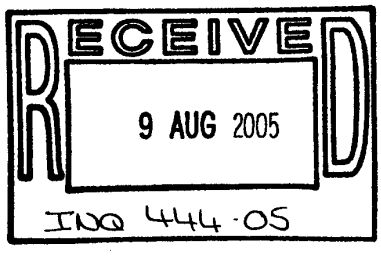
HEALTH AND SOCIAL CARE TRUST

TRUST HEADQUARTERS
Strathdene House, Tyrone & Fermanagh Hospital, Omagh,
Co Tyrone BT79 0NS
Tel - [redacted] **Fax -** [redacted]
e-mail: rhalls([redacted] **www.sperrin-lakeland.org**
Minicom Service is available within the Trust on request

8 August 2005

Your ref: FC-129-05/FC-284-05



PRIVATE AND CONFIDENTIAL

Ms Fiona Chamberlain
Solicitor to the Inquiry
The Inquiry into Hyponatraemia-related Deaths
3rd Floor,
20 Adelaide Street
Belfast
BT2 8GB

Dear Ms Chamberlain

Re: Inquiry into Hyponatraemia-related Deaths

I refer to your letters of 17 May addressed to my predecessor, Hugh Mills and your letter of 15 June 2005 addressed to myself. I am sorry for the delay in responding.

As you may know I am the Acting Chief Executive of Sperrin Lakeland Trust. Since I started in late June 2005, I have tried to acquaint myself with the details of this sad case. We have attempted in the reply that follows to answer your questions as fully as possible. However, if issues do remain unclear we will do our very best to clarify them for you.

To assist the Chairman in his inquiry, you have asked that we provide clarification in relation to a number of matters to help you understand the role of the Hospital Trusts in Northern Ireland. For ease of reference I will respond to each point in turn as they appeared in your letters, beginning with the letter of 17 May 2005.

1. Please explain the role and responsibilities of your Trust

Sperrin Lakeland Health and Social Care Trust is the primary provider of statutory health and social services to the people of the south west of Northern Ireland, serving a population of approximately 119,000 and covering a geographical area of around 1000 square miles. The area is largely rural with the towns of Omagh and Enniskillen being the main urban centres. Less than one third of the population live in these centres, the remainder living in smaller towns and villages and the open countryside.
As an integrated Trust, the services provided cover a wide spectrum. The main categories of services are:

- Acute hospital services, e.g. general surgery and medicine, accident and emergency and renal services
- Maternal and child health services, e.g. maternity services, neo-natal and paediatric services
- Family and child care services, e.g. child protection, fostering and adoption services
- Services for people with a physical or sensory disability, e.g. rehabilitation, therapeutic and advisory services
- Services for people with a learning disability, e.g. respite care, therapeutic and advisory services
- Primary health care services, e.g. district nursing and health visiting
- Health promotion, e.g. health campaigns, raising public awareness
- Mental health services, e.g. inpatient, outpatient, community and respite care services
- Elderly care services, e.g. residential and nursing home care, domiciliary care, day care services
- Community dental services, e.g. oral health, orthodontic and school dental services
- Services for the terminally ill, e.g. Macmillan nurse and palliative care services

A service director, who is part of the Senior Management Team and Trust Board, manages each directorate. The Trust Board consists of the chairman, five non-executive directors and five executive directors and is assisted in its business by five support directors who are non-voting, but fully participate in Trust Board meetings.

2. **Please explain the interaction between the Trust and (i) the Health Board, (ii) the other Health Trusts within Northern Ireland.**

(i) The Sperrin Lakeland Trust is fully accountable to the Department of Health and Social Services. It has, as provider, forged and maintained a sound and strong working relationship with the Board, the commissioner, ensuring effective and efficient delivery of services to a high standard taking into account the present and changing needs of its population. Board and Trust officers meet regularly to monitor, assess and take forward the provision and delivery of services. There are also regular meetings at Chief Executive level between the Trust and Board.

(ii) The Trust has established and maintained close links with other Trusts within Northern Ireland, sharing and learning through continuous dialogue and attendance at Regional Forums, for example:

- The Chief Executive Forum attended by all Chief Executives.
- The Medical Director Forum chaired by the Chief Medical Officer and attended by all Trust Medical Directors.
- The Nurse Leaders Network attended by Nurse Leaders from all the Trusts and the Chief Nurse at the Department of Health.

3. **Please explain how the Trust monitors the education and continuous development of its doctors and nursing staff. If there is an induction pack provided to doctors and nurses coming to work within the Trust for the first time please provide a copy of the same.**

With regard to nursing staff, education and continuous development is planned and monitored loosely at clinical directorate level. In relation to the inquiry, each nurse is responsible for personally maintaining education and practice standards as defined by the legislative body, Nursing and Midwifery Committee (NMC). Training needs for service provision in each clinical area is identified in discussion between the Ward Sister and Service Director with support from the Senior Nurse (Professional Development). The Ward Sister then identifies individual training needs of Nursing Staff both for service provision and personal professional development. Induction packs are provided to new staff now but at the time of Lucy's admission, the nursing staff involved had been in employment for a period of years.

Induction for clinicians is organised at the beginning of their six-month placements in all three hospitals in the Trust. It is more systematised in psychiatry in the Tyrone and Fermanagh Hospital with induction handouts. Induction on both general sites is structured with new doctors undergoing sessions with and receiving written material from Occupational Health,

representatives from Radiology, Labs, Infection Control and Human Resources. (See enclosed copy of Induction Programme Agenda). In addition to general induction there are speciality induction programmes, for example, paediatrics that cover specific clinical issues and their management. Induction for consultant staff is not yet formalised and is currently carried out by Clinical Directors. Induction process of medical staff will be reviewed through addressing the organisational issues in Phase 1 of the Assessment of Risk and Governance report.

4. Please explain the role of the Trust in the education and continuous development of doctors and nurses coming from overseas to work within the Trust. If there is an induction pack provided to such staff please provide a copy of the same.

With regard to the care of Lucy, there were no overseas nurses involved in her treatment. However, I can confirm that nurses from overseas currently working in the clinical area have undertaken an NMC approved adaptation programme. (See enclosed copy).

The education and continuous professional development of doctors coming from overseas to work within the Trust is overseen by the Clinical Director or, in the case of doctors in training, the clinical tutors.

5. Please explain the system in place within the Trust for the dissemination of information learned as a result of Coroner's inquests or other events both within the Trust to the Board and to other Health Trusts within Northern Ireland.

There is no formal system in place at the present time for the dissemination of learning from inquests or other events. This is, however, being addressed through the action plan of Phase 1, Clinical Governance Support Team.

At the time of Lucy's admission to hospital there was not a formal process for dissemination of information from Coroner's inquests. A copy of the report would not have routinely been made available to the Trust. However, verbal feedback was provided by the then Director of Nursing/Acute Services to the Chief Executive, Medical Director and Clinical Director.

I now refer to your most recent letter dated 15 June 2005. The Sperrin Lakeland Trust Incident Reporting Policy and Procedures was introduced in February 2005. In it, an incident is defined as, *"an unplanned or unexpected event that may or may not lead to injury, damage or loss".* (In light of the Assessment of Risk and Governance, this policy will be subject to review). Again, for ease of reference I will address each point in turn.

1. **How are adverse incidents/near misses/critical incidents recorded by the Trust?**

Adverse incidents/critical incidents are recorded on the DATIX system within the Trust. At the time of Lucy's death a formal Adverse Incident Reporting System did not exist. However, because of her sudden and unexpected death, there was a review of Lucy's care by the then Director of Nursing/Acute Services and the Clinical Director. The only reporting at this time would have been within the clinical directorate for clinical meetings. When the Trust introduced its policy for reporting adverse/clinical incidents, the clinical directorate (Women's and Children's) engaged with the reporting system and have since developed a multidisciplinary quarterly review of reported episodes.

2. **For how long has this system of recording been in practice within your Trust?**

This system was introduced in Sperrin Lakeland Trust in April 2003.

3. **How is the decision made as to what is recorded in respect of such incidents?**

Information that is recorded on the DATIX system is taken from the Incident Reporting forms.

4. **What is the criteria for identifying an adverse/near miss/critical incident?**

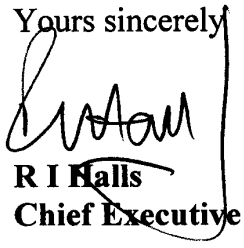
Once an incident or near miss is reported, the Departmental Manager, according to the incident's severity and the likelihood of reoccurrence, grades it. The level of investigation is then based on this grading. (See Section 5 of enclosed policy).

5. **What is the consequence of such a report, for example, does it lead to an internal investigation or a report to the Department of Health?**

Since 2004, the DHSSPSNI Guidance HSS PPM 06/04 has required serious adverse incidents to be reported to the Department. These are defined as; *"any event or circumstance arising during the course of the business of an HSS organisation/special agency or commissioned service that led or could have led to serious, unintended or unexpected harm, loss or damage"*. Serious adverse incidents are reported using a Hotline to the Trust Headquarters. The proforma is filled in and the incident reported to the Department. (See enclosed copy of current Adverse Incident Reporting and Investigating Procedures).

I hope that my response enables you to finalise the background information for the Inquiry. However, if you require further clarification or information please do not hesitate to contact me.

Yours sincerely



R I Halls
Chief Executive

Enc

SPERRIN LAKELAND

HEALTH AND SOCIAL CARE TRUST

Incident Reporting

Policy & Procedures

An Incident is an unplanned or unexpected event that may or may not lead to injury, damage, or loss. For the purposes of this policy, incidents of a clinical or non-clinical nature are reportable.

Date of Policy: February 2005

Date of Review: February 2006

INDEX

1.0 INTRODUCTION

Sperrin Lakeland Health and Social Care Trust is committed to the health and safety of its patients, visitors and staff. Accurate and appropriate reporting of all incidents is an essential part of promoting safety and reducing risks.

The Trust wishes to make it clear that incident reporting will not result in disciplinary proceedings, save in the most exceptional circumstances, for example, if there has been criminal negligence or criminal actions.

The Trust requires all clinical and non clinical incidents (which includes 'near misses') - involving or witnessed by a member of staff - to be formally reported. Disciplinary action may be taken against an individual who has knowingly been involved in or witnessed an incident but has failed to report it.

Incidents involving Trust staff that occur in other buildings/sites must be reported in the same way and the occupier of the site must be advised accordingly.

This Procedure is the Trust's method of meeting legal obligations under the **Health and Safety at Work (NI) Order 1978,** and **Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997,** and **Reporting and Follow-Up on Serious Adverse Incidents: Interim Guidance (HSS (PPM)06.04,** and of implementing requirements of **Risk Management Controls Assurance Standard**

The procedure replaces previous Trust guidance provided in "Procedures for Recording and Notifying Accidents, Untoward Events and Unusual Occurrences on Trust Premises".

This Policy should be read in conjunction with other related policies and procedures, eg. Reporting Deaths to Coroner, Theft, Corruption and Fraud Policy, Violence to Staff.

2.0 PRINCIPLES AND STANDARDS

- The Incident Reporting system does not aim to apportion blame but to promote learning from experience and to improve practice accordingly.
- All staff will be made aware of the Incident Reporting Procedure.
- Reporting will be prompt and completed as soon as possible after the incident – this should be within 24 hours.
- All Serious Adverse Incidents will be reported via the Trust Telephone Hotline - the DHSSPS and WHSSB will be informed of these within 72 hours.
- Reports will be made in an accurate and consistent way by all staff.
- Reports will be made externally as appropriate. Existing reporting procedures to external bodies will continue (including reporting to Statutory Bodies, eg. The Mental Health Commission and the reporting of Serious Adverse Incidents).
- Patients/clients, and their carers where appropriate, will be actively engaged in the reporting and investigative procedures. They will be informed of the outcome of any investigation of safety incidents which affected their care or treatment.
- Appropriate records of incidents and Near Misses will be kept centrally within the Risk Management Department.
- Investigation of the Incident should normally be completed within 20 working days.
- Support and Training needs for Investigators must be identified and actioned by the relevant Director.
- Regular feedback will be given by the appropriate managers to employees on progress concerning incident reports made by them.
- Reports of Clinical Incidents will be provided to the Clinical Director/Service Director and Medical Director on a monthly basis.
- Reports of all medication incidents and near misses will be provided to the Director of Pharmacy on a monthly basis.

- Reports will be provided on a 6-monthly basis to Clinical and Social Care Governance Committee.

3.0 DEFINITIONS

3.1 INCIDENT

"An event which gives rise to, or has the potential to produce unexpected or unwanted effects involving safety of patients, users and other persons" (HSE/RIDDOR 1997). The following table provides examples of the different types of incidents; it is not an exhaustive list.

Accidents	Burns, cuts, needlestick injury, trips and slips, bumps, manual handling injury.
Clinical Incident	Any event or omission arising during clinical care that results in unexpected physical or psychological harm to a patient or client. Examples include incorrect prescription or administration of drugs, incorrect patient assessment or health records not available during a consultation.
Violence/ Aggression	Assault (physical, verbal or sexual), violent, aggressive or severely disruptive behaviour by patients, staff or a member of the public.
Security Incident	Break-in, vandalism, damage to property, theft, trespass, etc. Any breach of information security involving the confidentiality, integrity or availability of data (both hard copy and electronic data) is also a security incident.
Dangerous Occurrences	Any specified events which may result in injury or have the potential to do significant harm, for example, the accidental release of a biological agent likely to cause illness, spillage of hazardous substances or an electrical short circuit causing fire.
Near Miss	An unplanned incident that does not cause injury or damage but has the potential to do so, for example, an unsheathed needle lying on the floor is picked up and disposed of properly before anyone is injured.

3.2 SERIOUS ADVERSE INCIDENT

The DHSSPSNI guidance (HSS(PPM)06/04 defines a serious adverse incident as ***"Any event or circumstance arising during the course of the business of a HSS organisation/Special Agency or commissioned service that led or could have led to serious unintended or unexpected harm, loss of damage".***

Serious Adverse Incidents will include:

- Any incident involving **serious harm or potentially serious harm to a patient, service user or the public**, including disease outbreaks, apparent clinical errors or lapses in care;
- Any incident which has **serious implications for patient or staff safety**, including potential or actual risk to patients and staff;
- Any incident involving **serious compromises or allegations of serious compromises in the proper delivery of health and social care services**.

The following table gives examples of serious adverse incidents which may occur in a hospital/clinical setting or in the community

Examples of Serious Adverse Incidents include:

Medical error leading to the death of a patient, reasonably believed to be due to incorrect administration of medicine
Retained instrument or other material after surgery requiring re-operation or further surgical procedure
Procedures involving the wrong patient or body part
Patient suicide in hospital
Death or serious injury to patient/client as a result of negligence or poor practice by staff
Poor practice which places clients/patients at considerable risk
Poor practice which results in seriously undermining of staff or public confidence in Trust services
Extreme attacks/abuse of staff
Extreme attacks/abuse of clients/patients by staff
Serious errors by staff, especially those which put patients/clients at risk
Serious abuse of vulnerable adults
Withdrawal or breakdown of component service

4.0 REPORTING PROCEDURE

4.1 REPORTING INCIDENTS

1. All incidents must be verbally reported to the appropriate Line Manager immediately. This must be followed up by the completion of the written Trust A3 Incident Reporting Form. Employees must ensure that they are aware of the location of the Incident Book.

2. **Serious adverse incidents must be reported to the Incident Reporting Hotline (Extension 5858)** before the end of the working shift by the relevant duty manager. **All deaths reported to The Coroner must also be notified to Trust Headquarters via the Hotline.**

3. The Incident Form should be completed by the employee concerned. Guidance on completion of forms is found on the dividing flap of Incident Books. If the incident involves a member of the public then the employee who witnessed or to whom the incident is reported should complete the incident form. When completing the incident report form, it must be remembered that only factual statements should be made. Opinions should be omitted. **The incident report must be with the appropriate Line Manager within 24 hours of the incident occurring**.

4. The **BLUE COPY** of the Incident Reporting Form will be forwarded to the Risk Management Team, Trust Headquarters, Strathdene House, Tyrone & Fermanagh Hospital within 3 working days.

5. The **YELLOW COPY** will be forwarded to the relevant Business Services/Clinical Services Manager/Director or in the case of medication errors/near misses, the Director of Pharmacy.

6. The **WHITE COPY** will be retained in the incident reporting book.

7. If, as a result of an incident at work, a member of staff sustains a major injury or has a sickness absence of more than 3 consecutive days, the Risk Management Team **MUST** be informed, and RIDDOR Form completed by Line Manager, as soon as is practicably possible.

8. Where an incident or 'near miss' involves a patient/client, it must be discussed with the patient/client or carers as soon after the incident as possible and the proposed actions which are being taken, and recorded in the patient's documentation.

9. The Manager on duty must follow-up all incidents and complete the Line Manager Section of the Incident Form by the end of the working shift.

Clinical Incident report forms MUST NOT be filed in patient notes, but it is important that a clinical entry is made in the notes and recorded that an incident form has been completed.

4.2 REPORTING SERIOUS ADVERSE INCIDENTS

The Procedure for Reporting of a Serious Adverse Incident does not replace the necessity of reporting through the Trust's mechanism for reporting ALL incidents.

The Service Manager will verbally report serious adverse incidents, including Reporting of deaths to the Coroner, to the Incident Reporting Hotline.

Information required when using **HOTLINE Telephone Number:** [redacted]
Outside line: [redacted]

- Name
- Department/ward
- Extension number
- Date of incident
- Time of incident
- Brief summary of incident
- Other individuals and/or organisations informed

The Clinical and Social Care Governance Support Officer will:

- Prepare an Adverse Incident Report using a standard proforma. The Chief Executive, Medical Director or other senior management team director will approve /finalise document. This will be forwarded to WHSSB and DHSSPS within 72 hours.

- Ensure that the Chief Executive is informed of ALL Serious Adverse Incidents.

- Ensure that the Medical Director is informed of ALL Serious Clinical Adverse Incidents.

4.3 STATUTORY REPORTING TO OTHER AGENCIES

The internal reporting arrangements within the Trust will not affect the obligation to continue to report to the relevant Statutory and other agencies.
These include:

- Northern Ireland Adverse Incident centre (for reporting of faulty Medical equipment, devices)
- RIDDOR – Reporting of Injuries Diseases, Dangerous Occurrences Regulations (Health and Safety Executive)
- Mental Health Commission
- SSI (Social Service Inspectorate)
- PSNI
- Coroner

This list is NOT exhaustive.

5.0 INVESTIGATION OF INCIDENT

The investigation of incidents and 'near misses' must be thorough and comprehensive to ensure causative steps are identified and remedial actions taken.

Investigations are used to identify the underlying and causal factors of the event and to *learn and change, where the need for this is identified.* Managers and investigators must remain aware that their staff and colleagues come to work to "do good" and bad outcomes rarely occur.

Please note that while all aspects of this process must be treated as confidential, all documentation is disclosable.

For the purpose of this Policy, Senior Managers are those reporting to a Trust Director, eg. Clinical Director/Clinical Services Manager/Director of Pharmacy/Business Services Manager.

Senior Managers are responsible for:

- Ensuring that all incidents (clinical and non-clinical) are investigated;
- Causative factors are identified and
- Steps to prevent reoccurrence are introduced.

The Clinical Director/Service Director/Community Services Manager must ensure that there was no evidence that deliberate harm was intended. The use of the Incident Decision Tree is recommended in order to do this. (See Appendix 2).

5.1 INCIDENT GRADING

Incidents will not all require the same level of investigation. Grading incidents will help inform what detail of investigation is required and the level at which the investigation should be conducted.

Departmental Managers will undertake initial Incident Grading using the Trust's risk evaluation matrix. All incidents must be graded according to the impact on patient/client or on staff member and the likelihood of recurrence. Incidents should be graded based on the actual impact whereas near misses should be graded based on the potential impact.

Step One – What was the outcome of the event?

A judgement is made as to the incident's severity based on the table below (descriptions are examples only and is not an exhaustive list).

Table 1: Severity/Possible Consequences

Score	*Descriptor*	Description
1	Insignificant/ No Harm	No obvious adverse outcome.
2	Minor	Non-permanent injury (eg injury that is resolved in one month),inappropriate sexual behaviour, buildings left unsecured, self-harm, manual handling, slip/trip/fall with no severe damage, staff sickness < 3 days.
3	Moderate	Possible semi-permanent injury (eg injury that takes up to one year to resolve, or more)/ill health/damage/loss of function, sexual assault breaches of security, violence and aggression, high degree of self-harm, staff sickness > 3 days.
4	Major	Possible permanent injury/ill health/damage/loss of function, serious sexual assault serious breach of security, serious damage to property, medical device failure, serious assault, attempted suicide, long-term staff sickness > 4 weeks.
5	Catastrophic	Unexpected death, suicide, homicide, rape, abduction, road traffic accident resulting in death, fire/ explosion in which building becomes unstable.

Step Two – What are the chances of the incident occurring again?

In order to obtain a realistic assessment of the event you need to consider how likely it is that the event will occur again under similar circumstances. This can be done using the likelihood table below.

Table 2: Likelihood

Score	Descriptor	Description
A	Almost Certain/ Very Likely	Expected to occur in most circumstances
B	Likely	Will probably occur in most circumstances
C	Possible	May occur occasionally
D	Unlikely	Don't expect it to happen but it is possible
E	Rare	Could only occur in exceptional circumstances

Step Three – What is the overall risk score for this incident?

Take the answers you obtained in Step One and Two and plot them on the table below. The colour category assigned determines the level of investigation required and the level at which the investigation should be conducted.

Table 3: Risk Matrix

LIKELIHOOD	CONSEQUENCE				
	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastropic
A. Almost Certain/ Very Likely	A1	A2	A3	A4	A5
B. Likely	B1	B2	B3	B4	B5
C. Possible	C1	C2	C3	C4	C5
D. Unlikely	D1	D2	D3	D4	D5
E. Rare	E1	E2	E3	E4	E5

This Table is consistent with the Risk Matrix on the A3 Incident Report Book and 'Guidance on Risk Assessment' document.

5.2 LEVELS OF INVESTIGATION

Green Incidents – Insignificant Harm or Very Low Risk

These are incidents that can generally be managed adequately and promptly at the time of the incident and require limited investigation. As an individual occurrence the incident does not have any serious consequences, implications or repercussions that could be ongoing and impact on the individual or the service.

Examples include:

- Patient fall with no injury sustained
- Minor bruise to patient when taking blood sample

Yellow Incidents – Minor Harm or Low Risk

These are incidents that may also be managed adequately and promptly at the time of the incident, however, the type of incident and its possible implications may require the manager to consider if further investigation is necessary. This will be relevant if the incident has the potential to cause injury, or an interruption to service.

Examples include:

- Visitor to Trust premises slips on wet floor and sustains injuries requiring A&E treatment.

- Member of staff goes home early as a result of a manual handling incident but returns to work the following day

Amber Incidents – Moderate Harm or Moderate Risk

All amber incidents must be drawn to the attention of the relevant Senior Manager who will ensure that an investigation takes place.

These incidents should be discussed at Directorate meetings. Any learning points, safety improvements, or actions taken as a result of the incident that are considered to be useful for other departments in the Trust must be submitted to the Chair of the relevant group including, for example, Risk Management Steering Group, Medical Devices Group, Drugs and Therapeutic Committee, etc.

Examples include:

- Patient sustains a fracture as a result of a fall
- Staff member off work more than 4 weeks as a result of a violent physical assault

Red Incidents – Major/Catastrophic Harm or High Risk/Very High Risk

These are extremely serious incidents that require investigation and may also

involve an enquiry led by agencies external to the Trust. These incidents require immediate reporting to the Serious Adverse Incident Voicemail Hotline. Investigation of red incidents will be carried out using Root Cause Analysis and led by investigators trained in this methodology. Where appropriate, an investigation panel will be set up which may include a Non-Executive Director of the Trust. Consideration must be given to seeking a legal view on the issue being examined.

Examples include:

- Unexpected death
- Permanent injury
- Abduction
- Rape

5.3 PREVENTATIVE ACTION

The responsible Line Manager must ensure that wherever possible appropriate remedial action is taken immediately to prevent a recurrence.

- If the incident is as a result of the failure of a medical device, or that a failure of a medical device is a contributing factor to the incident, the medical device must be taken out of use *immediately,* and RETAINED FOR INSPECTION.

5.4 INVESTIGATION PROCESS

It is important to remember that the object of the investigation is to find out what happened and why. Refer to Appendix (give number- Guidelines for Investigating incidents)

Most incidents will not have resulted from an intention to harm. *However, it is most important that investigations are able to identify those very rare incidents where there was intentional harm.* The Incident Decision Tree (National Patient Safety Agency) will assist in this (Appendix 2).Where intentional harm is suspected or proven, it is the manager's responsibility to ensure that the necessary authorities are informed, eg. Coroner, Human Resources, PSNI, etc. The Chief Executive and Medical Director must be informed of all cases when patient/client safety has potentially been affected – this should be via Telephone Hotline on ext. 5858.

5.4.1 WHO SHOULD INVESTIGATE?

- The Clinical Director/Clinical Service Director/Manager is responsible for ensuring that an appropriate person /people are identified to carry out the investigation.
- In the case of a major/red Incident where Root Cause Analysis investigation will be undertaken it is the responsibility of the Service Director (i.e Acute , Mental Health, Elderly and Community) to ensure that an appropriately trained team are identified to carry out the investigation.

5.4.2 THE PURPOSE OF THE INVESTIGATION

Investigations have a number of defined elements:

- To establish the full facts, with respect to the sequence of events that led to the incident occurring
- To determine what was managed well
- To determine what, if anything, went wrong, and to identify issues of concern
- To identify factors contributing to the event or near miss
- To identify the 'root causes' of any error, or concern

- To identify the actions required to prevent recurrence, and whether or not the local clinical or support team, management team, or organisation can implement them.

In order to accomplish its purpose an investigation must establish the following:

- WHAT happened?
- WHERE it happened?
- HOW it happened?
- WHY it happened?

The investigation will include all or some of the following:

- Interviews with the key individual(s) involved
- Interview(s) with the patient(s)
- Interview(s) with any witnesses
- Collection of written statements
- Examination of the physical location of the incident including the taking of photographic evidence where equipment, furniture, or other physical evidence needs to be preserved
- Examination of any equipment involved by relevant personnel
- Examination of any other available physical evidence
- Review of any appropriate policy or guideline documentation
- Review of the healthcare record(s) and care plan for patient events
- Interviews with staff not involved in the event, but who are familiar with the general modus operandi of the area or department(s) involved in the event(s)
- Expert review (Internal and/or External)
- Root Cause Analysis (Essential for major/ red incidents)

5.4.3 GATHERING THE EVIDENCE – THE FIVE P'S

1. FROM THE PERSONS INVOLVED IN THE EVENT

Interviews:

- All key members of staff must be identified and advised that an incident review is required. It should be made explicit that the purpose of the review is to find out exactly what happened, to identify areas of good practice, and areas where systems failed. They must be assured that the purpose of the investigation is not to focus on any personal human error or failing. All staff involved in incidents resulting in a major

adverse outcome must be advised of the availability of confidential support and counselling during what will be a stressful period, and that they can have a friend or union representative with them during any interview.

- All witnesses to the event should be interviewed if at all possible. They will have a different perspective and will have noticed and remembered different things that may be of value in piecing th event together

- Staff uninvolved in the event but who may be able to give valuable insight as to the workings of the department, the team dynamics, custom and practice

- The person affected, eg. Patient, visitor, contractor or staff member. It is always important to establish their version of the event. They can often provide essential information - however, tact and sensitivity are paramount in determining the appropriateness of approaching this individual following an event.

Statements

- All staff involved in, and witness to, the event should be asked to make as full a record of the incident (including events leading up to an following the event) as they can as soon as is possible after the event. Whilst memory recall is recognised to be good following very traumatic adverse events, often the detail of the sequence can be lost. It is therefore recommended that this process is started as soon as possible after event notification.

2. FROM THE PLACE (ENVIRONMENT) IN WHICH THE EVENT OCCURRED

- The investigators must visit the environment in which the incident occurred and make observations about its layout. A sketch of the area and its layout should be considered for events such as violence and aggression, equipment problems

- Photographic evidence of the environment can also be invaluable in recording and identifying environmental risk factors – eg. General lay out, points of potential danger, poor ergonomic design, blind spots, etc

A digital camera is available on loan from the directorate BSM teams and/or at the Risk Management Team at Trust Headquarters.

- Notation of the physical locations of staff members, visitor or witnesses should be made

3. FROM ANY PARTS (EQUIPMENT) INVOLVED

Any piece of equipment, or any implement, directly involved in an event should be removed and secured. Examples include the following:

- Medical equipment
- Fire hydrant
- Kitchen knife
- Computer hard-drive
- Bleep

4. FROM ANY PAPER EVIDENCE

- Guidelines, policy and procedures
- Clinical Audits
- Risk Management Audits
- Health and Safety Audits
- Incident reports
- Claims statistics
- Letters of concern written by staff
- Risk Alerts
- Medical equipment maintenance records, purchase orders, etc

5. FROM PARADIGMS, IE. "THAT'S THE WAY WE DO THINGS AROUND HERE"

It is important in eliciting the general custom and practice of a working environment to speak to persons uninvolved in the event who either normally works in the department or who have regular contact with it. The information obtained can help you shape the context in which factors leaving an area vulnerable to incidents have come to pass.

- What is the custom and practice of the department
- What is the prevailing attitude
- How are things usually done

5.4.4 REVIEWING THE EVIDENCE, IDENTIFYING PROBLEMS, GOOD PRACTICE, ETC

Once all of the relevant information relating to the case has been collected, it is recommended that the investigation team map the chronology of the event in a 'time line' format. This method of mapping the data collected will best enable you to identify information gaps and start the process of identifying the service performance failures along the incident chain that you want to explore in terms of contributory, influencing and mitigating factors.

You might want to undertake this on a large piece of paper initially as it does help you to frame your thoughts and questions. Alternatively, mapping it in a word table works reasonably well.

5.4.5 UNDERTAKING THE ANALYSIS

For each problem identified, the investigators must establish whether or not, any of the following factors were influential in any way to the course or outcome of the event:-

- Individual Staff / Visitor/ Contractor factors
- Patient factors
- Environmental factors (inc. buildings and plant)
- Task factors
- Work conditions
- Team factors
- Communication factors
- Education, training and supervision factors
- Equipment factors
- Strategic management factors

Individual factors

These are factors that the individual(s) involved in an event bring that are unique to them. They are often terms as personality factors but also include psychological factors, home factors, work relationship factors, etc.

Patient factors

Patient factors tend to be those issues that are unique to the patient, or patients involved in the event. They, like individual factors are often grouped in to social and cultural factors.

Environmental Factors (inc. buildings and plant)

These are issues around heating, lighting, ventilation and workspace requirements and where appropriate external factors should also be considered, ie. seasonal weather conditions, external structural work

Task Factors

Task factors are those that support and aid in the safe and effective delivery of particular functions within the healthcare process(es). These include guidelines, procedures and policies.

Working Conditions

Working conditions are all of those factors which affect the ability to function at the optimum in the work place. These include staffing issues such as skill mix, staff to patient ratio and use of temporary staff. Workload and hours of work, the environment, equipment, supplies, efficiency and reliability of administrative/IT systems are all factors to be considered.

Team Factors

Team factors include lack of clarity of role, poor attention to communication and supervision issues.

Communication Factors

Did any aspect of verbal, non-verbal or written communications contribute to poor performance, the occurrence of the event, or the containment of this issue? Factors to consider could include correct use of language, eligibility and completeness of records.

Education, Training and Supervision

Did staff receive adequate training, including refresher updates, in order to perform their job satisfactorily? Was the level of supervision appropriate?

Equipment Factors

Was the piece of equipment being used appropriately? Were procedures in place to ensure it was maintained according to manufacturers' updated guidelines, including decontamination?

5.4.6 GENERATING THE INVESTIGATION REPORT, RECOMMENDATIONS AND AN ACTION PLAN

The report must be easy to follow and clearly present the salient points.

Recommendations must be focused on addressing the root causes or fundamental issues associated with the incident, ie. *Those things that once addressed will prevent the problem from recurring.* Recommendations should make explicit where responsibility lies for operationalising the recommendations. Recommendations can include supervisory and training issues. Recommendations should also include some indication of the risk of doing nothing.

Key points for formulating action plans:

- All action planned must be within the control of the person/team making the plan
- The person/team must agree and own the content of the plan
- The person responsible for implementing each point of the plan must be identified and instructed
- Time scales for the delivery of completed action points must be agreed
- Monitoring and review processes must be agreed
- Communication issues must be agreed – these will include communication across directorates and with other Health and Social care Providers.

5.5 TRACKING INVESTIGATION

The Datix information system will be used to capture, track and analyse incidents.

NON CLINICAL INCIDENT

The Risk Management Team will oversee the reporting and follow-up investigation. Investigation will be tracked to ensure that they are completed in a timely manner and that lessons are disseminated.

CLINICAL INCIDENT

CSCG Support Office will oversee the reporting and follow-up investigation. CSCG will track all clinical incident investigations and work with directorates to ensure that these are completed in a timely fashion.

6.0 COMMUNICATION

- The Clinical Directors/Service Directors are responsible for ensuring that a named person will communicate with the patient and their carer.
- The patient/client and their carer (if necessary) must be informed of any investigation which is being undertaken relating to their care (the line manager is responsible for ensuring that this happens).
- The patient/client (and carer) will be given information as to the nature of the investigation timescale, and a contact name of who they can approach if they have any further queries.
- The patient/ client will be given the opportunity to meet with the appropriate staff to get feedback from the investigative process.

7.0 EDUCATION AND TRAINING

- All Staff must receive information regarding the Incident Reporting Policy at the time of Induction. This includes all Medical Staff.
- All Staff must be made aware that the Incident Reporting Policy is available on Trustnet.
- Directors must identify and facilitate training of their staff in incident investigation.
- The CSCG Committee will publish a regular safety update to share lessons learnt.
- Directors must ensure that staff receive regular updates regarding incident reporting.

8.0 SUPPORT TO STAFF

It is important, following an incident, for the manager to remain in touch with their affected member/s of staff. It is the manager's responsibility to provide primary support.

The Line Manager's role is to support their member of staff and make known to them departments which may offer emotional and physical support, including

- Occupational Health
- Staff Counselling Service

9.0 STAFF RESPONSIBILITIES IN INCIDENT REPORTING PROCEDURES

9.1. ALL PERSONNEL WORKING ON TRUST BUSINESS

- Must comply with the Policy and reporting procedures
- Assist with any incident investigation
- Take all reasonable steps to minimise risk

9.2. LINE MANAGERS/WARD MANAGERS/SUPERVISORS

- Must ensure that all reporting employees understand and follow the reporting procedure.
- On receipt of the Incident Reporting Form, all details **MUST** be checked to ensure that they have been completed correctly.
- Complete Manager's Section of Incident Reporting Form as appropriate.
- Provide each incident with a risk classification and record in Manager's Section.
- Investigate "yellow" incidents when deemed necessary, and refer "red" and "amber" incidents to the relevant Clinical Services Manager or consideration/action
- Be aware and have knowledge of supporting policies in risk management prevention, eg. COSHH, Child Protection, Infection Control and Radiation Safety, which can be used in the event that appropriate staff are unavailable.
- Under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997(RIDDOR), certain incidents are reportable to the enforcing authority, which in the case of the Trust is the Health and Safety Executive for Northern Ireland. Managers must familiarise themselves with reporting requirements outlined in Trust's "Guidance on the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997".
- Report incidents involving medical equipment or devices to the Northern Ireland Adverse Incident Centre (NIAIC). Managers must familiarise themselves with the Trust Document 'Distribution of Warning Notices & Reporting of Adverse Incidents in Relation to Medical Devices and Non-Medical Equipment – Procedural Arrangements'.

9.3. RESPONSIBILITIES OF SENIOR MANAGERS

- Disseminate this policy and procedure within their area of responsibility and ensure its promotion and implementation, by providing support and advice to managers and staff.
- Ensure that Incident Reporting is included in departmental induction.
- Ensure that appropriate staff are identified for and receive training in incident investigation and review.
- Ensure that staff have access to advice and training on incident reporting and management.
- The Clinical Director/Clinical Services Director/Community Service Manager will ensure that appropriate investigation is undertaken.
- Ensure that the patient, relatives and other persons who need to have details of the events receive timely and adequate explanations from appropriate members of staff.
- Ensure that appropriate records are maintained.
- Ensure that incidents are reviewed within the service area and that recommendations made as a result of investigations are put in place.
- Review, where appropriate, a current risk assessment or undertake a new assessment following an incident.

9.4. RESPONSIBILITIES OF CLINICAL AND SOCIAL CARE GOVERNANCE SUPPORT OFFICER

- Collate information from Serious Adverse Incident Hotline.
- Ensure that Chief Executive/Medical Director are informed of incident.
- Assist in compiling report to DHSSPSNI and WHSSB.
- Provide administrative support to the investigation of serious clinical incidents as agreed with the Medical Director.
- Collate information regarding notification of death to Coroner
- Ensure all clinical incident reports are recorded on the Datix system.
- Maintain database
- Develop appropriate reporting arrangements to Senior Managers.
- Respond to requests seeking analysis of incident trends
- Q.A of incident reporting
- Provide support and guidance to investigators of Adverse Incidents.

9.5. RESPONSIBILITIES OF RISK MANAGEMENT TEAM

- Ensure that data collection is complete and appropriate
- Prioritise reported incidents according to their significance
- Compile records of all incidents
- Make external reports as appropriate
- Advise on appropriate action to minimise risk
- Make reports to the Risk Management Committee, the Clinical Governance Committee, Management Executive and Trust Board as required.
- Ensure serious untoward events are reported to Trust's commissioner and DHSS&PS as per procedural requirements.

9.6 RESPONSIBILITIES OF SERVICE DIRECTOR/CLINICAL DIRECTOR/DIRECTOR OF PHARMACY

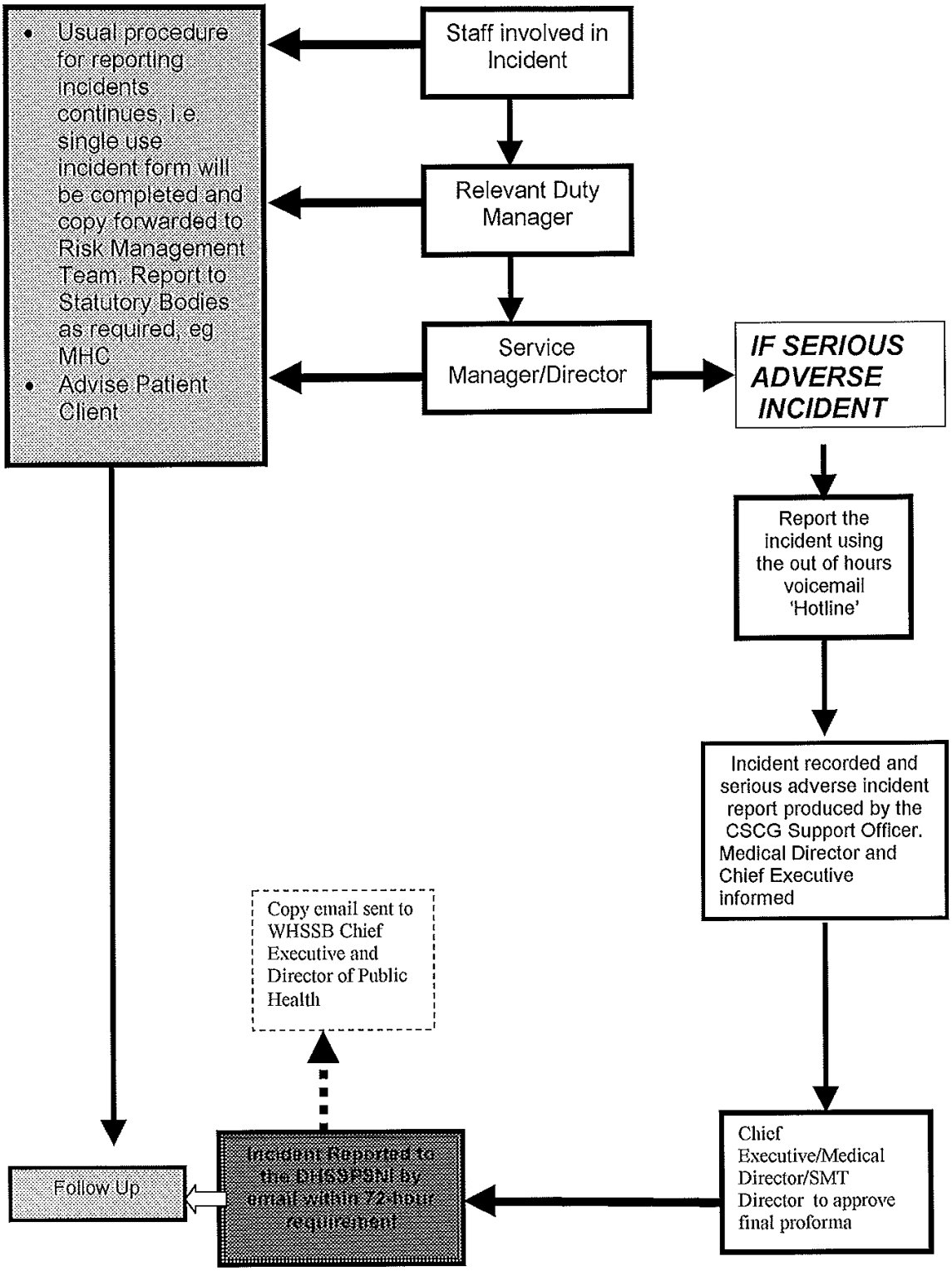
- Ensure that all staff in their Programme of Care receive information re Incident reporting.
- Ensure that 'learning' from incidents is incorporated into practice.
- Identify and facilitate Investigation Team for Incident Investigation/RCA.

9.7 RESPONSIBILITIES OF CHIEF EXECUTIVE

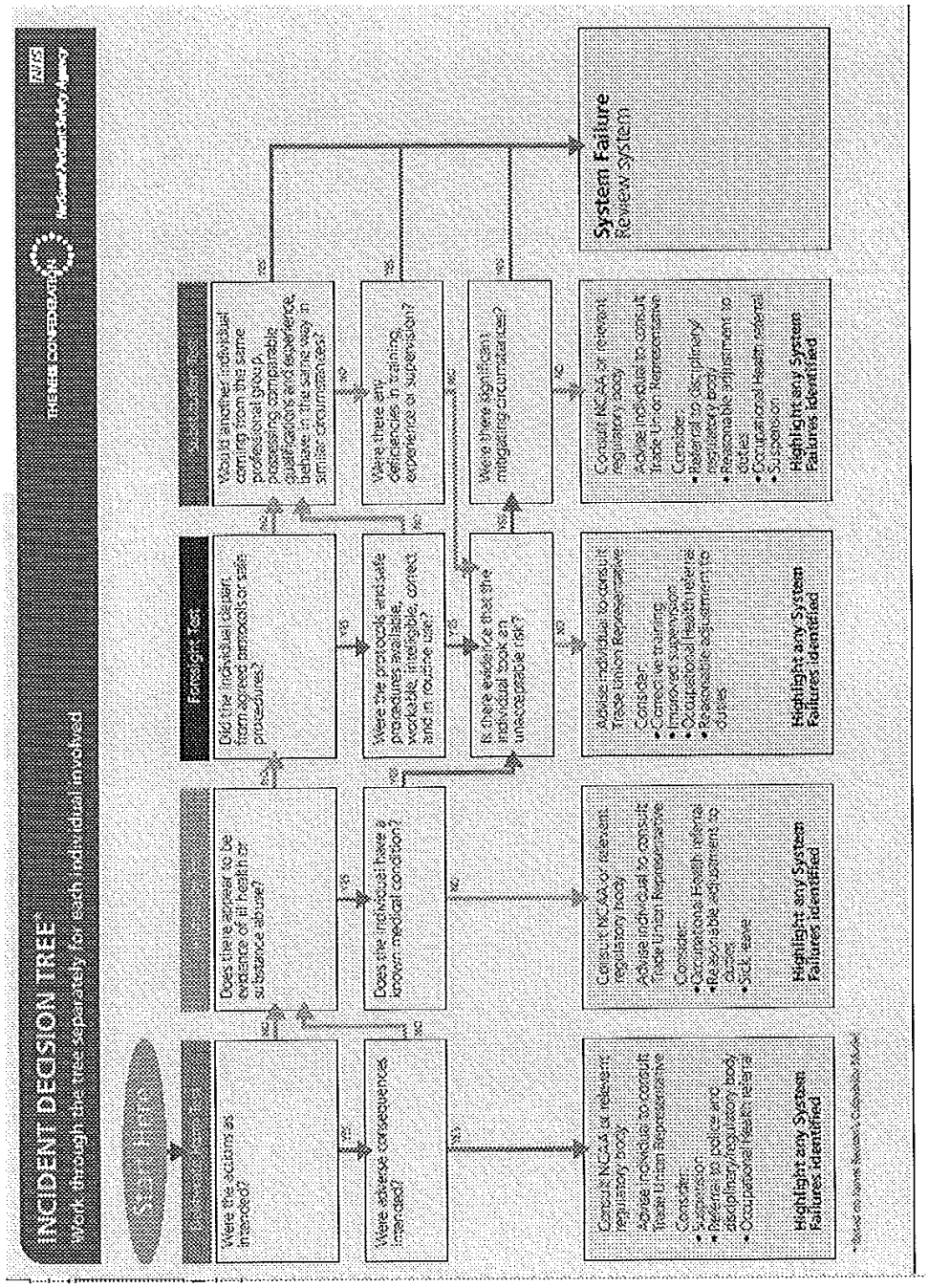
- Ensure that Incident reporting systems are in place and satisfy the statutory requirements.
- Develop a safety conscious culture within the Trust.

Appendix 1

REPORTING PROCEDURE

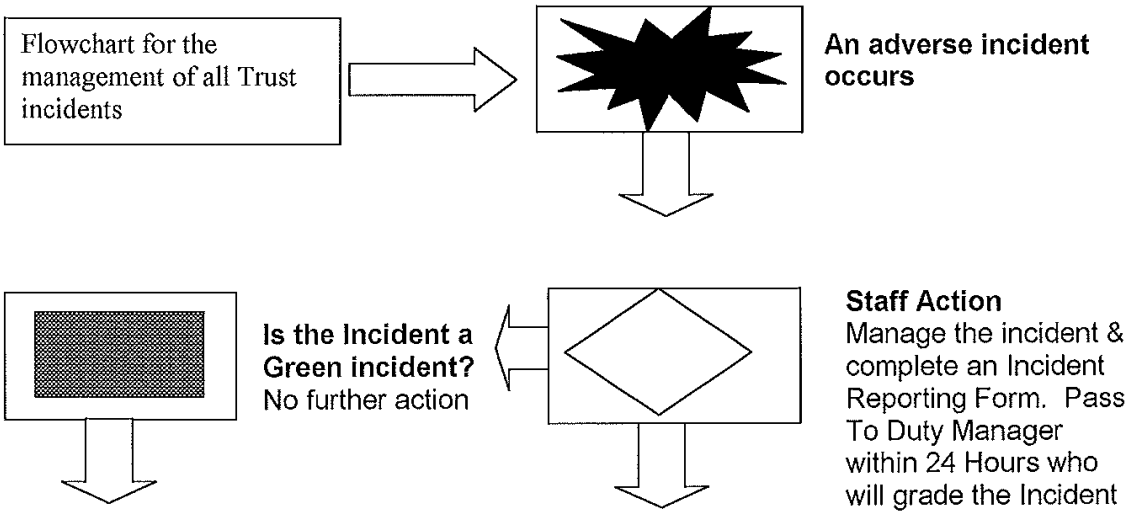


Appendix 2


INCIDENT DECISION TREE
Were the actions as intended?
Were adverse consequences intended?
Does there appear to be evidence of ill health or substance abuse?
Does the individual have a known medical condition?
Did the individual deliberately depart from agreed policies or safe procedures?
Were the protocols and safe procedures available, workable, intelligible, correct and in routine use?
Would another individual coming from the same professional group, possessing comparable qualifications and experience, behave in the same way in similar circumstances?
Were there any deficiencies in training, experience or supervision?
Were there significant mitigating circumstances?
Highlight any System Failures identified
System Failure
Review system

Appendix 3

FLOWCHART FOR THE MANAGEMENT OF ADVERSE INCIDENTS WITHIN WARD/DEPARTMENT/FACILITY



Appendix 4

TIPS FOR SUCCESSFUL INVESTIGATIVE INTERVIEWING

When interviewing staff following an adverse event, we often adopt the interviewing style with which we are most comfortable. Not infrequently this results in a series of short answer questions being asked of the interviewee, insufficient time for them to be able to respond and the interviewed maintaining control of the process.

Much of our interviewing experience is gained in interviewing people for jobs and the style is completely unsuitable for interviewing staff following an adverse event.

The following pointers are to assist you in reflecting upon your practice and to enable you to obtain as full information as possible from the interviewee, whilst leaving them feeling good about themselves at the end of the experience.

The start of the Interview

In order for an interviewee to open up to you in the interview they need to feel comfortable. They also need to believe that you the interviewer have an open and unbiased mind and that you are interested in them as a person.

The following key points should therefore be borne in mind:

- Welcome the interviewee
- Introduce self, including a little about yourself
- Ask the interviewee about himself or herself.

This approach will assist the interviewee in controlling or reducing their anxiety levels. This in turn may assist their memory recall about the even tin question.

Explaining the purpose of the Interview

Once the interviewee is seated and the preliminary introductions are complete, it is important to explain the purpose of the interview and the role of the interviewer and interviewee in this.

The important points to get across are:

- To find out as much as possible about the event from everyone involved;
- To understand how the event occurred
- That the interviewer wasn't there so he/she needs the interviewee to tell, or describe everything no matter how trivial they think it is.
- Inform the interviewee if you plan to take notes while he/she is talking

The Interviewees story/account

The interviewee will be given the opportunity to describe the event from their perspective. The interviewer's role during this phase is to facilitate the interviewee's recollection. It is therefore important that interruptions are kept to a minimum and that the interviewer shows interest in what you are being told.

Asking Questions

When the interviewee has completed their story the interviewer may then ask questions for either clarification purposes, or to try and draw more information from the interviewee.

It is normally recommended that the questions asked should only be related to what the interviewee has told you, and not related to what someone else has told you. However, in the healthcare scenario, this is often not practical. Frequently the interviewer will be aware of the broad sequence of events associated with an incident and they will need to ask the interviewee relevant questions even if they have not volunteered the information. It is the experience of many healthcare managers that interviewees are often reluctant to divulge crucial details because they don't want to be seen as a whistle blower.
If the interviewer has to explore areas about which the interviewee has not made reference, it is essential that the interviewer respect the honesty of the interviewee. It is often tempting to persist with a particular line of questioning because you believe that the interviewee must know something. All you will achieve is the alienation of the interviewee.

Prior to asking any questions the interviewer should remind the interviewee to:

- Report everything no matter how small
- And reassure the interviewee that not knowing the answer to a question is OK.

The key pointers for successful questions are:

- Where possible ask your questions in the same order that the interviewee has remembered the event.
- Complete all questions regarding each area of the event before moving onto the next – this saves the interviewee having to jump around their memory bank.
- Use Open Questions rather than Closed Questions. Words such as "Tell me" or "Describe to me".
- Use closed questions only to clarify certain facts, or where you want to limit the interviewees response. "What time did x happen", "Who was in the room with you".

If you want to maximise the opportunity for memory recall, you might want to repeat the incident scenario in the order that the interviewee has shared with you before moving in to the questioning phase.

Whilst there are certain questions which the interviewer will want answered, these questions should be reserved until the spontaneous questions about each phase of the event have been answered. Remember that through good interviewing techniques predetermined questions will almost always have been answered.

Summary

Once the interviewer has finished asking questions it is important that a summary of information shared is repeated back to the interviewee. The rule here is to use the interviewee's language not yours (it is their testimony not yours).
This phase allows the interviewee to identify inaccuracies in what the interviewer has interpreted and to add extra detail if necessary.

Closure

The closing of the interview is as important as the opening. It is during this phase that the interviewer must ensure that the interviewee is left in a positive frame of mind. Remember they are likely to be returning to their duties.

To assist this the interviewer should:

- Return to neutral topics of conversation
- Thank the interviewee for attending and for providing the information they have
- Ask the interviewee if they have any questions they would like to ask
- Provide the interviewee with a contact name and number if they feel they need to talk about the event again, or need support in coming to terms with it.
- Double check any demographic details associated with the interviewee, eg. Place of work etc.
- Inform the interviewee about feedback arrangements.

Paediatric SHO Induction Programme

Wednesday 2nd Feb General Hospital Induction

Thursday 3rd Feb Paediatric Specific Induction

Venue: Classroom Paediatric Ward

09:15-09:45	**RGN**	**General Intro**
10:00-10:30	[redacted]	**Labour Ward**
10:45-11:15	**Sr Millar**	**TCH Issues**
		Coffee
11:45-12:15	[redacted]	**Neonatal Unit**
12:15-13:00	**JOD**	**Medical records**
13:00-13:30		**Lunch**
13:30-14:15	[redacted]	**Study Leave/Ann Leave/Rota's**
14:15-14:45	[redacted]	**Maternity Ward**
14:45-15:30	[redacted]	**Safe Prescribing**
15:30-close		**Spotting the sick child**

Friday 4th Feb Paediatric and Neonatal resuscitation
All Day

Venue: Resus training Room 1st floor

Induction Programme

Week 2

	7/2/05	8/2/05	9/2/05	10/2/05	11/2/05
	Monday	Tuesday	Wednesday	Thursday	Friday
09:00-09:45	Neonatal examination	Neonatal examination	Neonatal examination	X-ray Dept Meeting	Neonatal examination
10:00-13:00	Ward Work orientation	Ward Work orientation	Ward Work orientation	Ward Work orientation	Ward Work orientation
13:00-14:00	Lunch	Lunch	Lunch	Lunch	Lunch
14:00-15:00	Fluids JOD	Meningitis [redacted]	Status Epilipticus [redacted]	Status Asthmaticus [redacted]	
15:00-16:00	Major incident plan [redacted] A&E consultant	Blood Transfusions Matt Hackett	Infection Control	Community Nursing [redacted]	
16:00-17:00	Immunisation UK policy [redacted]	[redacted]			

TBA
"Child Protection it's everybody's business "
[redacted] Social Services Training Team
Venue TBA

10-11 Mar European Paediatric Life Support (EPLS)
Tyrone County Hospital

6-8 Apr Advanced Paediatric Life Support (APLS)
Altnagelvin

SPERRIN LAKELAND

HEALTH AND SOCIAL CARE TRUST

Senior House Officer Induction

Wednesday 2nd Feb 2005
Doctors Library, Erne Hospital

9:00	Welcome	[redacted]
9:45	Pharmacy Services	[redacted]
10:00	Radiology	[redacted]
10:25	Occupational Health	[redacted]
10:45	Anaesthetics	[redacted]
11:00	Coffee Break	
11:15	Discharge summary	[redacted]
11:30	CPR training	Resus Training Officer
11:45	Personnel	Signing Contracts
	LUNCH	
13:00	Hospital Tour	(new SHO's)
13:30	Business Services	[redacted]
13:45	Information Services/coding	OCM training Information Services Dept
14:15	Laboratory	[redacted]
14:30	Infection Control	[redacted]
15:00	Questions/ Ward team introductions	

SPERRIN LAKELAND

HEALTH AND SOCIAL CARE TRUST

Senior House Officer Induction

Wednesday 4th August 2004
Doctors Library, Erne Hospital

9:00	Welcome	[redacted]
9:45	Pharmacy Services	[redacted]
10:00	Radiology	[redacted]
10:25	Occupational Health	[redacted]
10:45	Anaesthetics	[redacted]
11:00	Coffee Break	
11:15	Discharge summary	[redacted]
11:30	Business Services	[redacted]
11:45	Personnel	Signing Contracts
	LUNCH	
13:00	Hospital Tour	(new SHO's)
13:30	CPR training	Resus Training Officer
13:45	Information Services/coding	OCM training Information Services Dept
14:15	Laboratory	[redacted]
14:30	Infection Control	[redacted]
15:00	Questions	

SPERRIN LAKELAND

HEALTH AND SOCIAL CARE TRUST

Pre-Registration House Officer Induction

Tuesday 3rd August 2004
Doctors Library, Erne Hospital

9:15	Welcome	[redacted]
9:45	Pharmacy Services	[redacted]
10:00	Radiology	[redacted]
10:25	Occupational Health	[redacted]
10:45	Anaesthetics	[redacted]
11:00	Coffee Break	
11:15	Primary care/Discharge	[redacted]
11:30	Business Services	[redacted]
11:45	Personnel	Contracts
	LUNCH	
13:00	Hospital Tour	
13:30	CPR training	[redacted]
13:45	Information services/OCM training	
14:15	Laboratory	[redacted]
14:30	Shadowing existing PRHO's	

TYRONE AND FERMANAGH HOSPITAL

INDUCTION PROGRAMME - SHOS

WEDNESDAY 2nd FEBRUARY 2005

CONFERENCE ROOM 1 - CEDAR VILLA

9.00 am	-	COFFEE MEET CONSULTANTS
9.15 - 10.30 AM	-	MENTAL HEALTH ORDER [redacted] *Senior Social Worker*
10.30 – 12.00 noon	-	INTRODUCTION TO PSYCHIATRIC SERVICES SAFETY FOR TRAINEES [redacted] *Clinical Tutor*
12.00 – 12.30 pm	-	PHARMACY SERVICES [redacted]
12.30 – 1.00 pm	-	GENERAL PRINCIPLES OF INFECTION CONTROL [redacted] *Infection Control Nurse*
1.00 – 2.00 pm		*L U N C H*
2.00 *pm*	-	ADDICTION SERVICE **(GO TO ADDICTION TREATMENT UNIT)** [redacted] *Consultant Psychiatrist*
3.00 pm	-	E.C.T. [redacted] *Consultant Psychiatrist*
3.45 pm	-	COMMUNITY PSYCHIATRY [redacted] *Senior Nurse*
4.15 pm	-	MEDICAL RECORDS [redacted]

TYRONE AND FERMANAGH HOSPITAL

INDUCTION PROGRAMME - SHOS

THURSDAY 3rd FEBRUARY 2005

CONFERENCE ROOM 1 - CEDAR VILLA

9.15 am	-	COFFEE
9.30 - 10.30 am	-	WORKING TIME DIRECTIVE, ROTAS AND LEAVE ARRANGEMENTS [redacted] *Personnel*
10.30 - 12.00 noon	-	TAKING A PSYCHIATRIC HISTORY/MENTAL STATE EXAMINATION + RAPID TRANQUILLISATION PROTOCOL *Specialist Registrar* - [redacted]
12.00 - 12.30 pm	-	MANAGEMENT STRUCTURE [redacted] *Clinical Services Manager*
		LUNCH
2.00 pm	-	CONTRACT OF EMPLOYMENT *Personnel Staff*
3.00 pm	-	INTRODUCTION TO EPEX DATABASE MEDICAL LIBRARY, CEDAR VILLA [redacted]
4.00 pm	-	TOUR OF HOSPITAL Meet in Cedar Villa [redacted]

Either **MONDAY 7TH FEBRUARY *OR* WEDNESDAY 16TH FEBRUARY 2005**

CPR TRAINING
TYRONE COUNTY HOSPITAL

9.30 AM – 3.30 PM - CARDIO-PULMONARY RESUSCITATION
[redacted] *Resuscitation Officer*

CPR Training is mandatory – all doctors must have received training in the past twelve months.

The CPR Room is situated behind the General Office in Administration Block at Tyrone County Hospital (red brick building on left of main entrance driveway to TCH)

2 –day TRAINING - 21st / 22nd February 2005

VIOLENCE IN THE WORKPLACE
GREEN ROOM / LARCH A

DAY 1 GREEN ROOM
DAY 2 LARCH A

9.30 - 4 PM - BREAKAWAY TRAINING FOR DOCTORS

For this training you are advised to wear runners or other suitable soft shoes for the mats and also to wear track suits or other suitable casual loose clothing.

SPERRIN LAKELAND HEALTH AND SOCIAL CARE TRUST

JUNIOR DOCTORS INDUCTION PROGRAMME
~ DOCTORS LIBRARY, POST GRADUATE CENTRE ~
WEDNESDAY 4th AUGUST 2004
~ TYRONE COUNTY HOSPITAL ~

9.05am	Welcome - Post Graduate Tutor - [redacted]
9.15am	Information and Computer Services
9.30am	Registrar of Deaths
9.45am	Occupational Health Department
10.00am	Pharmacy Services Manager - [redacted]
10.10am	Educational Programme - [redacted]
10.20am	Resuscitation Officer - [redacted]
10.40am	Chief MLSO
10.55am	**Coffee** [redacted] **to address Medical SHO's)**
11.05am	Control of Infection Nurse
11.20am	Radiology Department
11.35am	Fire Safety
11.50am	Violence in the Workplace
12.05pm	[redacted] - Junior Doctors Implementation Officer
12.15pm	Business Services
12.30pm	Employment Services to attend from 12.30 to sign contracts
1.00pm	Tour of Hospital (visit to Telephonists to pick up bleeps)
	Lunch **Sponsor** [redacted] **– Medical Defence Union** [redacted] **will make a video presentation applicable to Junior Medical staff**

[redacted] **will be present throughout the morning.**