of complaint letters received.***



3.2.2 Top 5 Complaint Subjects During the Time Period: 1st April 2012 – 30th September 2016



Each complaint can often be multi-faceted, particularly patient and family concerns which may cover the multi-disciplinary team and relate to events over a short or extended period of time.

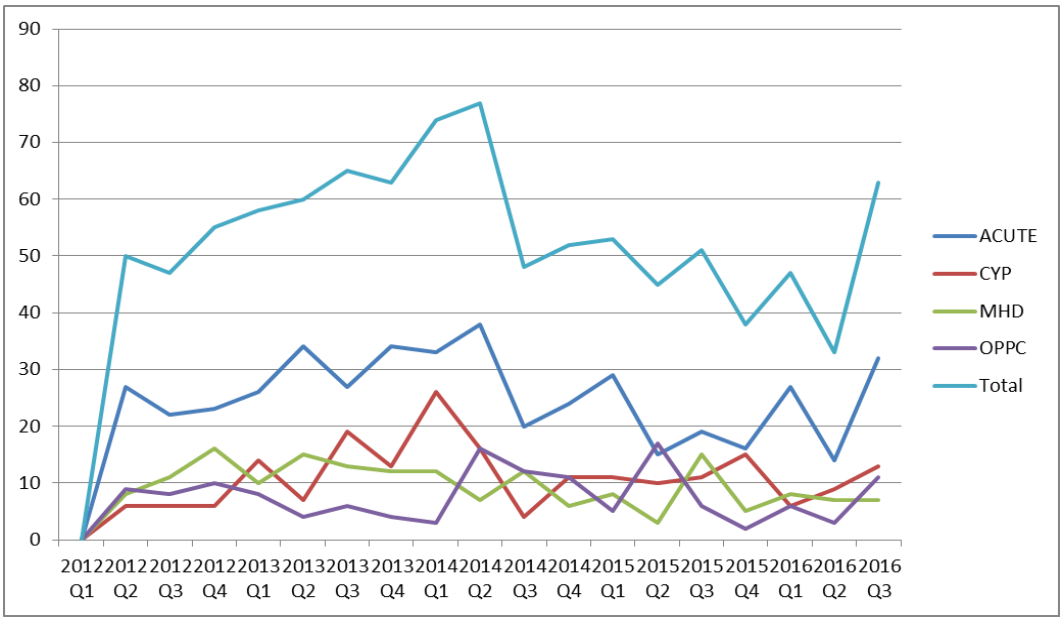
3.2.3 Acknowledgement and Response Times for Complaint Letters per Directorate

1st July 2015 – 30th September 2016

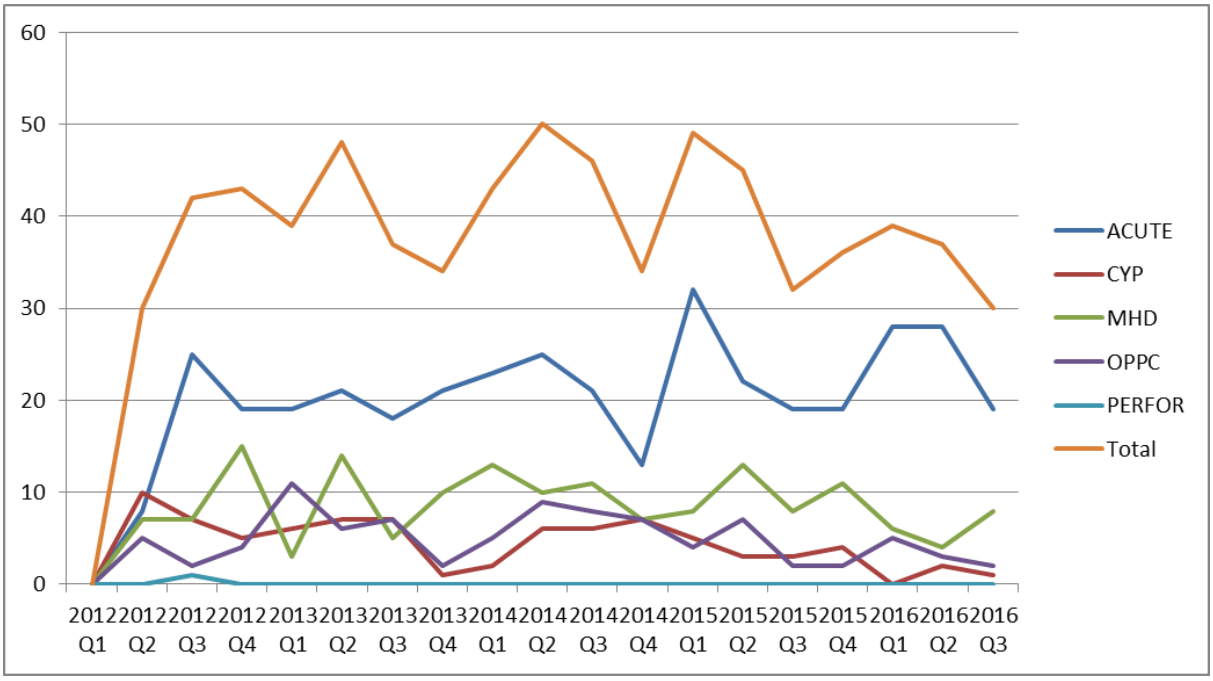
	Acute				CYP				MHD				OPPC			
	TOTAL Rec'd	2 WD ACK	20 WD RESPONSE	30 WD RESPONSE	TOTAL Rec'd	2 WD ACK	20 WD RESPONSE	30 WD RESPONSE	TOTAL Rec'd	2 WD ACK	20 WD RESPONSE	30 WD RESPONSE	TOTAL Rec'd	2 WD ACK	20 WD RESPONSE	30 WD RESPONSE
July 2015	30	100%	33%	53%	10	100%	40%	70%	13	100%	92%	100%	14	100%	79%	86%
Aug 2015	17	100%	35%	47%	11	100%	73%	82%	9	89%	78%	89%	8	100%	38%	63%
Sep 2015	28	100%	57%	79%	13	100%	54%	69%	7	100%	71%	100%	10	100%	70%	90%
Oct 2015	49	96%	57%	71%	12	100%	83%	92%	11	100%	73%	100%	3	100%	100%	100%
Nov 2015	35	100%	48%	80%	8	100%	44%	56%	9	100%	78%	100%	5	100%	100%	100%
Dec 2015	39	100%	41%	48%	9	100%	100%	100%	11	91%	75%	92%	1	100%	100%	100%
Jan 2016	33	100%	39%	70%	14	100%	65%	86%	10	100%	40%	60%	6	100%	83%	83%
Feb 2016	35	100%	37%	54%	14	100%	86%	100%	6	100%	50%	50%	3	100%	100%	100%
Mar 2016	49	100%	42%	72%	19	100%	81%	94%	13	100%	85%	85%	9	100%	89%	100%
April 2016	47	98%	51%	56%	17	100%	65%	82%	11	82%	91%	100%	1	100%	100%	100%
May 2016	48	98%	44%	84%	14	93%	64%	86%	9	89%	89%	100%	4	100%	100%	100%
June 2016	61	95%	73%	77%	12	100%	67%	83%	15	100%	80%	93%	4	100%	100%	100%
July 2016	30	97%	50%	53%	12	100%	75%	92%	9	100%	100%	100%	5	100%	80%	100%
Aug 2016	69	100%	25%	62%	12	100%	100%	100%	4	100%	100%	100%	7	100%	86%	100%
Sept 2016	61	97%	39%	59%	19	95%	79%	89%	17	100%	94%	100%	3	100%	67%	67%

KEY
2WD ACK = Complaint acknowledged within 2 Working Days
20WD = Complaint Responded to in 20 Working Days
30WD = Complaint Responded to in 30 Working Days

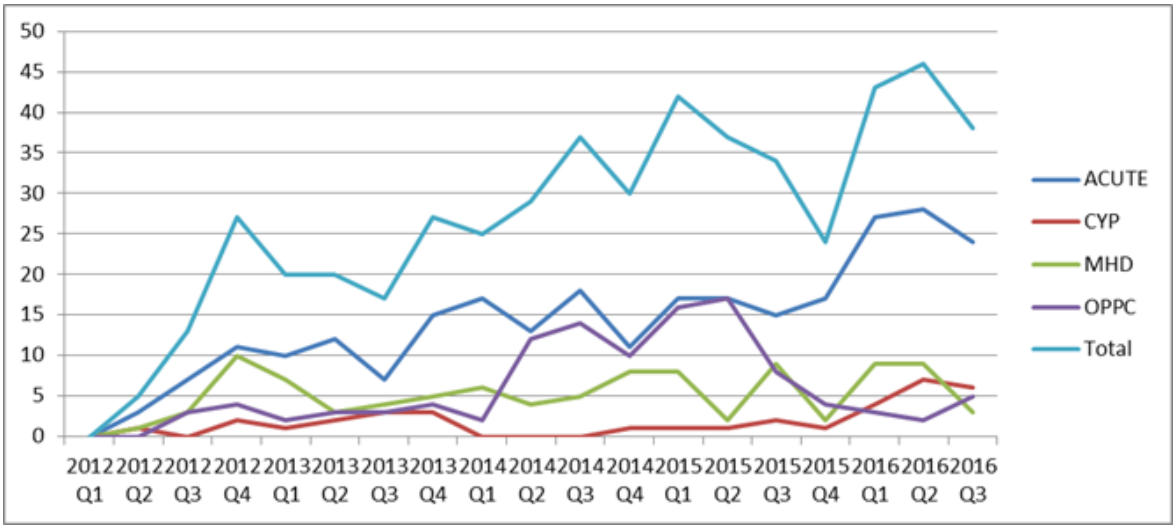
3.2.4 Quality of Treatment & Care (Total & By Directorate Over Time)
1st April 2012 – 30th September 2016



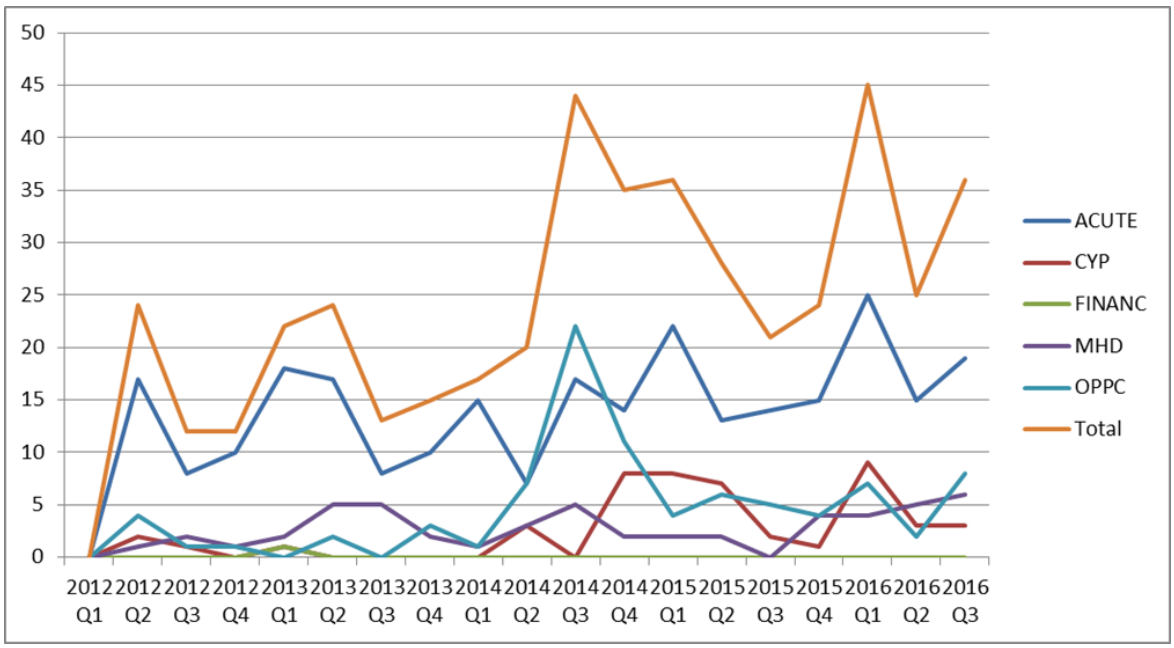
3.2.5 Staff Attitude & Behaviour (Total & By Directorate Over Time)
1st April 2012 – 30th September 2016



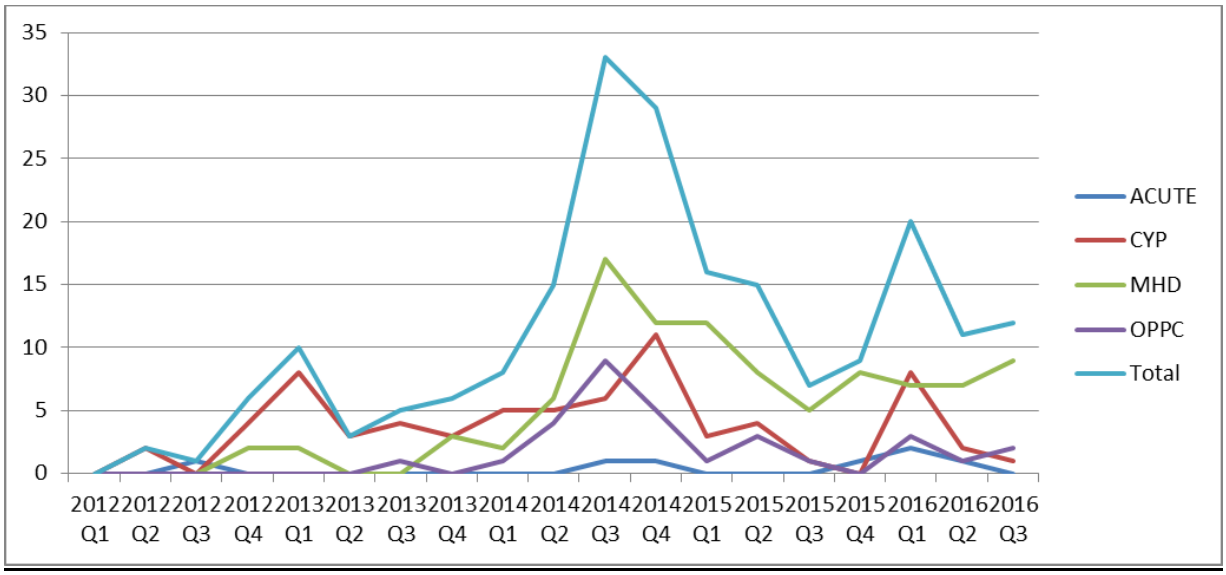
3.2.6 Professional Assessment of Need (Total & By Directorate Over Time)
1st April 2012 – 30th September 2016



3.2.7 Communication/Information (Total & By Directorate Over Time)
1st April 2012 – 30th September 2016



3.2.8 Quantity of Treatment & Care (Total & By Directorate Over Time)
1st April 2012 – 30th September 2016



3.2.9 Sample Complaints and Compliments from Last Quarter 2016

Theme:	Treatment and Quality of Care
Background to Complaint	The Trust received a complaint from a relative of a patient who was discharged from [redacted]. Although the patient's family were very happy with the medical and nursing care he received in [redacted], they expressed some dissatisfaction about the discharge planning process.
Action taken / Learning / Outcome	In order to ensure a smoother transition for patients being discharged from [redacted], particularly those who were not previously known to the community Memory Service; the Memory Services Team have now implemented a pre-discharge meeting to involve family and community staff. This would support greater clarity and effective communication in the discharge planning process.

Theme:	Treatment and Quality of Care
Background to Complaint	Young person received routine vaccine within the school environment by School Nurse. During interaction with young person, School Nurse, in the presence of other young people, questioned the young person in relation to her mental health status as school nurse had noticed fresh self-harm marks on the young person's arm. Young person became emotionally distressed. School Nurse contacted the young person's parent to advise of young person's self-harm, to which the school nurse was advised by the parent that the family were aware of same and young person was receiving appropriate support from other services. School Nurse continued to probe the parent with a number of questions in relation to her child's mental health. Parent felt that school nurse was acting in an unprofessional manner. Parent and young person were distressed following their interaction with the School Nurse.
Action taken / Learning / Outcome	The School Nursing service have a pathway in place for appropriate response when any concerns are identified with a child or young person in a school environment. Following this complaint the School Nursing Service has amended their pathway and incorporated a section to alert professionals that if, following contact with the parent, the child/young person is known to relevant services then no further probing or investigation with the parent is required. All School Nursing staff have been reminded of appropriate communication when liaising with parents and young people of a sensitive nature.

Compliment Examples

The Emergency Department, Daisy Hill Hospital

'My husband, a frequent hospital admission, unfortunately, due to multiple and complex medical conditions, was taken in by ambulance on Saturday 8th October, suffering from tachycardia. It was late afternoon and the A&E department was extremely busy.

He was treated by Staff Nurse Personal Information*, Doctor* Personal Information *and an* Personal Information redacted by the USI *Consultant.*
I have decided to write because I have accompanied my husband into hospital on many, many occasions. Many times this has been a horrendous, distressing and scary experience, often not helped by busy hospital staff (not in Daisy Hill). Both my husband and I were deeply impressed and touched by the level of compassion, care and treatment that he received. I, as his wife, was kept informed of everything that was happening at all times and treated with the utmost consideration.
I wanted to thank the staff and would hope that you would pass this on, as well as commending them on the exemplary service we received. I am sorry that I did not get the full names of the staff nurse and doctors, but I hope you are able to identify them.'
Thanks again.

The Day Procedure Unit, South Tyrone Hospital

'I attended the Day Procedure Unit at South Tyrone Hospital with my Mother earlier this week. We just wanted to say how impressed we were with the service we received. From the nurse who filled in the initial forms and explained the procedure, she really put my mum at ease. My mum said the doctor and all the theatre staff were lovely too. My mum felt really well taken care off the whole time. '

'Also, just to mention the building too, very clean and well kept.'

Well done on providing such a great service.

The Emergency Department, Craigavon Area Hospital

'I just wanted to compliment the staff in Craigavon A&E. I spent a couple of hours there this afternoon with my elderly mother who had fallen. She was seen quickly by triage who said they would get a nurse practitioner to see her. She was then seen by Personal Information *the Physio who was absolutely lovely with her - took her through everything very thoroughly, listened to her, got an X-ray done and sorted her out with a frame and some knee supports going home. She's arranged to see her again next week to check everything's OK. I know you probably only get people raising complaints but I just wanted to make sure you know how much we appreciated the courtesy and thoughtfulness of all the staff - right from the reception desk though the various people who helped put mum at ease. It would have been very easy for her to have had her confidence knocked by the fall but your team did a great job of making her feel supported and ok about going back home. In such a busy place that is a real achievement and thanks very much!'*

Section 4 Regional Mortality & Morbidity Review System (RM&MRs)

In 2008, an Inter-departmental Death Certification Working Group, established to review existing death certification processes in Northern Ireland, recommended enhancing the existing assurance arrangements for death certification with a view to strengthening and improving them and allowing for the implementation of independent medical review of non-reportable deaths. As part of this work the Minister for Health in April 2014 commissioned work to develop a regional electronic Mortality system that would include:

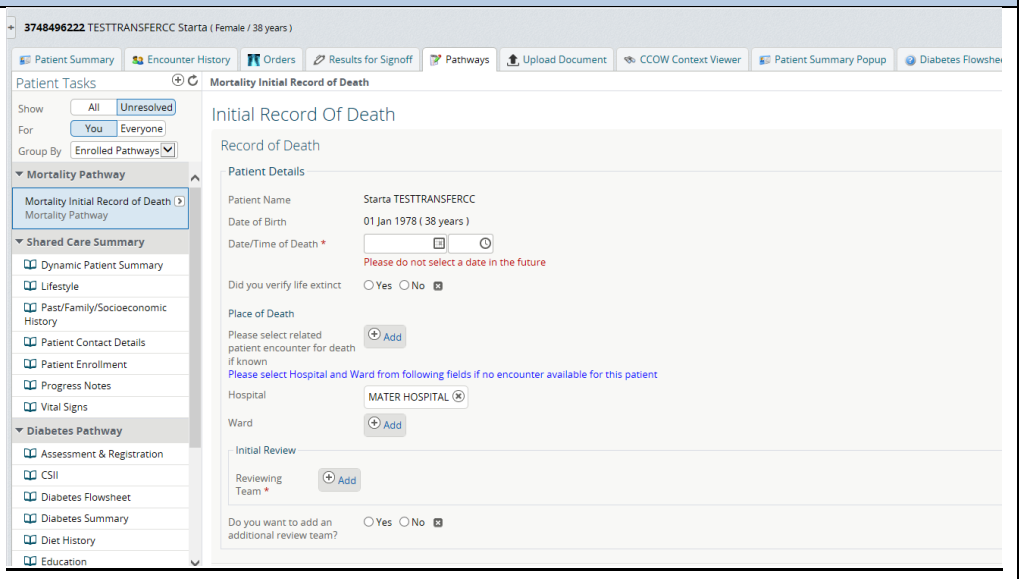
- Death Certification – Computer printing and recording of Death Certificates including contact with the Coroner
- Scrutiny of In-Patient Deaths – Facilitate the scrutiny of In-Patient Deaths
- Sharing Learning – Sharing of Learning locally with a view to regional learning to prevent reoccurrence of adverse events
- Facilitate the possible future independent scrutiny of deaths

As an output of this work the Trust has been nominated as a regional pilot site for the new Regional Mortality & Morbidity Review System (RM&MRs), designed to standardise the recording, reporting and scrutiny of hospital deaths throughout Northern Ireland. The SHSCT which currently uses a bespoke electronic system for capturing and reviewing mortality (IMMIX), has provided a lead role in shaping the new system and our existing M&M frameworks have informed the final regional programme.

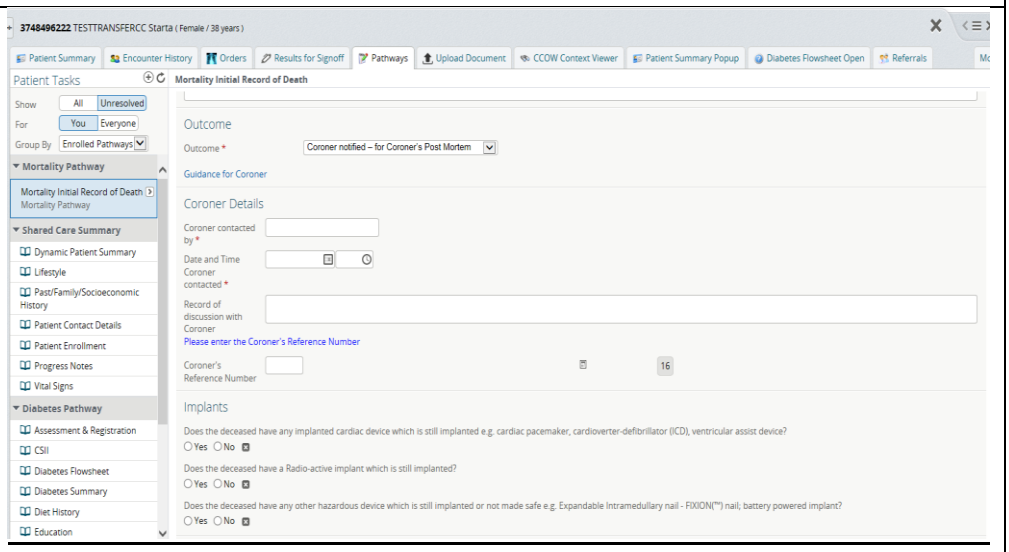
The Trust has nominated two specialities (Trustwide Surgery and Daisy Hill Hospital Medicine) to lead on the pilot which commenced 14th November 2016. Feedback to date from staff has been positive, the Trust has opened a support helpline and email account for staff which will help signpost and solve technical or access issues. It is anticipated that following the pilot test the system will be rolled out to all Trust M&M meetings by 31st March 2017.

RM&MRS Sample Screen Captures

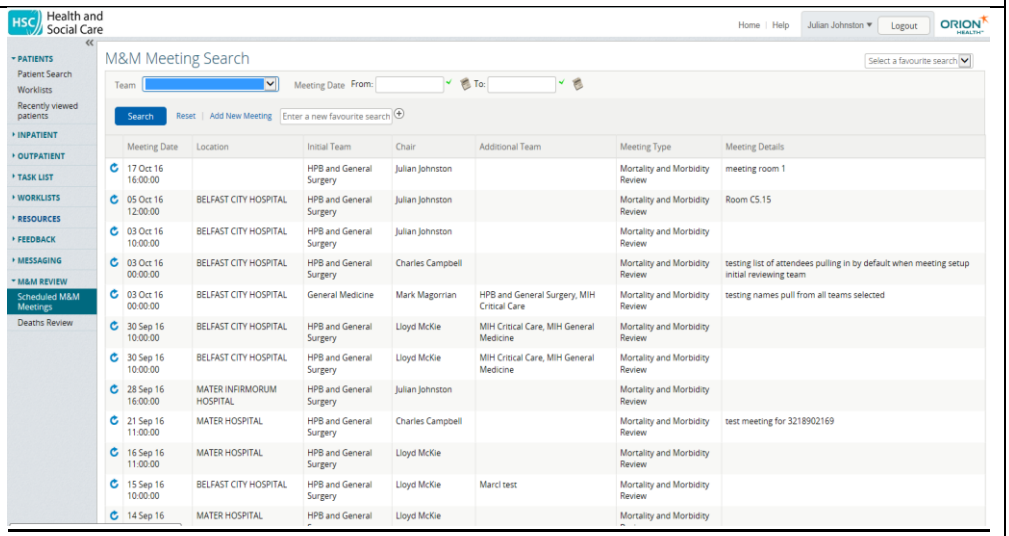
Screenshot of where initial record of death is recorded



Screenshot of Coroner contact detail record



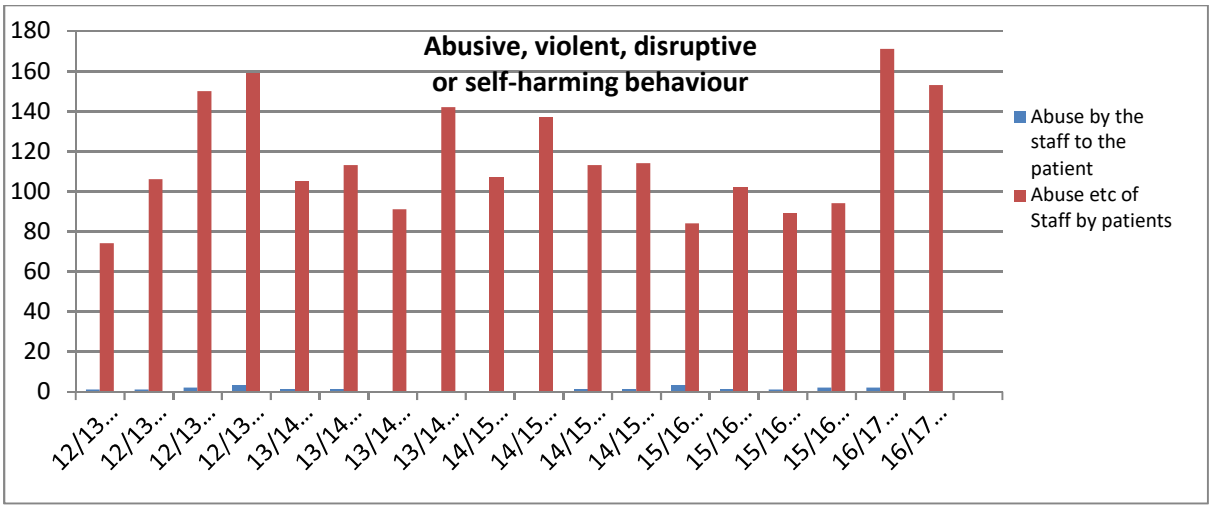
Screenshot of M&M List

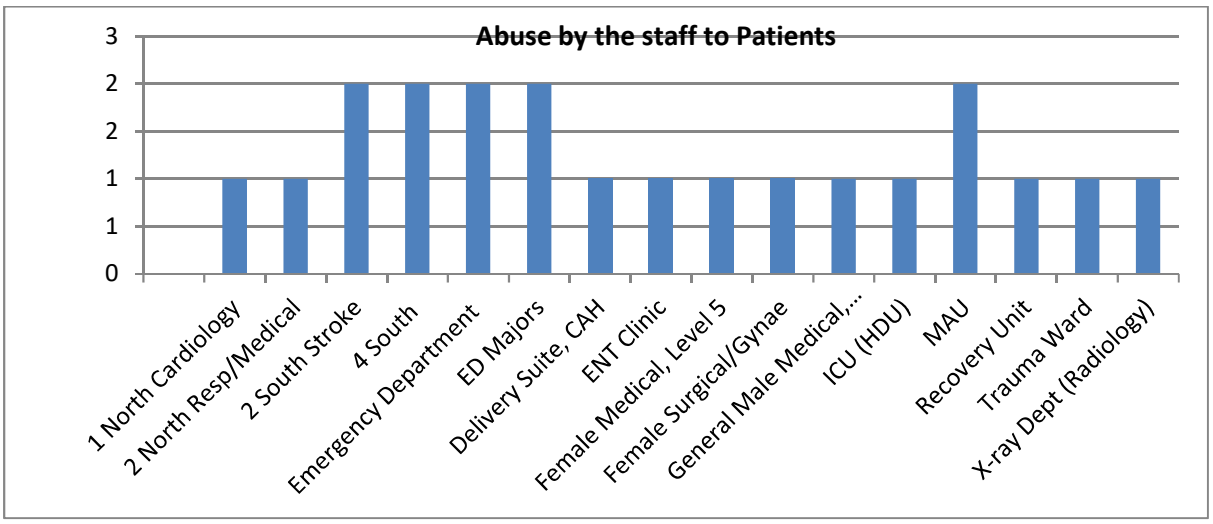


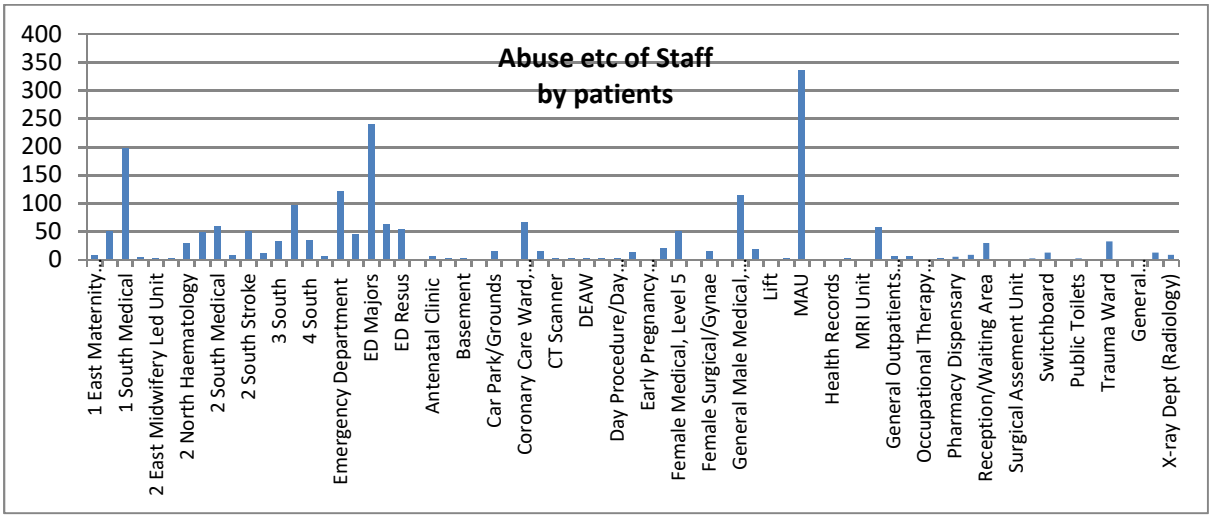
Governance Report Information

1. **Incident Management – Incidents relating to Verbal abuse and Physical abuse – break down by those affected i.e. staff or service user**

Abusive, violent, disruptive or self-harming behaviour graphs April 2012 to November 2016







2. High level summary of the SAIs reported in 2016/2017 i.e. what these were, where they occurred and learning/improvement as a result for assurance

Irrelevant information redacted by the USI

[redacted]

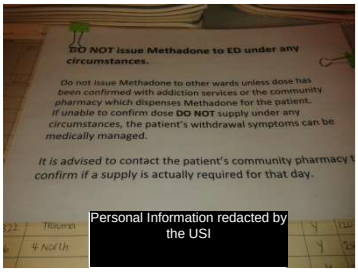
Recommendations

Recommendation 1 Staff involved in this adverse incident should be given feedback

Recommendation 2 Methadone should not be prescribed or administered in any of the Trusts Emergency Departments

Recommendation 3 The Trusts Guidelines for the Management of Patients Indicating Opiate Dependency Syndrome, within an Acute Setting section for ED needs updated.

Action plan in place



ED –EDC learning newsletter had an Alert on it for all staff 6/10/2015

Due to a recent case a Memo has been circulated from Mr O'Reilly re: Methadone. ***This is not to be prescribed by the Emergency Department.*** *There are community based addiction teams with stringent protocols for the administration for this much sought after and dangerous drug.*

Currently Acute ED staff and Additions team are updating Trust written guidelines on

Guidelines for the Management of Patients Indicating Opiate Dependency Syndrome, within Acute setting

3. Number of outstanding SAIs and contributory factors preventing compliance with time scales

- Delay in identifying incident / reporting
- Complexity of case being investigate- time line development
- Screening opportunities
- MDT membership of group
- Inexperienced chairs
- Conflicting job plans – unable to step down clinical work
- Multiple meetings needed, difficulty getting final approval from teams
- Volume of SAIs and time taken to draft a meaningful report
- Developing meaningful SMART recommendations
- Validation can be protracted

Initials	Div	Incident date	Date screened	Description	Details	Current Stage
Personal	MUC	12.4.12	22.7.15	Delay in follow up suspicious X ray Tumour	1st Draft completed	Under investigation
Personal	MUC	22.12.14	11.08.15	IP fall head injury	Being reviewed for de-escalation	Needs new chair Personal Information left Trust
Personal	SEC	3.4.15	30.9.15	Delay follow up colonoscopy	for further consideration re possible de-escalation awaiting image presentation at M&M	Not started
Personal	MUC	21.1.16	CYP	Out of hospital cardiac arrest		CYP taking lead.
Personal	SEC	17.2.16	15.3.16	Missed fracture	Meeting arranged for 20.9.16 @ 9am - going to ACG October 2016 or November 2016	Under investigation
Personal Informati	MUC	22.1.16	14.3.16	Norovirus in haematology	Report being drafted	Meeting being arranged.
Personal	MUC	19.5.15	8.6.15	inpatient fall with # NOF, died 2 days later	To Be De-escalated	Report not started
Personal	MUC	20.12.14	19.1.15 & 26.2.15	Inpatient fall #	RV completed report to be drafted? De-escalation following discussion with Personal [redacted] - report to be written regarding de-escalation.	Under investigation
Personal	SEC	6.1.16	15.3.16	Missed renal cancer	Not started - time line complete Meeting 10am Tutorial Rm 3	Under investigation
Personal	SEC	23.12.15		Diabetic adolescent	It is anticipated report completed by Feb ACG meeting	Meeting being arranged.
Personal	MUC	29.4.16	11.5.16	Carbon monoxide poisoning.	First RCA meeting 22.6.16	Under investigation
Personal Informatio	MUC	21.1.16	16.5.16	Cardiac arrest post transfer from Belfast	Needs discussion with Personal Information	Under investigation
Personal	MUC	18.05.16	23.05.16	Fall from stairwell	Letter to be issued to Family. Meeting with family to be arranged. Further meeting to be arranged for Feb	Under investigation
Personal	MUC	15.5.16		Thoracic aneurysm - link with RVH	Meeting being arranged	Under investigation
Personal	IMWH	19.8.16		Unexpected death of baby following breech delivery		Under investigation
Personal	OPPC/Acute	16.2.16		CVA - anticoagulant issues		Under investigation

4. **In relation to incidents –**

I have attached the violence and aggression information as there continues to be ongoing issues

Falls information with ADs- in-depth report by ward and department with background data shared with ADs who are reviewing for learning and trends

5. **Complaints**
    a. Response time for responding to complaints
        i. MDT nature of complaint – multiple staff needing access to note
        ii. Annual leave
        iii. Complexity of complaints
        iv. Acute are not coding MLA enquiries as formal complaints–these often straight forward to answer re discontentment with waiting times etc. as complaints we get approx. We believe other Directorates are coding MLS enquires as formal complaints – this is being discussed at governance co-ordinators meeting- if we added in our MLA enquires the complaint numbers would rise significantly

Monthly numbers of complaints and MLA/enquiries

Month	**Total No 2015/16**		**Total No 2016/17**	
Type	**Complaints**	**Enquiries / MLA / Informal**	**Complaints**	**Enquiries / MLA / Informal**
Apr	53	23	45	21
May	28	25	39	29
Jun	48	39	58	30
Jul	51	25	28	11
Aug	27	25	69	27
Sep	36	20	61	28
Oct	49	14		
Nov	35	11		
Dec	39	10		
Jan	64	19		
Feb	58	23		
Mar	67	18		
Total	**555**	**252**	**381**	**188**

Spike in Quality of Treatment and Care – in-depth report by ward and department with background data shared with ADs who are reviewing for learning and trends **(reports attached to email for your information)**

Spike in Communication/information in-depth report by ward and department with background data shared with ADs who are reviewing for learning and trends **(reports attached to email for your information**

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

Minutes of a meeting of the Governance Committee held on Thursday, 10th May 2016, at 10.15 am in the Boardroom, Trust Headquarters

PRESENT:

Dr R Mullan, Non-Executive Director (Chairman)
Mrs E Mahood, Non-Executive Director
Mr E Graham, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mrs S Rooney, Non-Executive Director
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Mr F Rice, Interim Chief Executive
Mrs E Gishkori, Director of Acute Services
Mrs A McVeigh, Director of Older People and Primary Care Services / Interim Executive Director of Nursing
Mr B McMurray, Acting Director of Mental Health and Disability Services
Dr R Wright, Medical Director
Dr T Boyce, Director of Pharmacy
Mrs M Marshall, Assistant Director, Clinical and Social Care Governance
Mrs P Tally, Acting Assistant Director Best Care Best Value *(for Mrs Magwood)*
Mrs D Johnston, CSCG Co-ordinator, Children & Young People's Services *(for Mr Morgan)*
Mrs V Toal, Head of Employee Engagement & Relations *(items 14 & 15 only)*
Mrs S Judt, Board Assurance Manager
Mrs S McCormick, Committee Secretary (Minutes)
Mrs L Gribben, Committee Secretary (Minutes)

1. WELCOME AND APOLOGIES

Dr Mullan welcomed those present to the meeting. Apologies were recorded from Mr K Donaghy, Director of Human Resources & Organisational Development, Mrs A Magwood, Acting Director of Performance and Reform, Mr Paul Morgan, Director of Children and

Young People's Services/Executive Director of Social Work and Ms Eileen Mullan, Non-Executive Director.

2. **DECLARATION OF INTERESTS**

Dr Mullan asked members to declare any potential conflict of interests in relation to items on the agenda. None were received and the business of the meeting proceeded.

3. **CHAIRMAN'S BUSINESS**

None.

4. **MINUTES OF MEETING HELD ON 4th FEBRUARY 2016**

The Minutes of the meeting held on 4th February 2016 were agreed as an accurate record and duly signed by the Chairman.

5. **MATTERS ARISING FROM PREVIOUS MINUTES**

There were no matters arising from the previous meeting.

Dr Mullan requested Items 8 and 10 be presented at this point in the meeting to facilitate Dr Wright.

6 CLINICAL AND SOCIAL CARE GOVERNANCE

i) Incident/Complaints/Patient Safety Report

Dr Wright presented the newly formatted report for the period 1 April 2012 – 31 March 2016, which sets out trends over time in respect of incidents, SAI's and complaints, as well as providing an update on key patient safety initiatives that support governance data to 31st March 2016.

Discussion focused on the Top 5 Incidents reported from 1 April 2012 – 31 March 2016 and the fact that the highest number of incidents fall within the following two categories - physical abuse, assault or violence and verbal abuse or disruption.

Mrs Rooney queried the figures for the Top 5 incidents, noting that if the 3 categories of falls incidents were combined, that provided an overall total of 45% which in turn would account for the highest incident category. Mrs Marshall noted this and advised that Dr Damien Gormley would be attending the next Governance Committee meeting in September 2016 to present the work being taken forward to minimise the number of falls. Mrs McVeigh stated that Nursing Homes now have a requirement to report all incidents of falls and this may explain the rise in the number of these episodes.

Mrs McCartan commented that physical abuse incidents are quite high. Mr McMurray advised that this is a regional trend across the Mental Health and Disability divisions. The SHSCT have a zero tolerance policy. Staff also undertake MAPA (Management of Actual or Potential Aggression) training and are trained in de-escalation techniques.

The pie-chart on page 3 of the report was discussed. Mrs McCartan sought clarity that the 35% of physical abuse incidents is a percentage of the Top 5 incidents and not the overall total. In light of comments received on the format of the pie-chart, Mr Rice agreed that this would be looked at for the next meeting.

Serious Adverse Incidents (SAI's) were discussed. Members noted that to date, there are 74 SAI investigations outstanding which are being progressed by the operational teams.

Mrs Marshall advised that the mandatory requirement to report all child deaths as SAIs has been removed by the HSCB/Department. She provided assurance that all child deaths remain subject to clinical review via the Trust M&M processes. Any death which meets SAI criteria will continue to be notified as a SAI. Since 1st February 2016, nine cases have been discussed. Mrs Marshall advised of the Trust Workshop on 28th June 2016 to review adverse and serious adverse incident procedures.

Complaints were discussed. Members noted that of the 52 complaints referred to the Ombudsman since April 2011, the Ombudsman has completed an investigation on 22 of the 52

complaints to date. A further 7 complaints were either referred back to the Trust or withdrawn. 23 complaints remain open.

Mrs Marshall advised there is an ongoing review on how formal complaints are categorized in order to provide greater insight into patient's experience. The Trust has presented a framework for complaint categorisation to the Department who has agreed to consider for regional implementation. The Trust has piloted this system retrospectively in Children and Young People's Services and Older People and Primary Care Directorates. Work is underway to incorporate this framework into the Trust DATIX system.

Dr Wright presented a supplementary paper which provides an update on the Clinical & Social Care Governance revisit.

Action – Mrs Marshall

ii) Managing Deteriorating Patients - Presentation

Mrs Gishkori introduced Mrs Trudy Reid, Governance Co-ordinator, Acute Services, for a presentation on Managing Deteriorating Patients. Mrs Reid gave a short overview on the arrangements in place and the next steps.

Mrs Rooney stated she has been involved in the NEWS working group and that consideration needs to be given to reinstate this group. Mr Rice agreed to look at this.

At this point, Mrs Rooney raised the fact that a Non Executive Director nomination for the Falls Sub Group was required to replace Mrs Hetty Kelly whose term of office concluded on 31st December 2015. Dr Mullan agreed to raise this issue with the Trust Chair.

Action – Dr Mullan

7. MORTALITY AND MORBIDITY

i) Annual Mortality Review October 2013 – September 2014

Dr Wright guided members through the paper and explained that the Trust currently use the CHKS Risk Adjusted Mortality Index (RAMI) indicator, however this will be changing and the Summary Hospital-level Mortality Indicator (SHMI) will be used for future reporting**.** Dr Wright informed the group that Trust's mortality figures are good in comparison with other peer groups.

ii) Update on the Regional Mortality and Morbidity Review System

Dr Wright gave a short presentation on the progress of implementation for the new regional M&M Review System, which SHSCT has been at the forefront in pioneering. Mrs Tally informed the group that the system has been nominated for a Health and Social Care Forum award.

Advantages of the system were discussed, one of which being the electronic death certificate function. The system will be piloted and this will commence in August 2016. Mrs Rooney commented that she was the Non-Executive Director nominated to work on this project and commended the leadership the Trust has shown.

Dr Wright left the meeting at 11.20am

8. CORPORATE RISK REGISTER

Mr Rice presented the Corporate Risk Register (CRR) and stated there are currently 23 risks – 13 high and 10 medium. Key changes noted on the register were discussed as follows:-

Medicines Management in domiciliary care – updated risk assessment was considered by SMT on 27th April 2016 and the decision taken to remove this risk from CRR and manage it on the Older People and Primary Care and Mental Health and Learning Disability Directorates Risk Registers.

Mr Rice advised of the addition of one new risk to the Corporate Risk Register that of the increased risk of significant service disruption as a result of high degree of construction activity on Trust sites.

Care Management reviews were discussed. Mrs Mahood referred to the recent Internal Audit report on this area which received a limited assurance. Mrs Mahood sought assurance that efforts are being made across relevant Directorates to improve performance. Mrs McVeigh stated there has been considerable work done to date and a full action plan would be brought to the next Audit Committee meeting.

Mrs Rooney referred to risk no.2 - Out-patient Reviews and Planned Treatment Backlogs and sought assurance that clinical risks had been minimised since contingency options were approved by SMT in April 2015. Mrs Gishkori explained that capacity was being prioritised to red flag referrals and urgent patients. Investment Proposal Templates (IPTs) have been prepared for additional funding, additional clinics introduced (both consultant and nurse-led), targeting of clinically urgent cases, and new initiatives have been introduced such as telephone clinics in some specialties. Non recurrent funding was received for Independent Sector. Mrs Mahood commented on the fact that this funding came late in the year.

Mr Rice referred to a potential new risk for escalation to the Corporate Risk Register in relation to reduced ability to provide 24/7 laboratory service across the two acute hospital sites due to insufficient Biomedical Scientists. A full risk assessment is being completed for consideration by the Senior Management Team.

Discussion took placed on risk no.19 - Implementation of Nursing Midwifery Council's (NMC) revised revalidation arrangements in April 2016. Mr Rice spoke of the large number of nurses to be revalidated very shortly which poses a huge challenge for the Trust.

9. MEDICINES GOVERNANCE REPORT

Dr Boyce presented the Medicines Governance report, which demonstrates that during the third quarter of 2015/16, 203 medication incidents were reported within the Southern HSC Trust. The average

number of reported medication incidents each month was 68, representing a decrease from 101 per month in the previous quarter.

There were no trends of specific concern amongst the reports and the number of reported medication incidents is set against the figure of approximately 7,500 medication transactions, including prescribing, dispensing and administration, happening in the Trust every day.

During the third quarter of 2015/16, there were no major or catastrophic incidents reported via Datix.

Dr Boyce discussed the new approach to the Drugs and Therapeutics Committee.

The regional Medication Safety Newsletter was welcomed by members. This newsletter is distributed quarterly; it is multidisciplinary and is disseminated out to the wider community.

10. DRAFT GOVERNANCE STATEMENT

Mr Rice presented a draft Governance Statement for member's consideration. This will be brought to Trust Board on 9th June 2016 for approval, prior to submission with the Trust Accounts.

11. CONTROLS ASSURANCE STANDARDS – REPORT ON COMPLIANCE 2015/16

Mr Rice presented the report on compliance against the 22 Controls Assurance Standards. Overall, he noted a good performance across the Trust with a substantive level of compliance achieved across all 22 standards in 2015/16. Mr Rice advised that Internal Audit independently verified 5 of the standards and concurred with the Trust's self-assessment ratings. The Trust submitted its compliance scores to the DHSSPS by the required deadline of 6th May 2016.

12. UPDATE OF CARERS ACTION PLAN

Mrs McVeigh spoke to the detail of the Carers Action Plan advising that key issues relate to capacity within teams to identify carers, offer assessments and develop support plans. Mrs McVeigh explained that

the NISAT v4 Carers Module has been approved and planned implementation date is September 2016.

Mrs Marshall left the meeting at 12.50pm

13. FREEDOM OF INFORMATION, ENVIRONMENTAL INFORMATION AND SUBJECT ACCESS REQUESTS – SUMMARY REPORT FOR THE PERIOD 1 JANUARY 2016 – 31 MARCH 2016

Dr Mullan welcomed Mrs Tally to present the summary report for the period 1 January 2016 – 31 March 2016. A total of 67 requests were received and responded to in this period and of these 54 were processed within the 20 day deadline. Members noted that the majority of requests were received from the public, businesses and the media. Details of the individual requests for information are included within the report.

Mrs Tally drew members' attention to detail on Subject Access Requests included within the report for the period 1 January 2016 – 31 March 2016. A total of 103 requests were received and responded to within the timeframe and of these 74 responses were processed within the 40 day deadline and 20 requests were processed outside of the 29 day deadline. The majority of Data Protection Act information requests were received from the public, insurance companies and family members.

Mrs Tally spoke about the ongoing workforce pressures and stated that the FOI requests responded to within the statutory time has increased from 74% to 80.5%, which is still below the threshold of 85%.

Dr Mullan queried the Acute FOI response of 68 days in relation to the protocol for patients attending MIU with a head injury and on an anticoagulant. Mrs Gishkori undertook to provide further detail on this request for the next meeting.

Action: Mrs Gishkori

14. DRAFT GIFTS, HOSPITALITY AND SPONSORSHIP POLICY

Mrs Toal presented the draft policy and informed members that this policy is a joint ownership between Human Resources and Finance Directorates.

Mrs Rooney drew member's attention to the section on Internal Hospitality. The provision of alcoholic beverages with meals was highlighted as a concern, following the 'drink awareness' campaign. Mrs Toal agreed to seek clarity around this issue.

Action: Mrs Toal

15. DRAFT CONFLICTS OF INTEREST POLICY

Mrs Vienne Toal presented the draft policy and informed members that this policy is a joint ownership between Human Resources and Finance Directorates. Mrs Toal explained that this policy requires staff members to declare any interests or perceived interests outside of their employment with the Trust. This will now be included for all new starts and be incorporated into their pre-employment checks. Mrs Toal advised members that there will be an annual reminder sent out to all staff from the Board Assurance Manager to complete the form and the Board Assurance Manager will keep the register.

Members were informed that there will be an information leaflet produced for all staff. The policy overview will be included in the Southern-i document, a global email will be circulated to all staff and it will be discussed at all team meetings.

16. GOVERNANCE COMMITTEE ANNUAL BUSINESS CYCLE 2016

Dr Mullan drew member's attention to the schedule of reporting for the remainder of the year.

17. LEADERSHIP WALKABOUTS

Members considered the Leadership Walks Report for the period October 2015 – March 2016. During this period a total of 8 leadership walk arounds were undertaken by Board members.

18. NON-EXECUTIVE DIRECTOR'S VISITS TO CHILDREN'S HOMES REPORT

The above named report was discussed briefly. During the period October 2015 – March 2016, a total of 7 Children's Home visits were undertaken by Board members. Three key themes were identified, details of which are included within Appendix 1 of the paper.

19. UPDATE FROM PATIENT AND CLIENT EXPERIENCE COMMITTEE

Mr Graham, Chair of the Patient and Client Experience Committee provided a verbal update on the meeting held on 10th March 2016. Mr Graham stated the Southern Trust Patient/Client Experience Steering Group has been established and the Terms of Reference have been discussed for approval. He highlighted Director attendance at meetings as an issue and Dr Mullan agreed to raise this with the Trust Chair.

Action: Mr Mullan

20. ANY OTHER BUSINESS

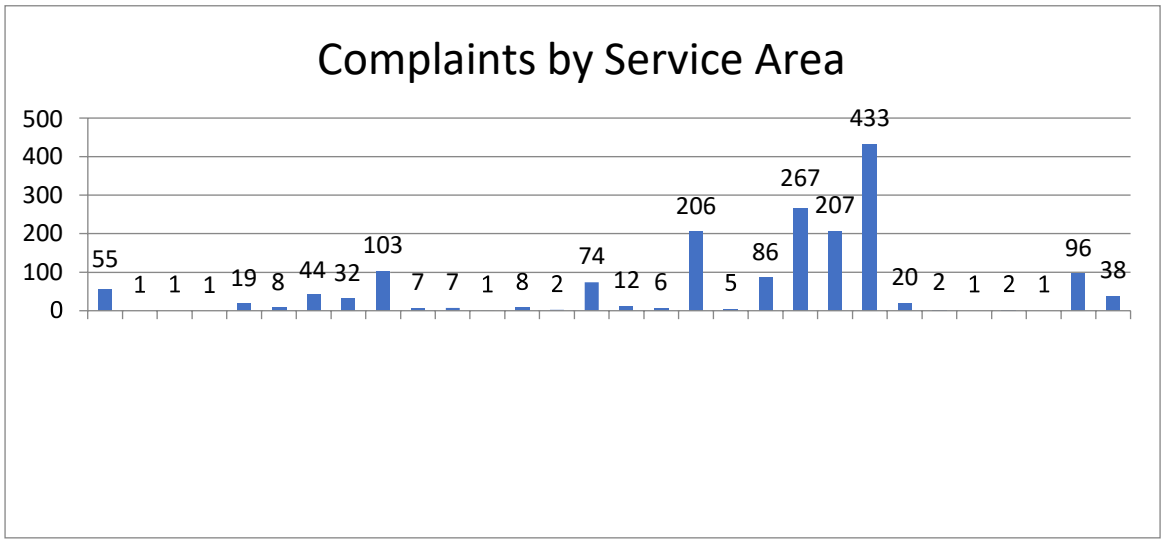
There was no further business.

The meeting concluded at 1.15 p.m.

SIGNED: _____

DATED: _____

Table – Complaints by service area April2016 to January 2019 provided by the Acute Governance Team



From: Reid, Trudy
Sent: 12 April 2018 20:46
To: Walker, Helen
Cc: Boyce, Tracey
Subject: FW: Governance post
Attachments: Clinical governance manager HW.doc

Helen we have approval to go out complete ereqs for the permanent Governance managers. I need to attached the JD to do the ereq, please see attached, this was based on the lead midwife and I can't remember if we ever formally approved/matched it.
I was wondering if we could put and or in the specification x number of years' experience as band 6 or above?

Could we also discuss the temporary governance officers post

Regards,

Trudy

Trudy Reid
Acute Clinical and Social Care Governance Coordinator
Administration Floor
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ
Telephone Personal Information redacted by the USI
Mobile Personal Information redacted by the USI

From: Reid, Trudy
Sent: 22 March 2018 17:26
To: Walker, Helen
Cc: Boyce, Tracey
Subject: Governance post

Helen we have approval to go out complete ereqs for the permanent Governance managers. I need to attached the JD to do the ereq, please see attached, this was based on the lead midwife and I can't remember if we ever formally approved/matched it.
I was wondering if we could put and or in the specification x number of years' experience as band 6 or above?

Regards,

Trudy

Trudy Reid
Acute Clinical and Social Care Governance Coordinator
Administration Floor
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ
Telephone Personal Information redacted by the USI
Mobile Personal Information redacted by the USI

Southern Health and Social Care Trust

THIS POST IS FOR EMPLOYEES OF THE SOUTHERN TRUST ONLY

JOB DESCRIPTION

JOB TITLE	Clinical Governance Manager
BAND	Band 7
DIRECTORATE	Acute Services
REPORTS TO	Acute Clinical and Social Care Governance Coordinator

JOB SUMMARY

The post holder will be responsible for monitoring and improving the delivery of patient care services within the SHSCT. The post holder will support the Clinical Governance agenda within the Acute Directorate, in Medicine and Unscheduled care and/or Surgery & Elective Care and ATICS level which will include risk management, clinical audit, clinical effectiveness and multidisciplinary education and training. The post holder will effectively support the implementation of the principles and practice of clinical governance and risk management, in the clinical setting within a framework which uses information to guide reflection, leading to action and outcomes monitoring.

KEY DUTIES / RESPONSIBILITIES

1 Risk Management

1.1 To coordinate and support the risk management process across the patient care Divisions.

1.2 To ensure that the Divisional risk registers are effectively populated from investigations received, to analyse and identify trends and actions required, supporting Ward Managers throughout.

1.3 To work alongside clinical audit to develop and implement an audit programme that supports the needs of clinical risk management.

1.4 To ensure that investigations generated through the risk management process are multidisciplinary and, that findings are appropriately disseminated through established networks.

1.5 To collect data from serious incidents/investigations for the purpose of clinical audit

1.6 To attend the Governance Fora, supporting the Assistant Director, Heads of Service

and Lead Nurses with the maintenance of this group

1.7 To assist in any investigation required for Divisional complaints, working with the Complaints Manager to collate divisional responses.

2 Clinical Governance/Collaborative working

2.1 To support the development and implementation of a clinical governance programme, aimed at improving the quality of clinical acre in the division.

2.2 To collate information and statistics which assist clinicians to reflect on their practice

2.3 To work alongside the Clinical Governance Lead Clinicians in facilitating a rolling programme of audit and training, based on local policies and national guidelines

2.4 To compile reports and present findings as required to the Trust Clinical Governance Committee and risk management committee.

2.5 To coordinate the implementation of decisions taken by the Clinical Governance Committee within the Division/s

2.6 To assist and support the development of the Divisional Clinical Governance Strategy, revising and developing as required.

2.7 To be responsible for the efficient dissemination of clinical governance information across the division/s

2.8 To work alongside the Clinical Governance Lead Clinicians to investigate reported incident and prepare incident report and action plans in line with current Trust and regional clinical governance guidance

3 Educational Responsibilities/Communications

3.1 To identify training needs highlighted through the implementation of the risk management process and inform the Head of Service of these.

3.2 To assist senior nursing and medical teams in training and induction programmes regarding risk management and clinical governance for all staff as required.

3.3 To regularly attend and provide reports to the Divisional risk management meetings, Clinical Governance fora.

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

3. Adhere at all times to all Trust policies/codes of conduct, including for example:
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - standards of attendance, appearance and behaviour

4. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

5. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

6. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

7. Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances. Other duties of a similar nature and appropriate to the band may be assigned from time to time.

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the band may be assigned from time to time.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

HSC Southern Health and Social Care Trust

PERSONNEL SPECIFICATION

JOB TITLE Clinical Governance Manager

DIRECTORATE Acute Services

Notes to applicants:

1. *You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being short listed.*
2. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

***ESSENTIAL CRITERIA** – these are criteria all applicants MUST be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;*

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

QUALIFICATIONS & EXPERIENCE

1. Degree or recognised professional qualification or equivalent / higher qualification AND 2 years' experience in a role involving the patient safety and governance in a clinical setting

3. Hold or be willing to undertake a patient safety or governance related module at Degree Level.

4. Experience in the use of Microsoft office products including Word, Excel, Outlook and PowerPoint.

5. Hold a full current driving license valid for use in the UK and have, on appointment, access to a car[1]

[1] *this criterion will be waived in the case of applicants who are prevented from driving due to a disability, providing the applicant can organise suitable alternative arrangements in order to meet the requirements of the post in full.*

The following are essential criteria which will be measured during the interview stage.

KNOWLEDGE & SKILLS

1. Have an excellent understanding of Clinical and Social Care Governance within the Trust setting.

2. Effective Planning & Organisational skills with an ability to prioritise own workload.

3. Highly effective Communications skills to meet the needs of the post in full and the ability to deal with difficult and/or distressing situations.

4. Ability to constructively question and challenge existing practices.

5. Ability to identify solutions to problems and implement them effectively.

6. Ability to work to tight timescales whilst meeting targets.

As part of the Recruitment & Selection process it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

All staff are required to comply with the Trusts Smoke Free Policy

Stinson, Emma M

From: Reid, Trudy [redacted]
Sent: 04 October 2016 16:36
To: McVey, Anne; Carroll, Ronan; Trouton, Heather; Boyce, Tracey; Conway, Barry; Carroll, Anita; Gishkori, Esther
Subject: Delays in appointments diagnosis or treatment.xlsx
Attachments: Delays in appointments diagnosis or treatment.xlsx

Please see attached as discussed

Regards,

Trudy

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

Delays in appointment / diagnosis

Datix number	Patient details	HCN	Summary of issue	Outcome	Recommendations if any	
Person	Personal Information	Personal	CT renal was done on 17/9/15. Report was received by secretary on 25/9/15. CT raised a suspicion of myeloma. Report was seen by me on 26/9/16 and I requested urgent OPD within 1-2 weeks with a specific mention that 'I am happy to see him as an extra patient' But, an OPD appointment was made only 13/7/16.MRI and blood tests requested 13/7/16. We need to wait for the reports. Hopefully, there is no malignancy.	13/07/16 - OPD letter - In essence, it is unlikely that there is any sinister problem but still I have requested an MRI spine and arranged for all relevant blood tests.		
Person	Personal Information redacted by the USI	Personal	Irrelevant information redacted by the USI			
Personal Information	Patient 136	Personal Information	Irrelevant information redacted by the USI			
Person	Personal Information redacted by the USI	Personal				
Irreleva	Breast clinic					
Person	Personal Information	Personal				
Person	Personal Information redacted by the USI	Personal	X-ray 4/7/15 not picked up 26/08/15 – not SAI was pending Personal Information report patient cancelled for TURP elective surgery due to suspicious lesion on CXR. Had been seen at preassessment where cxr (3/7/15 taken when inpatient) had been seen by preop anaesthetist and report noted bulky hilum. No follow up noted. Repeat cxr organised for 1/9/15. Lesion looked worse and decision taken to cancel elective surgery by myself and surgeon.	Died Personal Information under care of paliative team		
Person	Personal Information redacted by the USI	Personal	Irrelevant information redacted by the USI			
	Personal Information redacted by the USI		Irrelevant information redacted by the USI			
Person al	Personal Information	Personal	Irrelevant information redacted by the USI	Radiology Department to send electronic notification of unexpected abnormal findings to referring clinician, Creation and distribution for Name and Date stamp for each Emergency Department Clinician who are responsible for x-ray audit in the Emergency Department. stamped by Clinician who undertakes the daily audit, 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. 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,	Ensure rapid Each patient record to be Multi- SHSCT Clinicians to consider making an	

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

Personal	Patient 128	01/08/2014 Personal	In August 2012 Patient 128 underwent right radical nephrectomy for renal cell carcinoma. Histology revealed a Fuhrman Grade III tumour. Follow-up management plan included regular CT scans and clinical reviews. Pati was reviewed in February 2013. At this time a CT scan was arranged for May 2013, this was to be followed by a clinical review in June 2013. Pati did have a CT scan in May 2013 as arranged but was not reviewed in June. On 20th August 2014, concerned that Pati might have recurrent disease. Perso GP referred Pati back to the Southern Trust Urology Service. Metastatic recurrence was identified on CT scan.	Personal	The Review Team recommends a robust system for managing overdue Uro-oncology review is established. 2) A handover of patient caseload is required before a consultant leaves the trust. This arrangement must be formalised and robust. 2) A handover of patient caseload is required before a consultant leaves the trust. This arrangement must be formalised and robust. 3) All radiology reports must be actioned if required and signed off by an appropriate person. 4) A timely discharge letter should be dictated for every Urology patient. 5) The review team recommends a communication record is designed and instigated for use with Uro-oncology patients and named Key Worker
Personal	Personal	30th October 2013. Personal	Irrelevant information redacted by the USI		Recommendation 1 Consideration should be given to developing and introducing an electronic system of request for endoscopy 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. 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.
Personal	Personal	Personal	Irrelevant information redacted by the USI		reation 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 ll specialties to ensure that each procedure reflects each specialty's processes. Creation of Trust-Wide written guidance in relation to the validation of reports, results and histology by each Consultant-ead 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 eeds to be considered.
Personal	Person	Personal HCN	Irrelevant information redacted by the USI		The SHSCT Acute Services continue to monitor and reduce the Surgical Review Backlog and waiting times The Trust-Wide Outpatient Consultation Rooms are furnished with the waiting times for Review patients for each Consultant on a monthly basis The Trust-Wide Outpatient Consultation Rooms are furnished with Radiology waiting times for routine procedures 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.
Persona	Perso	Perso	Irrelevant information redacted by the USI		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. 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. 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. 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. 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. 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.
Patient 10	Patient 10	Patient 10	Patient Patient 10 . 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 reported 'Comparison to previous ultrasound dated 24/07/2014 and CT dated 24/06/2014. There is a large well-defined ovoid cystic mass, arising from the upper pole cortex of the right kidney, measuring 8.7 cm x 5.3 cm in size. This lesion is T2 hyperintense, T1 hypointense, and demonstrates no abnormal enhancement. The MR appearances are consistent with a cyst'. No comment made on the MRI report regarding the anterior lower pole which had concerning features on CT and US. The MR appearances are consistent with a cyst'. No comment made on the MRI report regarding the anterior lower pole which had. Had a further CT on 29/10/2014 as follow-up for breats cancer which again reported '3.6 cm exophytic complex cyst is seen in the lower pole of the left kidney anteriorly containing solid and cystic component. Simple cyst seen in the upper pole measuring 7 cm. Left kidney show no focal lesion...Complex cyst right kidney.(previously investigations noted)' Pat was referred to the urology department on 29/10/2014 for assessment and advice regarding the cyst with the MRI report. referral was marked as routine byt the ¦GP (on basis that MRI had reported a benign cyst). Referral was not triaged on receipt. Pat sent OP appointment for 6/1/2016. Consultant had noted in clinic preperation that the MRI report had not commented on the abnormal cyst and requested a further review by a consultant radiologist who reported the abnormal cyst as a likely cystic renal cancer. Pat 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.	Letter OPD 16/08/16 Diagnosis: Currently undergoing treatment for breast cancer Complex renal lesion felt likely to be cystic renal cancer Outcome: Outpatient review 8 weeks I reviewed this lady today. She continues on her breast cancer treatment. She tells me her chemotherapy had to be discontinued. I also note she was admitted with an atypical chest infection towards the end of June. Her next treatment is radiotherapy and this is due to start in the next week or two for duration of 5 weeks of treatment. I plan to review her in 8 weeks. She has had a follow up CT scan which was performed during her admission and on this CT scan the renal lesion is unchanged in size. Providing all is well when I see her in 8 weeks I will look to arrange her renal surgery.	Under review
Personal	Personal	Personal	Irrelevant information redacted by the USI		Feedback should be given to relevant staff as a way of informing practice 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
Personal	Perso	13.05.16	Irrelevant information redacted by the USI		The report should be shared with operational teams for learning There hould be a senior review on vulnerable patients with head/neck injuries .prior to discharge from ED When a patient s 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. Patients re-attending ollowing a recent relevant ED attendance should have a thorough review of notes and investigations from the first attendance A full assessment and examination should be carried out on all patients admitted to MAU in a timely manner. 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. The Trust should create a system for the timely reporting of ED X rays
Person	Personal	29/07/2014 P	Irrelevant information redacted by the USI		The patient is aware that the clinical findings are not typical of a cervical tumour A smear sent about a year ago was inadequate with a recommendation for a repeat in 3 months The patient states that the treatment room nurse took smears in the interim which do not seem to have been sent possibly because they were heavily blood stained 3 inadequate smears would have resulted in colposcopy When I took a smear she bled extremely heavily and I think this is possibly where the opportunity was missed I presume Per will investigate Might need to involve the GPs surgery Pers

Perso	P	19/11/2013 Personal	Irrelevant information redacted by the USI		Need recommendations
Perso	Person	20/07/2015	Irrelevant information redacted by the USI		Not complete
Perso	Personal	16/12/14 Personal			
Perso	Personal	19/08/2016 reported 21/09/2016 Personal			

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

Complaint - Professional Assessment of Needs

1 April 2016 - 30 June 2016

Record name	Ref	ID	Site	Division	Location exact (primary)	Description	Outcome
Personal Information redacted by the USI	AS61.16/17	Personal Information redacted by the USI	CAH	MUC	NEUROP	Irrelevant information redacted by the USI	
	AS23.16/17		DHH	MUC	A/E		
	AS42.16/17		CAH	MUC	A/E		
	AS55.16/17		CAH	MUC	A/E		
	AS10.16/17		CAH	MUC	A/E		
	AS41.16/17		CAH	MUC	A/E		
	AS46.16/17		DHH	MUC	A/E		
	AS56.16/17		CAH	MUC	A/E		

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

Stinson, Emma M

From: Reid, Trudy [redacted]
Sent: 30 September 2016 16:16
To: Boyce, Tracey; Trouton, Heather; Conway, Barry
Subject: Delays in appointments diagnosis or treatment.xlsx
Attachments: Delays in appointments diagnosis or treatment.xlsx

As discusssed

Trudy

Delays in appointment / diagnosis

Datix number	Patient details	HCN	Summary of issue	Outcome	Recommendations if any	
Person	Personal	Personal	CT renal was done on 17/9/15. Report was received by secretary on 25/9/15. CT raised a suspicion of myeloma. Report was seen by me on 26/9/16 and I requested urgent OPD within 1-2 weeks with a specific mention that 'I am happy to see him as an extra patient' But, an OPD appointment was made only 13/7/16.MRI and blood tests requested 13/7/16. We need to wait for the reports. Hopefully, there is no malignancy.	13/07/16 - OPD letter - In essence, it is unlikely that there is any sinister problem but still I have requested an MRI spine and arranged for all relevant blood tests.		
Person	Personal	Personal	Irrelevant information redacted by the USI			
Person	Patient 136	Personal	Patient was waitlisted for removal of ureteric stent on 17/11/2014, This request was registered in the book in stone treatment centre. A green booking form was also filled in at the same time. But this was overlooked. Patient had to have the stent in unnecessarily too long He was reviewed in clinic today and realised that the stent was still ins itu. Arranged to remove the stent only today..			
Person	Personal	Personal	Irrelevant information redacted by the USI			
Irreleva	Breast clinic					
Person	Personal	Personal				
Person	Personal	Personal	X-ray 4/7/15 not picked up 26/08/15 – not SAI was pending Personal report patient cancelled for TURP elective surgery due to suspicious lesion on CXR. Had been seen at preassessment where cxr (3/7/15 taken when inpatient) had been seen by preop anaesthetist and report noted bulky hilum. No follow up noted. Repeat cxr organised for 1/9/15. Lesion looked worse and decision taken to cancel elective surgery by myself and surgeon.	Died Personal under care of paliative team		
Person	Personal Information	Personal	Irrelevant information redacted by the USI			
	Personal Information		Irrelevant information redacted by the USI			
Person al	Personal	Personal	Irrelevant information redacted by the USI		Radiology Department to send electronic notification of unexpected abnormal findings to referring clinician, 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, 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. 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,	

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

Personal	Patient 128	01/08/2014 Personal	In August 2012 Patient 128 underwent right radical nephrectomy for renal cell carcinoma. Histology revealed a Fuhrman Grade III tumour. Follow-up management plan included regular CT scans and clinical reviews. Pati was reviewed in February 2013. At this time a CT scan was arranged for May 2013, this was to be followed by a clinical review in June 2013. Pati did have a CT scan in May 2013 as arranged but was not reviewed in June. On 20th August 2014, concerned that Pati might have recurrent disease, Pati 's GP referred Pati back to the Southern Trust Urology Service. Metastatic recurrence was identified on CT scan.	Personal	The Review Team recommends a robust system for managing overdue Uro-oncology review is established. 2) A handover of patient caseload is required before a consultant leaves the trust. This arrangement must be formalised and robust. 2) A handover of patient caseload is required before a consultant leaves the trust. This arrangement must be formalised and robust. 3) All radiology reports must be actioned if required and signed off by an appropriate person. 4) A timely discharge letter should be dictated for every Urology patient. 5) The review team recommends a communication record is designed and instigated for use with Uro-oncology patients and named Key Worker
Personal	Personal	30th October 2013. Personal	Irrelevant information redacted by the USI		Recommendation 1 Consideration should be given to developing and introducing an electronic system of request for endoscopy 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. 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.
Personal	Personal	Personal	Irrelevant information redacted by the USI		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. 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.
Personal	Person	Personal HCN	Missed cancer.Anaemia CT Colon- May 14 ? cancer ascending colon.Direct visualisation advised- not booked. Patient presented April 15 Obstructing caecal cancer with Liver mets- likely incurable disease.	Deceased 16/12/15	The SHSCT Acute Services continue to monitor and reduce the Surgical Review Backlog and waiting times The Trust-Wide Outpatient Consultation Rooms are furnished with the waiting times for Review patients for each Consultant on a monthly basis The Trust-Wide Outpatient Consultation Rooms are furnished with Radiology waiting times for routine procedures 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.
Persona	Perso	Perso	Irrelevant information redacted by the USI		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. 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. 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. 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. 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. 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.
Patient 10	Patient 10	Patient 10	Patient Patient 10 . 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 reported 'Comparison to previous ultrasound dated 24/07/2014 and CT dated 24/06/2014. There is a large well-defined ovoid cystic mass, arising from the upper pole cortex of the right kidney, measuring 8.7 cm x 5.3 cm in size. This lesion is T2 hyperintense, T1 hypointense, and demonstrates no abnormal enhancement. The MR appearances are consistent with a cyst'. No comment made on the MRI report regarding the anterior lower pole which had concerning features on CT and US. The MR appearances are consistent with a cyst'. No comment made on the MRI report regarding the anterior lower pole which had. Had a further CT on 29/10/2014 as follow-up for breats cancer which again reported '3.6 cm exophytic complex cyst is seen in the lower pole of the left kidney anteriorly containing solid and cystic component. Simple cyst seen in the upper pole measuring 7 cm. Left kidney show no focal lesion...Complex cyst right kidney.(previously investigations noted)' Pati was referred to the urology department on 29/10/2014 for assessment and advice regarding the cyst with the MRI report. referral was marked as routine byt the]GP (on basis that MRI had reported a benign cyst). Referral was not triaged on receipt. Pati sent OP appointment for 6/1/2016. Consultant had noted in clinic preperation that the MRI report had not commented on the abnormal cyst and requested a further review by a consultant radiologist who reported the abnormal cyst as a likely cystic renal cancer. Pati 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.	Letter OPD 16/08/16 Diagnosis: Currently undergoing treatment for breast cancer Complex renal lesion felt likely to be cystic renal cancer Outcome: Outpatient review 8 weeks I reviewed this lady today. She continues on her breast cancer treatment. She tells me her chemotherapy had to be discontinued. I also note she was admitted with an atypical chest infection towards the end of June. Her next treatment is radiotherapy and this is due to start in the next week or two for duration of 5 weeks of treatment. I plan to review her in 8 weeks. She has had a follow up CT scan which was performed during her admission and on this CT scan the renal lesion is unchanged in size. Providing all is well when I see her in 8 weeks I will look to arrange her renal surgery.	Under review
Personal	Personal	Personal	Irrelevant information redacted by the USI		Feedback should be given to relevant staff as a way of informing practice 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
Personal	Perso	13.05.16			The report should be shared with operational teams for learning There should be a senior review on vulnerable patients with head/neck injuries .prior to discharge from ED 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. Patients re-attending following a recent relevant ED attendance should have a thorough review of notes and investigations from the first attendance A full assessment and examination should be carried out on all patients admitted to MAU in a timely manner. 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. The Trust should create a system for the timely reporting of ED X rays
Person	Personal	29/07/2016 P			The patient is aware that the clinical findings are not typical of a cervical tumour A smear sent about a year ago was inadequate with a recommendation for a repeat in 3 months The patient states that the treatment room nurse took smears in the interim which do not seem to have been sent possibly because they were heavily blood stained B inadequate smears would have resulted in colposcopy When I took a smear she bled extremely heavily and I think this is possibly where the opportunity was missed I presume Per will investigate Might need to involve the GPs surgery Pers

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

Perso	P	19/11/2013 Personal	Irrelevant information redacted by the USI		Need recommendations
Perso	Person	20/07/2015	Irrelevant information redacted by the USI		Not complete
Perso	Personal	16/12/14 Personal			
Perso	Personal	19/08/2016 reported 21/09/2016 Personal			

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

Complaint - Professional Assessment of Needs

1 April 2016 - 30 June 2016

Record name	Ref	ID	Site	Division	Location exact (primary)	Description	Outcome
Personal Information redacted by the USI	AS61.16/17	Personal Information redacted by the USI	CAH	MUC	NEUROP	Irrelevant information redacted by the USI	
	AS23.16/17		DHH	MUC	A/E		
	AS42.16/17		CAH	MUC	A/E		
	AS55.16/17		CAH	MUC	A/E		
	AS10.16/17		CAH	MUC	A/E		
	AS41.16/17		CAH	MUC	A/E		
	AS46.16/17		DHH	MUC	A/E		

Personal Information redacted by the USI	AS56.16/17	Personal Information redacted by the USI	CAH	MUC	A/E	Irrelevant information redacted by the USI

Outbreak – cost –

Friday 25th November

Result sign off. – Dr Wright
– Kathleen Weeve
– Brian

NICER lab sign off

Xray / histology / cytology.

New technology allows us to sign off all

Proposal – All results are signed off –

11 k – 12.5 k results 50% go to GPs to are acknowledged

6 k to acute

* Obs & gynae & maternity – Shared care

Brian to check ECR re what is available – – Sign off by ward
– Team
– Consultant

* Switch paper off – by ward –
– OPD

* Training.

* Process – admin –

Speak to Heather re formality of midwives sign off.

ENT – Irrelevant information redacted by the USI

OPD

Pilot 6 weeks + review –

From: Reid, Trudy
Sent: 05 June 2017 18:00
To: Boyce, Tracey
Subject: Delays
Attachments: Delays in appointments diagnosis or treatment for AMD meeting.xlsx
Delays action plan 2 06 17.xlsx

Tracey for discussion tomorrow, if we are happy I will put it under AOB for tomorrows governance meeting

Regards,

Trudy

Trudy Reid
Acute Clinical and Social Care Governance Coordinator
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ
Telephone Personal Information redacted by the USI
Mobile Personal Information redacted by the USI

Delays in appointment / diagnosis

Datix number	HCN	Summary of issue	Outcome	Investigation / Recommendations if any	
Person	Personal	CT renal was done on 17/9/15. Report was received by secretary on 25/9/15. CT raised a suspicion of myeloma. Report was seen by me on 26/9/16 and I requested urgent OPD within 1-2 weeks with a specific mention that 'I am happy to see him as an extra patient' But, an OPD appointment was made only 13/7/16.MRI and blood tests requested 13/7/16. We need to wait for the reports. Hopefully, there is no malignancy.	13/07/16 - OPD letter - In essence, it is unlikely that there is any sinister problem but still I have requested an MRI spine and arranged for all relevant blood tests. 31 08 16 Dear Personal We discussed all of your recent imaging; ultrasound, CT and MRI scan at our x-ray meeting this morning. This reported that there was no concerning features and that the abnormalities seen within your spine are only small benign collections of blood vessels. We have therefore discharged you back to the care of your GP	140716cc-this incident was incorrectly classified on submission. Has been amended to be managed by SEC with FSS. AD and HOS notified by communication emails today. Access provided. Access also provided to Irrl and Irrl to support investigation. Communication emails sent. Response from Irrl -I can confirm that the Secretary emailed the Referral & Booking Centre to book this appointment as per Consultant instruction (the clinics are usually booked 6 weeks in advance and the Secretary does not have the facility to overbook clinics). I have therefore liaised with Acting RBC Manager and on this occasion it would appear that this has been an oversight i.e. human error due to the volume and lack of capacity of clinic appointment slots. The RBC Manager and I will review process to ensure failsafe's and avoid recurrence.	
Person	Personal	Irrelevant information redacted by the USI			
Person	Personal				
Person	Personal	X-ray 4/7/15 not picked up 26/08/15 – not SAI was **pending** Personal report patient cancelled for TURP elective surgery due to suspicious lesion on CXR. Had been seen at preassessment where cxr (3/7/15 taken when inpatient) had been seen by preop anaesthetist and report noted bulky hilum. No follow up noted. Repeat cxr organised for 1/9/15. Lesion looked worse and decision taken to cancel elective surgery by myself and surgeon.	Died Personal under care of paliative team		
Person	Personal 5/11/15	Irrelevant information redacted by the USI			
Person Personal	Personal			Recommendation 1 Radiology Department to send electronic notification of unexpected abnormal findings to referring clinician, Recommendation 2 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. Recommendation 3 Each patient record to be stamped by Clinician who undertakes the daily audit, 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. Recommdation 5 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,	
Personal	01/08/2014 Personal	In August 2012 Patient 128 underwent right radical nephrectomy for renal cell carcinoma. Histology revealed a Fuhrman Grade III tumour. Follow-up management plan included regular CT scans and clinical reviews. Patie was reviewed in February 2013. At this time a CT scan was arranged for May 2013, this was to be followed by a clinical review in June 2013. Patie did have a CT scan in May 2013 as arranged Prominent subentimeter lymph node in the right renal hilar/porta hepatic region but is not significantly enlarged according to size criteria, Conclusion on May CT scan No metastassis or significantly enlarged lymph nodes are seen, but **was not reviewed in June**. On 20th August 2014, concerned that Pati might have recurrent disease. Pati's GP referred Pati back to the Southern Trust Urology Service. Metastatic recurrence was identified on CT scan.CT on 01/09/14 6x3.4 cm enhancing, retrocaval mass seen on the medial aspect of liver. Multiple irregular hypodense lesion seen in the segment VI of the liver, the largest measure 6cm in size.. Stones seen in the gallbladder. Spleen and pancreas appear normal. Left kidney show no focal lesion. Urinary bladder is empty. No uterine lesion seen. Diverticular disease seen in the sigmoid colon. Multilevel degenerative changes are seen in the spine. Conclusion Recurrent disease. 1. Large perideudenal/mesenteric mass which appear to involve/projecting into the lumen of deudenum. Endoscopy/barium meal examination suggested for further evaluation. 2. Large retrocaval mass on the medial aspect of the liver. 3. Large metastasis in the segment VI of the liver.	At the MDT we felt on balance she should have surgery and the Oncologist did not feel she would need pre-op chemotherapy. I have therefore discussed this with her today and I am boarding her for same for the 3 November.	The Review Team recommends a robust system for managing overdue Uro-oncology review is established. 2) A handover of patient caseload is required before a consultant leaves the trust. This arrangement must be formalised and robust. 2) A handover of patient caseload is required before a consultant leaves the trust. This arrangement must be formalised and robust. 3) All radiology reports must be actioned if required and signed off by an appropriate person. 4) A timely discharge letter should be dictated for every Urology patient. 5) The review team recommends a communication record is designed and instigated for use with Uro-oncology patients and named Key Worker	
Personal	30th October 2013. Personal	Irrelevant information redacted by the USI		Recommendation 1 Consideration should be given to developing and introducing an electronic system of request for endoscopy 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. 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.	
Personal	Personal	Irrelevant information redacted by the USI		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. 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.	
Personal	Personal HCN	Irrelevant information redacted by the USI		The SHSCT Acute Services continue to monitor and reduce the Surgical Review Backlog and waiting times The Trust-Wide Outpatient Consultation Rooms are furnished with the waiting times for Review patients for each Consultant on a monthly basis The Trust-Wide Outpatient Consultation Rooms are furnished with Radiology waiting times for routine procedures 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.	

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

Person	Pers	Irrelevant information redacted by the USI		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. 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. 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. 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. 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. 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.
Personal	13.05.16	Irrelevant information redacted by the USI		1) The report should be shared with operational teams for learning 2) There should be a senior review on vulnerable patients with head/neck injuries prior to discharge from ED 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. 4) Patients re-attending following a recent relevant ED attendance should have a thorough review of notes and investigations from the first attendance 5) A full assessment and examination should be carried out on all patients admitted to MAU in a timely manner. 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. 7) The Trust should create a system for the timely reporting of ED X rays
Person	29/07/2014 Pe	Irrelevant information redacted by the USI		The patient is aware that the clinical findings are not typical of a cervical tumour A smear sent about a year ago was inadequate with a recommendation for a repeat in 3 months The patient states that the treatment room nurse took smears in the interim which do not seem to have been sent possibly because they were heavily blood stained 3 inadequate smears would have resulted in colposcopy When I took a smear she bled extremely heavily and I think this is possibly where the opportunity was missed I presume Per will investigate Might need to involve the GPs surgery Pers
Pers	19/11/2013 Personal	Irrelevant information redacted by the USI		RECOMMENDATIONS FOLLOWING THE LEVEL ONE SEA: Recommendation 1 Awareness of Desmoplastic Melanoma should be raised within the Trust to enhance learning. Action This case was presented at the Dermatology Multidisciplinary Meeting on 30/04/15 Completed 30/04/15 Recommendation 2 Steps should be taken to address delays in Dermatology patients being reviewed at Outpatients. Action The Trust should consider a workforce review in relation to medical staffing in Dermatology.
Pers	20/07/2015	Irrelevant information redacted by the USI		Recommendation 1 The current system for follow up of patients that have suspicious chest X rays needs reviewed and improved. Recommendation 2 Relevant staff and teams should receive feedback to raise awareness of this problem and case. Recommendation 3 More clinical information should be available on NIPACS
		Irrelevant information redacted by the USI		
Personal	Personal	Patient Patient 10 . 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 reported 'Comparison to previous ultrasound dated 24/07/2014 and CT dated 24/06/2014. There is a large well-defined ovoid cystic mass, arising from the upper pole cortex of the right kidney, measuring 8.7 cm x 5.3 cm in size. This lesion is T2 hyperintense, T1 hypointense, and demonstrates no abnormal enhancement. The MR appearances are consistent with a cyst'. No comment made on the MRI report regarding the anterior lower pole which had concerning features on CT and US. The MR appearances are consistent with a cyst'. No comment made on the MRI report regarding the anterior lower pole which had. Had a further CT on 29/10/2014 as follow-up for breats cancer which again reported '3.6 cm exophytic complex cyst is seen in the lower pole of the left kidney anteriorly containing solid and cystic component. Simple cyst seen in the upper pole measuring 7 cm. Left kidney show no focal lesion...Complex cyst right kidney.(previously investigations noted)' Pati was referred to the urology department on 29/10/2014 for assessment and advice regarding the cyst with the MRI report. referral was marked as routine byt the |GP (on basis that MRI had reported a benign cyst). Referral was not triaged on receipt. Pati sent OP appointment for 6/1/2016. Consultant had noted in clinic preperation that the MRI report had not commented on the abnormal cyst and requested a further review by a consultant radiologist who reported the abnormal cyst as a likely cystic renal cancer. Pati 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. **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 Pati sent OP appointment for 6/1/2016. Pati 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.**		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 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.
Pers		Irrelevant information redacted by the USI		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. Recommendation 2 - Consideration should be given to rolling out on-line electronic referrals within Secondary Health Care settings. Recommendation 3 - Referrals relating to suspected cancer should be forwarded to the appropriate Cancer Services team for advancement. 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. **Recommendation 5 - All necessary personnel must be made aware of the Referral process and how to access this. 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. Recommendation 7 - General Practitioners should be informed of all onward referrals, "Red Flag" /"31 Day Target" referrals should be clearly identified in correspondences.**
Pers		Irrelevant information redacted by the USI	hosed.	**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. **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.

				Recommendation 3 - Presentation to both SHSCT MUSC M&M **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	30/03/2017	Irrelevant information redacted by the USI		
Personal	02/08/2016			

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

Delays Action plan

Reference number	Recommendations	Designated responsible person	Action required	Date for completion/ timescale		Date recommendation completed with evidence
1	Regular performance management reports		1. OP traige report		Triage report to Secretaries, HoS and AD (monthly)	Ongoing
			2. No outcome/disposal report		Service administrators send to secretaries and ward clerks (monthly)	Ongoiing
			3. Dictation backlog report		Service administrators send to Consultant, HoS & ADs (monthly)	Ongoing
			4. Typing backlog report		Service administrators send to Consultant, HoS and ADs (monthly)	Ongoing
			5. Clinic outcome sheets/documented outcome at clinic		Adhoc check of who is using clinic outcome sheets/clinic lists	
			6. Clinic attendace report		HF circulates weekly to service administrators - then to secretaries and receptions	Ongoing
			7. Review backlog report			
			8. Discharge awaiting result report (consider rule for appropriate time span for results)		Service administrators to secretaries monthly	ongoing
			9. DTR / DTC report (consider rule for appropriate time span for results)		Referral and booking centre	
			10. Missing e-discharge report			

2	New development and changes to processes should include administration staff in project groups		Invitation to be sent to senior administration staff if new developments or new systems are to be implemented which may impact on administration processes			
			Administration senior staff to attend project group meetings			
	Medical-local staff induction on documentation requirements		Develop a local induction programme by specialty area			
			A4 Hand out to be developed			
			Audit templated to be developed			
			Audit and feed at specialty meeting			
	Bleep numbers to be available		Medical staff bleep numbers to be provided to appropriate staff for display and updated as bleep numbers change			
	Medical staffing rotas to be available		Medical staff rotas to be provided to appropriate staff for display and updated as changed			
			Develop circuation list for rotas and updated rotas			
			Develop a shared drive for sharing of medical rotas			
	Medical & Sugical Model Rules to be shared		Draft a poster with various model rules			
			Short presentation to be developed and delivered to ward clerks and secretaries			
	E discharge to be completed in a timely manner for all discharges		Medical staff to complete e-discharge for all patients to include results follow up and appointments required			
			Guidance on discharge letters to be provided to medical staff			
			Trial of discharge pharmacist			
			Ward clerk/secretary to put appointments on PAS or send to referral and booking centre or list as DRO-specific SOPs to amended as required			
	Sign off for results e.g. X-ray, histology etc					

Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES

Director: Mrs Esther Gishkori

Tel: Personal Information redacted by the USI

ACUTE CLINICAL GOVERNANCE ACTIONS

Date: Friday, 9th June 2017 8am

1.0	**Apologies**: Anita Carroll, Mark Haynes, Martina Hogan, Dr Boyd, Jeff McCracken, Colin Weir, Gareth Hampton.	
2.0	**Matters Arising/Actions**	
3.0	**Standards and Guidelines** Acute Services SG Forum - Agenda 06 Ju SQR-SAI-2017-028 -Blood Transfusion (T SQR-SAI-2017-027 - How to examine newt SQR-SAI-2017-026 - Reducing the risk of t ISO Connectors DCMO Letter HSC-SQSD-16-17 Managing risks during Trudy gave an update on the three latest alerts received – risks of retained throat packs, blood transfusions and examination of new born for red eye reflex. Neuoraxial connectors – still some difficulty in sourcing them but work is ongoing.	
4.0	**Review of process regarding clinical results to minimise the risk of adverse incidents** Delays in appointments diagnos Delays action plan 2 06 17.xlsx Trudy led the discussion on the above reports. The action plan was developed following meetings with the various admin teams involved. The admin teams are going to put some time frames around some of the reports they are proposing in relation to escalation to consultants. Sign off of results was discussed. Emailing of results does seem to be helping the ED issues. Dr Murphy feels that the responsibility for follow up lies with the discharging consultant. The discussions re who the results should be emailed back to. The key issue is around unexpected results. Would the electronic acknowledgment of results help? Would an admin role a bit like the cancer trackers help? A group will be set up with Katherine Robinson, Helen Forde, David Gracey, Philip Murphy, Mary Burke and Gareth Hampton will assist.	
5.0	**Acute Medical Audit Committee** No discussion this meeting.	

6.0	**SAIs**: SAI Summary spread sheet – for information  SAI Position Report 5 06 17.xlsx SAI recommendations – for information  SAI Recommendations 2 (Personal - Trudy presented the report in Dr Hogan's absence. Report approved. As this is combined report it will also go through the CYP process.  RCA report Personal Draft 7.6.17 approved.doc Personal – Dr Murphy presented the report. The homes understanding of enoxaparin was a large facto – even in the lead up to the patient's attendance at hospital initially and this is being addressed by OPPC with them. Report approved.  Personal 05 June 17 1.docx Personal – Trudy presented the report. Regionally the paediatric age has changed from 14 to 16 although CYP has still to implement this in our Trust. Esther to raise this with CYP. Apparently Neta Chada has also spoken to the Medical Director about this. Report approved so that it can now go to CYP for their approval. We will also ask for a meeting re the paed age issue with Dr Wright.  Report Checklist Personal draft 8.docx Personal information	Esther Trudy
7.0	**Complaints Position** all for information • Quarterly Complaints Report • Ombudsman Recommendations • Reopened complaints • Weekly reopened • Numbers of complaints • Complaint action plan • Complaint template – updated  Formal Complaints April 17 - May 17.xlsx  complaints and enquiries 2017 Template 2  Current Complaints 070617.xlsx  Weekly Re-Opened Report 050617.xlsx	All

	Ombudsman weekly 050617.xlsx Recipient.docx Template - Complaint Action Plan.docx	
8.0	**Incident Management Position** • Incident review position - (paper enclosed) Incident Review Position as at 010617 • Majors and above for May 2016 (paper enclosed) Major and Catastrophic Incident • Violence and aggression, absconding pts and Falls reports Violence and Aggression Incidents Violence and Aggression Incidents - Acute Services (01.0 Absconding Incidents Acute Services - Falls Incidents (Moderate a • Medicines incidents Medication incidents April 2017 Acute.xlsx •	All
9.0	**Regional NEWS Trigger Reset Guidance** • update	
10.0	**Risk Registers** – additions, amendments and closures – all for information SEC.ATICS Div.HOS.Team RR Ju Pharmacy Risk Register May17.xlsx MUC HOS.Team RR May17.xlsx MUC RR May17.xlsx IMWH Div.HOS.Team RR May17.xlsx FSS Div.HOS.Team RR May17.xlsx CCS Div.HOS.TEAM RR May17.xlsx Directorate RR May17.xlsx	ADs & AMDs
11.0	**Management of Trust Clinical Guidelines**	
12.0	**Any Other Business** **Acute Governance report – Colum Robinson** **Patient Support report** **Effectiveness and Evaluation** Acute Governance Report June17.doc Patient Support Enquiries Report April Patient Support Enquiries Report April (6) Corporate Governance Paper fo	
13.0	**Date of Next Meeting:** **Friday 7th July 2017 at 8.00 am in the Board Room, CAH**	

Delays in appointment / diagnosis

Datix number	HCN	Summary of issue	Investigation / Recommendations if any	
Persona	Personal	CT renal was done on 17/9/15. Report was received by secretary on 25/9/15. CT raised a suspicion of myeloma. Report was seen by me on 26/9/16 and I requested urgent OPD within 1-2 weeks with a specific mention that 'I am happy to see him as an extra patient' But, an OPD appointment was made only 13/7/16.MRI and blood tests requested 13/7/16. We need to wait for the reports. Hopefully, there is no malignancy.	140716cc-this incident was incorrectly classified on submission. Has been amended to be managed by SEC with FSS. AD and HOS notified by communication emails today. Access provided. Access also provided to Per and Per to support investigation. Communication emails sent. Response from Per -I can confirm that the Secretary emailed the Referral & Booking Centre to book this appointment as per Consultant instruction (the clinics are usually booked 6 weeks in advance and the Secretary does not have the facility to overbook clinics). I have therefore liaised with Acting RBC Manager and on this occasion it would appear that this has been an oversight i.e. human error due to the volume and lack of capacity of clinic appointment slots. The RBC Manager and I will review process to ensure failsafe's and avoid recurrence.	
Person	Personal	Irrelevant information redacted by the USI		
Persona	Personal	Irrelevant information redacted by the USI		
Person	Personal	X-ray 4/7/15 not picked up 26/08/15 – not SAI was **pending** Person report patient cancelled for TURP elective surgery due to suspicious lesion on CXR. Had been seen at preassessment where cxr (3/7/15 taken when inpatient) had been seen by preop anaesthetist and report noted bulky hilum. No follow up noted. Repeat cxr organised for 1/9/15. Lesion looked worse and decision taken to cancel elective surgery by myself and surgeon.		
Person	Personal 5/11/15	Irrelevant information redacted by the USI		
Person	Personal			
Person SAI Perso	Personal		Recommendation 1 Radiology Department to send electronic notification of unexpected abnormal findings to referring clinician, Recommendation 2 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. Recommendation 3 Each patient record to be stamped by Clinician who undertakes the daily audit, 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. Recommdation 5 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,	
Personal	01/08/2014 Personal	In August 2012 Patient 128 underwent right radical nephrectomy for renal cell carcinoma. Histology revealed a Fuhrman Grade III tumour. Follow-up management plan included regular CT scans and clinical reviews. Patie was reviewed in February 2013. At this time a CT scan was arranged for May 2013, this was to be followed by a clinical review in June 2013. Patie did have a CT scan in May 2013 as arranged Prominent subentimeter lymph node in the right renal hilar/porta hepatic region but is not significantly enlarged according to size criteria, Conclusion on May CT scan No metastassis or significantly enlarged lymph nodes are seen, but **was not reviewed in June**. On 20th August 2014, concerned that Patie might have recurrent disease. Patie s GP referred Patie back to the Southern Trust Urology Service. Metastatic recurrence was identified on CT scan.CT on 01/09/14 6x3.4 cm enhancing, retrocaval mass seen on the medial aspect of liver. Multiple irregular hypodense lesion seen in the segment VI of the liver, the largest measure 6cm in size.. Stones seen in the gallbladder. Spleen and pancreas appear normal. Left kidney show no focal lesion. Urinary bladder is empty. No uterine lesion seen. Diverticular disease seen in the sigmoid colon. Multilevel degenerative changes are seen in the spine. Conclusion Recurrent disease. 1. Large perideudenal/mesenteric mass which appear to involve/projecting into the lumen of deudenum. Endoscopy/barium meal examination suggested for further evaluation. 2. Large retrocaval mass on the medial aspect of the liver. 3. Large metastasis in the segment VI of the liver.	The Review Team recommends a robust system for managing overdue Uro-oncology review is established. 2) A handover of patient caseload is required before a consultant leaves the trust. This arrangement must be formalised and robust. 2) A handover of patient caseload is required before a consultant leaves the trust. This arrangement must be formalised and robust. 3) All radiology reports must be actioned if required and signed off by an appropriate person. 4) A timely discharge letter should be dictated for every Urology patient. 5) The review team recommends a communication record is designed and instigated for use with Uro-oncology patients and named Key Worker	
Personal	30th October 2013. Personal	Irrelevant information redacted by the USI	Recommendation 1 Consideration should be given to developing and introducing an electronic system of request for endoscopy 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. 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.	

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

Personal	Personal	Irrelevant information redacted by the USI	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. 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.	
Personal	Personal HCN	Irrelevant information redacted by the USI	The SHSCT Acute Services continue to monitor and reduce the Surgical Review Backlog and waiting times The Trust-Wide Outpatient Consultation Rooms are furnished with the waiting times for Review patients for each Consultant on a monthly basis The Trust-Wide Outpatient Consultation Rooms are furnished with Radiology waiting times for routine procedures 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.	
Personal	Perso	Irrelevant information redacted by the USI	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. 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. 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. 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. 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. 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.	
Personal	13.05.16	Irrelevant information redacted by the USI	1) The report should be shared with operational teams for learning 2) There should be a senior review on vulnerable patients with head/neck injuries prior to discharge from ED 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. 4) Patients re-attending following a recent relevant ED attendance should have a thorough review of notes and investigations from the first attendance 5) A full assessment and examination should be carried out on all patients admitted to MAU in a timely manner. 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. 7) The Trust should create a system for the timely reporting of ED X rays	
Persona	29/07/2016 Personal	Irrelevant information redacted by the USI	The patient is aware that the clinical findings are not typical of a cervical tumour A smear sent about a year ago was inadequate with a recommendation for a repeat in 3 months The patient states that the treatment room nurse took smears in the interim which do not seem to have been sent possibly because they were heavily blood stained 3 inadequate smears would have resulted in colposcopy When I took a smear she bled extremely heavily and I think this is possibly where the opportunity was missed I presume Per will investigate Might need to involve the GPs surgery Pers	
Perso	19/11/2013 Personal	Irrelevant information redacted by the USI	RECOMMENDATIONS FOLLOWING THE LEVEL ONE SEA: Recommendation 1 Awareness of Desmoplastic Melanoma should be raised within the Trust to enhance learning. Action This case was presented at the Dermatology Multidisciplinary Meeting on 30/04/15 Completed 30/04/15 Recommendation 2 Steps should be taken to address delays in Dermatology patients being reviewed at Outpatients. Action The Trust should consider a workforce review in relation to medical staffing in Dermatology.	
Perso	20/07/2015	Irrelevant information redacted by the USI	Recommendation 1 The current system for follow up of patients that have suspicious chest X rays needs reviewed and improved. Recommendation 2 Relevant staff and teams should receive feedback to raise awareness of this problem and case. Recommendation 3 More clinical information should be available on NIPACS	
		Irrelevant information redacted by the USI		

Personal	Patient 10	Patient Patient 10 . 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 reported 'Comparison to previous ultrasound dated 24/07/2014 and CT dated 24/06/2014. There is a large well-defined ovoid cystic mass, arising from the upper pole cortex of the right kidney, measuring 8.7 cm x 5.3 cm in size. This lesion is T2 hyperintense, T1 hypointense, and demonstrates no abnormal enhancement. The MR appearances are consistent with a cyst'. No comment made on the MRI report regarding the anterior lower pole which had concerning features on CT and US. The MR appearances are consistent with a cyst'. No comment made on the MRI report regarding the anterior lower pole which had. Had a further CT on 29/10/2014 as follow-up for breats cancer which again reported '3.6 cm exophytic complex cyst is seen in the lower pole of the left kidney anteriorly containing solid and cystic component. Simple cyst seen in the upper pole measuring 7 cm. Left kidney show no focal lesion...Complex cyst right kidney.(previously investigations noted)' Pati was referred to the urology department on 29/10/2014 for assessment and advice regarding the cyst with the MRI report. referral was marked as routine byt the |GP (on basis that MRI had reported a benign cyst). Referral was not triaged on receipt. Pati sent OP appointment for 6/1/2016. Consultant had noted in clinic preperation that the MRI report had not commented on the abnormal cyst and requested a further review by a consultant radiologist who reported the abnormal cyst as a likely cystic renal cancer. Pati 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. **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 Pati sent OP appointment for 6/1/2016. Pati 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.**	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 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.
Perso		Irrelevant information redacted by the USI	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. Recommendation 2 - Consideration should be given to rolling out on-line electronic referrals within Secondary Health Care settings. Recommendation 3 - Referrals relating to suspected cancer should be forwarded to the appropriate Cancer Services team for advancement. 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. **Recommendation 5 - All necessary personnel must be made aware of the Referral process and how to access this. 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.** **Recommendation 7 - General Practitioners should be informed of all onward referrals, "Red Flag" /"31 Day Target" referrals should be clearly identified in correspondences.**
Perso		Irrelevant information redacted by the USI	**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. **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. **Recommendation 3 -** Presentation to both SHSCT MUSC M&M **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	30/03/2017	Irrelevant information redacted by the USI	
Personal	02/08/2016	Irrelevant information redacted by the USI	

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

Complaint - Professional Assessment of Needs

1 April 2016 - 30 June 2016

Record name	Ref	ID	Site	Division	Location exact (primary)	Description	Outcome
Personal Information redacted by the USI	AS61.16/17	Personal Information redacted by the USI	CAH	MUC	NEUROP	Irrelevant information redacted by the USI	
	AS23.16/17		DHH	MUC	A/E		
	AS42.16/17		CAH	MUC	A/E		
	AS55.16/17		CAH	MUC	A/E		
	AS10.16/17		CAH	MUC	A/E		
	AS41.16/17		CAH	MUC	A/E		
	AS46.16/17		DHH	MUC	A/E		

Personal Information redacted by the USI	AS56.16/17	Personal Information redacted by the USI	CAH	MUC	A/E	Irrelevant information redacted by the USI

Received from Trudy 6/05/2023. Annotated by the Urology Services Inquiry.

Delays Action plan

Reference number	Recommendations	Designated responsible person	Action required	Date for completion/ timescale		Date recommendation completed with evidence
1	Regular performance management reports		1. OP traige report		Triage report to Secretaries, HoS and AD (monthly)	Ongoing
			2. No outcome/disposal report		Service administrators send to secretaries and ward clerks (monthly)	Ongoiing
			3. Dictation backlog report		Service administrators send to Consultant, HoS & ADs (monthly)	Ongoing
			4. Typing backlog report		Service administrators send to Consultant, HoS and ADs (monthly)	Ongoing
			5. Clinic outcome sheets/documented outcome at clinic		Adhoc check of who is using clinic outcome sheets/clinic lists	
			6. Clinic attendace report		HF circulates weekly to service administrators - then to secretaries and receptions	Ongoing
			7. Review backlog report			
			8. Discharge awaiting result report (consider rule for appropriate time span for results)		Service administrators to secretaries monthly	ongoing
			9. DTR / DTC report (consider rule for appropriate time span for results)		Referral and booking centre	
			10. Missing e-discharge report			
2	New development and changes to processes should include administration staff in project groups		Invitation to be sent to senior administration staff if new developments or new systems are to be implemented which may impact on administration processes			
			Administration senior staff to attend project group meetings			

	Medical-local staff induction on documentation requirements		Develop a local induction programme by specialty area			
			A4 Hand out to be developed			
			Audit templated to be developed			
			Audit and feed at specialty meeting			
	Bleep numbers to be available		Medical staff bleep numbers to be provided to appropriate staff for display and updated as bleep numbers change			
	Medical staffing rotas to be available		Medical staff rotas to be provided to appropriate staff for display and updated as changed			
			Develop circuation list for rotas and updated rotas			
			Develop a shared drive for sharing of medical rotas			
	Medical & Sugical Model Rules to be shared		Draft a poster with various model rules			
			Short presentation to be developed and delivered to ward clerks and secretaries			
	E discharge to be completed in a timely manner for all discharges		Medical staff to complete e-discharge for all patients to include results follow up and appointments required			
			Guidance on discharge letters to be provided to medical staff			
			Trial of discharge pharmacist			
			Ward clerk/secretary to put appointments on PAS or send to referral and booking centre or list as DRO-specific SOPs to amended as required			
	Sign off for results e.g. X-ray, histology etc					

SAI REPORT

Division	Patient	Background	Comment	Panel	Owner
		Cases for Screening			
ED/MUSC	Personal Information	ED CXr Missed CA lung	Information of Xray escalation required / review again / Take to Acute Clinical Goverance meeting for discussion		
ED/MUSC	Personal Information redacted by the USI	Perforation ? Following PEG tube insertion	Write up as internanl SEA and organise family meeting with Dr Murphy and Dr Hampton		
MUSC	Personal Information	# Ankle endocarditis RIP	Time line started Requested RVH and DHH notes to enable completion of time line		Danielle following up notes.
SEC	Personal Information	Delay in tumour management	Need time line		
SEC	Personal Information	Not preped for CT scan - aspirated	Need time line		
SEC	Personal Information	CT showed PE not actioned	Time line complete		
MUSC	Personal Information	Delayed review new lesion	Screened not SAI		
CCS	Personal Information	Delayed review disease progression	Screened by Medicine for CCS screening Friday 26th May		
MUSC	Personal Information redacted by the USI	Cardiology referral by Dr Re respiratory referral	rescreen		
MUSC	Personal Information	? Sepsis screen post M&M	rescreen		
ED/MUSC	Personal Information	H+C Personal Information medical admission 10/3/17 - 16/3/17 ECG performed in A+E - not reviewed Clinical history - off Feet + anaemia + infection B/g bioprosthetic AVR / CCF / Colorectal CA Treated for infection ? source with initial improvement and MDT input Abrupt decline on ward 16th 4:30 - pulmonary oedema with trop 4000 ECG from 16th and 10th reviewed - missed presentation of STEMI Subsequent complaint letter relating to RVH letter about mycobacterium from march 2017	Notes requested for time line preparation		
SEC	Patient 12	Delay in diagnosis and treatment of prostate cancer	Time line complete	Dr Hampton, Mary Burke.	
sec	Patient 14	Delay in diagnosis and management of prostate cancer	Notes requested- time line complete		Danielle requested notes for Trudy 17.05.17.
SEC	Patient 11	Delay in diagnosis and treatment of prostate cancer	Notes requested- time line complete		Danielle requested notes for Trudy 22.05.17.
MUSC/SEC	Personal Information redacted by the USI	Ulcerative colitis	Notes requested for time line preparation		
SEC/MUSC	Personal Information redacted	Transferred to 3S under wrong specialty	05/06/2017 Discussed at screening Mrs McVey to Speak to Mr Carroll re solutions		
		SAIs waiting completion			
SEC	Patient 13	Missed urology CA	Need datix then notify, need external urologist, complete notificatin		
SEC	Patient 16	Delay in treatment - missed oportunity for DXT	Need datix then notify, need external urologist , complete notification	Need panel members	
MUSC	Personal Information	No cardiology referral	Need datix then notif HSCB set up meeting	Need panel members	
ED/MUSC	Personal Information	Aneurysm	Need meeting organised.	Dr Moore, Mary Burke & Trudy/Kay	Danielle organising meeting.
SEC/MUSC	Personal Information	OGD enoxaparin	Sent to OPPC for final drafting	Dr Savage, Kay Carroll, Paul Sheridan, Trudy Reid.	Pamela organising meeting.
SEC	Personal Information	DKA	Finalising Report , awaiting comments from Shilpa	For final draft	
	Personal Information redacted by the USI	OGD adenocarcinoma	Was this reported to HSCB???? Advice required	Dr Chada, Dr Brown, Dr Fergusion, Grace Hamilton, Nichola McClennaghan etc at final draft	
SEC	Personal Information	RVH neucrotic feet	1st Meeting held with Connie		
ED/MUSC	Personal Information	Absconded fall from a bridge	1st Meeting held with Connie	Dr John, Mr Lewis, Sandra Burns, John Harty, Trudy Reid	
ED/MUSC	Personal Information	Missed lung CA	Ready for AMD governace		
IMWH	Personal Information	RIP	Finalising Report	Passed AMD governance	David to organise letter to family and report to HSCB
IMWH	Personal Information	Suicide - Mental health & IMWH	Mental health leading		
ED/MUSC	Personal Information redacted by the USI	spinal fracture	1st Meeting held with Connie		
MUSC	Personal Information redacted by the USI	Fall	Need meeting organised.	Meeting organised for 25.05.17 at 2pm.	
ED/MUSC	Personal Information	ED tansfer to CCU DHH	Need meeting organised.	Dr Savage, Mary Burke, Catriona McGoldrick, Trudy Reid	Pamela organising meeting.
ED/MUSC	Personal Information	Delay in diagnosis and transfer Cardiogenic shock	Need meeting organised.	Paul McGarry, Paul Smyth, Trudy Reid	Pamela organising meeting.
MUSC & SEC	Personal Information	Fall and delayed diagnosis of Fracture	Letter needed for family and report to HSCB Approved at ACG etc	Dr Hampton, Mary Burke, Michael McConville NIAS, Trudy Reid	Danielle organising meeting.
ED/MUSC	Personal Information redacted by the USI	Carbon monoxide poisioning	Approved at ACG etc , family notification letter required		David to organise letter to family and report to HSCB
MUSC	Personal Information	Norovirus	Trudy to discuss with Dr Boyd re recommendations and return to ACG in June 17 for approval.		David to organise letter to family and report to HSCB
SEC	Endoscopy	Decontamination	Need drafted		
ED/MUSC	Personal Information	Fall in ED #C1	Organise meeting	Hilda Nicoll Trudy Reid Paul Smith	
MUSC/ED	Personal Information redacted by the USI	Homocide	Time line complete MHLD leading same		Danielle requested notes for Trudy 17.05.17.
		Internal Review			
	Irrelevant information redacted	Power failure - CAH	Need meeting organised.	Meeting organised for 26.05.17 at 3pm.	
MUSC	Personal Information redacted by the USI	DKA	Need meeting organised.	Dr Bradley, Mary Burke, Trudy Reid.	Danielle organising meeting.
MUSC	Personal Information	Collapse in corridor in DHH	Need meeting organised.	Dr Moore, Kay Carroll, Mary Burke, Trudy Reid.	Danielle organising meeting.
ED/MUSC	Personal Information	Sedation issue post #	Need meeting organised.	Dr Holmes, Paul Smyth, Trudy Reid	Pamela organising meeting.
	Personal Information				
	Personal Information				
	Personal Information				
ED/MUSC	Personal Information redacted by the USI	ED discharged returned OD - ICU Antrim	Time line complete Write to Dr Chada to see if she will assist with internal SEA	Dr Chada, Gareth Hampton and Mary Burke Trudy Reid	
		Other to do			
SEC	Personal Information	#Hip	Response post meeting to family		Trudy to agree further response.
ED/MUSC	Personal Information	Necrotising faciatis	Response needs to be drafted to family's recent letter.	Anne McVey, Dr Hampton, Paul Smyth, Anne McVey	Pamela organising meeting.
sec		Retained swab	Need DARO guidance		
ED/MUSC	Personal Information	Update action plan	For DRO		
	Personal Information	Update guidance to litigatoin			
	Personal Information	Letter to family re deescalaton			
	Personal Information	HSCB to contact us re learning letter			
		M&M follow up			
SEC	Personal Information	# amputation	Need M&M notes (presented)		
SEC	Personal Information	Lisfranc #M&M surgical/T&O and ED/medicine	For escalation to Main M&M from T&O M&M		
ED	Personal Information redacted by the USI	DKA ED	Need M&M notes from ED		
SEC	Personal Information	Colonoscopy M&M	Need M&M notes from GSUR		
ED/Radiology	Personal Information redacted by the USI	SAH delay in CT ED and Radiology	Need M&M notes		
SEC	Personal Information	Cholecystistis arrest Cardiology and Surgery	Need M&M notes Cardiology (presented) and Surgery		
ED/MUSC	Personal Information	dicusssion re appropriate placement of patient with NIPPI surgeons accepted	Need M&M notes (presented)		
SEC	Personal Information	RIP tumour Surgery M&M	Need M&M notes - same requested		
ED/MUSC	Personal Information	Chest drain insertion	Time line complete and approved not SAI - need M&M notes when presented		

ACUTE SERVICES - SAI Recommendations

SAI Number	Patient	Location of incident	Location report	Date Approved	Description of Incident	RIP	Level	ResponsibleDivision	Recommendations	Actioned	Current Position	SAI Report
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.			I:\SAI's and RCA's\CLOSED SAI\SAI Personal \SEA
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	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 3 -** 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 4 -** 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 5 -** 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	Cath Lab	02/05/2014	Patient was admitted to cath lab theatre (transfer from DHH) for a cardiac cath and died intra procedure.	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.			I:\SAI's and RCA's\RCA\RCA P \RCA Final Draft
Perso	Personal	Cath Lab	Cath Lab	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	Cath Lab	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	Cath Lab	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	Cath Lab	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	Cath Lab	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	Cath Lab	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	Cath Lab	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	Cath Lab	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	Cath Lab	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	Cath Lab	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	Pers	ED DHH	ED DHH	02/05/2014	Perso came into the department around 11:30. He was a previously well Personal who appeared to have fallen down the stairs and hit his head at some point during the night before.	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	Pers	ED DHH	ED DHH	02/05/2014		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	Pers	ED DHH	ED DHH	02/05/2014		Yes	Internal review	MUC	**Recommendation 3 -** All documentation should be completed as contemporaneously as possible in			
Perso	Pers	ED DHH	ED DHH	02/05/2014		Yes	Internal review	MUC	**Recommendation 4 -** Fluid Balance and Medication Prescriptions should be completed in keeping with Trust Guidelines and Policy.			
Perso	Pers	ED DHH	ED DHH	02/05/2014		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	Pers	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	Pers	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	Pers	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	Pers	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 Informa	ED DHH	Home Treatment MHD	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	No	Internal review	MUC	**Recommendation 1 -** Establish interface meetings between mental health and ED staff			
Perso	Personal Informa	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 Informa	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 Informa	ED DHH	Home Treatment MHD	06/06/2014		No	Internal review	MUC	**Recommendation 4 -** Roll-out the regional self-harm pathway			

Received from Trudy 6/05/2023. Annotated by the Urology Services Inquiry.

Perso	Personal Informa	ED DHH	Home Treatment MHD	06/06/2014	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 5 -** Ensure patients are registered on arrival to ED			
Perso	Personal Informa	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 Informa	ED DHH	Home Treatment MHD	06/06/2014		No	Internal review	MUC	**Recommendation 7 -** Review ED security arrangements			
Perso	Personal	Female Medical DHH	Female Medical DHH	06/06/2014	when staff noted that patient had not came out of the toilet and was not responding to their calls the toilet door was opened from the outside Perso was found lying on the floor with a set of headphones wapped around her neck,scissors where used to cut them,medical staff were alerted and oxygen applied Person was then assissted back to her bed	No		MUC	**Recommendation 1 -** Even with small rises in serum troponin T, in the clinical context of cardiac sounding chest pain a differential diagnosis of non-ST elevation myocardial infarction must be considered.			
Perso	Personal	Female Medical DHH	Female Medical DHH	06/06/2014		No		MUC	**Recommendation 2 -** Consideration should be given to expediting investigations and management of patients with chest pain should they re-present to ED with on-going symptoms within a short time period.			
Perso	Personal	Female Medical DHH	Female Medical DHH	06/06/2014		No		MUC	**Recommendation 3 -** There should be good lines of communication between primary and secondary care and acknowledgement of correspondence and evidence to show this.			
Perso	Personal	Female Medical DHH	Female Medical DHH	06/06/2014		No		MUC	**Recommendation 4 -** In a post-operative patient presenting with chest pain and shortness of breath, a differential diagnosis of pulmonary emboli must be considered.			
Perso	Personal	Female Medical DHH	Female Medical DHH	06/06/2014		No		MUC	**Recommendation 5 -** Documentation in the medical notes could be improved. It should be logical, concise, legible, timed and dated. This will ensure continuity of care and better patient management.			
Perso	Personal	Female Medical DHH	Female Medical DHH	06/06/2014		No		MUC	**Recommendation 6 -** Communication with patients and their family members can help alleviate anxiety and frustration especially in a complex case. Good documentation that discussions have taken place, what was said and how the information was received is essential.			
Perso	Personal	Female Medical DHH	Female Medical DHH	06/06/2014		No		MUC	**Recommendation 7 -** Access to outpatient cardiology procedures within the Southern Trust site is now currently within thirteen weeks, but there is an on-going need to maintain clinically appropriate access times. Adequate capacity within the Trust needs to be maintained for both urgent and routine patients. Specific access time targets for urgent outpatients should be considered.			
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.			I:\SAI's and RCA's\CLOSED SAI\SAI Personal \SEA
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	Personal	Pers referred by GP with chest pain, Risk factors for IHD. Had pain for 4 days but it had veen worse the night before into both arms. ECG and Traponin normal. Discharged for OP RACOC Died later that day. PM blocked "artery in heart".	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			..\Level 1\SAI Person CLOSED\Report\SAI Report Pers .pdf
Perso	Personal	ED CAH	ED CAH	Personal		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 0 li w h [redacted]	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.			L:\Acute Governance\Level 2\SAI Persona \Report\Report, timeline & checklist.pdf
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	A patient was found yelling in the toilet, staff went into the toilet to attend the patient. Upon entering it was evident that the patient had carried out a self attempted peniectomy.	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.			I:\SAI's and RCA's\SAI Persona \Response to DRC 19 1 15.pdf
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:			
Perso	Personal	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			
Perso	Personal	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.			
Perso	Personal	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			
Perso	Personal	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.			
Perso	Personal	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.			
Perso	Personal	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			I:\SAI's and RCA's\SAI Personal \Reports\Report Checklist SAI Investigation SAI Pers .pdf
Perso	Personal	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			
Perso	Personal	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.			
Perso	Personal	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.			
Perso	Personal	ED DHH	ED DHH	07/11/2014	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. Personal Information redacted by the USI [redacted]	Yes	2	MUC	**Recommendation 1 -** Insulin dose must be addressed in advance of or at the time of requirement			I:\SAI's and RCA's\SAI Person [redacted] CLOSED 25.8.15\Final
Perso	Personal	ED DHH	ED DHH	07/11/2014		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.			
Perso	Personal	ED DHH	ED DHH	07/11/2014		Yes	2	MUC	**Recommendation 3 -** The "Glucose Monitoring Chart/ Subcutaneous insulin prescription and administration" documentation must be used within the EDs of SHSCT.			
Perso	Personal	ED DHH	ED DHH	07/11/2014		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			

Received from Trudy 6/05/2023. Annotated by the Urology Services Inquiry.

Perso	Personal	ED DHH	ED DHH	07/11/2014		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.			
Perso	Personal	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.			
Perso	Personal	ED DHH	ED DHH	07/11/2014		Yes	2	MUC	**Recommendation 7 -** The established system to log mandatory training must be used and current.			
Perso	Personal	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			
Perso	Personal	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			
Perso	Personal	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.			
Perso	Personal	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.			
Perso	Personal Informa	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 .	No	1	MUC	**Recommendation 1 -** Copies of protocol "Transfer of miscarriage/Products of Conception to laboratory" to be made available to both emergency departments			
Perso	Personal Informa	ED CAH	ED CAH	07/11/2014	Nurse went to deal with another patient 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			
Perso	Personal Informa	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			
Perso	Personal Informa	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			
Perso	Personal Informa	2 North CAH	2 North CAH	07/11/2014	patient mobilising to bathroom according to fellow patients in bay. patient turned around to talk to another patient and lost balance and fell to ground.		1	MUC	**Recommendation 1 -** Falls risk assessment section of care plan must be completed on all admissions			..\Level 1\SAI Personal - Fall 18mar\report\SEA L1 Report Pers to Board.pdf
Perso	Personal	ED DHH	ED DHH	[redacted]	PATIENT REATENDED ED 1 DAY POST DISCHARGEFROM ED IN CARDIAC ARREST,RESUSITATION ATTEMPT UNSUCCESSFUL AND THE PATIENT DIED IN ED. PM FINDINGS SUGGESTIVE OF SIGMOID VOLVULUS THAT WAS	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.			I:\SAI's and RCA's\CLOSED SAI\SAI Personal - CLOSED 26.3.15\SAI report ID Pers - Level 1 Investigation.pdf
Perso	Personal	ED DHH	ED DHH	[redacted]	NOT HIGHLIGHTED BY RAIOLOGIST ON FIRST ATTENDANCE	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 was transferred to the Royal Victoria Hospital ICU on 03/10/13 from Craigavon Area Hospital with a left temporal lobe abscess and middle cranial fossa floor defect following mastoid surgery undertaken in September 2013. Whilst a patient in the Royal Victoria Hospital the patient has required significant further surgery and	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	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 female patient (H&C Personal) who was involved with the Trust's Home Treatment / Crisis Response Team and previously been admitted to Silverwood Ward, Bluestone Unit attempted suicide in the community by overdose and was admitted to the Intensive Care Unit. The patient	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.			
Perso	Personal	Community	ICU CAH	09/01/2015	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 • 11/01/2014 - 11/02/2014 (which included home leave 08/02/2014 -	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.			
Perso	Personal	Community	ICU CAH	09/01/2015	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 and took the overdose on 20/02/2014	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	Fall on ward from bed resulting in head injury with significant intracereal haemorrhage which wl likely result in death.	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	on administering 1st dose of iv antibiotic 1.2g benzypenicillan, alerted that patient was allergic to penicillan.	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		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	patient brought to emergency theatre from 2 north for emergency laparotomy. Arterial lne inserted, blood gas taken, oxygen therapy via non-rebreathing mask at 15l/min. Discussion between Dr xxxxx, Mr xxx & Mr xxxx and deciion made that proceeding with surgery was not the best course of action for paient.	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	Personal Information redacted by the USI .	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 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 care. Death confirmed a Personal	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		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		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	patient seen on ward round with nurse in charge at 08:45 patient complaining of numbness to fingers and pain. handed over to 2 nurses looking after B bay to split backslab and pain team to see. at 11:00 seen by consultant- backslab not split, patients sensation and pain remains- patient to go for emergency fasciotomy. no reason voiced as to why backslab was not split.	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		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	Patient 128	Urology OPD CAH	Urology OPD CAH	02/03/2015	This patient was diagnosed with Renal Cell Carcinoma in 2012. Reviewed in March 2013,and was to be reviewed again in June 2013 with Perso who has since left the Trust. Was not placed on any review list. GP re-referred as red flag and patient was seen 23 August 2014, now has widespread metatastic disease. Complaint recieved for management on 09/10/14. Date on letter, 9/9/14. Datix completed today. Timeline completed today. date for SAI screening tbc. Draft response to complaint is being compiled.	Yes Personal Information	2	SEC	**Recommendation 1 -** The Review Team recommends a robust system for managing overdue Uro-oncology review is established.				
Perso	Patient 128	Urology OPD CAH	Urology OPD CAH	02/03/2015		Personal Information	2	SEC	**Recommendation 2 -** A handover of patient caseload is required before a consultant leaves the trust. This arrangement must be formalised and robust.				
Perso	Patient 128	Urology OPD CAH	Urology OPD CAH	02/03/2015		Personal Information	2	SEC	**Recommendation 3 -** All radiology reports must be actioned if required and signed off by an appropriate person.				
Perso	Patient 128	Urology OPD CAH	Urology OPD CAH	02/03/2015		Personal Information	2	SEC	**Recommendation 4 -** A timely discharge letter should be dictated for every Urology patient.				
Perso	Patient 128	Urology OPD CAH	Urology OPD CAH	02/03/2015		Personal Information	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				
Perso	Personal Informati	4 North CAH	4 North CAH	02/03/2015	Pt should have been added to list for a flexible sigmoisoscopy but wasnt. Now she has a probable Ca	No	2	SEC	**Recommendation 1 -** Consideration should be given to developing and introducing an electronic system of request for endoscopy.				
Perso	Personal Informati	4 North CAH	4 North CAH	02/03/2015		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.				
Perso	Personal Informati	4 North CAH	4 North CAH	02/03/2015		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	Personal GOT UP TO GO THE TOILET WITHOUT USING HIS ZIMMER FRAME.FOUND LYING ON THE FLOOR HIS HEAD WAS BLEEDING AND HE WAS UNRESPONSIVE	rip Personal	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		Pe rso nal	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		Pe rso nal	2	ALL	**Recommendation 3 -** The Southern Trust should formally implement a delirium pathway.				
Perso	Personal	3 South CAH	3 South CAH	14/09/2015		Pe rso nal	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		Pe rso nal	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		Pe rso nal	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		Pe rso nal	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		Pe rso nal	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 Persona n that the Pts BM was 2.9mmol on leaving DHH and 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 104/79 P96 News=10, pt transferred onto bed and her own bedsheet from PNH was still underneath her. Oxygen 5lts via facemask	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		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		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, Glucogel given and contacted HAN #1795 and asked for immediate JHO to assess patient. Huggy bear 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 1hourly news remains between 4-6. Pt reviewed by Trauma on call #1777 and to be reviewed again in the morning by consultant. Died Personal	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		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	Patient attended A+E on 2 separate occasions with a significant mechanism of injury to his Abdomen. Discharged on 2 occasions. 3rd attendance to A+E prompted admission and subsequent Laparotomy.	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		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 Inform	4 North CAH	4 North CAH	12/10/2015	Patient A alerted the staff by shouting that fellow patient B was on the floor. Patient A did not witness the fall as she was sleeping and had ear phones in her ear. Nurses immediately reacted. Patient B was lying on the floor on their back, alert, head bleeding perfusely. Pressure bandage applied. CNS observations recorded. Patient made comfortable. Trust guidelines on falls followed.	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	NG tube inserted into bronchus	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		Yes	2	SEC	**Recommendation 2 -** VTE and AKI assessment tools should be completed.			
Perso	Personal Informatio	4 South CAH	4 South CAH	11/12/2015	Unexpected cancer was identified on pathology results following a routine cholecystectomy. Th result was signed and filed, but not acted upon. Patient has now represented to another trust with metastatic disease 2 years later.	YES Personal Infor	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 Informatio	4 South CAH	4 South CAH	11/12/2015		Pers onal Infor matio	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 Informatio	4 South CAH	4 South CAH	11/12/2015		Pers onal Infor matio	2	SEC	**Recommendation 3 -** Review and Record in report significant findings in previous Radiological investigations			
Perso	Personal Informatio	4 South CAH	4 South CAH	11/12/2015		Pers onal Infor matio	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 Informatio	4 South CAH	4 South CAH	11/12/2015		Pers onal Infor matio	2	SEC	**Recommendation 5 -** The appropriate clinician must check all patients' pathology results on receipt post-operatively.			
Perso	Personal	General Surgery OPD STH	General Surgery OPD STH	11/03/2016	This patient was undergoing bowel investigations. Previous history of Rt hemicolectomy and ileostomy for malignancy. Colonoscopy done on 6/3/14 and 5/4/14 with poypectomys done on both occasions. Patient reviewed by consultant 26/8/14 and patient informed that there evidence of malignant disease in polyps. Patient should have been reviewed in April 2014 with results. Cons informed pt and wife of omission	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	Person al	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	Yes	1	SEC	**Recommendation 1 -** The SHSCT Acute Services continue to monitor and reduce the Surgical Review Backlog and waiting times			
Perso	Person al	4 North CAH	4 North CAH	11/03/2016	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	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	Person al	4 North CAH	4 North CAH	11/03/2016	metastases.	Yes	1	SEC	**Recommendation 3 -** The Trust-Wide Outpatient Consultation Rooms are furnished with Radiology waiting times for routine procedures			
Perso	Person al	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	Personal ATTENDED AFTER rta KNEE PAIN XRAY INITIALLY READ BY ED DOCTOR NORMAL. OFFICAL REPORT WAS THEN MADE BY REPORTING RADIOGRAPHER 2DAYS LATER REVEALING A FRACTURE	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	patient booked on the emergency list on saturday 11/07/15 for tuesday 14/07/15 by dr Pers On 14/07/15 when in theatre 1 ,following induction of anaesthetic patient had a cardiac arrested and emergency buttons called at 12:05. Resusitation continued until 12:38.Patient confirmed	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	deceased at Pers . During this time resusitation & CPR continued. A Massive Blood Loss was called by the Anaesthetist.Several attempts were made to contact relatives during this. GP phoned to try to obtain another phone number of relatives to no avail. Ward contacted to try and reach relative.Chaplin contacted and attended.Patient was on ward 1 South. Relatives (2 daughters arrived but didnt want to see patient). at approximately 14.00 hrs.	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 history of psychotic depression and an element of learning disability. On long-term trazadone, lithium and quetiapine. Admitted on 22 June 2015 to MAU following 3 weeks of bizarre, erratic behaviour, slurred speech, polydipsia and polyuria for 3/7. Had been	Yes	2	MUC	**Recommendation 1 -** The Review Panel were not in a position to make recommendations in relation to the primary care aspects of EG's care, however it is hoped that this will be addressed by HSCB governance team			L:\Acute Governance\Action plans\ Personal Pe , Action plan SAI template.docx
Perso	Personal	AMU CAH	AMU CAH	15/07/2015	seen by Mental Health Rapid Treatment for 4 days prior to attendance. In ED, BM noted to be 'Hi'. Blood ketones 4.2. On admission to MAU, blood sugar 33.3mmol/l. NaCl 145. Commenced on Hyperosmolar	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.			
Perso	Personal	AMU CAH	AMU CAH	15/07/2015	Hyperglycemic (HONK) protocol. Over the next 24 hours in MAU patients serum sodium level rose to 173mmol/l despite fluid therapy. At 17:00 hrs on 23 June 2015, patient seen by ICU team and transferred to ICU at 18:45hr. HONK protocol maintained. Patient agitated on	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	admission to ICU and Glasgow Coma Scale (GCS) was fluctuant –intubation followed. Remained in ICU for 10 days following sodium correction. Attempts to lighten sedation were made on several occasions	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			
Perso	Personal	AMU CAH	AMU CAH	15/07/2015	but extubation was not possible Personal patient developed a rapid, irregular heartbeat and cardiovascular instability. Patient sadly passed away at Personal information	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			

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

Perso	Personal	Theatres CAH	Theatres CAH	22/04/2016	Patient anaesthetised for a procedure. After anaesthetic induced the surgeon decided that surgical intervention was inappropriate and the patient was woken and sent to recovery	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 DHH ED with Abdominal pain. Sudden onset of left lower quadrant pain in morning. Home with analgesia. Return if any concerns. GO if pain not settling. (Departure time 22:15hrs) OnThursday 5 March 2015 at 12:20hrs, Personal arrived to DGG ED 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. 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.		Case presented at M&M and recommendations shared with both medical and nursing staff. Nov 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	L:\Acute Governance\Action plans\ Personal \So'R Action plan SAI template1.docx
Perso	Personal	ED DHH	ED DHH	25/04/2016		Yes	2	MUC	**Recommendation 2 -** 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 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 3 -** 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.		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	Personal admitted from home following fall. Diagnosed fractured neck of femur on 02/05/15. Well on admission. Bloods: 02/05/15 - Na	Yes	2	ATICS	**Recommendation 1 -** Develop guideline for cancellation of patients on the emergency theatre list.			L:\Acute Governance\Action plans\ Personal \MC
Perso	Personal	Trauma Ward CAH	Trauma Ward CAH	22/04/2016	130, Hb 143, 03/05/15 Na 123, Hb 101, 04/05/15 Na127, Hb92. Pre-assessed for theatre - delayed theatre date to optimise electrolytes.	Yes	2	ATICS	**Recommendation 2 -** Develop fasting guidance for patients on the emergency theatre list.			
Perso	Personal	Trauma Ward CAH	Trauma Ward CAH	22/04/2016	Theate 6/5/15. Post-op GI bleed 7/5/15 - duodenal ulceration on OGD - large volume blood products transfused. Transferred to ICU post-OGD for I+V and inotropic support.	Yes	2	ATICS	**Recommendation 3 -** evelop process for documentation of anaesthetic assessment for patients on the emergency theatre list.			
Perso	Personal	CAH ED	2N Resp	13/05/2016	PT ADMITTED WITH DKA UNWELL ON ADMISSION HAD SRC INSERTED IN A+E WHICH SUBSEQUENTLY CAUSED A PARAPHINESIS RESULTING IN A THEATRE ADMISSION FOR DEBRIDEMENT	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	CAH ED	2N Resp	13/05/2016		No	1	MUC	**Recommendation 2 -** The Urinary Catheter Insertion and Monitoring Form should be reviewed and updates considered			
Perso	Personal	CAH ED	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	CAH ED	2N Resp	13/05/2016	Personal , presented with chest pain and SOB. Seen in ED on 10/1/15. Diagnosed primary spontaneous pnuemothorax. Attempted aspiration done in ED Resus Room at 2200. No improvement. Admitted	No	1	MUC	**Recommendation 1 -** There should be a system to raise awareness of this condition for clinical staff			L:\Acute Governance\Action plans\ Personal \IB Action plan SAI template
Perso	Personal	CAH ED	2N Resp	13/05/2016	for High Flow Oxygen overnight to CDU. Overnight increased pain and SOB (NEWS steady at 2 due to Oxygen treatment). Repeat CXR	No	1	MUC	**Recommendation 2 -** Trust Guidelines need changed to include information on the initial management of spontaneous haemopneumothorax			
Perso	Personal	CAH ED	2N Resp	13/05/2016	showed large pleural effusion and complete pnuemothorax with some tethering. Required intercostal drain insertion. 1400ml of blood from drain. Given stat dose of Tranexamic acid. Drain inserted at 10:45am. Referred medically for ongoing management. Transferred to 2 North Resp at 14:30. At approximately 03:00 on the 12/1/15 a further 1500ml of blood 'gushed' out of drain. Drain clamped and case discussed with Thorasics team in RVH. Patient for transfer to RVH. Case discussed at	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.			
Perso	Personal	CAH ED	2N Resp	13/05/2016	04:00 with Medical COnsultant on call. Delay in getting blood from lab, when blood finally received by ward it was not packaged for transport resulting in further delay.	No	1	MUC	**Recommendation 4 -** The absence of NEWS recording in CDU needs to be addressed to improve NEWS recording			
Perso	Personal	CAH ED	2N Resp	13/05/2016		No	1	MUC	**Recommendation 5 -** Junior medical staff should escalate promptly patients that are deteriorating			
Perso	Personal	CAH ED	2N Resp	13/05/2016		No	1	MUC	**Recommendation 6 -** Chest x-rays with haemothorax as well as pneumothorax should have accurate reports.			
Perso	Personal	CAH ED	CAH ED	13/05/2016	Personal attended ED with head injury and neck pain after fall in nursing home. was discharged back to NH after x rays. returned ED 3	Yes	2	MUC	**Recommendation 1 -** The report should be shared with operational teams for learning			
Perso	Personal	CAH ED	CAH ED	13/05/2016	days later unwell. admitted UTI, off feet. subsequently established C Spine fracture was not indetified on her initial attendence 12/05/15. patient arrested and died on ward Person	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	CAH ED	CAH ED	13/05/2016		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	CAH ED	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	CAH ED	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	CAH ED	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	CAH ED	CAH ED	13/05/2016		Yes	2	MUC	**Recommendation 7 -** The Trust should create a system for the timely reporting of ED X rays			

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

Perso	Personal Informat	MIU STH & ED DHH	MIU STH & ED DHH	13/05/2016	patient attended with history of fall, facial bruising denied neck tenderness. discharged following asesment and facial bones x rays.	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 Informat	MIU STH & ED DHH	MIU STH & ED DHH	13/05/2016	attended ED DHH 2 days laer with vomiting. CT brain NAD, no c spine t5enderness, admitted as minor head injury to femaile surgical ward. Ct C spine 23/10/15 showed c spine fracture.	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 Informatio	2N Resp	2N Resp	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			
Perso	Personal	ED DHH	ED DHH	13/05/2016	A Personal Information attended the emergency department on the 10/09/15 by ambulance. He claimed to be a heroin addict and was seeking methadone as he had not had methadone in 3 days. Pe was assessed and treatment involving methadone was administered. Pe 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 1 -** Staff involved in this adverse incident should be given feedback			L:\Acute Governance\Action plans\Personal Information
Perso	Personal	ED DHH	ED DHH	13/05/2016		Yes	2	MUC	**Recommendation 2 -** Methadone should not be prescribed or administered in any of the Trusts Emergency Departments			
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.			
Perso	Personal	Community	Community CYP	13/05/2016	Personal Information redacted by the USI	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			
Perso	Personal	Delivery Suite CAH	Delivery Suite CAH	13/05/2016	Personal Information redacted by the USI	Yes	1	IMWH	None, as extreme premature			
Perso	Personal Informatio	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 Informatio	Neonatal Unit CAH	Neonatal Unit CAH	10/06/2016		Yes	3	IMWH	**Recommendation 2 -** Re-emphasise the importance of CTG training for all doctors and midwives annually.			
Perso	Personal Informatio	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 Informatio	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 Informatio	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 Informatio	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 Inform	Delivery Suite CAH	Delivery Suite CAH	10/06/2016	Personal Information redacted by the USI	Yes	1	IMWH	None, as extreme premature			
Perso	Personal Informa	Orthopaedic Ward CAH	Orthopaedic Ward CAH	10/06/2016	patient had news of 5 @ 3pm obs not carried out rest of shift and not handed over to night staff patient has high news, patient nursed in a 45 degree tilt instead of up right, patient had news of 8 checked at 20.40 in a period of 20 mins doctor bleeped x2 and clincal co-ordinator at night bleeped x4 nurse said over bleep please contact trauma 2 urgently no one replied until the event of cardiac arrest and team was called.	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 Informa	Orthopaedic Ward CAH	Orthopaedic Ward CAH	10/06/2016		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 Informa	Orthopaedic Ward CAH	Orthopaedic Ward CAH	10/06/2016		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 Informa	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 Informa	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	The Patient presented initially on the 7/7/15 with abdominal pain. The patient was examined and history taken and a diagnosis of gastroenteritis given. The patient was dicharged. The patient continued to have abdominal pain and presented to their GP on the 09/07/15 wth vomiting and abnormal observations - their GP rerefered the patient back to the ED. Following assessment and investigation it was determined that the patient had a superior mesenteric thrombus with ischaemic gut. The patient was then transfered to the RVH for further managment.	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		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	alerted by loud noise. patient found lying on the floor. assisted back to bed by 2 staff.	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, Per 's 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 Per 's 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 Per 's risk of falls.			
Perso	Personal	Female Medical DHH	Female Medical DHH	10/06/2016	Patient found on floor at bedside in ward 22 bed 4. Patent states she had used the commode and was returning to bed when she fell to the floor.	No	1	MUC	None.			
Perso	Personal	Theatres DHH	Theatres DHH	10/06/2016	Pt arrested in theatre after surgery and prior to transfer to ICU whilst on the transfer trolley. Ambulance crew were in theatre awaiting to transport her.	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		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		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	heard anoise in ward 21 and found patient kneeling at bottom of bed	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		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	CYP DHH	10/06/2016	Health visitor notified by GP that a child had been injured in her home.	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	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	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	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 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.	No	1	SEC	**Recommendation 1 -** SHSCT CVP bundle/proforma is amended to include the assessment of patency and presence of lumen caps				
Perso	Personal	Gastroenterology Clinic	Gastroenterology Clinic	08/07/2016	Patient with inflammatory bowel disease prescribed azathioprine at Dr xxx Clinic. Hospitalised a short time later with life-threatening pancytopenia secondary to azathioprine. I received a phonecall on 24/12/2015 from lab stating that a previous TPMT result from 2011 indicated that patient could never be prescribed azathioprine safely. This result was not on NIECR and was not spotted by Medical Team when azathioprine prescribed.	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	Gastroenterology Clinic	08/07/2016		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	Gastroenterology Clinic	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	Gastroenterology Clinic	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	Gastroenterology Clinic	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	Gastroenterology Clinic	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	No	1	IMWH	None, as recognised complication.				
Perso	Personal	ED CAH	ED CAH	08/08/2016	Patient admitted to Bluestone from ED with thoughts of harmiong others, denied taking drugs. once in Bluestone informed staff there he had taken x 2 Lyrica the previous day. transferred back to ED, while waiting reassessment suffered respiratory arest. intubated and admitted ICU, discharged back to Bluestone 2 days later. Case screened 11/05/16, level 1 SEA commissioned	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 CAH	ED CAH	08/08/2016		No	1	MUC	**Recommendation 2 -** Cooperation and team working between Emergency care and Psychiatry should continue to be enhanced.				
Perso	Personal	Male Surgical	Male Surgical	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 in CAH. The patient has now been discharged from ICU and remains a patient in DHH.	No	2	MUC	**Recommendation 1 -** Permanent and consistent provision 24 hour Staff Grade cover in DHH ED.		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	L:\Acute Governance\Action plans\Personal information	
Perso	Personal	Male Surgical	Male Surgical	12/09/2016		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.		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	Male Surgical	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.		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		
Perso	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 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 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.			L:\Acute Governance\Action plans\Personal information\Quality Improvement Action Plan SAI Personal information	
Perso	Personal	Theatres DHH	Theatres DHH	12/09/2016		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				
Perso	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.				
Perso	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.			..\Level 2\SAI Per ..\Report\\Report to HSCB.pdf	Personal infor redacted
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	Personal Information that attended her GP on the **7th April 2014** complaining of a five day history of abdominal pain, vomiting and diarrhoea. She had been in contact with the GP Out Of Hours Service 2 days prior to this. Her GP referred Pe to the Emergency Department (ED) Daisy Hill. returned to the ED Daisy Hill the next day (8th April). returned to the ED Daisy Hill for a third time on the 9th April 2014 with abdominal pain and vomiting. returned to Daisy Hill ED on the 17th April 2014 for a fourth time feeling quite unwell. She had a subtotal colectomy with an ileostomy. Pe was transferred to the Intensive Care Unit in the Belfast City Hospital post operatively. She returned to Daisy Hill Female Surgical ward on the 26th April 2014. Pe was discharged on the 19th May 2014	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.				
Perso	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.				
Perso	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.				
Perso	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				
Perso	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.				
Perso	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 Informatio	AMU CAH	AMU CAH	16/05/2012	Septic Left Sacro ileits – Sudden Death. Personal presented at the Emergency Department (ED) CAH, on 09/04/12 with a history of experiencing a sudden pain in the left buttock whilst jumping out of bed. There was no history of trauma. Tenderness over the left gluteus was noted. A diagnosis of a gluteus maximus tear and possible early		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 Informatio	AMU CAH	AMU CAH	16/05/2012	abscess was made. Perso was prescribed anti-inflammatory medication and analgesia. Perso was discharged from ED, but advised to return if redness or swelling occurred.On 11/04/12 at 13.31 hours Pe returned to ED via ambulance and complained of being unable to walk because of severe left buttock pain. Inflammatory markers were elevated. An abscess of gluteus maximus or a sacro-iliac joint infection		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	Personal Information patient who was initially referred to the SHSCT by GP in 2009 with symptoms of nausea, vomiting, abdominal pain and weight loss. During the time frame of this investigation, Perso was referred to and assessed by, a variety of medical specialities within the SHSCT; the detail of which is contained within the accompanying Timeline (Appendix 1). As part of the assessment process, Perso underwent several investigations between 30 November 2009 and 15 July 2012. These are tabulated in Appendix 2.As part of the assessment process, Perso underwent several investigations between 30 November 2009 and 15 July 2012. These are tabulated in Appendix 2. The investigations which were carried out and reported up until the 3rd July 2012 did not identify a specific cause for Perso 's 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		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. "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	Personal Information who presented to the Minor Injury Unit (MIU) in South Tyrone Hospital accompanied by his father on the 7th September 2015. Pe returned to the Minor Injury Unit on the 16th September 2015 at 09:14 hours one day earlier than planned. The	No	1	MUC	**Recommendation 1** Learning and awareness from this SEA should be shared with the relevant teams			L:\Acute Governance\Action plans\ Personal , Action plan SAI template1.docx
Perso	Personal	MIU STH	MIU STH	07/07/2015	plaster cast was removed from his left leg. He was assessed by another ENP (ENP 2). ENP 2 reviewed the radiology report from the x ray taken on the 7th September. The report stated no recent displaced fracture	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	was seen on the images. Pyomyositis is a bacterial infection of the skeletal muscle - was diagnosed	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 Personal and presented in cardiac arrest.	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	Resuscitation was commenced but tragically the patient died.	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.	
Perso	Asault 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	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.			
Perso	Asault on Nurse	Carpark CAH	Carpark CAH	09/04/2014	imediately notified and are currently investigating the incident.	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.			
Perso	Asault 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.			
Perso	Asault 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	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	recording of NEWS scores and subsequent actions.	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.	
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 Informatio	ED CAH	ED CAH	10/10/2014	Lady in Resus presented with pv bleeding passed large clot ? gestational sac. Clot placed on inco pad and set on dressing trolley .		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		L:\Acute Governance\INTERNAL SEA\ Personal .
Perso	Personal Informatio	ED CAH	ED CAH	10/10/2014	Nurse went to deal with another patient Inco pad not on trolley when doctor from gynae came to see patient.		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		L:\Acute Governance\INTERNAL SEA\ Personal .
Perso	Personal Informatio	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.			
Perso	Personal Informatio	ED CAH	ED CAH	10/10/2014			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		Patient attended ED CAH on the Personal information 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.		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		Patient attended ED CAH on the [redacted]. 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.		2	IMWH	**Recommendatiion 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	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	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	SHSCT to continue to work in conjunction with the Regional Safety Forum on Sepsis Management			

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

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 Informati	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 Informati	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 Personal 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 Personal . 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 Informa	Cardiac catheterisation lab	Cardiac catheterisation lab	20/07/2015	Personal Information was admitted for angiography, which was performed on Personal . 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			
Perso	Personal Informa	Cardiac catheterisation lab	Cardiac catheterisation lab	20/07/2015		Yes	1	MUC	**Recommendation 2 -** Internal defibrillation paddles are now kept on the thoracotomy tray			
Perso	Personal Informa	Cardiac catheterisation lab	Cardiac catheterisation lab	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 Informa	Cardiac catheterisation lab	Cardiac catheterisation lab	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. 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	**Recommendatioon 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		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 redacted 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. The SHSCT wish to submit this incident as a SAI in order to establish any areas of learning	Yes	1	MUC	None			
Perso	Personal Inform	ED CAH	ED CAH	21/04/2015	Personal Information redacted by the USI [redacted]	No	1	MUC	None			
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.	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 26/04/2014 Pe attended E/D in CAH. Person was transferred from ED to MAU on the same date and appeared asymptomatic.	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	On the 27/04/2014 Person was transferred to ward 1 STH for rehabilitation - she remained asymptomatic. Person was commenced on Trimethoprim on 27.4.14 @ 0800 whilst in ED for a UTI. On 02/0520/14 @ 10:50hrs Person was noted to have two type 6 bowel motions and was moved into side room 6. At 18:45hrs Perso had a type 7. On 03//05/14 Person had a type 6/7 a type 5/6 a type 5 and a type 6. On 04/05/14 Person had 3 type 7 stools from 04:00hrs onwards. Sample sent NEWS at 11:00hrs - seen by Dr P arranged immediate transfer to ED. On same date (4.5.14) Microbiology contacted E/D at approx. 13:30hrs with a diagnosis of C Diff. Person was then transferred to MAU @ 16:30hrs. Thereafter, Oral metronidazole Treatment commenced at 22.00 hrs. Person condition continued to deteriorate. She received one dose of oral Metronidazole 400mg On 05/05/14 Person had her oral Metronidazole discontinued and was commenced on Metranidazole 500mgs IV this was not administered. The patient passed away on the Personal	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 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 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-rays were reviewed and indicated that the medial epicondyle was trapped in the elbow joint. 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		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		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		

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

Perso	Personal	ED DHH	ED DHH	11/09/2015	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	Persona l	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.	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	Persona l	ED CAH	ED CAH	13/11/2015	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.	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	Persona l	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	Personal	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	Personal	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	Personal	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			
Perso	Persona l	ED DHH	ED DHH	01/09/2015	Personal Information redacted by the USI	Yes	2	MUC	**Recommendation 1 -** The interim protocol put in place post Perso s death for patients that attend with abdominal pain should be reviewed with senior medical paediatric input.			L:\Acute Governance\Action plans\ Personal
Perso	Persona l	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.			
Perso	Persona l	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			
Perso	Persona l	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			
Perso	Persona l	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			
Perso	Persona l	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.			
Perso	Persona l	ED DHH	ED DHH	01/09/2015		Yes	2	MUC	**Recommendation 7 -** There should be provision for on-going support for Perso 's family and staff affected by this tragic incident			
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 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 1 -** Oral Potassium prescribed to treat acute hypokalaemia should be prescribed for a period of 2-3 days until medical review review	Prescribers to ensure they record clear instructions on the Medicine Prescription and Administration Record		
Perso	Personal	1 South CAH	1 South CAH	13/11/2015		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.		
Perso	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		
Perso	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 after taking an overdose of medication, he absconded from the ED. He was Found by PSNI lying in hospital grounds outside, ambulance brought him back to ED 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		
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		
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 Personal Information 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		L:\Acute Governance\Action plans\ Personal \ Action plan SAI template.docx
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		
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.		
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		
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		
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		
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		
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 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 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		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 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 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		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 Informatic	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,	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.			

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

Perso	Personal Informatic	AMU CAH	AMU CAH	18/11/2016	patient continued to deteriorate and was taken to theatre for an emergency laparotomy on 6 October 2015.Pt was in ICU on high dose inotropic support following laparotomy and sadly passed away on 21 October 2015.	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 Informa	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 GH sadly died on the Personal 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.			L:\Acute Governance\Level 2\SAI Persona\Report\Report
Perso	Personal Informa	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.			L:\Acute Governance\Level 2\SAI Personal - SAI Quality Improvement Action Plan SAI Personal docx
Perso	Personal Informa	2 North CAH	2 North CAH	23/11/2016		Yes	2	MUC	**Recommendation 3 -** Presentation to both SHSCT MUSC M&M			
Perso	Personal Informa	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 Informa	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 Personal	Yes	1	MUC	None			
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 Personal	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 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.	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		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 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.	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.			..\..\Level 1\SAI P. \Report\Report to HSCB 18.1.17.pdf
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.			
Perso	Personal Inform	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 Personal having suffered a cardiac arrest at home. The patient was pronounced dead a Persona . 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.	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 Pers 's 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.			
Perso	Personal Inform	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.			
Perso	Personal Inform	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.			
Perso	Personal Inform	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.			
Perso	Personal Inform	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.			
Perso	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.			
Perso	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.			
Perso	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.			
Perso	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.			
Perso	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.			
Perso	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.			
Patien	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 12/8/2014 . Referred back to urology consultant in view of Pa	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			L:\Acute Governance\Level 2\SAI Personal \Report\Report to HSCB.pdf

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

[redacted]	Patient 10	Urology OPD CAH	Urology OPD CAH	15/03/2017	MRI performed 2/9/2014. Referral to Urology was not triaged on receipt [redacted] sent OP appointment for 6/1/2016. [redacted] 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 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.			
Perso	Personal Inform	4 North CAH	4 North CAH	09/10/2015	Personal was admitted to 4 North following fall at home on Persona 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 Persona	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	04/04/2017	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 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 and melena on admission to ICU. Patients condition did not improved despite maximum inotrope support. On Person patient had a distended abdomen. CT scan reveal large areas of bowel ischema. The patient passed away on [redacted]	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	04/04/2017		No	1	MUC	**Recommendation 2 -** This SAI report is to be shared with ward staff involved in TM care to ensure learning is disseminated			
Perso	Per son	1 South CAH	1 South CAH	04/04/2017		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	04/04/2017		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	Perso	ED CAH		12/04/2017	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.	no	1	MUS	**Recommendation 1** The current system for follow up of patients that have suspicious chest X rays needs reviewed and improved. **Recommendation 2** Relevant staff and teams should receive feedback to raise awareness of this problem and case. **Recommendation 3** More clinical information should be available on NIPACS			
Perso	Per	ED DHH		12/04/2017	Personal Information gentleman who attended the Emergency Department Daisy Hill by ambulance in the early hours of Personal 2016. He lived alone and had called the ambulance as he was having palpitations. Per had a history of a myocardial infarction 11 days previously where he had been admitted to another Hospital Trust facility where he had coronary stents inserted on the 20th April 2016. On arrival at the Emergency Department Daisy Hill the nursing staff recorded his clinical observations and an ECG. Per was then assessed by the ED Doctor and following examination and blood testing he was discharged home. Per was found dead in his home over 15 hours later from his discharge from hospital. The fire service advised the paramedics that there was a positive carbon monoxide reading in the house. A review of the blood tests done in the Daisy Hill ED showed an elevated carbon monoxide level. Per 's preliminary post mortem findings confirmed carbon monoxide poisoning and a recent myocardial infarction.	yes	2	MUC	**Recommendation 1** All POC devices installed in the Trust should have the reference range of results available and operational in printout of results before they are declared operational. **Recommendation 2** The report should be shared with operational teams for learning **Recommendation 3** The Trust should have sufficient staffing whose responsibility is to monitor and audit the POC devices			

Director ate of Acute Services

Insert organisation Logo

Root Cause Analysis Report on the investigation of a Serious Adverse Incident

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

Date of Incident/Event: Personal information redacted by USI

HSCB Unique Case Identifier:

Personal Information redacted DOB Personal Information redacted by the USI Gender: Female Age: Personal Information redacted by the USI

Personal Information redacted by the USI DOB Personal Information redacted by the USI Gender: Male Age: Personal Information redacted by the USI

Responsible Lead Officer: Dr Katharine Loane

Designation: Consultant Obstetrician and Gynaecologist

Report Author: The Review team

Date report signed off:

Date submitted to HSCB:

1.0 EXECUTIVE SUMMARY

Irrelevant information redacted by the USI

[redacted]

2.0 THE INVESTIGATION TEAM

- Dr Katharine Loane Consultant Obstetrician and Gynaecologist (DHH)
- Dr Phil Quinn Consultant Paediatrician
- Mrs Trudy Reid Acute Clinical and Social Care Governance Co-Ordinator
- Mrs Patricia Kingsnorth Lead Midwife

2.0 THE INVESTIGATION TEAM

- Sister Maria Garvey Supervisor of Midwives

3.0 INVESTIGATION TERMS OF REFERENCE

Irrelevant information redacted by the USI

[redacted]

4.0 INVESTIGATION METHODOLOGY

The Maternity Hand held notes

The infant clinical notes

Staff statements

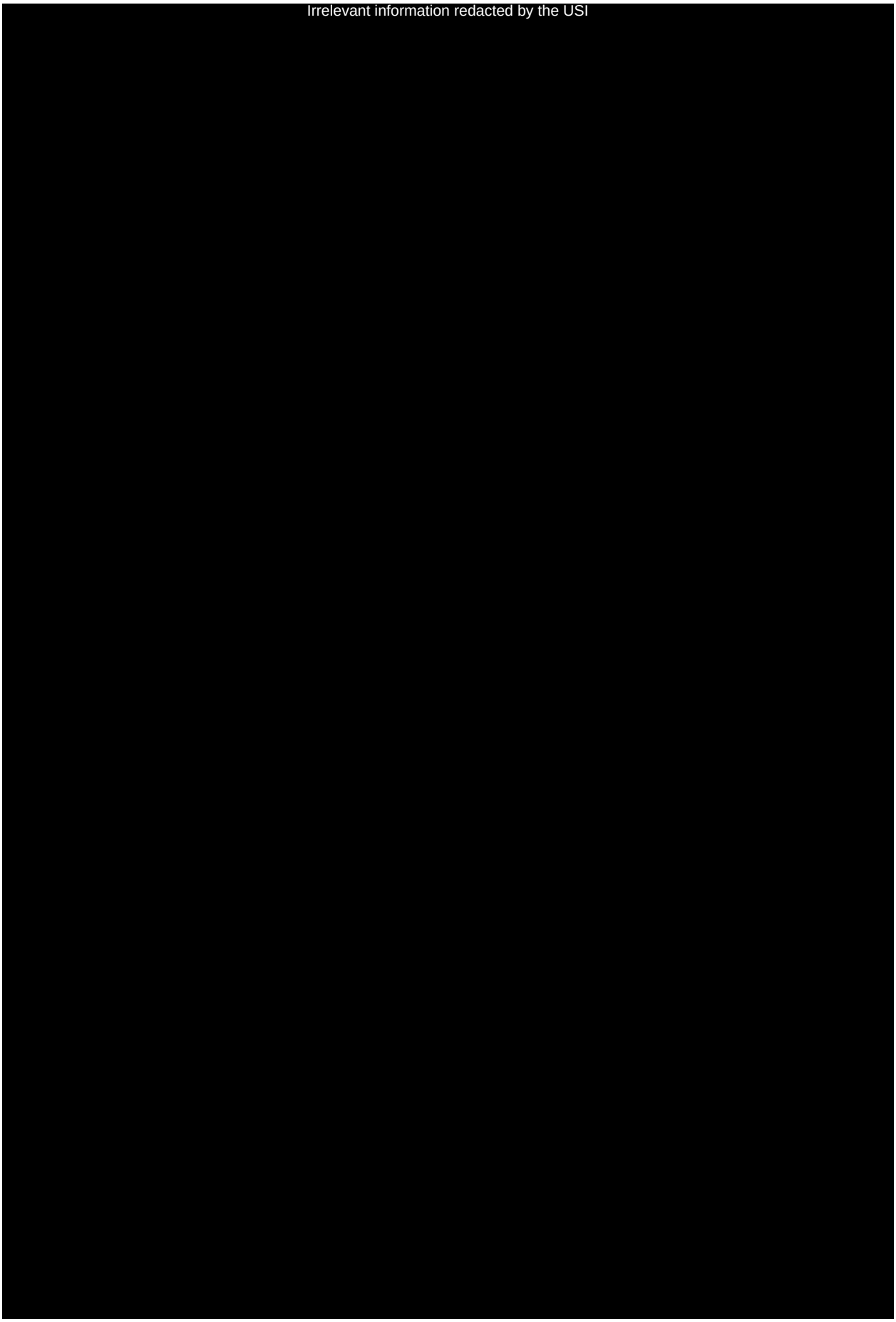
SEA investigation

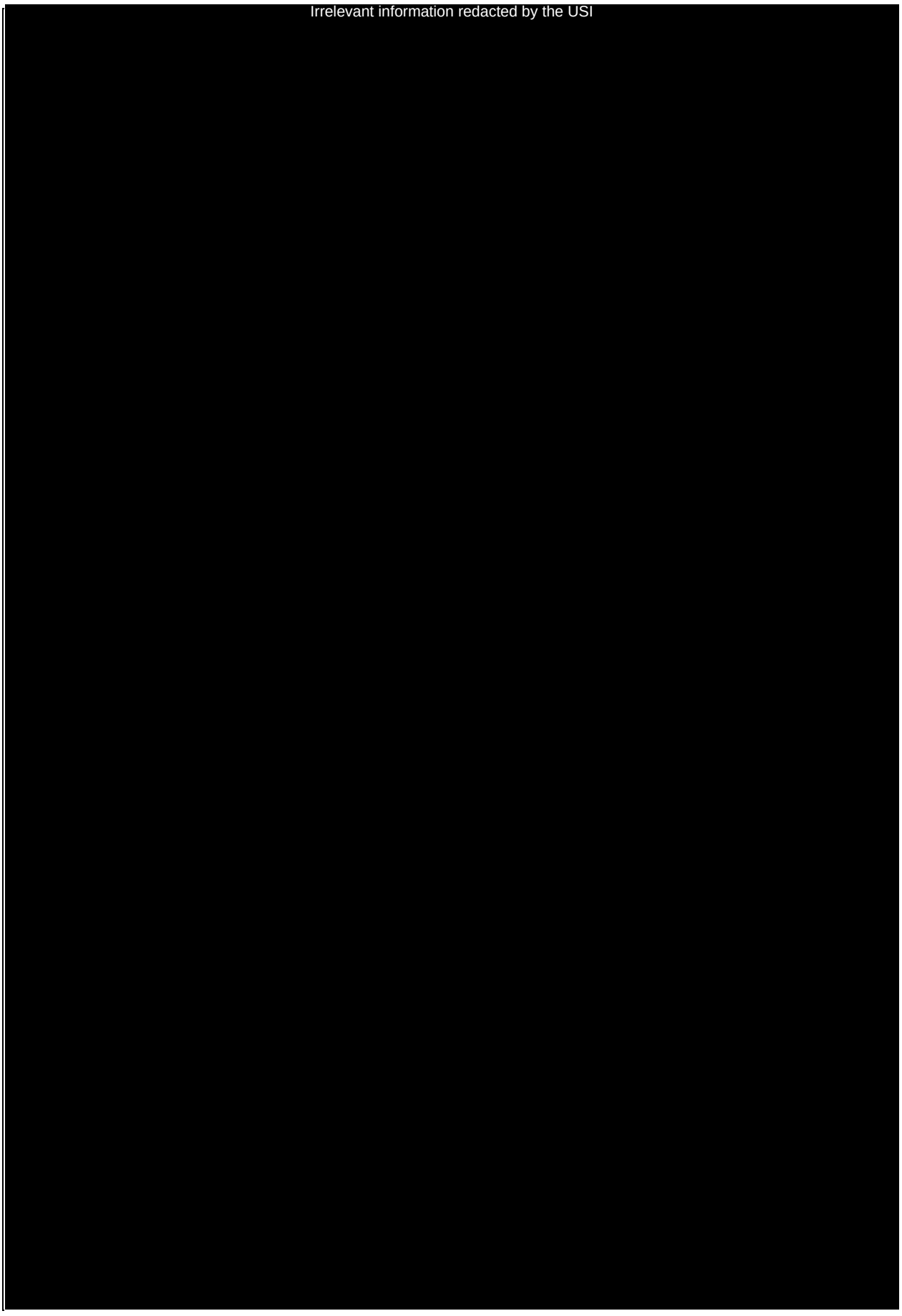
Post-mortem report and subsequent communications with pathology team.

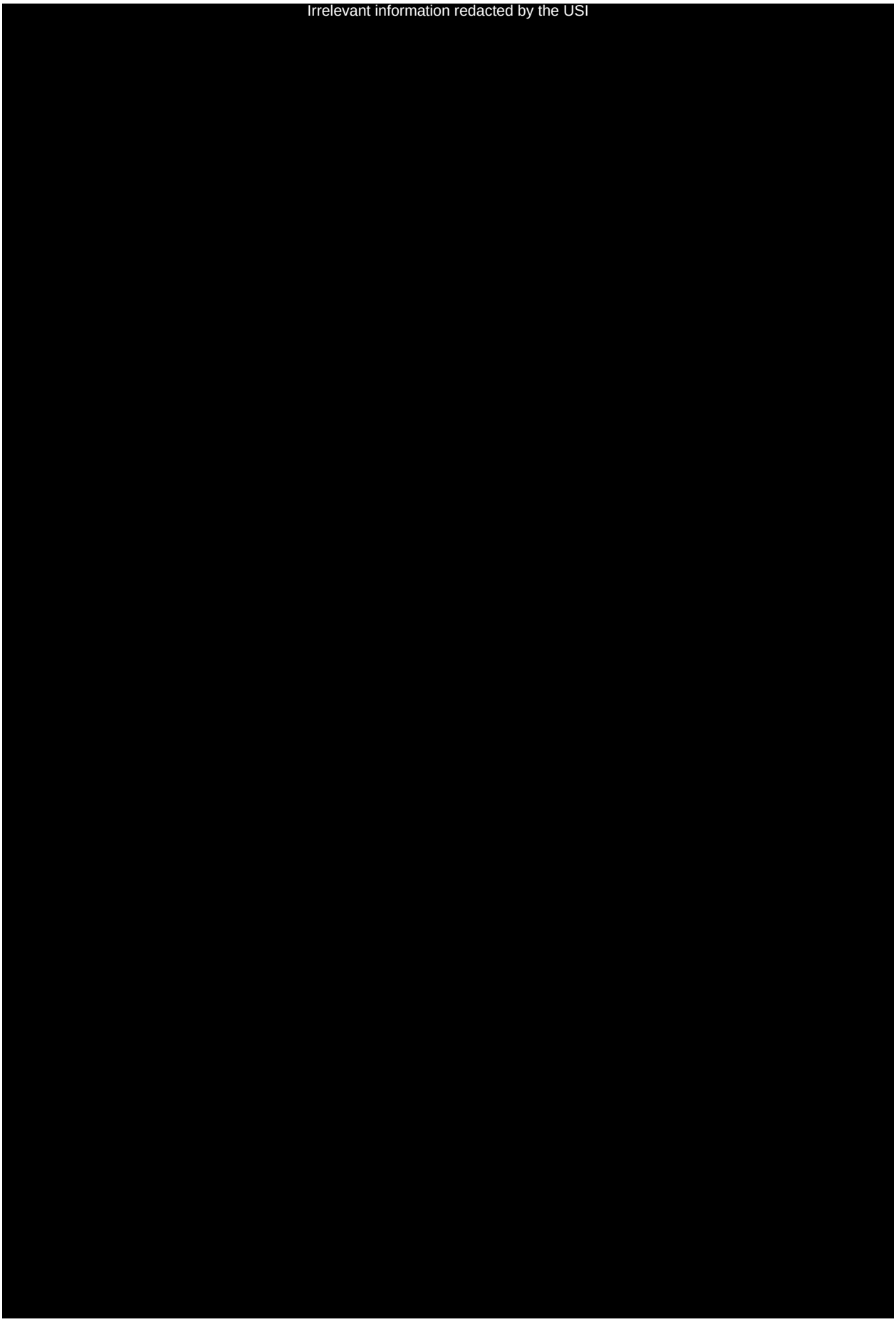
5.0 DESCRIPTION OF INCIDENT/CASE

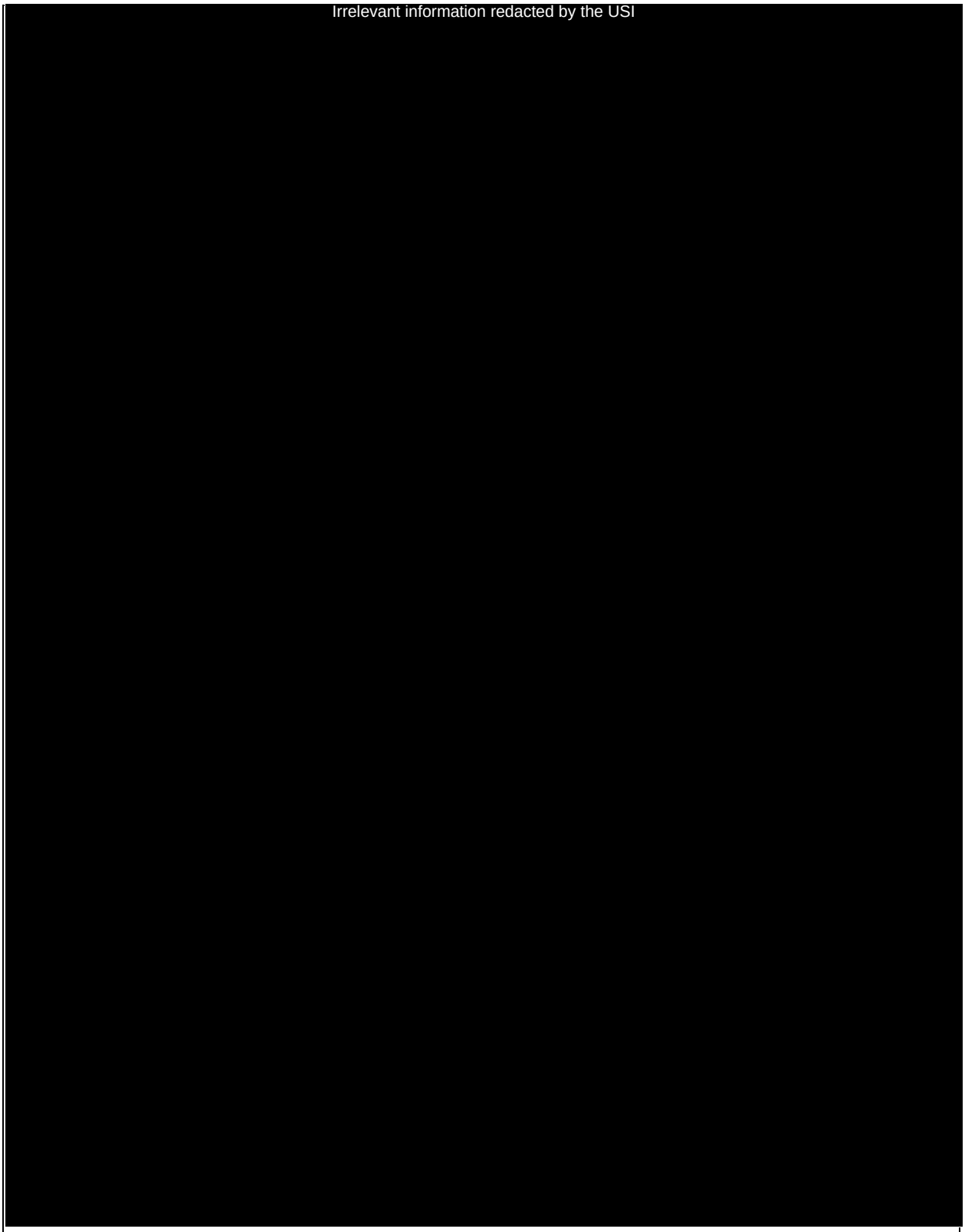
Irrelevant information redacted by the USI

[redacted]


Irrelevant information redacted by the USI


Irrelevant information redacted by the USI


Irrelevant information redacted by the USI


Irrelevant information redacted by the USI

POSTMORTEM FINDINGS

Irrelevant information redacted by the USI

[redacted]

Irrelevant information redacted by the USI

6.0 ANALYSIS

Irrelevant information redacted by the USI

6.0 ANALYSIS

Irrelevant information redacted by the USI

7.0 LESSONS LEARNED

Irrelevant information redacted by the USI

8.0 RECOMMENDATIONS AND ACTION PLANNING

1. The review team recommend the Trust to update their guidelines on management of breech births.
2. Professional communication should be practiced through multidisciplinary staff training including PROMPT (Practical Obstetric Multi-Professional Training) and simulated drills.
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.

8.0 RECOMMENDATIONS AND ACTION PLANNING

.

9.0 DISTRIBUTION LIST

References

1. The Management of Breech Presentation RCOG Greentop guideline No. 20b Peer review draft April 2016
2. The Management of Breech Presentation RCOG Greentop guideline No. 20b (Dec, 2006)
3. Advanced Neonatal Life Support Guidelines. Resuscitation council (2015).
4. Management of Infants who are at risk of early-onset sepsis. Neonatal network Northern Ireland (August, 2012)

Southern Health and Social Care Trust

Quality Care - for you, with you

Root Cause Analysis Report on the investigation of a Serious Adverse Incident

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

Date of Incident/Event: Personal information redacted by USI

HSCB Unique Case Identifier: Personal information redacted by USI

Responsible Lead Officer: **Melanie McClements**

Designation: **Assistant Director Older People's Services**

Report Author: Review team

Date report signed off: *[Insert]*

Date submitted to HSCB: *[Insert]*

1.0 EXECUTIVE SUMMARY

Irrelevant information redacted by the USI

2.0 THE INVESTIGATION TEAM

Irrelevant information redacted by the USI

Investigation Team for Older People and Primary Care Directorate

- Melanie McClements, Assistant Director Older People's Services (Chair)
- Jane Greene, Nurse Consultant Older People's Services and Head of Service Care Home Support Team (CHST)
- Jackie Toner, Older Peoples' Specialist Nurse CHST
- Claire McNally, Clinical and Social Care Governance Co-ordinator for Older People and Primary Care
- Eamon Farrell, Team Manager for Acute Care at Home Service
- Jilly Redpath, Medicines Governance Pharmacist
- Dr Shauna Heanen General Practitioner (involvement report)
- Niamh Murray, Manager Private Nursing Home (PNH)
- Patricia Greatbanks, Regional Manager for Nursing Home.

Investigation Team for Acute Directorate

- Dr Christophe Hillemand
- Mrs Marie Wilson Lead Nurse ATICS and Nurse Endoscopist
- Jilly Redpath, Medicines Governance Pharmacist
- Mrs Trudy Reid Acute Clinical and Social Care Governance Co-ordinator

3.0 INVESTIGATION TERMS OF REFERENCE

Irrelevant information redacted by the USI

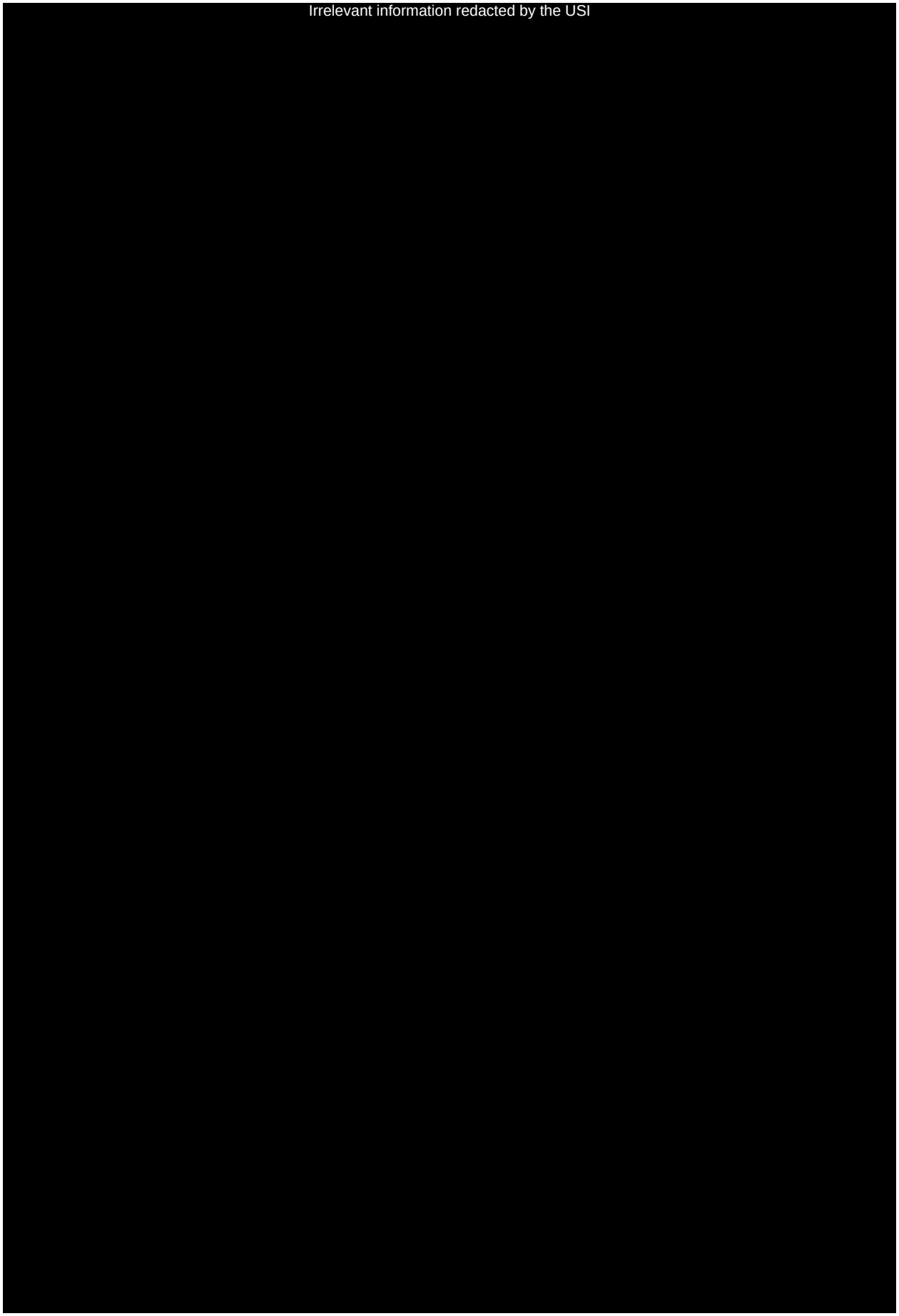
4.0 INVESTIGATION METHODOLOGY

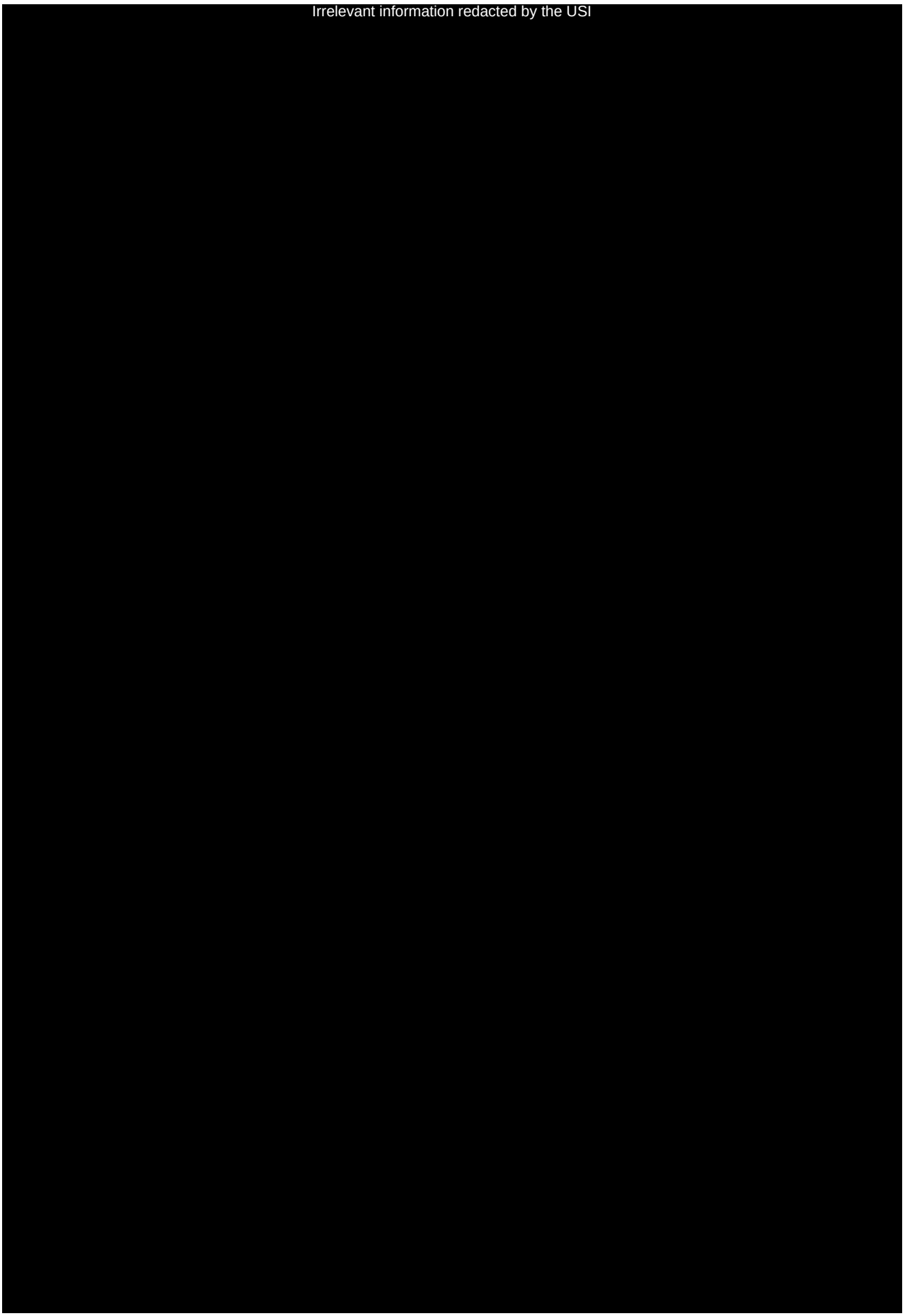
Irrelevant information redacted by the USI

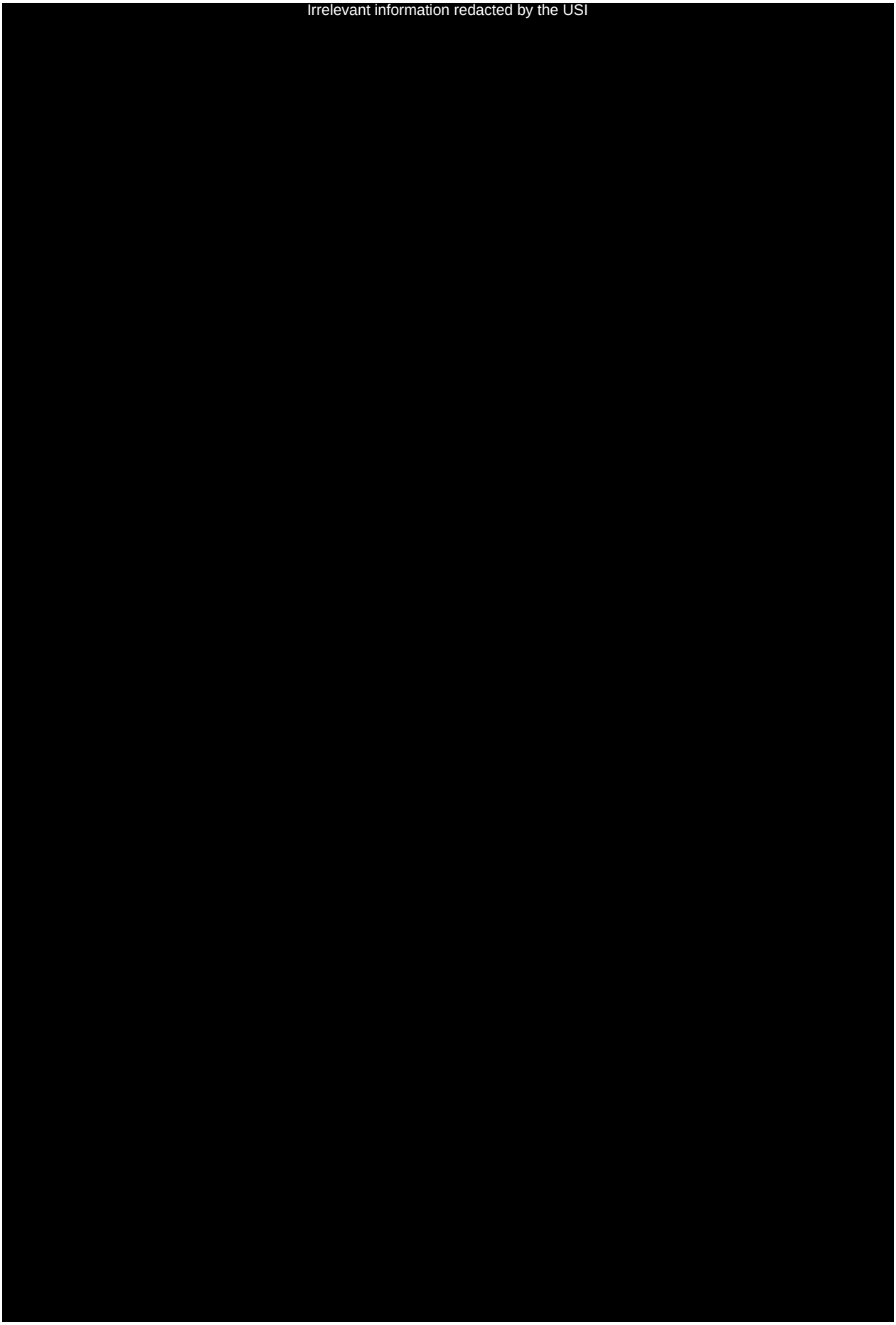
5.0 DESCRIPTION OF INCIDENT/CASE

OPPC Directorate Review

Irrelevant information redacted by the USI



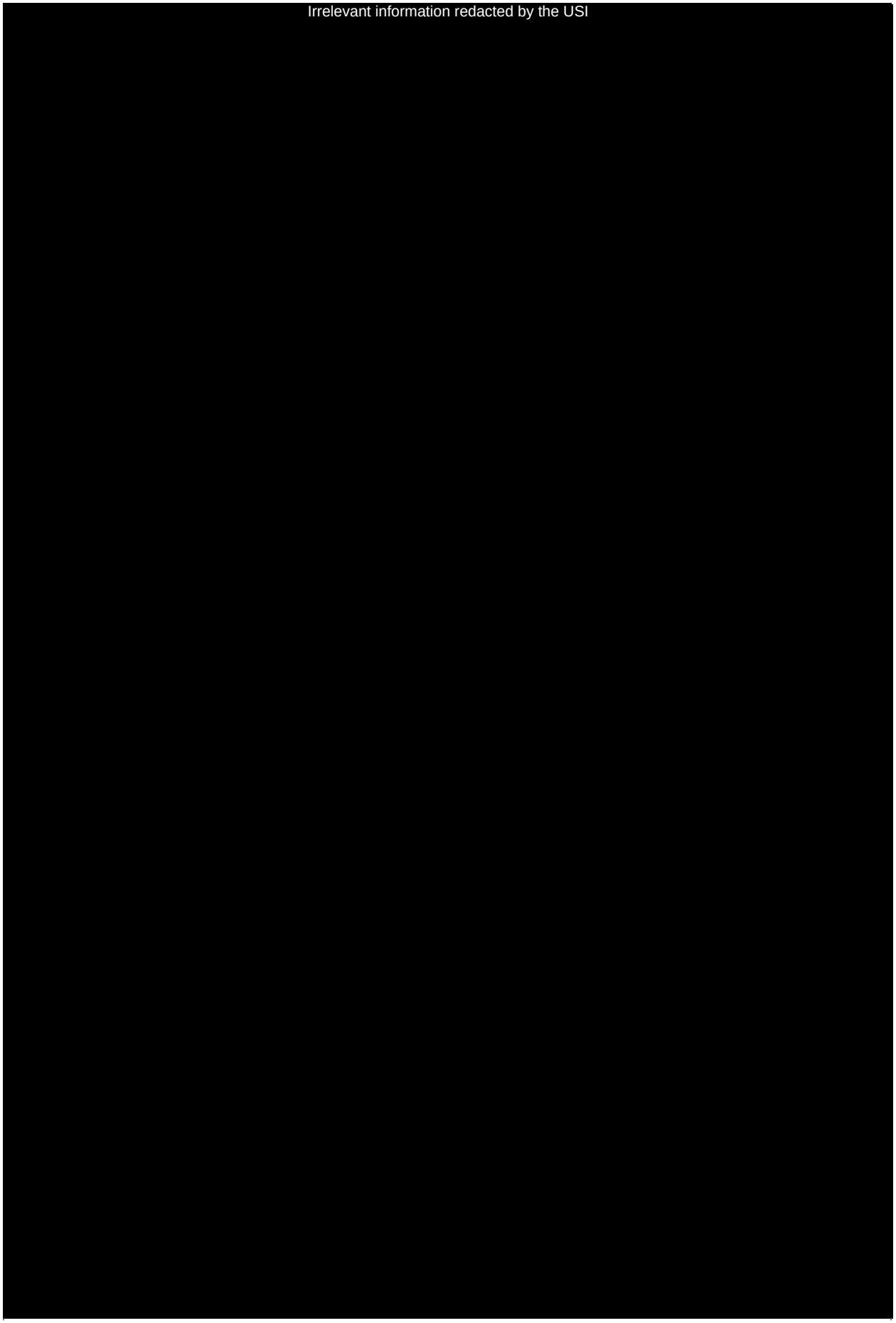




Irrelevant information redacted by the USI

6.0 FINDINGS

Irrelevant information redacted by the USI



Irrelevant information redacted by the USI

7.0 CONCLUSIONS

OPPC Directorate
There was a breakdown in communication between DSU and PNH with the result that the PNH did not administer enoxaparin medication as prescribed post procedure.

There was a further breakdown in communication between the PNH and the GP practice again with the result that the opportunity to identify and rectify the administration of enoxaparin post procedure was missed.

The PNH staff did not have an escalation process in place to obtain clarity when needed.

Acute Directorate:

Post-procedure advice regarding anticoagulation was communicated verbally by DSU and not understood by the nursing home. This communication was not supported by written communication.

The change in pre-procedure enoxaparin dose was communicated verbally and appears to have been received, understood and actioned by the PNH.

In DSU there appeared to be no attempt at medicine reconciliation thus biopsies were

7.0 CONCLUSIONS

not taken due to an incorrect assumption that enoxaparin 60mg had been administered.

No risk assessments were completed in relation to Personal Information's anticoagulation status before she was added to the waiting list for endoscopy.

8.0 LESSONS LEARNED

OPPC and Acute Directorates:

- The focal point of learning from this incident for both Directorates is the need to ensure that there is clear process for patients on discharge from the Acute Directorate to Primary Care setting and that the system of transfer in place for patients includes written instruction on anticoagulation medication. This process needs to ensure that this written communication is shared with the patient and/or their carers (in this case the PNH) and the GP.

OPPC Directorate:

- There is further learning in the need for a communication strategy between PNHs and GP practices with an escalation process embedded when urgent clarity is needed. This needs to include triggers for the PNH staff as to when the escalation process needs to be enforced.

- There is local learning for the OPPC Directorate that will be considered and actioned through the Care Home Support Team in relation to medicines management and administration with particular reference to critical medications.

Acute Directorate:

- 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" need to be completed for all at risk patients.

- BSG guidelines 'Endoscopy in patients on antiplatelet or anticoagulant therapy, including direct oral anticoagulants' and Trust guidance must be adhered to when reviewing and prescribing anticoagulation prior and following endoscopy

- Best Practice Guidance (Learning letter SQR/SAI/2015/016 AS) requires that any necessary medication changes are communicated to the patient and their GP. This learning letter must be adhered to including medicines reconciliation. There appears to have been no attempt at medicines reconciliation in DSU.

- Changes to anticoagulants, immediately prior to and after the endoscopy procedure were not being communicated in writing to GPs or PNHs.

- The SHSCT Endoscopy Report did not include clear instruction regarding anticoagulation therapy when the patient was discharged.

- Written communication in relation to anticoagulation therapy for patients' pre and post-surgical procedure is essential.

7.0 CONCLUSIONS

- There is local learning within Acute Directorate in relation to assessing anticoagulation risk for patient's pre procedure.

9.0 RECOMMENDATIONS AND ACTION PLANNING

Recommendation 1:
Endoscopists must include written instructions for post-procedure management of anticoagulant and antiplatelet medicines for all patients and ensure these are communicated to the in-patient team or GP as appropriate.. These must also be communicated in writing to the GP, patient and/or carer on discharge from the Acute Directorate.

Recommendation 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" need to be completed for all at risk patients.

Recommendation 3:
There is a need for a communication strategy between PNHs and GP practices with a process for escalation when urgent clarity is needed.

Recommendation 4:
There is a need for a local learning plan within this PNH in relation to medicines management particularly with regard to critical medications and the need for an escalation process when there is an issue with administration and / or supply of these.

Complete: September 2016

10.0 DISTRIBUTION LIST

- HSCB
- NOK
- Director of Older People & Primary Care
- Director of Acute
- Relevant Trust staff
- PNH
- RQIA

Southern Health and Social Care Trust

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

Organisation's Unique Case Identifier: [redacted]

Date of Incident/Event: [redacted]

HSCB Unique Case Identifier: [redacted]

Service User Details: (*complete where relevant*)
D.O.B: [redacted] Gender: [redacted] Age: [redacted] yrs

Responsible Lead Officer: Dr Neta Chada

Designation: Consultant in Psychiatry

Report Author: Review Team

Facilitator: Trudy Reid- Acute Governance Co-Ordinator

Date report signed off:

Date submitted to HSCB:

Table of Contents

1.0 EXECUTIVE SUMMARY

Irrelevant information redacted by the USI

[redacted]

2.0 THE REVIEW TEAM

Names	Titles
Dr Neta Chada (Chair)	Consultant Psyciatrist
Dr Shilpa Shah	Consultant Paediatrician
Dr Andrew Ferguson	Consultant, Intensive Care and Anaesthetics
Mr Robin Brown	Consultant Surgeon
Mrs Grace Hamilton	Head of Community Paediatrics, Community Children's Nursing and Specialist Services for CYP
Sr Nichola McClennaghan	Surgical Ward Sister
Jilly Redpath Governance	Pharmacist
Derek McKillop	Clinical Scientist
Mrs Trudy Reid	Acute Governance Co-Ordinator

3.0 SAI REVIEW TERMS OF REFERENCE

Irrelevant information redacted by the USI

[redacted]

3.0 SAI REVIEW TERMS OF REFERENCE

Irrelevant information redacted by the USI

[redacted]

4.0 REVIEW METHODOLOGY

Irrelevant information redacted by the USI

[redacted]

5.0 DESCRIPTION OF INCIDENT/CASE

AH is a15 year old girl with Type 1diabetes mellitus who was transferred on 12th December 2015 from the South West Acute Hospital to Craigavon Area Hospital (CAH) intensive care unit (ICU) with acute exudative pancreatitis, Type 1 diabetes, serum sodium of 126mmols/l, Calcium 1.9 mmols/l and triglycerides 91.1 and a Glasgow coma score of 4. ICU diagnosis - severe pancreatitis secondary to hypertriglyceridemia. From Northern Ireland Care Record (NICER) it was established that AH diabetic control at home appeared good from a recent diabetic clinic attendance in SWAH, a letter documented an HBA1C level of 54 mmols/mol. It was noted that over the past month she had had 14 episodes of hypoglycaemia during the day with no episodes overnight, some of which was attributed to poor injection technique. AH used the Expert Meter and was on variable doses of NovoRapid with all meals and Lantus at night.
AH was discharged from ICU to ward 4 North (4N) an adult surgical admission ward on 14th December 2015. A comprehensive time line of patient care is attached for review (appendix 1).
Patient management including diabetes and fluids was mainly managed by surgical teams, with daily review by a surgical consultant and limited consultation from the paediatric teams from discharge from ICU on 14/12/2106 to 30/12/2016 the day of readmission to ICU (see appendix 2). AH care appeared to focus around her pancreatitis.

Magnetic resonance cholangiopancreatography (MRCP) on the 21st December showed 'Ongoing acute pancreatitis with peripancreatic fluid collections and free fluid. No biliary dilatation. No common bile duct stone'.
A computerised tomography (CT) scan on 29th December showed
1. Evolving peripancreatic fluid collections.
2. No pancreatic necrosis.'

Blood glucose recording was carried out using the patient's own device and not the Trust point of care testing (POCT) equipment (appendix 3 and http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/documents/SHSCTPOCTPolicyFormatUpdated.pdf), thus there is no laboratory record of blood glucose. Nursing notes record 'BM checked (self)', 'mum checked ketones... .', '(checked by mother)', and 'BM monitored by mum'. POCT refers to analytical tests undertaken by non-laboratory health care staff outside a recognised diagnostic laboratory.

Results of blood glucose and ketones are available on appendix 2 and in the graph below. There continued to be a general upward trend in blood glucose until 30th December. Ketones were rarely recorded as recommended.

5.0 DESCRIPTION OF INCIDENT/CASE

Irrelevant information redacted by the USI

[redacted]

5.0 DESCRIPTION OF INCIDENT/CASE

Irrelevant information redacted by the USI

[redacted]

5.0 DESCRIPTION OF INCIDENT/CASE

Irrelevant information redacted by the USI

[redacted]

6.0 ANALYSIS/FINDINGS

Irrelevant information redacted by the USI

[redacted]

6.0 ANALYSIS/FINDINGS

Irrelevant information redacted by the USI

[redacted]

6.0 ANALYSIS/FINDINGS

Irrelevant information redacted by the USI

[redacted]

6.0 ANALYSIS/FINDINGS

Irrelevant information redacted by the USI

[redacted]

6.0 ANALYSIS/FINDINGS

Irrelevant information redacted by the USI

[redacted]

Irrelevant information redacted by the USI

8.0 LESSONS LEARNED

Irrelevant information redacted by the USI

provision gap will remain

9.0 RECOMMENDATIONS AND ACTION PLANNING

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

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

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/

Recommendation 4. Children and young person's 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 hyperglycemia 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

Recommendation 5. 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

Recommendation 6. Trust POCT equipment must be used as per policy when

9.0 RECOMMENDATIONS AND ACTION PLANNING
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 **Recommendation 7.** Ketone meters to be provided in all areas of the hospital where children or adults with diabetes may be managed **Recommendation 8.** 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 **Recommendation 9.** 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. **Recommendation 10.** 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. **Recommendation 11.** Total parenteral nutrition in children must be managed in consultation with a team specialising in paediatric TPN at the tertiary centre. **Recommendation 12.** 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

10.0 DISTRIBUTION LIST

Appendix2:- Time Line

Date	Source	Time Line	Comments
[redacted]		Irrelevant information redacted by the USI	

Date	Source	Time Line	Comments
[redacted]		Irrelevant information redacted by the USI	

Date	Source	Time Line	Comments
[redacted]	[redacted]	Irrelevant information redacted by the USI	[redacted]

Date	Source	Time Line	Comments
		Irrelevant information redacted by the USI	

Date	Source	Time Line	Comments
[redacted]		Irrelevant information redacted by the USI	

Date	Source	Time Line	Comments
[redacted]		Irrelevant information redacted by the USI	

Date	Source	Time Line	Comments
		Irrelevant information redacted by the USI	

Date	Source	Time Line	Comments
[redacted]		Irrelevant information redacted by the USI	

Date	Source	Time Line	Comments
[redacted]		Irrelevant information redacted by the USI	

Date	Source	Time Line	Comments
[redacted]		Irrelevant information redacted by the USI	

Date	Source	Time Line	Comments
[redacted]		Irrelevant information redacted by the USI	

Date	Source	Time Line	Comments
Irrelevant information redacted by the USI			

Date	Source	Time Line	Comments
[redacted]		Irrelevant information redacted by the USI	

Date	Source	Time Line	Comments
		Irrelevant information redacted by the USI	

Date	Source	Time Line	Comments
[redacted]		Irrelevant information redacted by the USI	

Date	Source	Time Line	Comments
[redacted]		Irrelevant information redacted by the USI	