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Email: jim.livingstone[redacted]
Date: 18 September 2008
Our ref: SECGM/716/2008

Dear Alice

RE: RQIA INDEPENDENT REVIEW INTO THE APPLICATION OF NPSA SAFETY ALERT 22, *REDUCING THE RISK OF HYPONATRAEMIA WHEN ADMINISTERING INTRAVENOUS INFUSIONS TO CHILDREN*

Thank you for your letter of 6 August 2008 to Andrew McCormick enclosing a copy of the above report. The prevention of hyponatraemia, and the wider need to ensure the highest standards of care and treatment, are key priorities for the Minister and the Department. RQIA's review is therefore particularly welcome and highlights a number of issues that need to be addressed to ensure that all Trusts are adhering to NPSA guidelines.

There are a small number of issues that I would be grateful if you could consider. The first relates to the handling of the report. I note your intention to publish the review in late September. However, following discussions within the Department, it is the general feeling that, as the Department commissioned the review, it should be the Department that takes the lead in issuing it to the Service. It would be our intention to do so as soon as we receive the final version of the review from RQIA. I trust that you are content with this approach, but I am happy to discuss further.

While your review notes that HSC Trusts and independent hospitals have undertaken considerable work to reduce the risk of hyponatraemia when administering intravenous fluids to children, it also makes clear that there is still some way to go before full compliance with NPSA patient safety Alert 22 is achieved. RQIA's review makes a number of important recommendations in this regard, and I consider that it will be essential to follow these up. As such, it would be our intention to commission RQIA to repeat the review in April 2009 to assess how far trusts and independent hospitals have progressed in the implementation of RQIA's and NPSA's recommendations.

'On a related point, it would be helpful if RQIA could specify timescales for full implementation of its recommendations. It would be our view that the majority of the recommendations could be fully implemented by March 2009. However, for recommendations 4, 6, 8 and 10 it may be difficult to achieve 100% coverage of training and assessment by March 2009 due to the constantly changing nature of the workforce. As such, it may be worth specifying the progress to be achieved, for example 90% of the relevant workforce to be trained or assessed by March 2009. I would welcome RQIA's view on this matter.

With regard to the content of the report, I have listed below some factual inaccuracies and points of clarification which it would be helpful if you could address:

- On pages 3 and 4, the references to the annexes of the report appear to have become confused. The circular issued by the Department in April 2007 appears to be attached at Annex C, rather than at Annex B as stated. Similarly, the addendum to this circular, which was issued in October 2007 and which included the regional paediatric fluid guideline wall chart, is attached at Annex B, not Annex C. In addition, the paediatric parenteral fluid wall chart, which the review states is attached at Annex D, appears to have been omitted. I have attached a copy of the October 2007 regional guidelines wall chart for ease of reference.

- The second sentence on page 4 should be amended to read '...the DHSSPS published a paediatric parenteral fluid wall chart', not 'parental'.

- I note that the review does not cover all hospitals. We need to be able to assure ourselves about the implementation of NPSA Safety Alert 22 at all hospitals, including the Mater, Royal Victoria and Belfast City hospitals, on an individual basis. I should be grateful for RQIA's views of current practice in these hospitals and whether it is content that representation from these hospitals at the discussion group was sufficient in this regard.

- The review notes many examples of local, good practice initiatives. It would perhaps be helpful if RQIA could provide more details of these initiatives and specifically address them in the recommendations to enable good practice to be shared regionally.

- Re. NPSA Recommendation 1, the review notes that the retention of No. 18 solution for use in some areas 'requires local management from the perspective of robust supply processes, and clear labelling'. I would welcome the review team's assessment of the extent to which this local management was in evidence.

- Re. NPSA Recommendation 2, the review refers to the 'exemplary action' in relation to raising staff awareness of the clinical guidelines at Antrim Area Hospital, Altnagelvin and RBHSC. It would be helpful if the review could provide more detail on what this action entailed. I note that all hospitals have revised existing local written guidance, and would appreciate if RQIA could confirm that this revised guidance is in line with the regional guidelines.

- RQIA's Recommendation 5 requires that all previous versions of the wall chart are removed. RQIA could perhaps specify that the most recent version of the wall chart, and the only one which should be displayed, is that issued by the Department in October 2007.

- RQIA's Recommendation 6 includes a requirement that competency assessment tools are developed for 'all (multi-professional) staff'. Should this be amended to read 'all relevant (multi-professional) staff'?

- Re: NPSA Recommendation 5, the review notes 'a general culture of under-reporting'. Presumably this is intended to apply to all incidents and not just incidents related to hospital-acquired hyponatraemia. This finding is particularly worrying, especially in light of RQIA's Clinical and Social Care Governance Overview Report for 2006/07 which noted an 'increase in independent reporting and gradual change towards an open and learning culture'. Perhaps RQIA could clarify this point.

I should be grateful if you would consider the above comments and reflect them in the final version of the report as appropriate. I would also welcome the opportunity to discuss with you in more detail our proposed handling strategy and the intention to repeat the review in April 2009.

Yours sincerely

DR J F LIVINGSTONE
Director

cc. CMO
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Dr Carolyn Harper
Dr Heather Livingston
Dr Martin Donnelly
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