Paper 1

Issue 1

Membership of Children's Hospital Governance Group

Chair: to be nominated by the Service Area: [redacted], Consultant Paediatric Anaesthetist

Secretarial support: [redacted] (secretary to Service Manager, [redacted])

Membership:

- Co-Director : [redacted]
- Clinical Director : [redacted]
- Service Manager : [redacted]
- Clinical Lead for Paediatric Quality and Effectiveness : [redacted], Consultant Paediatric Anaesthetist
- Clinical Lead for Surgery : [redacted], Consultant Paediatric Surgeon
- Clinical Lead for Community : [redacted], Consultant Community Paediatrician
- Clinical Lead for Medicine : [redacted], Consultant Paediatric Cardiologist
- Governance and Quality Senior Manager : [redacted]
- Administration representative : Vacant at present (replacement to be nominated by [redacted])
- Medical workforce Manager : [redacted]
- Pharmacy representation : [redacted]
- Health and Safety representation : [redacted]
- Service Area Risk/Quality staff : [redacted]

Issue 2

Assurance Framework

Please refer to Appendix B. A new steering group with formal sub-committees has been formed to focus on learning from experience. The terms of reference for this group have been developed and will be considered at the inaugural meeting. The draft terms of reference are attached at Appendix 1. The previous assurance framework committee structure has been attached at Appendix 2 for ease of reference.

Issue 3

Quality Forum

The Belfast Health and Social Care Forum is a six month pilot initiative in conjunction with the regional Health and Social Care Safety Forum. There is a programme of events which are publicised via the Trust's intranet. The focus is on engagement

with all staff to encourage and facilitate innovation of services at all levels of the organisation. Events are held at lunchtime to facilitate attendance by clinical staff. Two sample programmes have been attached for information at Appendix 3 and 4. The initial six month programme covers a range of quality/patient safety issues with a strong link to the Trust's Quality and Safety Improvement Plan which has already been submitted to the IHRD (Appendix 6 of the BHSCT Quality and Safety Initiatives paper).

Issue 4

The Trust would like to confirm that Appendix 6 of the original Trust paper is the Trust's Quality and Safety Plan (outlined on page 12 of the document). A copy of BRAAT can be provided if required.

Issue 5

Post Governance Francis Action Plan

The Trust has developed an action plan which is monitored by the Assurance Committee of Trust Board. The actions are under a number of key themes including the following:

- Communication/awareness of Report and findings
- Assurance/Governance & Board Effectiveness
- Principle of Openness and Candour
- Patient Safety Standards/Guidelines
- Incidents, Complaints and Claims management
- Medical, Nursing and Midwifery training and education
- Records Management

A number of actions have been completed or are in the process of being implemented. These actions include; raising awareness of the Francis Report and its findings across the organisation, revision of the Assurance Framework and creation of a Learning from Experience Steering Group, developing a formal liaison meeting with the Coroner's Office, the review of a number of policies including complaints, adverse incident reporting, whistleblowing and the 'Being Open' policy. A number of other actions are planned over the next six to twelve months which include; continuing to contribute to the development of the Regional Adverse Incident and Learning System, considering role of service user in the development of policy and procedure, further complaints management and investigation training, further root cause analysis training, human factors training programmes, the review of governance arrangements in medical training and education and continuing to work closely with the universities to support and further develop the nursing and midwifery

curriculum post Francis Report, work in collaboration with Nursing and Midwifery Education Commissioning Group and trade unions to further develop leadership and all levels and to continue to support the review of the role of the ward sister/charge nurse to enable them to have a higher presence in the ward/department and to work alongside staff as a role model.

Issue 6

Complaints Management

The Trust deals with approximately 450 formal complaints and 200 general enquires (for example queries about appointments, car parking, transport and records management) per quarter. All formal complaints are graded by the Complaints Department upon receipt and occasionally this grading may be changed following investigation. Approximately 50% of formal complaints annually are graded as low/no harm for example a delay in car parking which did not result in being late for or missing an outpatient appointment. Approximately 2% of complaints annually are graded as high with significant treatment/care issues. These types of complaints will also typically be reported as a Serious Adverse Incident to the Health and Social Care Board (HSCB) if they meet the regional criteria. The most frequent subjects of complaints are in relation to aspects of the quality of treatment and care, communication/information given to patients, delays or cancellations of outpatient appointments, staff attitude and behaviour and delays or cancellations of admissions to hospital. Typically complainants want their issues addressed, an apology offered and the Trust to put in place measures which will help prevent recurrence.

Use of Lay Reviewers (LRs)

Lay Reviewers are typically used to give an impartial perspective of non-clinical/technical issues. They are not used as advocates, conciliators or investigators. The BHSC Trust have used LRs to review communication issues, quality of record keeping, attitudes/relationships and access/appointments. A number of LRs were enlisted following interview by the HSCB and a representative from the BHSCT. The HSCB provides training for LRs.

The Trust uses Independent Experts (IE) more often than Lay Reviewers expertise or support. IE reports may be helpful to management and staff in providing opinion as to care management issues and best practice. This may be important in complex cases or where a resolved internal opinion is not possible. The Trust may also consider IE where there are wider issues of patient/public safety or where issues of professional performance need to be considered. It is up to the Complainants to agree to the use of either LR and/or IE.

Assurances of Independence if no LR

It is the Belfast HSCT policy that medical staff cannot investigate their own complaint. Responses in these cases are the subject of internal peer review. The

Complaints Managers are members of Trust staff but are not employed by the Directorates and will always attempt to act on behalf of the complainant. The Trust's Complaints Review Committee is chaired by a Non-Executive Director who monitors and reviews all levels of complaints and not just the more serious matters. The Non-Executive Director has also chaired a number of family meetings and was accepted by the complainants as an independent voice. The Trust is required under the HPSS policy and procedure to do its best to resolve matters at local level. All complainants will be offered the use of LR or IE if they are not happy with the response provided. Complainants are also advised of their right to appeal to the Ombudsman. Complainants may also choose to involve an independent advocate for example the Patient Client Council, Mental Health or the Voice of Young People in Care (VOYPIC). They will also on occasion involve from the onset their political representative/MLA.

Family Involvement

The BSHCT Complaints Policy is based on DHSSPS guidance which has limited reference to family in current format. The Trust is currently reviewing the complaints management policy and is holding a workshop to include service users as part of the consultation process. Training for complaints management will always advocate dealing whenever possible with complaints at local level when they arise. This means the staff interacting directly with the family/carer. In answering a formal complaint the Trust will undertake an investigation to establish the events and circumstances which then inform the response. In practice family meetings may be offered at various stages of the investigation of a formal complaint and not just at the final stage. This will very much depend upon the nature of the complaint. If a Moderate/High Risk Complaint triggers an SAI then Trust policy and root cause analysis training emphasises the importance of family/patient/carer involvement. Often investigative teams will meet with the family ahead of completing a report to ensure that their experiences of the service are fairly and accurately captured, learning identified and appropriate recommendations made.

Issue 7

Adverse Incident Policy

Examples of adverse incidents which were considered to be "far removed from acceptable practice" are inappropriate examination of an intimate nature, taking of inappropriate images of staff colleagues and bullying and harassment.

Issue 8

CHIP

Please find attached at Appendix 5 and 6 a sample of copies of the note of the meetings for the Children's Hospital Incident Panel.

Issue 9

Serious adverse incidents

SAIs to Trust Board

The following are examples of SAIs that were brought to Trust Board for information and discussion:

Recall of patients – School of Dentistry

Information governance issue at Belvoir Park Hospital

Outbreak of *Pseudomonas* in the Neonatal Unit

Care management issues and unexpected death in the Emergency Department

Unreported x-rays – potential delay in treatment

SAI reports to Assurance Committee

A copy of the annual SAI report for the period 1 April 2012 to 31 March 2013 has been attached at Appendix 7 for information.

RBHSC SAIs to the HSCB

The following are examples of types of SAIs reported to the HSCB by the Children's Hospital in the period prior to the issue of the new HSCB guidance on SAIs effective from 1 October 2013:

- Unexpected death of a child.
- Death of a child following delayed diagnosis and treatment of an acute illness, (transfer to RBSHC from another Trust also involving Primary Care).
- Information governance breach relating to the IHRD by clinicians.
- Cross infection of measles.

Issue 10

RCA Training

The following numbers of senior members of staff have received training in root cause analysis methodology from the Children's Hospital in the period from 2006 to date:

Clinical director	1
Clinical lead	1
Consultant paediatric anaesthetist/intensivist	2
Consultant paediatrician	2

Co Director	1
General Manager	2
Nurse/Service Manager	4
Ward sister/assist service manager	3

Issue 11

Expert Evidence to Coroner

The Belfast HSC Trust is and has always been fully committed to assisting the Coroner by providing all relevant information to the Coroner in order to enable him/her to effectively perform his/her Coronial functions. This includes the provision of statements, investigative reports, root cause analysis reports and independent expert reports obtained during any of these investigative processes.

Issue 12

NCEPOD

Please find attached at Appendix 8 a copy of the arrangements for dissemination of NCEPOD reports.

Standards and Guidelines Committee

Please find attached at Appendix 9 and 10 copies of minutes of the Standards and Guidelines Committee.

Issue 13

Letter to Consultants

The following data is available and accurate at 1 pm on the 4 November 2013. This is an on-going process and the Medical Director has written a reminder to those staff who have not yet responded to the letter and responses are still being received by the Medical Directors Office. The Medical Director has been informed that a small number of clinicians are on sick leave, maternity leave or career break at this time and will be followed up in due course.

(1) The letter was sent to 862 clinicians in total.
(2) A total of 378 to date have responded that they do not administer fluids to children in the course of their work.
(3) A total of 300 have completed training.
(4) This information will be supplied as soon as possible.

Business Services Organisation

Directorate of Legal Services
PRACTITIONERS IN LAW TO THE HEALTH & SOCIAL CARE SECTOR

2 Franklin Street, Belfast, BT2 8DQ
DX 2842 NR Belfast 3

Your Ref:
AD-0670-13

Our Ref:
HYPB04/06

Date:
7th November 2013

Mrs Dillon
Solicitor to the Inquiry
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Madam,

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS-DEPARTMENTAL AND ADDITIONAL GOVERNANCE SEGMENT

I refer to your letter of 14th October 2013 and my letter of 5th November 2013 enclosing Paper 1 prepared by the Belfast Trust. You will note that the Trust's response to Part 4 of Issue 13 was incomplete. I now enclose the Trust's response to same for your attention.

I trust that this is in order.

Yours faithfully

Joanna Bolton
Solicitor Consultant

Paper 1 Issue 13 part 4

The Medical Director's office has received some additional responses to the letter since the submission of the data on the 5th November 2013. A total of 310 clinicians have confirmed that they have undertaken the training and 386 clinicians have responded that they do not administer fluids to children in the course of their work. The timeframe for training is as follows:

21 completed it prior to the letter going out on the 22/8/13

54 completed their training between the 22/8/13 and 30/9/13

235 have completed their training after the 30/9/13.

Belfast Health and Social Care Trust

ASSURANCE FRAMEWORK

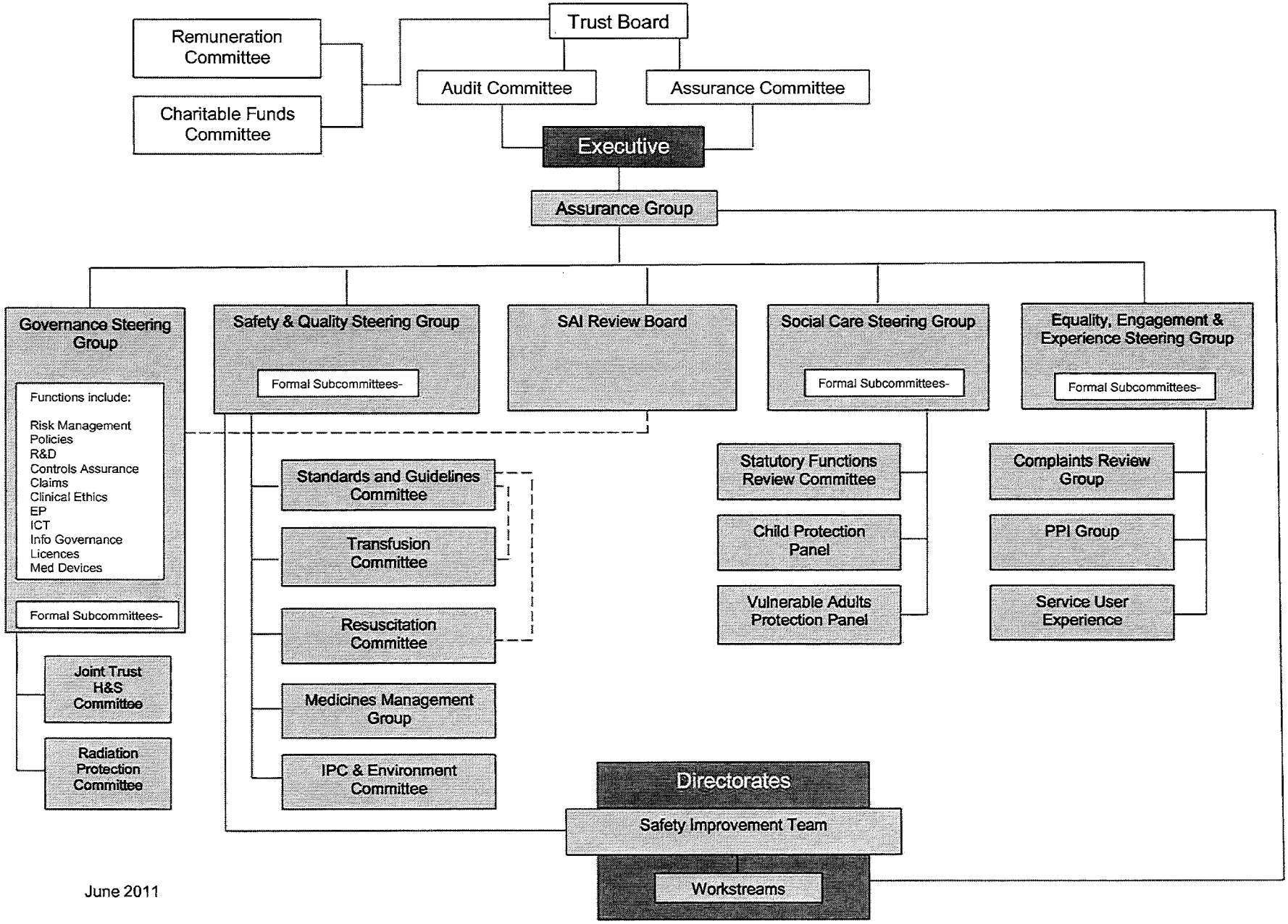
COMMITTEE TERMS OF REFERENCE

COMMITTEE	Learning from Experience Steering Group
PURPOSE	As a sub-committee of the Assurance Framework the purpose of the Learning from Experience Steering Group is to provide assurance to the Assurance Committee around the effectiveness of structures and processes established to support learning from the events and experiences of our service users and staff. The Learning from Experience Steering Group will bring together aspects of the assurance framework agenda in order to realise continuous improvement in safety and quality.
MEMBERSHIP	**Chair:** TBC **Membership:** All Directors of the Trust Co Director Risk & Governance / Head of Office of the Chief Executive **In attendance:** The chair or nominated representative of each of the reporting sub committees. Any Senior Manager of the Trust may, where appropriate, be invited to attend. **Secretary:** Corporate Governance Services Should a member be unavailable to attend, they may nominate a deputy to attend in their place subject to the agreement of the Chair. **Member Appointments** The membership of the Learning from Experience Steering Group shall be determined by the Assurance Committee, based on the recommendations of the Chair – taking into account the skills and expertise necessary to deliver the Learning From Experience Steering Group's remit.
DUTIES	The Learning from Experience Steering Group will, in respect of its provision and advice to the Assurance Committee, monitor the work of and hold reporting sub committees to account for the Trust as follows: • Review and approve the assurance updates from each of the sub committees on a quarterly basis; • Receive learning reports escalated by each of the sub committees as they become available.

	• Agree learning – the format, method and appropriate level of dissemination both internal and external to the organisation as appropriate. • Seek assurance that agreed sharing of learning has occurred. • Seek assurances that learning disseminated has been used to improve safety and quality • Ensure improvements in safety and quality as a result for learning from the events and experiences of our services users and staff, are appropriately published.
AUTHORITY	The Learning from Experience Steering Group is authorised by the Assurance Committee to investigate, or have investigated, any activity within its terms of reference. In doing so, the Learning from Experience Steering Group shall have the right to inspect records or documents of the Trust relevant to the Learning from Experience Steering Group's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any: • Employee (and all employees are directed to co-operate with any reasonable request made by the Steering Group); • Other Committee, subcommittees or group established within the Assurance Framework to assist in the delivery of its functions.
MEETINGS	**Quorum** The quorum for the meeting will be no less than 60% of the membership and must include as a minimum the Chair or Deputy Chair and representations from 4 of the Directorates. **Frequency of Meetings** The Learning from Experience Steering Group will meet monthly and shall agree a schedule of meetings at least 12 months in advance. **Papers** Agenda and papers will be disseminated to the Learning from Experience Steering Group members four working days before the date of the meeting and wherever possible electronically. **Meeting Arrangements** The Chair of the Learning from Experience Steering Group in discussion with the Group's Secretary shall determine the time and place of meetings and procedures of such meetings. **Withdrawal of individuals in attendance** The Learning from Experience Steering Group may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of a particular matter.
REPORTING	The Learning from Experience Steering Group is directly accountable to the Assurance Committee for its performance in exercising the functions set out in these terms of reference.

	The Learning from Experience Steering Group, through its Chair and members, shall work closely with the Assurance Framework Steering Groups and Committees, to provide advice and assurance to the Assurance Committee: • Joint planning and co-ordination of Assurance Framework business; • Sharing of information. In doing so, the Learning from Experience Steering Group shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Trust's overall risk and assurance framework. The Learning from Experience Steering Group shall embed the Trust's corporate standards, priorities and requirements, e.g., equality and human rights, through the conduct of its business. The Learning from Experience Steering Group Chair shall: • Report formally, regularly and on a timely basis to the Assurance Committee on the Group's activities. This includes verbal updates on activity, the submission of minutes and written reports; • Bring to the Assurance Committee's specific attention any significant matter under consideration of the Learning from Experience Steering Group; • Ensure appropriate escalation arrangements are in place to alert the Executive Team, or Chairs of other relevant Committees/ Steering Groups, of any urgent/critical matters that may compromise patient/client care and affect the operation and/or reputation of the Trust. The Senior Manager for Corporate Governance, on behalf of the Chair of the Learning from Experience Steering Group, shall oversee a process of regular self-submission of minutes and written reports, including that of any sub-committees established.
CONFLICT/ DECLARATION OF INTEREST	The Chair shall seek and record any declaration or conflict of interest from members prior to every meeting of the group.
REVIEW	These terms of reference and operating arrangements will be reviewed on at least an annual basis by the group.

ASSURANCE COMMITTEE
SUB-COMMITTEE STRUCTURE



June 2011

DLS

332-056-010

DLS

Sepsis –
Quality Improvement Initiative in the Emergency Department

Belfast Health and
Social Care Trust

332-056-011

DLS

BHSCT ED Safety Forum

- Part of Regional Emergency Care Collaborative
- Focus on time dependent conditions- Stroke, MI, Sepsis
- **Sepsis – Most challenging**
- Increased awareness amongst staff
- Increase understanding about Sepsis
- Correct management of patients

Belfast Health and Social Care Trust

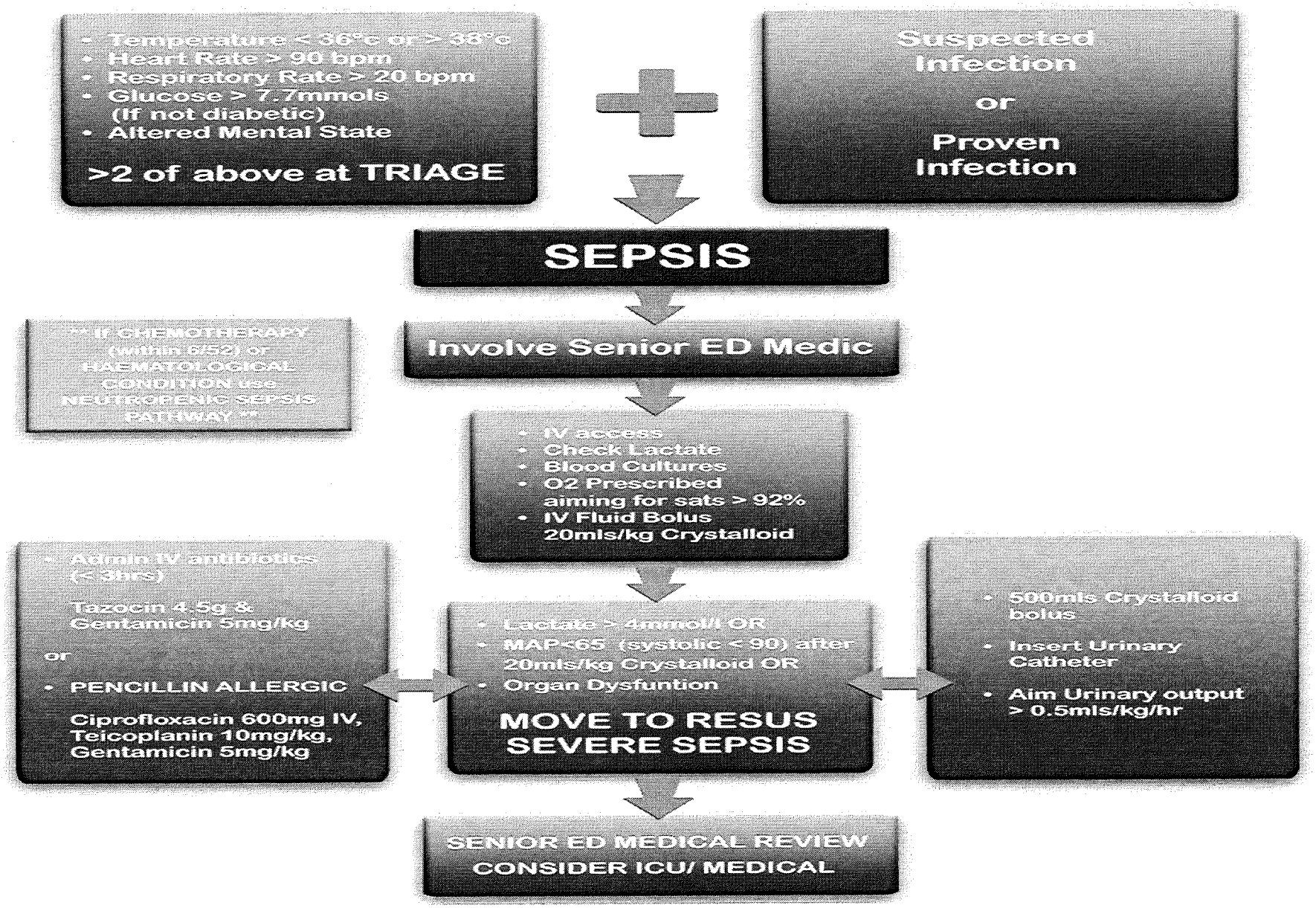
332-056-012

Plan Do Study Act Cycles

- **Plan:** Increase awareness/ Education amongst staff
- **Do:** Pathway design, Sepsis Week, workshops with staff, Feedback from staff
- **Study**: Baseline Data/ Ongoing data Samples of 10 patients per month (for both MIH and RVH ED's)
- **Act:** Standardized, consistent means of measuring performance – Spreadsheet, ~~Sepsis Box, Sepsis Stickers~~

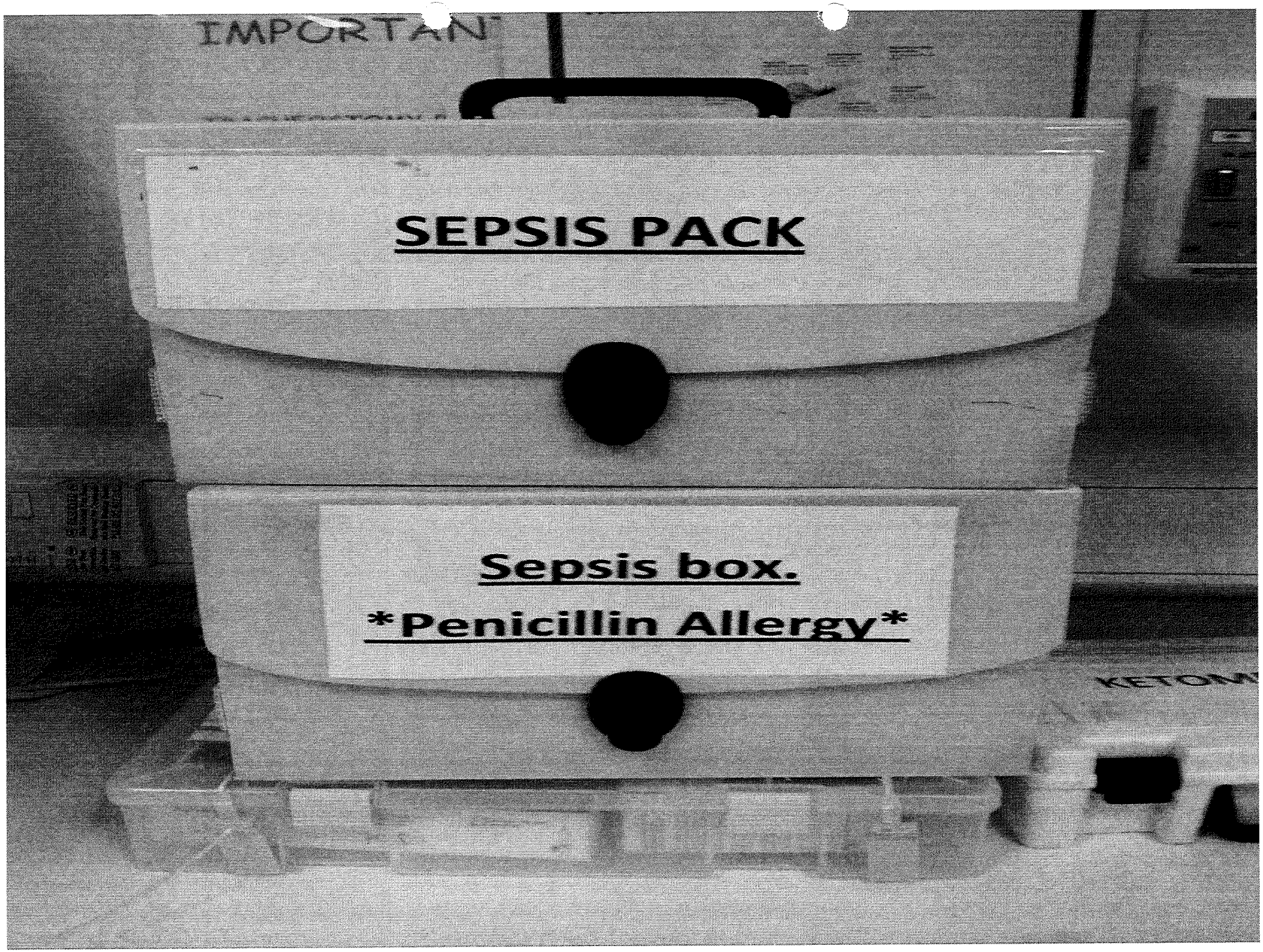
Belfast Health and Social Care Trust

SEPSIS PATHWAY



DLS

332-056-014



DLS

332-056-015

IV FLUIDS
LACTATE
BLOOD CULTURES
ANTIBIOTICS
CATHETER
SEPSIS BUNDLE
OXYGEN
IV FLUIDS
LACTATE
BLOOD CULTURES
ANTIBIOTICS
CATHETER
INITIAL & TIME
SEPSIS BUNDLE
OXYGEN
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INITIAL & TIME
SEPSIS BUNDLE
OXYGEN
IV FLUIDS
LACTATE
BLOOD CULTURES
ANTIBIOTICS
CATHETER
INITIAL & TIME

DLS

April 2012 – April 2013

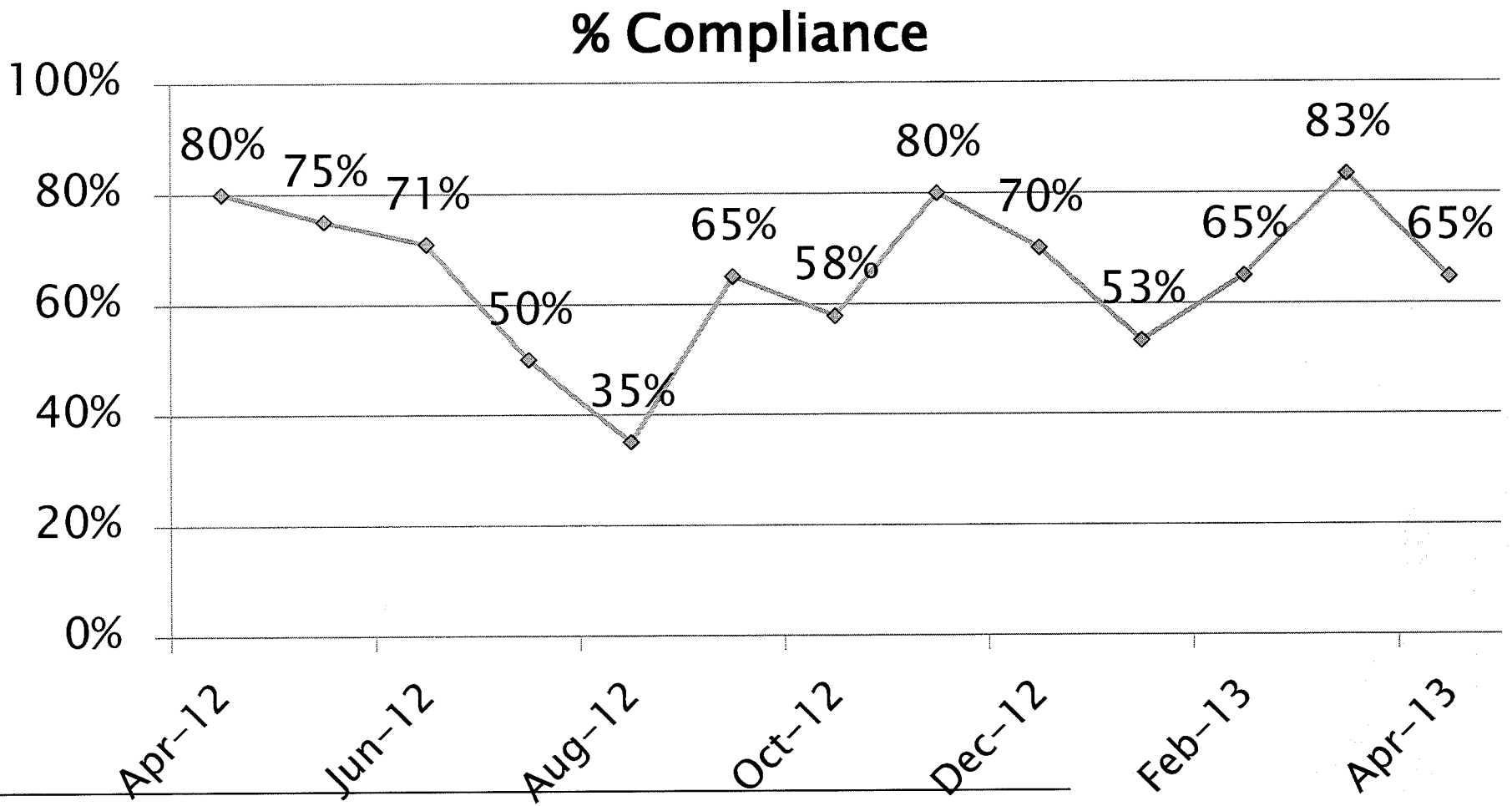
SEPSIS RUN CHARTS
BHSCT EMERGENCY DEPARTMENTS

332-056-017

Belfast Health and
Social Care Trust

DLS

Arrival to triage <= 15 mins – Target 100%



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332-056-018

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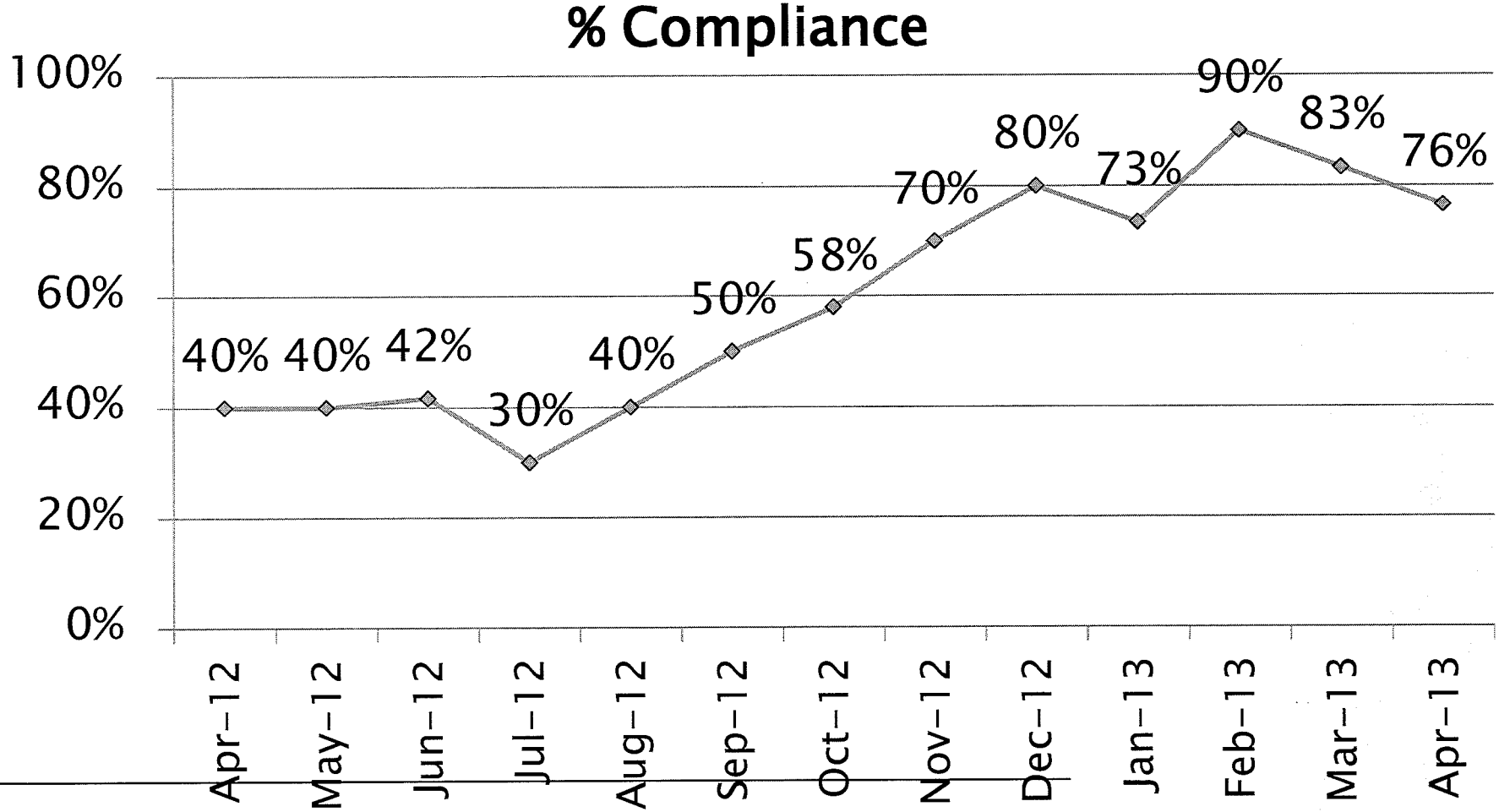
All observations recorded (T, P, Bp, GCS, RR) Target 95%



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332-056-019

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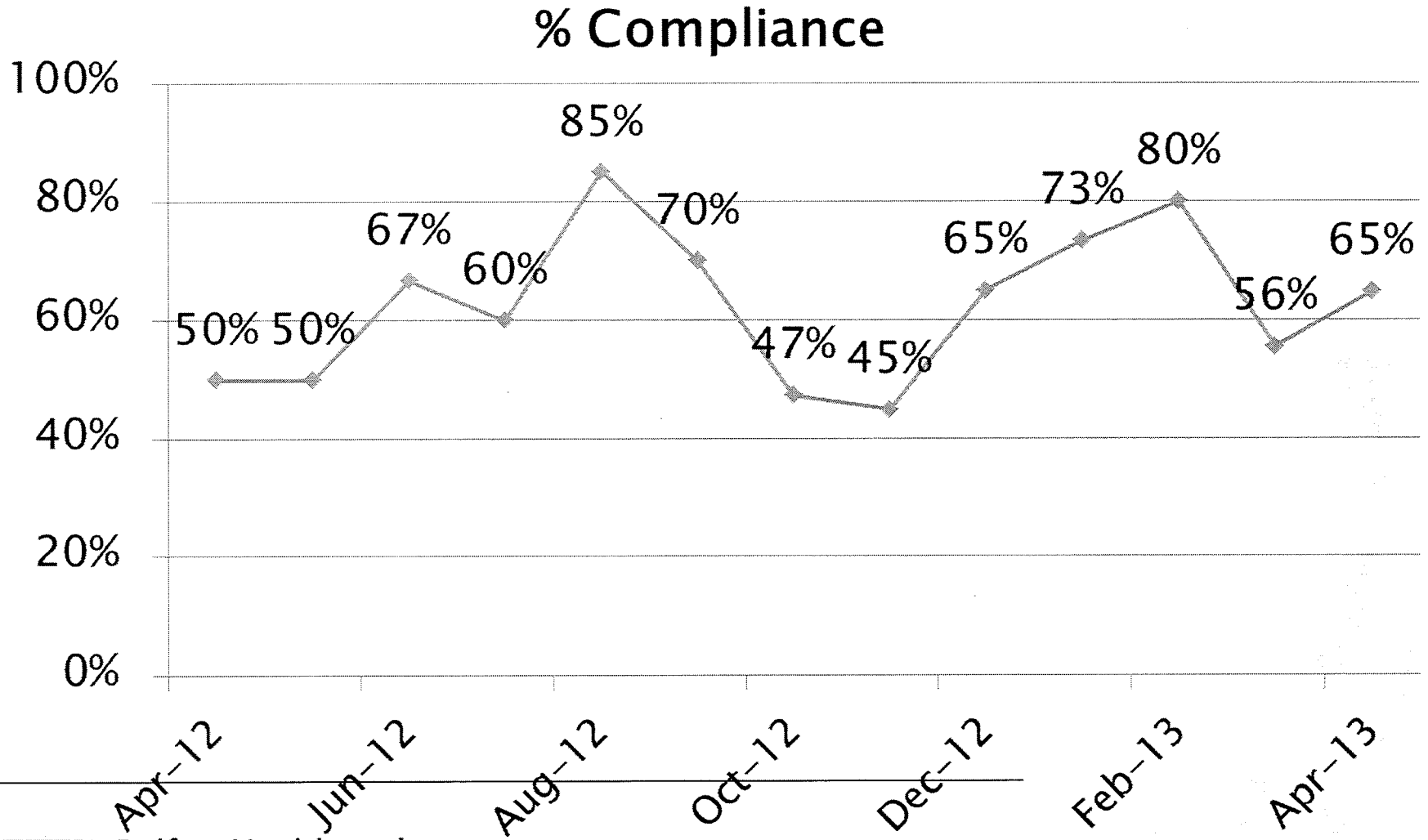
Urinary output monitoring - Target: 90%

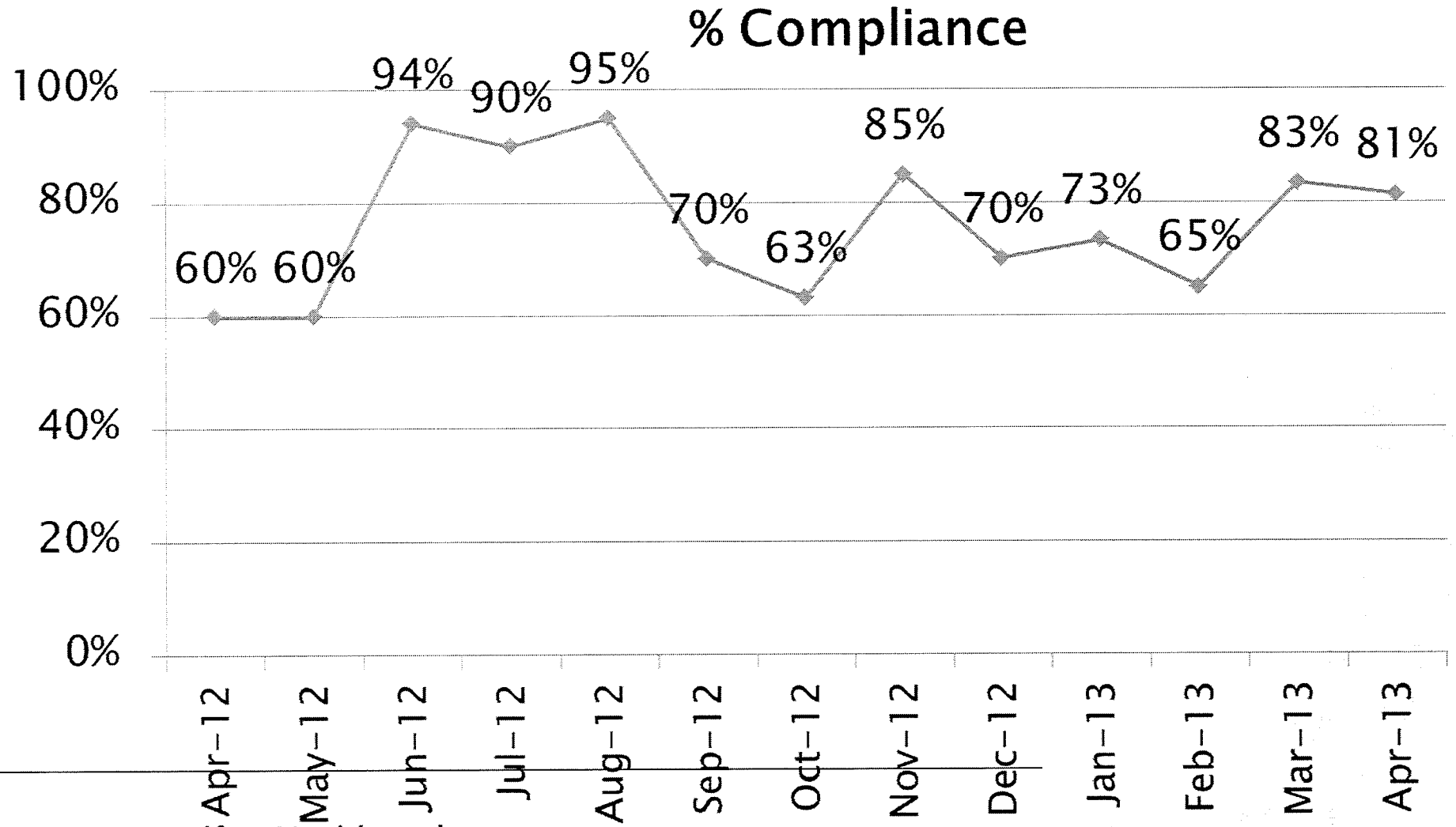


HSC Belfast Health and Social Care Trust

332-056-020

DLS

Blood cultures (95% before leaving ED)

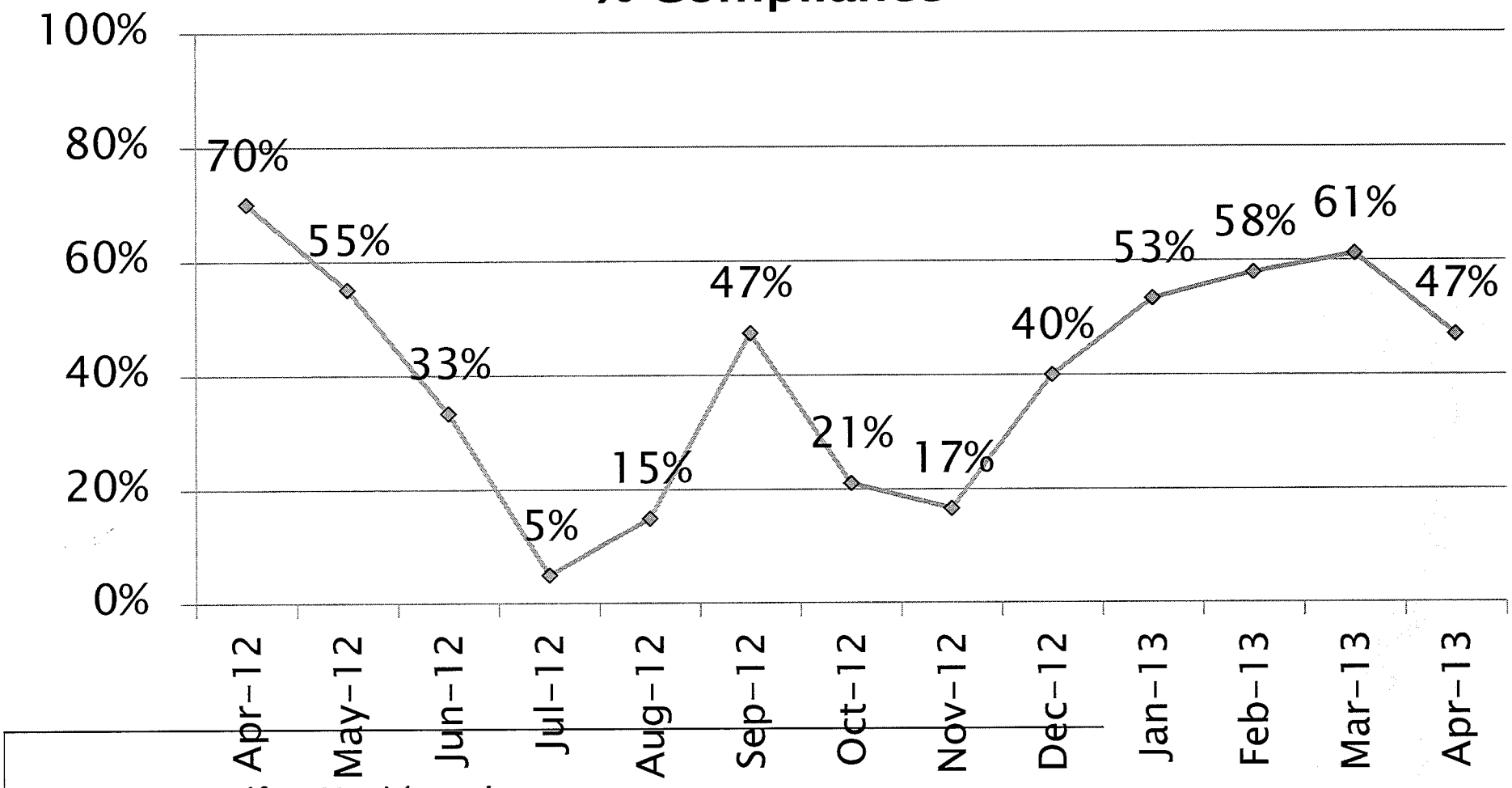


HSC Belfast Health and Social Care Trust

332-056-021

DLS

Antibiotics (50% within 1 hr)

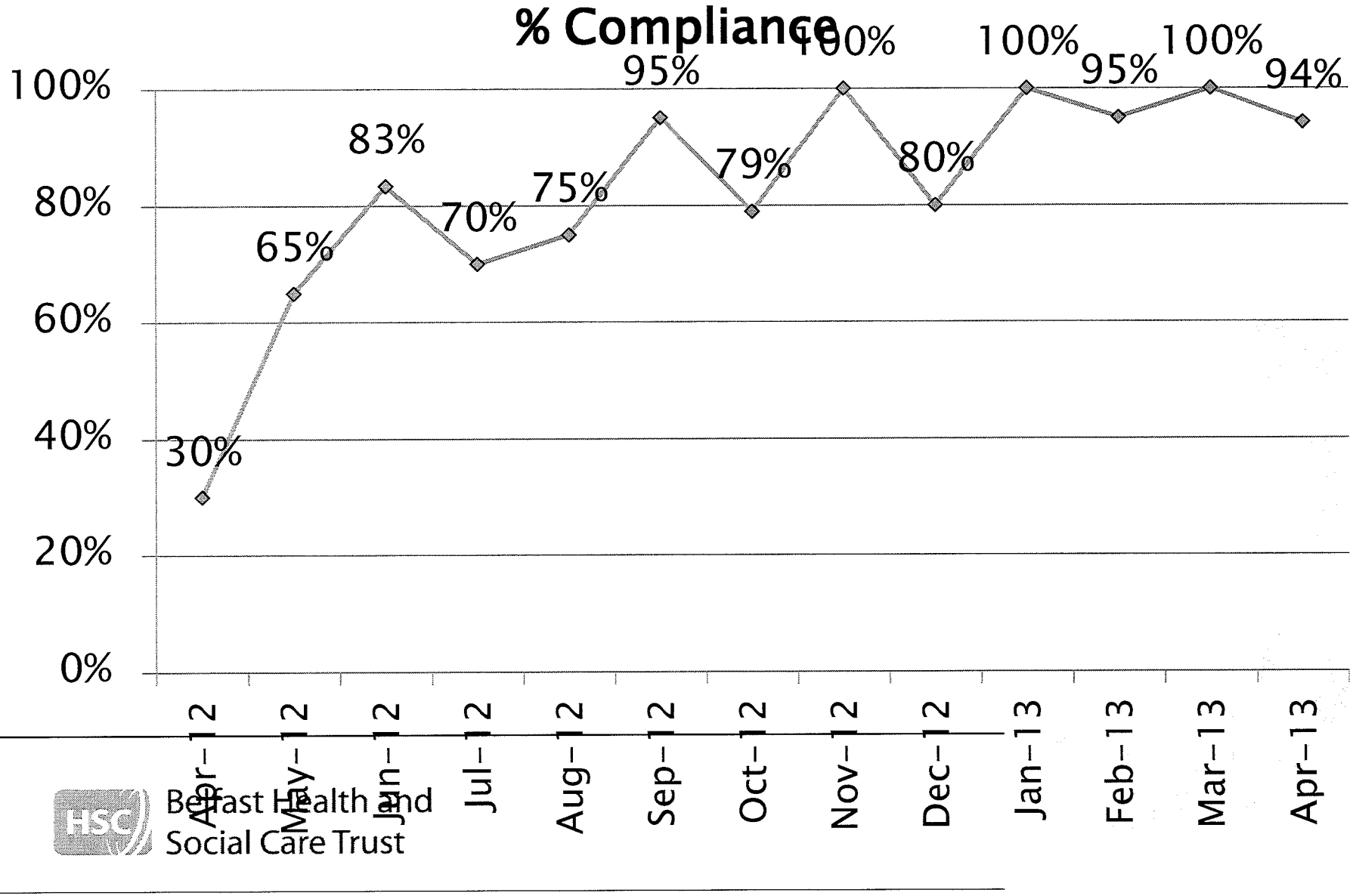


Belfast Health and Social Care Trust

332-056-022

DLS

Serum Lactate (95%before leaving ED)



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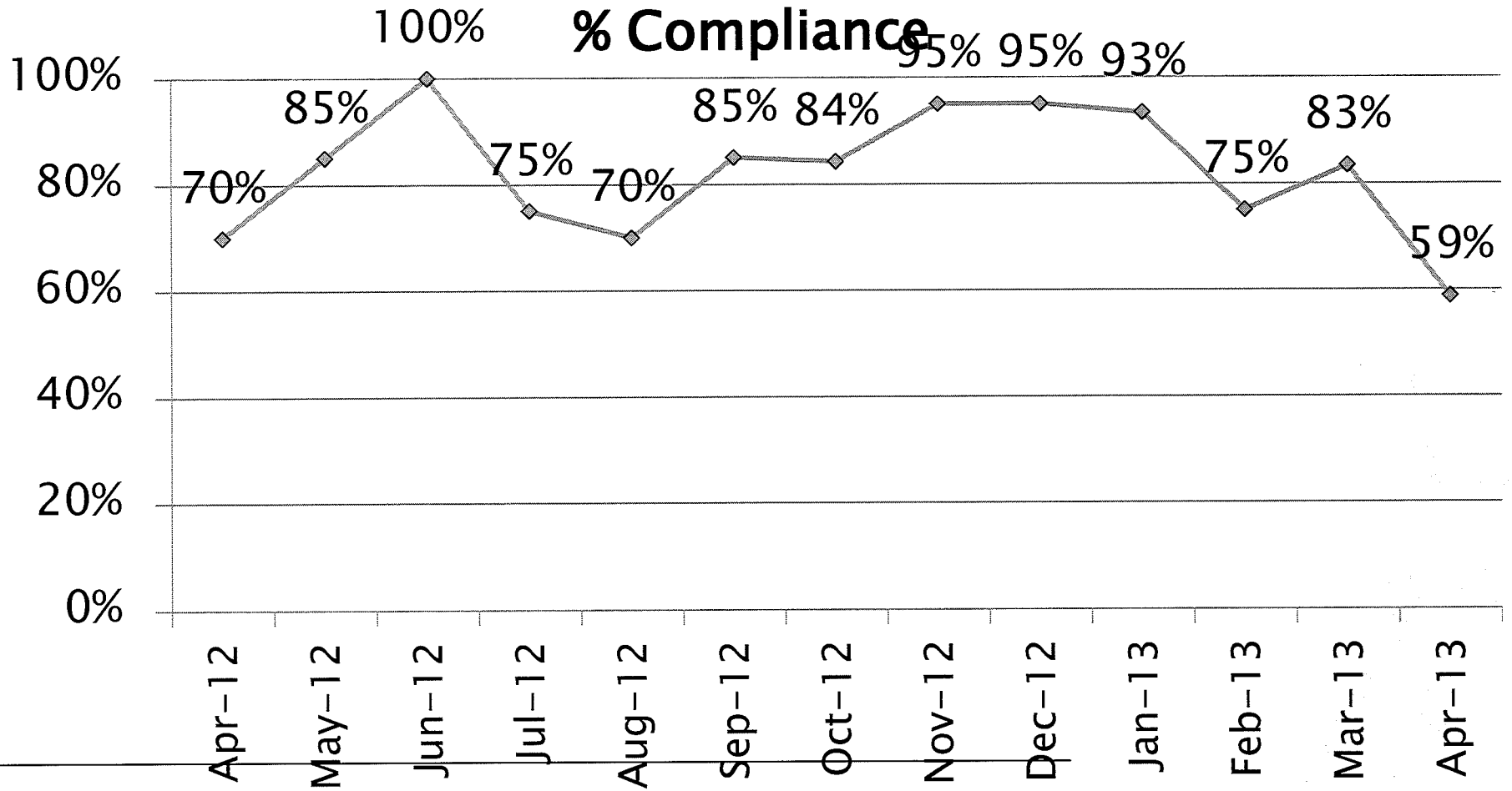
332-056-023

DLS

IV fluids (100% before leaving ED)

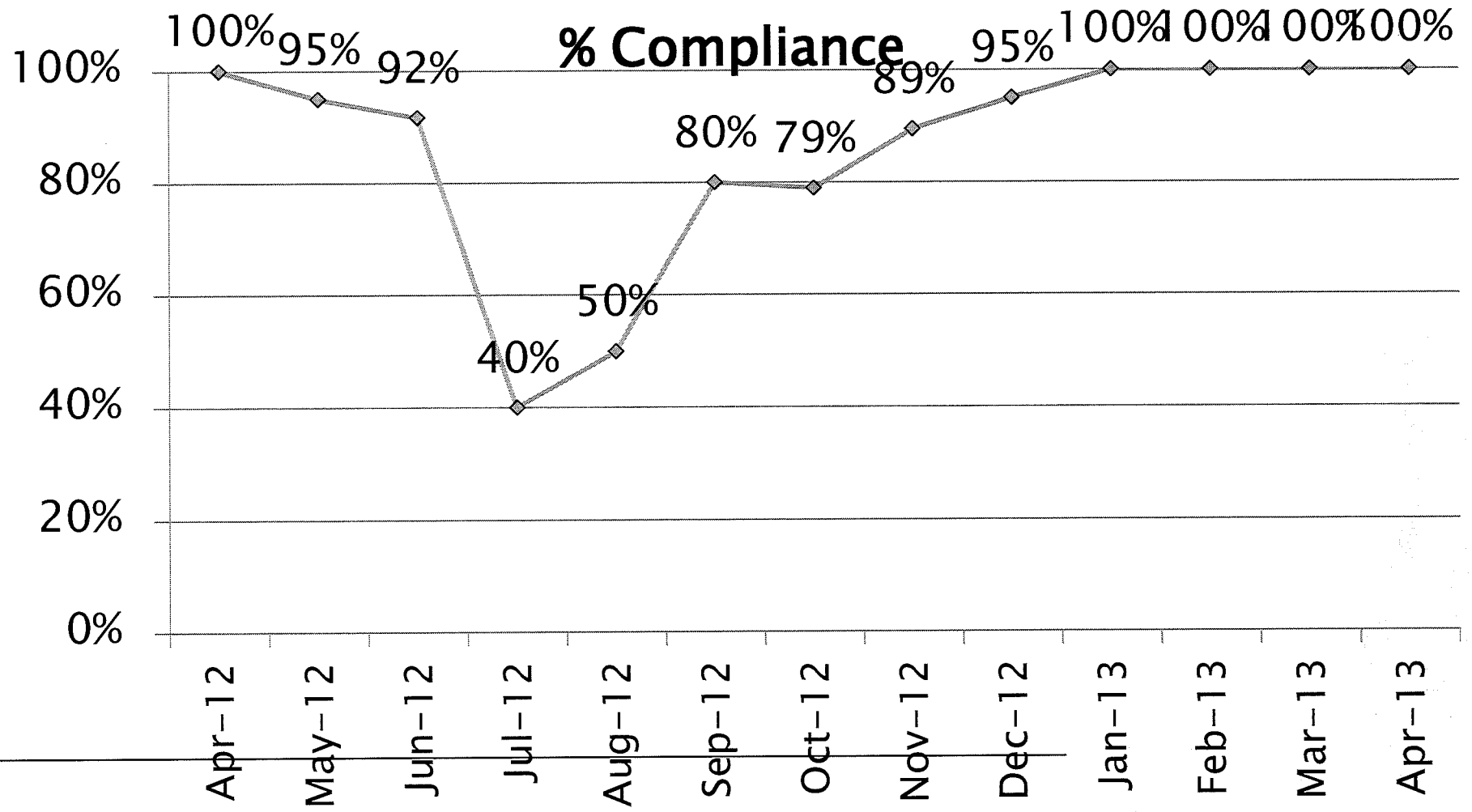


Belfast Health and Social Care Trust

332-056-024

DLS

Antibiotics (100% before leaving ED)



HSC Belfast Health and Social Care Trust

332-056-025

Challenges

- Overcrowding in the ED's – conflicting demands
- Multiple time critical conditions
- Staff awareness, early recognition of patients with Severe Sepsis at point of triage
- Need to improve involvement of permanent members of staff in audit cycles
- Shared tasks = nurses do it!!
- New issues highlighted in every audit
- Need to promote changes/ communication with staff
- Data collection – Validation of results

DLS

Next Steps

- Continue audit process
- Engagement with GP's to enable identification of patients with severe sepsis
- Increase involvement of permanent nursing/ medical staff
- Potential to improve interface with other areas – e.g acute medicine/ surgery/ critical care
- Measure outcomes for patients

DLS

QUESTIONS

332-056-028

Belfast Health and
Social Care Trust

DLS

Acknowledgements

Belfast Health and
Social Care Trust

332-056-029

Belfast Trust Quality Forum Aims to:

- Build capacity and capability in Quality Improvement.
- Raise awareness of the safety agenda and the Trusts Quality Improvement Plan.
- Involve people who use our services.

We will:

- Offer mentoring and support for Quality Improvement
- Facilitate access to Quality Improvement training and development
- Involve all levels of staff.

Open Invitation

Date: 28th October 2013

Time: 12:15 – 2:00pm

Venue: Lecture Rooms 3 & 4, Elliott Dynes Education Centre, RVH

Speaker: Dr Ron Daniels
NHS Institute Safer Care Faculty
Chair: United Kingdom Sepsis Trust & Pre-hospital Working Group

Presentation: Sepsis

LUNCH PROVIDED

CAN YOU PLEASE CONFIRM ATTENDANCE FOR CATERING PURPOSES TO:-

simon.dunlop[redacted]

Present - AB, PF, AF, CN 7/10/13
Apols - Name

Ref	Incident	Action	Comp
W42466 BW	Inaccurate calculation of fluid requirements	Fluids recalculated. - To be discussed further re [redacted] Child in PICU	
W42011 BW	Noted that incorrect IV fluids erected before surgery. Other errors noted on fluid balance chart.	Need to pull chart. Ward staff informed Anaesthetist attended Fluid Balance Chart. - Raise re [redacted], [redacted] - Issue also to be raised re Anaesthetist involved	
W42693 Theatre	BP not monitored on child during case.	Omission related to interruptions etc.	
W42712 AW	Sorey pump constantly beeping flow error overnight.	Pump replaced. NIAIC form to be completed. ✓	
W42675 CH1	NSI - SIN picked up needle and syringe	First aid, Occ Health informed. ? Sharps cat. pathway.	
W42560 DU1	Father verbally assume to Sister who had informed him that child's admission had been cancelled	ENT consultant tried to ~~see~~ speak re parents by phone but numbers went straight to answer machine.	
W42496 A+E	Wrong patient labels attached to blood samples	Bloods had to be repeated.	
W42468 BW	Incorrect Na result reported by labs and corrective treatment	Correct result phoned through. Na supplements cancelled. Sent through. L.	

W42467 OPD	Member of nursing staff sustained NSI while assisting & venepuncture (using safety needle device)	Care pathway commenced. Occ Health informed.
W42419 PW	Long delay in discharge meds being dispensed by Pharmacy.	Forwarded to JS.
	Incidents/issues to keep on radar:-	
1.	Delay in MRI. did [redacted] respond to [redacted]s email to [redacted] ie who is on this panel.	6. Monitors in PICU.
2.	SAI 12/49 someone to provide training on mgt of older/larger child (to include fluid calculation)	
3.	Child [redacted] - SAI or not - Has [redacted] replied to [redacted] re/my involvement	
4.	W40720 [redacted]	
5.	W41544	

Ref	Incident	Action	Comp
W42766 PICU	Baby's weight incorrect - drugs had been calculated according to initial weight.		
W42616 OPD	Appointment letters arrived a day before and day of clinic :- Centre had to cancel appts.	Referred to OT.	
W42654 BCW	Child fell while getting out of bed.		
W 42801 BW	BW Supplementary book unable to be found		
W 42795 PW	Patient fell against cot sides while running.		
W 42765 BW	Baby's peripheral IV line site noted to be red.	TPN discontinued. SHO examined baby - no treatment ordered.	
W 42761 BCW	Child bumped head on wall		
W42754 PICU	S/N cut top of finger on fan blade.	- ? need more info, how did this happen	
W 42752	Non supply of O_2 Sats probes	? New Contract out to tender.	

1142 149 PICU	NSI while suturing an arterial line.	First aid, sharps care pathway completed, Occ Health informed.
	No deaths reported at CHIP on 3/10/13 - CN.	

Present - AP, PF, AB, CN, MON 14/10/13
Apols PJ

Ref	Incident	Action	Comp
W 43184	Child had to have bloods repeated as original samples did not reach lab	Send to [redacted] - Also, send to [redacted] for labs	
W 42901 A+E	Patient not given IVAB in A+E as prescribed.	On investigation, IVAB were not prescribed in appropriate section of Kinray. Needs further investigation - [redacted] was on duty in ED. - Copy to I.P.	
N 42045	Same incident as that reported in Incident Form W42011	Incorrectly referred to A+E by Anne Reg who completed the form. Needs addressed - contact R+G. Incident Form needs corrected.	
N43068 A+E	No nurse screening notes available in RBHSC.	? Forward to Governance. - 11/10/13 further escalation - Glen Shutting.	
W 42740 OPD	Queue to RBHSC Car Park resulted in mother being 30 mins late for clinic. Consultant unable to see patient due to prior commitment.	Mother very upset. Another appointment arranged for child to be seen. Sr M'Cann emailed Stephen Whelan re inform him of car parking issues → Email to PJ.	
W42996	Patient noted to have Grade Pressure area on buttocks	Moved on to pressure relieving mattress. Team f	

30 31 W	Child (12yrs) slipped on wet floor. Was using crutches and was pre-op for SUFE repair. Parents had told child floor was wet and sign was in situ.	No injury sustained - Check if child was seen by doctor - Yes 15/10/13
43029 CC	Member of WBH Team sustained an abrasion on her arm after picking up something off the floor.	Referred to WBH Ops Manager.
2998 W	No O_2 sats probes in hospital	Sent to [redacted] along & similar incident forms completed in Allen Ward. - Escalated to colleague [redacted].

Incidents to keep on radar:-

1. Delay in MRI - parent make-up
2. SA 12/49 - staff to provide training re Child mgt in older child
3. W41544 Orthoptist in BW - ? feedback from [redacted]
4. Fluids in renal baby

? ASH FOR RIV MTG ?

MON 14/10/13 (contd)

Ref	Incident	Action	Comp
W 43287 WJ BeW	Delay in provision of discharge prescription	Forward to [redacted].	
W 43280 AW	Delay and mix ups regarding take home meds for suspended admission -24hrs.	" " Initial response from [redacted] 14/10/13	
W43293 AW	Child sustained laceration to lower lip while playing in cot.	S/B Doctor - no treatment required.	
	No deaths reported @ CHIP today - CN		

Belfast Health and Social Care Trust

SERIOUS ADVERSE INCIDENT REPORT

1 April 2013 – 26 September 2013

Introduction

A total of 12,178[1] adverse incidents were reported in the period 1 April 2013 to 26 September 2013.

An adverse Incident is defined as "*Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation.*" 32 of these adverse incidents were graded as "major" and 47 were graded as "catastrophic" i.e. 79 adverse incidents were reported as being significant in severity, substantially those where harm was deemed to have resulted in permanent physical or emotional injury or death.

During the same period a total of 34 (0.3%) adverse incidents were considered to be "Serious Adverse Incidents (SAIs)" according to the Health & Social Care Board (HSCB) criteria (table 1 below lists the total SAIs reported during the same period since 2009).

Table 1

Total SAIs reported	Year
34	Apr-Sep 2013
44	Apr-Sep 2012
50	Apr-Sep 2011
30	Apr-Sep 2010
23	Apr-Sep 2009

For the period in question, the following criteria determines whether or not an adverse incident constitutes a Serious Adverse Incident (SAI) as defined by the HSCB[2] :

1. Serious injury to, or the unexpected/unexplained death, (including suspected suicides or serious self harm) of:
    - a service user;
    - a service user who has been known to Mental Health services (including Child and Adolescent Mental Health Services (CAMHS) or Learning Disability (LD) within the last two years);
    - a staff member in the course of their work;
    - a member of the public whilst visiting a Health and Social Care facility

[1] Figure correct at 27 September 2013
[2] HSCB Procedure for the reporting and follow up of SAIs April 2010

2. unexpected serious risk to service user and / or staff member and / or member of the public
3. unexpected or significant threat to provide service and / or maintain business continuity.
4. serious assault (including homicide and sexual assaults) by a service user
    - on other service users,
    - on staff or
    - on members of the public

    occurring within a healthcare facility or in the community (where the service user is known to mental health services (including CAMHS or LD) within the last two years).
5. Serious incidents of public interest or concern involving theft, fraud, information breaches and data losses.

Revised SAI Procedures from 1 October 2013.

From 1 October 2013 the above criteria have been revised as part of a revision of the SAI procedures[3] by HSCB. The following key changes are highlighted for your information:

- An additional criterion has been included - "any death of a child in receipt of HSC Services (up to eighteenth birthday). This includes hospital and community services, a Looked After Child or a child whose name is on the Child Protection Register".

- The qualification timeframe[4] for reporting serious self-harm and serious assault (including suspected suicides, homicides and sexual assaults) SAIs, has been revised from 24 months to 12 months prior to the incident.

From 1 October 2013, the revised SAI reporting criteria will be adopted along with the associated reporting documentation.

Investigation levels

- The new HSCB procedure has introduced Investigation levels with associated timescales. The single investigation process for all SAIs has been replaced by three levels of investigation to reflect the complexity of the incident and to ensure the timely identification of learning.

The introduction of the revised investigation levels and associated timescales will be implemented by individual organisations over the next six months, to be fully operational from 1 April 2014. This is to provide sufficient time for all organisations

[3] HSCB Procedure for the reporting and follow up of SAIs October 2013

[4] Qualification timeframe is the timeframe prior to the incident, within which the service user was last known to/ referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services. This is now 12 months.

to provide training for staff and put in place local operational protocols to support the Procedure.

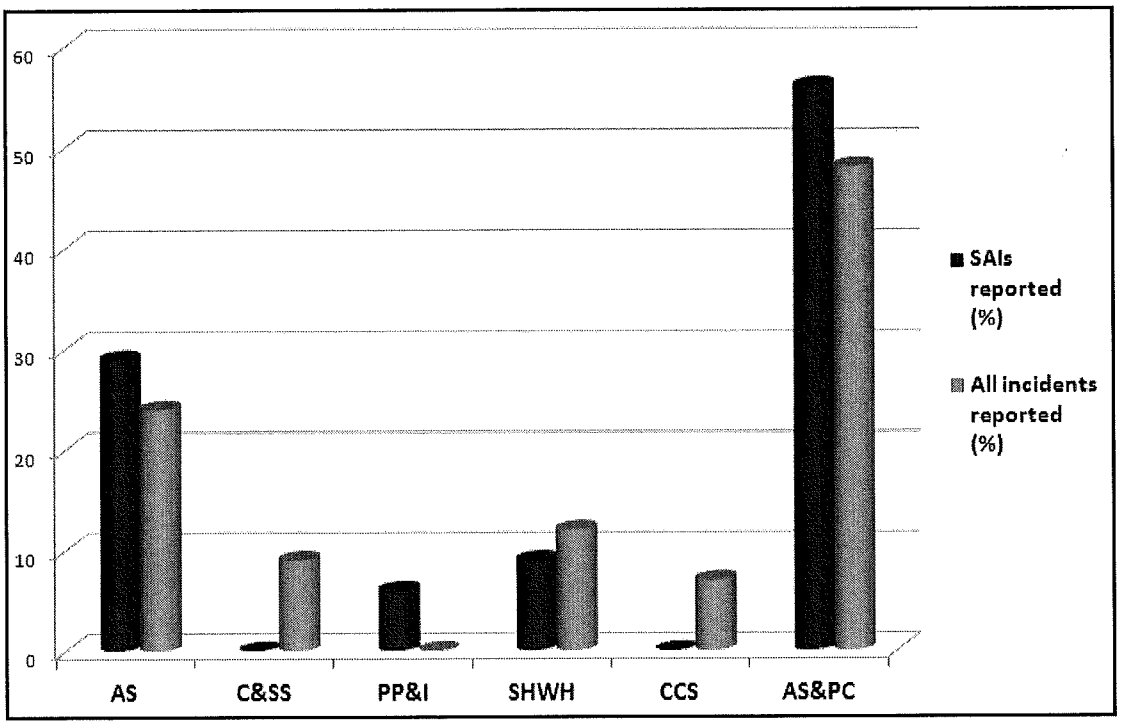
The objectives of the SAI reporting system is to encourage an open reporting and learning culture, acknowledging that lessons need to be shared in order to improve service user and staff safety and apply best practice in assessing and managing risks. It also aims to provide feedback on high level analysis and themes arising from reported incidents. Meeting the deadline for submitting final investigation reports to HSCB can be challenging especially with complex investigations. Corporate Governance continues to liaise closely with External Bodies and Directorates to secure extensions beyond this timeframe if necessary. The revised SAI procedures with different levels of investigation and timescales depending on complexity should assist in meeting the deadlines going forward.

Trust performance in the management of SAIs continues to be monitored and progress reports are provided for SAI Review Board on all outstanding SAI investigations and a procedure remains in place to assist with timely submission of investigation reports. This is currently being revised in preparation for full adoption of the revised SAI procedures by April 2014.

Incidents by Directorate

Serious Adverse Incidents have been reported from across the Directorates within the BHSCT **See Table 2 below**. This table reflects the percentage of SAIs reported across directorates against percentage of overall incidents reported e.g. Adult Social & Primary Care reported 48% of all incidents and 56% of SAIs within the period. Children's Community Services reported 7% of all incidents and no SAIs. Acute Services reported 24% of all incidents and 29% of all SAIs. Cancer & Specialist Services reported 9% of all incidents and no SAIs. Specialist Hospitals & Child Health reported 12% of all incidents and 9% of SAIs. Performance, Planning & Informatics report less than 0.2% of all incidents and 6% of SAIs.

Table 2 Comparison by Directorate of percentage share of SAIs reported against all incidents reported for the period 1 April 2013 – 26 September 2013



Discussion regarding SAIs Reported 01/04/2013 – 26/09/2013
See Appendix 1

Appendix 1 details the SAIs reported by the Trust grouped by category.

Twenty-two SAIs reported during the period 1 April 2013 – 26 September 2013 involved the death of a service user(s); a SAI report which documents a death does not necessarily imply that the circumstances relating to the adverse incident contributed to the cause of death.

Eight deaths are suspected suicides, four relate to unexpected deaths of clients where cause of death is not yet determined, one was an unexpected death after a procedure, one occurred during inpatient treatment/monitoring, one occurred after discharge from hospital, two deaths related to delayed assessment/treatment, two SAIs related to unexpected child deaths in hospital, another involved a service user awaiting an urgent hospital appointment and two were deaths of patients in non-Acute hospital settings and following initial investigation one of these was withdrawn.

The category "Other" is only used where current incident information is insufficient to code more accurately. This category includes the four deaths of clients in the community known to Mental Health services where the cause of death had not been determined, one of the unexpected child deaths in hospital and the two unexpected deaths in non-Acute facilities. One suspected assault is also included in this category but this SAI has since been withdrawn.

SAIs reported to other organisations

RQIA

The Regulation and Quality Improvement Authority (RQIA) continues to require incidents to be reported to it in accordance with the statutory responsibilities it assumed associated with the transfer of functions from the Mental Health Commission (as detailed in the UTEC Committee guidance August 2007). 8 SAIs were suspected suicides (out of a total of 22 deaths) and these were reported to RQIA and HSCB. For such incidents the Trust is required to conduct a multidisciplinary team review independently 'chaired' by a senior manager from outside the Service Area and in these reviews family, carer or advocate involvement is actively encouraged to optimise learning.

Early Alert notifications

With effect from 1 June 2010, the Trust is required to make the Department (and thus the Minister) aware of those events (which may include potential SAIs) which may require urgent attention or possible action by the Department. The Department issued guidance outlining seven criteria which may trigger an "Early Alert" notification. The Trust has made 12 Early Alert notifications during this period; 3 were also deemed to be SAI's in the period (one fell within the category - Treatment/procedure, one regarding clinical tests/examinations, and one regarding professional standards.

Northern Ireland Adverse Incident Centre (NIAIC)

The Northern Ireland Adverse Incident Centre (NIAIC), part of Health Estates, exists to record and investigate reported adverse incidents involving medical devices, non-medical equipment, plant and building items used in HPSS and to issue warning notices and guidance to help prevent recurrence and avert patient, staff, client or user injury. One SAI has required to be reported to NIAIC for this period and one is pending at date of writing. For all such incidents, normal NIAIC procedures are followed.

Health & Safety Executive (under RIDDOR).

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1997 (RIDDOR) require employers and others to report accidents and some diseases that arise out of or in connection with work. These reports enable the enforcing authorities to identify where and how risks arise and to investigate serious accidents. No SAI was reported to Health & Safety Executive under RIDDOR for this period.

Operational Flow chart for the completion of NCEPOD audits

NCEPOD initiate study with Local Reporter / Information Dept to identify relevant cases.

NCEPOD select study sample from list and write to case consultant requesting data collection / case note copying.

Standards, Quality & Audit Dept

- Inform all consultants involved in the process for NCEPOD audit.
- *Organise any support requested from consultants / clinical areas.

- Send AMDs audit details, timelines and list of cases.
- Provide regular reports on progress to NCEPOD Ambassador and AMD/s

Clinical Area

Administration

- Organisation of Notes
- Case Note copying
- Return of case note copies to NCEPOD

Consultant

- Complete and return Clinicians Questionnaire

*Should the Consultant / Clinical area require any support, they should contact the Local Reporter

NCEPOD Ambassador / Associate Medical Directors (AMDs)

- AMDs to receive audit details, timelines and list of cases. Depending on the number / speciality of cases, a lead clinician may be identified.

- NCEPOD Ambassador to monitor progress on returns and raise issues with the Clinicians / AMDs. Agree actions.

Contact Details:

Local Reporter – Fintan McErlean, Audit Manager, Standards, Quality & Audit
fintan.mcerlean[redacted]

STANDARDS AND GUIDELINES COMMITTEE MEETING

3rd July 2013 at 2:00pm
Seminar Room 3, Cancer Centre,
Minutes

Present:
[redacted] (Chair) [redacted]

In Attendance: [redacted], [redacted]

[redacted] introduced [redacted] to the committee. She is the NI NICE facilitator and was invited to sit in on one of the Standards and Guidelines meetings.

1	**Apologies:** [redacted] (Chair), [redacted], [redacted], [redacted], [redacted], [redacted]	
2	**MINUTES OF THE PREVIOUS MEETING** -29th May 2013 Approved.	**ACTION**
3	**CONFLICTS OF INTEREST PROCEDURES** None.	
4 4.1	**Matters Arising** **Intranet "Hub"** [redacted] and [redacted] still working with [redacted] with having a policy in 2 places on the hub.	[redacted]
4.2	**Policy for the Use of Procedural Sedation in the BHSCT** [redacted] to circulate this policy to [redacted] (Radiology). To be tabled at D+T.	[redacted]
4.3	**Dissemination of Policies (715)** Now to be authored by [redacted]. The full version will also be going to Policy Committee for comment. [redacted] informed the group that 2 comments so far have been received and incorporated. [redacted] has also incorporated comments from AMD's. [redacted] to send out an email to those who are listed as having responsibilities to get their agreement. [redacted] to forward the most recent version (V0.5). This can be circulated to the S+G committee and comments back for next meeting. [redacted] to check for [redacted] comments and [redacted] will send through some typos.	[redacted]
4.4	**Medical staff trainee documents** [redacted] to be asked to inform us of who the lead will now be.	[redacted]
5	**Chairman's Business** **S+G Membership to Directors** [redacted] has sent out an email regarding this - deadline for reply is Thursday 11th July	
6	**New Interventional Procedures** [redacted] (DHHSPSNI) has sent out consultation on New Interventional Procedures. It has also been sent out to AMD's.	

7	**Amended versions previously tabled** None	
8 8.1	**New Guidelines Submitted for Approval –** **Line Labelling Policy (708)** This is Regional Policy for all 5 Trusts. [redacted] (SEHSCT) has recently had more meetings and some more changes were made. [redacted] would like to read these comments and feed back to [redacted]. [redacted] to forward email. A query was raised if this policy should cover labelling of cannulae or if a separate policy should cover that. [redacted] informed the group that there is an existing peripheral cannulation policy but it does not discuss labelling apart from on the form. It was suggested that labelling should be added to this policy and not the line labelling one. [redacted] to add this. [redacted] suggested adding a date on the line instead of just on the observation chart. [redacted] was involved in covering the neonatal information of the policy and had comments regarding the size of labels. She was reassured that their labels would be size appropriate. Final action would be for the labels to go out to tender and get numbers for labels needed.	[redacted]
8.2	**WHO Checklist (694)** It was explained to the group why this cannot cover correct site surgery. The correct site surgery is to be reviewed. Maternity to be added. [redacted] to discuss with managers. [redacted] requested that sections missing be completed and appendices be forwarded to S+G. To come back to next meeting.	[redacted]
8.3	**Care for and safeguarding children admitted to an adult ward (730)** [redacted] presented policy. Discussed whether scope to include mental health patients. [redacted] to send titles and include in policy. [redacted] to send to [redacted] for comment. She was also informed that he has some good leaflets that could be placed on adult wards. Training leaflets and BNF's should also go on these wards. To check regarding Risk Assessment document. [redacted] to check RQIA document. [redacted] will send [redacted] their version of Risk assessment. [redacted] to circulate to [redacted], [redacted], [redacted] and other identified people for comments. Further changes are still to be made to this policy.	[redacted]
9 9.01 9.02 9.03 9.04 9.05 9.06 9.07	**Ratification of policies approved by Service Directorate** **Adult Social and Primary Care** **Evaluating Quality Care (EQC)-Guidelines of (720)** Ratified **Levels of Supervision/Observations within Learning Disability Inpatient Services (721)** Ratified **Facilitating Visits by Children to Mental Health and Learning Disability Inpatient/Residential Facilities (722)** Ratified **Observations within Mental Health Services (723)** Ratified **Securing Patient/Client Records following a Serious Adverse Incident within Adult Social and Primary Care (724)** Ratified **Adult Mental Health and Learning Disability Absent without Leave Procedure (AWOL) (725)** Ratified **Use of Personal Alarm Systems on the Muckamore Abbey Hospital Site (726)** Ratified	

	Cancer and Specialist Services **Haematology**	
9.08	**Antifungal Policy for Adults with Haematological Disorders (729)** Send to [redacted] and [redacted]. Ratified pending comments	[redacted]
	Specialist Hospitals, Womens Health **Maternity**	
9.09	**Cleansing of a baby's skin prior to invasive procedures in the Neonatal Intensive Care Unit (NICU), Royal Jubilee Maternity Service(RJMS) (728)** Send to [redacted]. Ratified pending comments	
9.10	**Routine cleaning of a bed space in the Regional Neonatal Unit (RNU), Royal Jubilee Maternity Service (RJMS) (727)** Send to [redacted] and [redacted]. Ratified pending comments	[redacted]
10	**D+T**	
10.1	**Granulocyte colony stimulating factor (GSCF) in adult oncology & malignant haematology patients-Guidelines for the use of (719)** Ratified	
10.2	**Safe Warfarin Management (681)** [redacted] sent out for comment about head injured patients. [redacted] to speak to [redacted].	[redacted]
10.3	**How to Prescribe Medicines in the Belfast Health and Social Care Trust** **A guide for Foundation Year One (F1) Doctors (460)** [redacted] to send updated version. Ratified	[redacted]
10.4	**Guidelines for empirical antibiotic prescribing in hospitalised adults (666)** Ratified	
11	**Policies for review**	
11.1	**Disorders of sexual development in neonates - Guidelines for the investigation and management of (357)** [redacted] has to send this out for comment. It also has to go into the new template and changes recorded in the version control. Comments from [redacted] to be sent to [redacted] and cc [redacted]. Approved pending changes.	[redacted]
11.2	**Head Injury Discharge Advice (Adult) (606)** Comments from [redacted]. Approved pending changes	[redacted]
11.3	**Northern Ireland New Entrant Service (NINES) Operational Protocol** Title to be changed. The TB committee is tomorrow and they should see this document. Copy to S+G committee for comments. The title of the policy that it has superceded needs to be clarified and corrected. To come back. Not Approved	[redacted]
12	**Policies from other Trusts for possible adoption**	
12.1	**Policy for Care of the Patient / Client in the Presence of an Escorting Officer (SE)** [redacted] explained HSC Collaborative was disbanding. Will retain links to allow policies from other Trusts to be tabled for information only. These are not to be taken as BHSCT policy. Can be taken up as source material for adoption if anyone feels necessary.	
13	**GAIN** None	
14	**Care Pathways**	
14.1	**Care pathway for the management of patients in the Bridgewater haematology** No rep attended to discuss this. Deferred	

15	**New External Guidance**	
15.01	Using NICE guidance and quality standards to improve practice – *To be issued to directors via* [redacted]	
15.02	Allocation letter for the MMR vaccination catch-up campaign (10435) - *Sent to all Directors from CEOs office*	
15.03	PHC/16/2013 – Drug alert Class 2 Medicines recall (Bristol,Questran,Colestyramine) (10436) - *Sent to* [redacted] *&* [redacted] *from CEOs office*	
15.04	Allocation letter for the changes to the Men C Vaccination Schedule (10437) - *Sent to* [redacted] *and* [redacted]	
15.05	Updated statement on practical procedures from the Royal Colleges of Physician - *Noted*	
15.06	HSS (MD) 20/2013 - Panton-Valentine Leukocidin (PVL) *Staphylococcus Aureus* cases (10442) - *Circulated to* [redacted] *and medical staff*	
15.07	HSS (MD) 21/2013 - Incidents Potentially linked to Substance Misuse (10443) - *Noted*	
15.08	LL/SAI/2013/018 (AS) Haemolysis during or after haemodialysis (10444) - *Sent to* [redacted] *and* [redacted]	
15.09	RCP Acute Care Toolkit 6 - The medical patient at risk (10445) - *Document to be forwarded to* [redacted] *for information.*	
15.10	Letter re Improving quality of coding for medicines related admissions (10446) – *To be assigned*	
15.11	Consultation on minimum standards for independent Healthcare Establishments (10447) - *Sent to* [redacted] *and all directors*	
	Technology Appraisals	
15.12	TA 267 – Ivabradine for the treatment of chronic heart failure (10291) - *Sent to* [redacted] *and* [redacted]	
15.13	TA 265 - Denosumab for the prevention of skeletal-related events in adults with bone metastases from solid tumours (10292) - *Sent to* [redacted], [redacted], [redacted] *&* [redacted]	
15.14	TA 284 - Not recommended - Bevaizumab in combination with paclitaxel & carboplatin for first line treatment of advanced ovarian cancer (10296) - *Sent to* [redacted]	
15.15	TA 266 - Mannitol dry powder for inhalation for treating cystic fibrosis (10290) - *Sent to* [redacted] *and* [redacted]	
15.16	TA 284 - Not recommended - Bevaizumab in combination with paclitaxel & carboplatin for first line treatment of advanced ovarian cancer (10296) - *Sent to* [redacted]	
15.17	TA 268 - Ipilimumab for previously treated advanced (resectable or metastatic) (10293) - *Sent to* [redacted], [redacted], [redacted] *&* [redacted]	
15.18	TA 269 - Vemruaafenib for treating locally or advanced or metastatci BRAF V600 (10294) - *Sent to* [redacted], [redacted], [redacted] *&* [redacted]	
15.19	TA 285 - Not recommended - Bevacizumab in combination with gemcitabine & caboplatin for treating the first recurrence of platinum sensitive advanced ovarian cancer (10295) - *Sent to* [redacted] [redacted] *and* [redacted]	
16	**Correspondence**	
16.1	Northern Ireland Formulary – Update for HSC	
16.2	Letter to service users re resp_endo_muscul_June 2013 (2)	
17	**Medical staff trainee documents** None	
18	**News Stories** None	

19 19.1 19.2	**Any Other Business** Allergy NI is a local charity. They read the NICE Clinical Guideline 134 regarding Anaphylaxis and felt that a local self help group should be referenced in the BHSCT policy. [redacted] is author dealing with this. To follow. **Attendance** The group was made aware that an attendance record is being kept and directorates will be informed.	[redacted]
20	**DATE, TIME AND VENUE OF NEXT MEETING** Wednesday 14th August, Seminar Room 3, Cancer Centre, BCH @ 2pm	

STANDARDS AND GUIDELINES COMMITTEE MEETING

14th August at 2:00pm
Seminar Room 3, Cancer Centre,
Minutes

Present:
[redacted] (Chair)
[redacted] (Chair)
[redacted]
[redacted]

[redacted] chaired the meeting. He introduced [redacted] (Assistant Service Manager) to the committee. She is representing Acute services/Unscheduled Care along with [redacted]. Other membership updates included:
[redacted] covering both Adult Social and Primary Care and Social Work and Children's Community Services. [redacted] and [redacted] represent Community Nursing.

1	**Apologies:** [redacted]	
2	**MINUTES OF THE PREVIOUS MEETING** -3rd July 2013 Approved.	**ACTION**
3	**CONFLICTS OF INTEREST PROCEDURES** None.	
4 4.1.	**Matters Arising** **Intranet "Hub"** Policies are currently only available in one place and a process has been identified that means the policy can appear as a link on a policy page within the directorate. To pilot this by development of Directorate policy pages in Children's; Colorectal and Mental Health and Learning Disability.	[redacted]
4.2	**Line Labelling Policy (708)** Regional work still underway. The remaining issue is around line labelling in the community. It was agreed to advise the group that the policy should return to allowing no labelling when there is only one line in the community.	
4.3	**WHO Checklist (694)** Reviewed correct site surgery still to be submitted for approval. There was discussion around whether they should be integrated into a "Safe Surgery policy". [redacted] to discuss with [redacted].	[redacted]
4.4	**Care for and safeguarding children admitted to an adult ward (730)** Changes being made following the last meeting and this will be re-submitted at the September meeting. [redacted] to organise feedback from Trauma and Orthopaedics. [redacted] to finalise trigger list with [redacted] and send to [redacted]. [redacted] to send information relating to safeguarding and risk assessing in terms of placement. [redacted] reported that some areas have a key-worker identified and that this is good practice and would be reflected in the policy.	[redacted]

5 5.1 5.2	**Chairman's Business** **Memorandum of understanding** This impacts on a number of areas of policy relating to incident reporting and [redacted] /Corporate Governance updating these. [redacted] to send legacy documents on preserving evidence to [redacted] for inclusion in this work. [redacted] queried about the impact of this on deaths in the community. Agreed to highlight relevant issues to [redacted] for comment. "Actions to be taken after a patient's death" to be revised and any changes made. **Clinical policies on Q-Pulse- Haematology/Immunology** Agreed storing clinical policies on Q-Pulse system could happen in principle if we ensured that all staff, for whom the guidance applies, could access on Q-Pulse and there was no conflict with existing Trust guidelines. To submit list of clinical polices for review.	[redacted]
6 6.1	**New Interventional Procedures** **Endovascular repair of abdominal aortic aneurysms (EVAR) or Endovascular aneurysm sealing (EVAS)** Approved-[redacted] [redacted] has responded to DHSS consultation on IPs and sent comments back to [redacted]	
7 7.1	**Amended versions previously tabled** **Dissemination Policy (715)** This will apply to all internal policies. Agreed that this will not cover external guidelines/alerts as these are covered by a different process. [redacted] to make final changes and submit final version to [redacted] for submission to the Trust Policy Committee. Approved pending changes.	[redacted]
8 8.1	**New Guidelines Submitted for Approval –** **Obtaining consent for examination, treatment or care in adults and children (739)** [redacted] to comment from Mental Health perspective. [redacted], [redacted] and [redacted] have comments also. Agreed that all comments to be sent to [redacted] by the end of August. A final version to be circulated for approval to Clinical Ethics and at September S+G meeting.	[redacted]
9 9.01 9.02 9.03	**Ratification of policies approved by Service Directorate** **Community Childrens Services** **Maternal and Pre School Child Nutrition Guidelines (734)** Ratified **Specialist Hospitals, Womens Health** **Children's Services** **Operational Child Protection Policies and Procedures for Nurses Working in Community Child Health (625)** Ratified **Maternity** Discussion around format of policies submitted with key content located in different parts/inconsistency of language. Agreed to feed these comments to [redacted] and take forward. **Management of HIV positive pregnant women in BHSCT (731)** This is a PHA guidance. Agreed it should be tabled at next D+T for information. [redacted] also has minor comments to be sent to author. Approved	[redacted]

9.04	**Weighing a clinically stable baby who is nursed in an incubator or cot in the Regional Neonatal Unit (RNU) Royal Jubilee Maternity Service (RJMS) (735)**	
9.05	**Weighing an ill or clinically unstable baby in the Regional Neonatal Unit (RNU), Royal Jubilee Maternity Service (RJMS) (736)** Comments around merging these 2 policies were agreed. Not to ratify until comments addressed. [redacted] to forward both policies to [redacted]	[redacted]
9.06	**Bathing a baby (if required) in the Regional Neonatal Unit (RNU), Royal Jubilee Maternity Service (RJMS) (737)** Ratified	
9.07	**Identification of babies in the Belfast Trust (738)** Ratified	
9.08	**Dentistry** **GDC Standards Guidance for all Dentists** Ratified	
	There was discussion on use of policy template for processing externally published guidelines (e.g. 9.01, 9.08). Members agreed that the box on the front page would be suffice. This needs reviewed by committee chairs. To be tabled at pre-meeting.	[redacted]
9.09	**Cancer and Specialist Services** **Infusional Services** **Infusional Services nursing staff to consent patients prior to Peripheral Inserted Central Catheter (PICC) insertion (740)** Ratified	
9.10	**Infusional Services nurses to request Radiological Examination post Peripheral Inserted Central Catheter (PICC) insertion (741)** Ratified	
9.11	**Infusional Services nurses to determine Peripheral Inserted Central Catheter (PICC) tip position following chest X-ray (742)** Ratified	
10	**D+T**	
10.1	**Guidelines for management of steroid induced hyperglycaemia for adult patients (732)** Ratified	
10.2	**Initial Management of Bacterial Sepsis during Pregnancy and the Puerperium - Guideline of (733)** Formatting to be revised. Consultation process to be updated to reflect microbiology input. [redacted] to verify that it has been reviewed by microbiologist [redacted]. Also to send to [redacted] (Critical Care Unit) and update consultation process to reflect both microbiology and ICU consultation once confirmed/complete. Ratified pending above comments and inclusion of links to relevant antibiotic policies.	[redacted]
10.3	**Safe Warfarin Management (681)** Ratified	
10.4	**Outpatient Treatment Advice note policy (743)** Discussed applicability of this to all clinical areas and agreed that this does not require trust wide authoring but is should specify 'For implementation' in all areas. [redacted] suggested [redacted] and [redacted] have a discussion re implementation.	[redacted]
10.5	**Guideline for the Hospital Management of Hypoglycaemia in Adults with Diabetes Mellitus (677)** Ratified	

	New Drugs JEXT adrenaline auto injector for patients with allergic disease at risk for anaphylaxis	
11 11.1 11.2 11.3 11.4 11.5 11.6	**Policies for review** **Operational Child Protection Policies and Procedures for Nurses Working in Community Child Health (625)** See 9.02 **Delivery at margins viability and guidance for staff on counselling (361)** [redacted] email address to be updated. Title to be revised to make remit clear. Ratified pending changes. **Emergency Platelet Management Policy (437)** [redacted] has some comments to send. Approved pending. **Mortality and Morbidity (593)** This has been revised to reflect the launch of the Mortality Review System including the addition of four "How to" guides in using the system. Confirmed that this applies to all inpatient areas including Mental Health, all inpatients death should be recorded on the system but the analysis and review will happen under the regional SAI process for Mental Health. To add Mental Health and Learning Disability to the Mortality review system roll-out. To use term "Intranet Hub" as opposed to "Intranet". Approved pending changes and inclusion of "How to" guides. **Recording fluid prescription and balance charts (45)** Discussed if this chart was applicable in the community and agreed to revise policy to confirm that this does not apply to community settings. Point 8.10 second sentence to become point under output section (8.15). Need to include the word sub-cut under section 7. 8.15 to re-word. [redacted] to revise with these changes. And forward to [redacted] for discussion with Community colleagues. Approved. **Hyponatraemia + IV fluids for children (311)** The monitoring section has been updated and this change was approved. [redacted] queried the statement in the Scope re: excluding specialist wards. It was agreed to revise this policy again as further changes required to, Scope, Training and List of Fluids.	[redacted] [redacted] [redacted]
12 12.1	**Policies from other Trusts for possible adoption** None	
13 13.1	**GAIN** None	
14 14.1	**Care Pathways** None	
15 15.01 15.02 15.03 15.04	**New External Guidance** HSS (MD) 26/2013 - Codeine For Analgesia: Restricted Use In Children And Adolescents Because Of Reports Of Morphine Toxicity (10449) - *Sent to* [redacted] *and* [redacted] HSS (MD) 27/2013 - Introduction of shingles vaccine for people aged 70 years (routine Cohort) and 79 years (catch-up cohort) (10448) - *Sent to* [redacted] HSCB/PHA protocol for implementation of safety and Quality alerts Revised process for handling of NICE Clinical Guidelines (10450) - HSS (MD) 28/2013 - Tuberculosis in Northern Ireland - updated guidance on BCG and TB Risk assessment for infants and children (10451) –	

15.05	LL/SAI/2013/019 (AS) - Know the Massive Haemorrhage Protocol (10453) - *Sent to all service directors. Response due by 30/8/13*	
15.06	HIV Positive Pregnant Women and their Infants (10454) - *Sent to* [redacted] *and* [redacted]	
15.07	RQIA Review of the Management of Controlled Drug Use in Trust Hospitals (10456) - *Sent to* [redacted] *and* [redacted]	
15.08	HSS (MD) 29/2013 - Updated guidance on the management and treatment of *Clostridium difficile* infection (10459) - *Sent to* [redacted]	
15.09	Participation in community skin infection (CSI) surveillance programme (10460) - *Already sent to* [redacted]	
15.10	HSS (MD) 31/2013 - Oral ketoconazole: do not prescribe or use for fungal infections – risk of liver injury outweighs benefits (10461) - *Sent to all service directors*	
15.11	HSS (MD) 32/2013 - The seasonal influenza vaccination programme 2013/14 (10462) - *Sent to Relevant directors*	
15.12	NICE guideline development group members: IV fluid therapy for Children and young people in hospital (10463) - *Sent to* [redacted] *and* [redacted]	
15.13	HSS (MD) 33/2013 - RCOG patient leaflet regarding GBS infection in newborn babies (10464) - *Sent to* [redacted]	
15.14	HSS (MD) 34/2013 - Introduction of the Royal College of Paediatrics and Child Health	
15.15	(RCPCH) school-age (2-18 years) growth charts (10465) - *Sent to* [redacted]	
15.16	HSS (MD) 35/2013 - Protecting children and young people (10466) - *Sent to* [redacted]	
	Technology Appraisals	
15.17	TA 275 - Apixaban for the prevention of stroke and systemic embolism in people with non-valvular atrial fibrillation (10297) - *Sent to* [redacted] *and* [redacted]	
15.18	TA 289 - NOT RECOMMENDED - Ruxolitinib for disease-related splenomegaly or symptoms in adults with myelofibrosis (10298) - *Sent to* [redacted]	
15.19	TA 291 - NOT RECOMMENDED - Pegloticase for treating severe debilitating chronic tophaceous gout (10299) - *Sent to* [redacted] *and* [redacted]	
15.20	TA 274 - Ranibizumab for treating diabetic macular oedema (rapid review of technology appraisal guidance 237) (10300) - ??	
16	**Correspondence** None	
17	**Medical staff trainee documents** None	
18 18.1	**News Stories** Recording Fluid Balance. Policies revised in light of Memo of understanding (external guidance) New Fluid Balance chart.	[redacted]
19 19.1 19.2	**Any Other Business** **Safe sedation for endoscopy**- Send a copy to [redacted]. To go on Hub. **Peri-operative diabetes monitoring chart** – [redacted] informed the group that this is being piloted through test and spread. To be submitted in due course once final version ready. **Belfast Heart Centre/Algorithms** – went to D+T and were not approved as were not in line with NICE TA's. Noted by S+G.	
20	**DATE, TIME AND VENUE OF NEXT MEETING** 19th September @ 2pm – Committee Room, BCH	