Angela Kerr

From: Mitchell, Darren <[redacted]>
Sent: 20 November 2014 13:35
To: O'Brien, Aidan
Subject: [redacted]

Aidan –could I ask you to have a look at this case which was passed to me as the regional MDT chair.

Looks like young man with high grade organ confined disease from 2012. From my prospective he would have been considered for neo-adjuvant hormones for 3-6months followed by EBRT in early 2013. He may have been suitable for combined EBRT + BT (pending LUTS assessment). His high grade disease would have encouraged us to offer him 2-3years of adjuvant hormonal therapy after EBRT depending on 2008 or 2014 NICE guidelines and pt tolerance.

I'm not aware of any of his co-morbidities or performance status.

As hormonal therapy in this case we would use LHRHa or occasionally Bicalutamide 150mg OD monotherapy.

I'm told he has only just been referred for radiotherapy at 2 years after initial MDT presentation.

I'm not aware of supportive research for 24months of neo-adjuvant hormones prior to EBRT but the trans-tasmin group 0 vs 3 vs 6 and the Canadian 3 vs 8 are already quoted in our radiotherapy protocol and based on those studies we typically think of 6 months neo-adjuvantly in this kind of case.

6 months of LHRHa prior to EBRT is also recommended in the STAMPEDE protocol for men with high risk non-metastatic disease who are for radical radiotherapy.

I'm also told that he was on Bicalutamide 50mg OD for the first year of his management.

The NICAN hormone protocol (in process) would be useful in standardising our therapy across the region but Bicalutamide 50mg is not licenced for mono-therapy use and will not be recommended in the protocol other than within the licenced context for the management of flare with LHRHa.

The MRHA site provides information on 'off-label' prescribing and our responsibilities within that.

http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON087990

Happy to discuss this further.

Southern Health and Social Care Trust

Southern Health & Social Care Trust

Findings of the Root Cause Analysis – Personal Information redacted by the USI
Incident Ref – Personal Information redacted by USI
SAI Ref - Personal Information

October 2010

7 Conclusions, Recommendations and Learning

The method of recording swabs which were temporarily used in the patient cavity that day in theatre is inconsistent. A standardised protocol for the counting and recording of all swabs across all theatres needs to be implemented urgently.
The responsible scrub nurse in this case is unclear because there were two scrub nurses. When the scrub nurse hands over to another scrub nurse he/she should sign off the current state of swabs in use and used.
The first post-operative scan (1st October 2009) was not reviewed at routine follow up because there was no follow up for 12 months due to the length of the urology outpatient waiting list. The urology waiting list for post-operative follow up needs to be cleared.
Several abdominal x-rays were performed on Personal Information redacted by the USI's readmission but the swab was missed by several doctors. This is presumably because they have never seen a retained swab on a radiograph previously. This case should be presented, with the radiographs, at Surgical and Medical Morbidity and Mortality meetings to demonstrate the appearance of a retained swab.

7.1 Local Recommendations

The local recommendations are set out in table 1

7.2 Regional Recommendations

No regional recommendations are deemed necessary.

7.3 Action Planning

The action plan below sets out the proposed lead individuals and completion dates for the recommendations contained in this investigation.

Table 1 local recommendations

Recommendation	Evidence of Action	Lead Individual	Completion	Completion Date
All swab and instrument counts must be interruption free and where possible the same circulating nurse completes count –	Write SOP for all Theatre within Trust	Lead Nurse ATIC AMD's Surgery & Gynaecology	Jan 11	
Swabs that are temporarily used in a patients cavity must be recorded on the white board and struck through when removed until operation complete – the record must not be 'rubbed out'	Incorporate new SOP for all Theatres within Trust	Lead Nurse ATICs	Jan 11	
As far as is operationally	Each month five	Lead Nurse ATICs	Jan 11	

possible the same nurse should remain as the scrub nurse for the entire operation. Signing off of swab status must take place by the Scrub Nurse if there is a changeover.	patients charts will be reviewed to ensure all necessary documentation is complete			
It needs to be recognised and reaffirmed that time is required at the end of the operation to the scrub nurse to ensure that all swabs, instruments and equipment are accounted for.	This will be incorporated in WHO' Patient Safety Checklist'	Lead Nurse ATICs	Feb 11	
Where possible and practical there should be a 'surgical pause' before wound closure.	This will be incorporated in WHO' Patient Safety Checklist'	AMD's Surgery & Gynaecology	Feb 11	
Findings of the RCA will be presented at the next radiology peer review discrepancy meeting		Dr Hall	18th January 2011	
Presentation of case with radiographs at Radiology, Surgical and Medical M&M.		AMD Radiology Dr S Hall AMD Surgery Mr E Mackle AMD Medicine Dr P Murphy	18th January 2011	
Reduction in all Out-Patient waiting times		Assistant Directors Acute Services		

Time line of events beginning 15.07.09
Re [redacted] Unit Number [redacted]
Datix Incident Number [redacted]

This timeline is subject to further revision as information is gathered during the review process.

Date	Time	Event	Comments
23.06.09 Tuesday		Had **pre-op CT scan abdomen** done	
15.07.09 Wednesday	08.55	Elective Right Nephroureterectomy radical cystectomy & ileal conduit for bladder cancer	Anaesthetics Dr 4 – no anaesthetic issued identified on chart review Surgeon Mr 1 All swabs accounted for on 'SWAB COUNT' list **Instrument check section NOT signed at 'cavity closure' or 'Prior to closure'.**
15.07.09	12.45	1st unit packed cell erected	
15.07.09	12.55	2nd unit packed cell erected	
15.07.09	15.00	3rd unit packed cells erected	Operation was scheduled for 9am – 12.30 but [redacted] was In theatre until 15.40 > 6 hours with estimated blood loss 2000 mls
19.07.09 Sunday		Discharged from ICU	
24.07.09 9th day post - op Friday		Discharged home	
05.08.09 Wednesday		Histology Clinic	
01.10.09 Thursday		**Had CT scan abdomen in STH**	Dr 3 (consultant radiologist)
06.07.10 Tuesday		Attended A&E C/O abdominal pain & vomiting for 2weeks and diahorrea for 2 days	
06.07.10	11.50	Admitted to MAU under Dr 1 (physician)	
07.07.10 Wednesday		**Had abdominal x-ray**	
08.07.10		**Had abdominal x-ray**	

09.07.10 Friday		Transferred to surgery	
09.07.10		**Had CT scan abdomen**	Reporter – Dr 3 (consultant radiologist) who compared this scan to Personal Information redacted by the USI's pre-op scan of 23.06.10 **** Small Bowel Obstruction likely due to adhesions
12.07.10 Monday (Bank holiday)		Seen by Mr 3 - Discharged 2pm	
14.07.10	18.10	Readmitted with 4N abdominal pain	
14.07.10		**Had abdominal x-ray**	
14.07.10	23.20	Transferred to 1 South with cough	
16.07.10 Friday		**Had abdominal x-ray**	
19.07.10 Monday	03.00	Dr 2 (SHO) reviewed abdominal x-ray flag raised	
19.07.10		Ward round Dr 4 – discussed abdominal x-ray with radiologists	
20.07.10 Tuesday		**Had abdominal x-ray**	
21.07.10 Wednesday		CT R/V Dr 5 & Mr 2	
21.07.10		To theatre for laparotomy - medium sized swab found	
21.07.10	IR1 form completed by Sr 1		
27.08.10 Tuesday	IR1 form received in central reporting point		

Diane Corrigan

From: Diane Corrigan
Sent: 07 April 2011 07:03
To: [redacted: Charlie McAllister's email address]
Subject: Re: SAI - Retained swab

I'll be on the road to Belfast so won't be able to answer till after 9.20ish. Then in a meeting from 9.30. However no rush on this. Text sometime when free over the next few days and I may be able to come out of a meeting and call you back.
Thanks
Diane

----- Original Message -----
From: CHARLES MCALLISTER [mailto:[redacted: Personal Information redacted by the USI]
Sent: Thursday, April 07, 2011 06:51 AM
To: Diane Corrigan
Subject: Re: SAI - Retained swab [redacted]

Hi Diane

It might be better to discuss this.

Can I ring you later this morning?

Charlie

On 6 Apr 2011, at 21:33, Diane Corrigan <[redacted: Personal Information redacted by the USI] wrote:

> "This email is covered by the disclaimer found at the end of the message."
>
>
> _____ [redacted]
>
>
> Charlie
> I have just read the RCA report on the case on which you were lead investigator. I have a couple of queries. Normally I route those back through formal channels - but often it takes months to get a response and even then the answer tends not to address the question
>
> Would it be OK to ask you the questions 'off the record/informally'? Depending on the answer then I can either close the file or ask Paddy's office for a formal response. However if you would prefer the query was sent formally at the outset that would be fine.
>
> I knew that review appts were behind in general - but was not aware that something like a first review post major complex cancer surgery could be deferred from early Dec and not yet seen by the following July. There weren't that many major complex pelvic surgery cases per year in CAH pre-2010 - indeed that was the rationale for centralisation in the Urology Review. If that sort of patient wasn't being reviewed then who was?
>
> Am I being hopelessly naïve to suggest that having a system where test results are not reviewed - even in the most superficial way - until the patient's appointment comes round is bound to result in unpleasant surprises? Seems

fraught with medicolegal danger. Better not to do a test at all than to do it and not read the result. I know that without the notes to hand it could be argued that reviewing tests would be wasteful of time/inappropriate - but it could catch the occasional high risk problem.
>
> I suspect you must have discussed this - but the recommendation was for the Trust to put right review backlogs - which sounds like it won't happen quickly. Even if the latter was put right, a patient who cancelled and rescheduled a few times could delay their review while a seriously abnormal result sat waiting on their chart.
>
> Is any other interim action/ safetynet needed - or am I missing the point?
>
> Best wishes
>
> Diane
>
> _____
>
>
>

HSC Public Health Agency

South Office
Tower Hill
ARMAGH
Co Armagh
BT61 9DR

Tel : Personal Information redacted by the USI
Fax :
Web Site : www.publichealth.hscni.net

Strictly Confidential

Ms D Burns
Assistant Director Clinical &
Social Care Governance
Southern Health & Social Care Trust
Old College of Nursing
Craigavon Area Hospital
68 Lurgan Road
PORTADOWN
BT63 5QQ

14 November 2011

Dear Ms Burns

I refer to the Trust's report on the Root Cause Analysis of this incident. The report is thorough, clearly identifying the chronology of events and making recommendations on actions to avoid recurrence. As might be expected, the report concentrates on the primary event, which occurred during the patient's operation on 15th July 2009 and the x-ray findings which might have aided detection prior to her emergency admissions in July 2010.

The patient was expected to have an outpatient review four months after her major complex cancer surgery in July 2009. It was also expected that at that review attendance the CT scan, undertaken three months post-operatively, would be available for the consultant urologist to see. This scan was done promptly in early October 2009 and the report identified an abnormality. Although not identified as a retained swab, one of the differential diagnoses was recurrence of the patient's cancer.

The RCA report identifies that, due to a backlog in outpatient reviews, in fact the patient was not seen at outpatients in the 12 months after surgery, at which stage she was admitted as an emergency. The recommendation relating to this issue was that outpatient backlog reviews should be cleared. This recommendation is reasonable, albeit not necessarily easy for the Trust to

implement given the resources required to do so. However, this aspect of the SAI does raise a wider cause for concern which has not been addressed directly in the RCA or the recommendations.

The report records that it was the practice of the patient's consultant urologist not to review laboratory or radiology reports until patients attended their outpatient appointment. There was no further comment on this practice, nor any recommendation relating to this. I believe that this highlights an area where the Trust would have considered action to be appropriate. It is possible that this was not seen as directly relevant to the actions required to minimise the likelihood for further SAIs relating to retained swabs, hence there were no recommendations for action in this particular RCA report. I am writing to ask whether this issue has been taken forward, for example by considering whether there is a need for a formal Trust policy, such as review of all test results by medical staff before filing, whether or not the patient is awaiting outpatient review.

Yours sincerely

[redacted]
Personal Information redacted by USI

Dr D Corrigan
Consultant in Public Health Medicine

cc Dr J Simpson
Dr G Rankin
Mrs J McCulla

[redacted]

6

Southern Health and Social Care Trust

Quality Care - for you, with you

02 August 2012 Ref: mm / bmc

Dear Dr Corrigan

I refer to your letter of 14 November 2011 regarding the SH&SCT Root Cause Analysis report relating to a retained swab following surgery, (SAI Personal Information redacted by the USI HSCB ref Personal Information redacted by the USI

Please find below the process which has been implemented in the Trust on the management of patients Discharged but awaiting results.

PAS Function

The communication system used within the Trust to manage patient appointments and patient episodes, including the Discharge of patients awaiting results is PAS. PAS provides a function to alert Secretaries of patients who are discharged but still await results. This function has now been activated within the PAS system and Consultant's Secretaries have been trained in the Management of the function.

A standardised operating procedure (SOP) is now in place. In this SOP there is a checklist of diagnostic tests and the turn-around time/average wait for specific test/results as a guideline – to ensure that patients are not waiting any longer than they should be for a review appointment.

Diane Corrigan

From: Diane Corrigan
Sent: 23 April 2014 17:47
To: Marshall, Margaret ([redacted]; john.simpson[redacted]
Cc: serious incidents
Subject: SAI [redacted]- Incident ref [redacted]- retained swab
Attachments: Letter from Trust with update on Action Plan (2).docx

Dear John and Margaret

This SAI has been open for a long time. In retrospect perhaps it should have been escalated earlier but on various occasions it seemed very close to closure so I held on for the final information needed. I have summarised below the process to date with a view to getting your comments on how and whether we can bring this to a conclusion. John, I appreciate that you may not routinely be involved in SAI issues, but this one relates to medical practice across almost all specialties so I felt that I should make you aware of the issue.

The patient involved in this SAI was found to have a retained swab following major urological cancer surgery. This came to light when the patient presented as an emergency 1 year later with abdominal pain/sub-acute obstruction and the swab was found at laparotomy.

The RCA identified swab counting issues in theatre and proposed changes to Trust procedures which would have minimised the risk of recurrence. As a DRO, I accept that these would have been sufficient to support sign-off of the primary cause of this SAI. However I did not sign it off for the following reason. It was noted in the RCA that an abnormality/mass had been reported on a planned follow-up CT scan 3 months post-op and reported as either a seroma or a local cancer recurrence. The patient had been due for scheduled out-patient review soon after the scan (i.e. at 4 months post-op) but because of outpatient review backlogs this never took place. It was reported in the RCA that it was the practice of the consultant concerned not to review reports of investigations until a patient was due to attend outpatients.

If this patient had had a recurrence of her cancer, the delay in the scan result being reviewed by her consultant would almost inevitably have resulted in significant consequences.

As DRO I asked the Trust to consider if a system was needed to ensure all reports of diagnostic tests were seen before filing to avoid missing issues needing urgent action (as would be the case in general practice). The Trust agreed to consider this; the first step proposed was to scope the scale of the issue across specialties. After some time had passed the Trust submitted new recommendations (attached). I could not be confident that the action proposed would avoid a similar problem in future so I asked the Trust to reconsider.

I had expected to receive a final report/proposal setting out how the issue would be addressed. Instead a swab counting protocol was forwarded to me via the serious incidents team. Unfortunately it appears that if anything this has gone backwards rather than forward – however I am aware that Governance staff moved jobs in 2013 and it may be that this has inadvertently resulted in some crossed wires in this case.

Could I ask you to re-read the attached description of revised processes in the Trust which was forwarded to me in 2012? My reading of this is that these arrangements only deal with patients discharged from the ward, so would not apply to results following outpatient investigation. Even if that is put to one side, I think that if the sequence of events that happened in this SAI case were to happen again, the patient, who had an abnormal result at 3 months post-op and one month before an expected outpatient review, would not be flagged by the consultant secretary as needing escalation until after the review date – i.e. at least 1 month after the abnormal result had been returned/filed. I don't feel I could sign this off as safe practice. Am I missing something obvious? Can I ask you both what your opinion is on this issue?

Diane Corrigan

From: serious incidents
Sent: 21 July 2014 12:20
To: Diane Corrigan
Subject: SHSCT SAI [redacted] HSCB REF: [redacted] - SAI Thematic Review: - Relating to Review of SAIs, where a Failure in the Referral or Follow-up Process has occurred.

Importance: High

Dr Corrigan,

See below response from the Southern Trust in relation to the above incident. I assume this is in response to your email of 23 April to Margaret Marshall and John Simpson.

Regards.
Elaine Hyde
Governance Office
Health and Social Care Board - Southern Office
Tower Hill
Armagh BT61 9DR
Tel: [redacted]
Email: [redacted]
www.hscboard.hscni.net

From: McCooey, Blaithnid [mailto: Personal Information redacted by the USI]
Sent: 17 July 2014 11:12
To: serious incidents
Cc: Marshall, Margaret
Subject: SAI Thematic Review: - Relating to Review of SAIs, where a Failure in the Referral or Follow-up Process has occurred.
Importance: High

Elaine
Please see below
Can you please bring this to the attention of Dr Corrigan who is the DRO involved in this query.

Kind regards
Blaithnid

Follow up of patients who are waiting for investigations

Further to previous correspondence on the 2 August 2012 regarding SH&SCT Root Cause Analysis – SAI Personal Information redacted by USI HSCB Ref Personal Information redacted by USI

SHSCT wish to provide some clarification.

In order to ensure that no patient is lost to follow up by a clinician, while waiting for the results of their investigations, the SHSCT has set up a specific code on the Patient Administration System (PAS) to ensure that there is a process in place which will enable the secretary to record that the patient is waiting for

investigations, and also that the process will enable a report to be run detailing all patients waiting for their investigation, which can then be used as a monitoring tool.

Process

1. The secretarial staff will discharge the patient on PAS using the code DARO – *Discharge Awaiting Results – Outpatients.*
2. The Line Manage runs a report on a monthly basis which provides a list of all patients by consultant who are recorded as DARO.
3. Each secretary checks this report to ensure that there is no delay in any of the investigations being performed, and they chase any areas of delays with the relevant diagnostic service.
4. When the results are returned these are brought to the attention of the clinician, and PAS is updated to reflect that the results have been received.
5. This report is also checked each month by the Line Managers and any areas of concern are raised with the secretary to determine what action has been taken to date.
6. If there remains a delay in the investigations being performed the Line Manager will escalate this to the appropriate Head of Service for their action.

Subject: Request for update: SHSCT SAI [redacted]; HSCB REF: [redacted]
Importance: High

Blaithnid/Eileen,

I refer to Dr Corrigan's email below to Margaret Marshall. To date no response has been received. I would be grateful if you would follow-up with Margaret and provide a response as soon as possible please.

Regards.
Elaine Hyde
Governance Office
Health and Social Care Board - Southern Office
Tower Hill
Armagh BT61 9DR
Tel: [redacted]
Email: [redacted]
www.hscboard.hscni.net

From: Diane Corrigan
Sent: 21 July 2014 16:12
To: Marshall, Margaret ([redacted])
Cc: serious incidents
Subject: FW: SHSCT SAI [redacted] HSCB REF: [redacted] - SAI Thematic Review: - Relating to Review of SAIs, where a Failure in the Referral or Follow-up Process has occurred.
Importance: High

Dear Margaret

Thank you for forwarding this clarification. It certainly demonstrates that a robust system is in place to monitor and act on investigations awaited – with the emphasis on ensuring that delays in patients having investigations done are escalated. However this SAI was not about a delay in the patient having her investigation. It was done promptly at the time requested post-surgery. The problem arose because the result was put on file awaiting the outpatient review appointment. In earlier correspondence it was stated that it was the practice of the patient's consultant not to review such results until they attended the clinic. I don't see how the system detailed below prevents that happening again. Am I missing something?

Regards

Diane

From: serious incidents
Sent: 21 July 2014 12:20
To: Diane Corrigan
Subject: SHSCT SAI [redacted] HSCB REF: [redacted] - SAI Thematic Review: - Relating to Review of SAIs, where a Failure in the Referral or Follow-up Process has occurred.
Importance: High

Dr Corrigan,

See below response from the Southern Trust in relation to the above incident. I assume this is in response to your email of 23 April to Margaret Marshall and John Simpson.

Diane Corrigan

From: serious incidents
Sent: 18 December 2014 12:32
To: Diane Corrigan
Subject: Trust Resp: DRO Request for update/Outstanding Trust response: SHSCT SAI [redacted] HSCB REF: [redacted]

Dr Corrigan,

See below response from the Southern Trust in relation to your email to Margaret Marshall of 21 July 2014 (also below).

Elaine Hyde
Governance Office
Health and Social Care Board - Southern Office
Tower Hill
Armagh BT61 9DR
Tel: [redacted]
Email: [redacted]
www.hscboard.hscni.net

From: McCooey, Blaithnid [mailto: [redacted]]
Sent: 17 December 2014 09:55
To: serious incidents
Cc: Carroll, Anita; Marshall, Margaret; Corporate.Governance
Subject: Resp: DRO Request for update/Outstanding Trust response: SHSCT SAI [redacted] HSCB REF: [redacted]

Elaine [redacted]

In relation to Dr Corrigan's outstanding concerns, the process is as follows:

- Secretaries have confirmed that they do not file results without them first being viewed by the consultant.
- Consultants mostly sign these and some then dictate a letter.

I do not think that the Trust can really provide any further assurance on this other than the above feedback from Secretaries?
Can you please outline how Dr Corrigan would wish to move forward on this issue?

Kid regards
Blaithnid

From: serious incidents [mailto: [redacted]]
Sent: 27 October 2014 09:57
To: Corporate.Governance
Subject: FW: Request for update/Outstanding Trust response: SHSCT SAI [redacted]; HSCB REF: [redacted]
Importance: High

Blaithnid/Eileen,

Diane Corrigan

From: Diane Corrigan
Sent: 07 November 2017 10:51
To: serious incidents
Subject: RE: Request for update on closure: SHSCT SAI - FEMALE (DOB Personal Information redacted by USI HSCB REF: Personal Information redacted by USI

Elaine
In Brid's absence I have read the documentation provided. As you know the additional request for sight of lab protocols for results was made by members of the SAI group and I was not involved. The unread report in this SAI was a radiology report, so I am not sure if some wires got crossed in seeking lab report arrangements. In either event, what has been provided is a laboratory protocol (which to be fair is what was asked for) but this understandably does not address the wider issue of Trust protocols to ensure results are then seen by a member of medical staff in a reasonable timescale and before being filed away, or left on a file awaiting an outpatient review which may be delayed (as happened in this case). This has therefore not progressed the issue on which the SAI group wanted additional information/reassurance.

I was not part of the SAI group discussion, which stimulated this request for additional information. The Trust appears to have interpreted the request literally and without reference to the underlying SAI. In retrospect perhaps the request was not clear from this end if it was to be actioned by someone in the Trust who had no knowledge of the background issue. The SAI group may wish to decide whether they still need additional information.

Diane

From: serious incidents
Sent: 07 November 2017 09:58
To: Diane Corrigan
Subject: Request for update on closure: SHSCT SAI - FEMALE (DOB Personal Information redacted by USI HSCB REF: Personal Information redacted by USI

Dr Corrigan,

Further to the email below, just wondering if you have you had an opportunity to consider the above incident for closure.

Regards

Elaine Hyde
Governance Office
Health and Social Care Board - Southern Office
Tower Hill
Armagh BT61 9DR
Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI
www.hscboard.hscni.net

From: serious incidents
Sent: 24 October 2017 12:25
To: Diane Corrigan
Subject: FEMALE (DOB Personal Information redacted by USI HSCB REF: Personal Information redacted by USI

Southern Health and Social Care Trust

Quality Care - for you, with you

DRAFT

ADMINISTRATIVE & CLERICAL Standard Operating Procedure No.

Title	Discharge Awaiting Results – Outpatients (DARO)	
S.O.P. Number		
Version Number	v1.0	**Supersedes:** v0.1
Author	Operational Support Leads	
Page Count	9	
Date of Implementation	November 2010	
Date of Review	November 2011	**To be Reviewed by: OSL's**
Approved by		

3) If a patient is awaiting results prior to a decision regarding follow up treatment being made, they must be recorded as a discharge (DIS) **and not** added to the OP Waiting List for review.

4) All outcomes/disposals should be recorded on PAS for each patient. For those patients who have had a disposal code of DIS, WL, BKD, DNA or WL recorded, you will then be prompted to select each patient individually for discharge (when you enter "Yes" – when using AAD function).

```
        R e c o r d   A t t e n d a n c e   a n d   D i s p o s a l
      Outpatients                                          09/11/10 09:12 CAH
+-------------------------------------------------------------------------------+
| Clinic: CS1      Doctor:    CS1      Date: 25/10/2010  Session: 08:00-13:00  |
|                                                                               |
|Time  Status   Case Note No Name                  Attd      Disp Grade         |
|08:45 OP REG   CAH12345     BLOGGS, J              ATT      :REV :             |
|08:45 OP DSCH  CAH23456     GREEN, J              :ATT      :WL  :             |
|08:45 OP DSCH  CAH10000     SMIITH, M             :ATT      :DIS :             |
|09:00 OP DSCH  CAH45678     THOMPSON, P           :ATT      :DIS :             |
|09:00 OP REG   CAH56789     BROWN, C              :ATT      :REV :             |
|09:15 OP REG   CAH67890     WEIR, M               :ATT      :RVL :             |
|09:15 OP REG   CAH78900     MACKLE, C             :ATT      :RVL :             |
|09:15 OP DSCH  CAH54321     SLOAN, E              :ATT      :WL  :             |
|09:20 OP REG   CAH43210     MCKEOWN, G            :ATT      :REV :             |
|09:25 OP REG   CAH10101     CLARKE, J             :ATT      :RVL :             |
|09:25 OP REG   CAH10000     BLACK, N              :ATT      :REV :             |
|09:30 OP DSCH  CAHE0000     WHITE, D              :ATT      :WL  :             |
|                                                                               |
|                                                                               |
+-------------------------------------------------------------------------------+
```

For those patients who require test results before a decision is made regarding follow-up treatment:

Record using function "AAD" on PAS –

- Record "Discharge On" (discharge date) as the date of the clinic.
- Record Disposal "Reason Code" as ***DARO (Discharge Awaiting Results - Outpatients)***
- Record an appropriate comment in the "Reason Text" field – for example:

    - Await MRI results
    - Await CT scan/x-rays/barium enema/ultrasound etc.
    - Await injection
    - Await blood results
    - Await urodynamics
    - Await histology results
    - Await physiotherapy treatment
    - Await Anaesthetic Assessment