Adams, James (DHSSPS)

DH1/09/32580

From: Livingstone, Jim
Sent: 01 December 2008 17:47
To: McBride, Michael; Bradley, Martin; Morrow, Norman
Cc: Ferrin, Sean; McCormick, Andrew; McKee, Christine; 'McCarthy, Miriam'; Harper, Carolyn; Livingston, Heather; Donnelly, Martin; Scullion, Sean; Timoney, Mark; Taylor, Diane; Robinson, Philip; Porter, Nicola; Browne, Andrew; Mooney, Jennifer; Lawson, Elaine; Baird, Billy; Craughwell, Eva
Subject: URGENT *** Submission re RQIA review into NPSA Safety Alert 22: Reducing the risk of hyponatraemia when administering intravenous fluids to children
Attachments: Sub re RQIA review into NPSA Safety Alert 22 Reducing the risk of hyponatraemia when administering intravenous fluids to children.DOC; Sub re RQIA review into NPSA Safety Alert 22 Reducing the risk of hyponatraemia when administering intravenous fluids to children.tr5

Please see URGENT Submission attached on publication of RQIA report on Hyponatraemia requiring your clearance prior to submission to Minister.

Jim

Dr Jim Livingstone

Director of Safety, Quality and Standards
DHSSPS
Room C3.8
Castle Buildings
Stormont
Belfast BT4 3SQ

Tel: [redacted]
Fax:

DHI/08/144519

From: Andrew Browne
Safety & Quality Unit

Date: 28 November 2008

To:

1. Dr Jim Livingstone (**Approved 1/12/08 – requires urgent clearance**)
2. CMO, CNO and CPO for signature of relevant letters
3. Michael McGimpsey

INDEPENDENT REVIEW BY RQIA INTO THE APPLICATION OF A SAFETY ALERT BY THE NATIONAL PATIENT SAFETY AGENCY ON REDUCING THE RISK OF HYPONATRAEMIA IN CHILDREN

Summary

Issue:	It has been agreed with RQIA that the Department will issue this report on the application of *NPSA Safety Alert 22: Reducing the Risk of Hyponatraemia when Administering Intravenous Fluids to Children.* The final version has now been received.
Timing:	**Urgent** – To issue to the service on 3 December and publically on 4 December.
Presentational Issues:	Given the ongoing interest in hyponatraemia (most recently in relation to the current GMC hearing of Dr Jarlath O'Donohoe's role in the Lucy Crawford case) and the public inquiry chaired by John O'Hara QC, it is likely that this report will attract some media attention.

FOI Implications: Fully discloseable

Recommendation: That you note the key findings of the report, suggested handling strategy, lines to take and press release.

Background

1. The RQIA wrote to Dr Andrew McCormick on 6 August 2008 enclosing a draft report of its review into the application in Northern Ireland of *NPSA Safety Alert 22: Reducing the Risk of Hyponatraemia when Administering IV Fluids to Children*. The Department responded in September, seeking a small number of factual changes and requesting clarification on a few points. We also asked that the Department lead on issuing the report to the service. RQIA has accepted the majority of our suggested amendments and submitted a final version of the report which it has agreed the Department will issue.

2. This submission sets out the key findings and recommendations of RQIA's review, together with a proposed handling strategy. Also attached are:
   - **TAB A** – lines to take
   - **TAB B** – letter for issue to Alice Casey, RQIA
   - **TAB C** - press release
   - **TAB D** – letter to HSC

Position

3. The RQIA notes that HSC Trusts and independent hospitals have undertaken considerable work to reduce the risk of hyponatraemia when administering intravenous fluids to children, and it highlights a number of

good practice initiatives. However, it is clear that there is still some way to go before full compliance with NPSA Safety Alert 22 is achieved.

Key findings

Clinical Practice

4. The review team noted that, in a number of hospitals, paediatric consultants have taken on the role of clinical champions to ensure trust-wide dissemination of the regional fluid therapy guidelines, and the implementation of revised paediatric intravenous fluid prescription and fluid balance charts. However, it considers that there is a need to ensure that these measures are consistently applied in adult wards where children are treated.

Use of Sodium Chloride No.18 solution

5. Four hospitals have completely removed No.18 solution from stock. RQIA points to the potential risk at sites where No. 18 solution remains available. This requires robust local management of supply and labeling processes, which RQIA states was not evident to the review team.

Staff training

6. RQIA found that the provision of intravenous prescription and administration training for non-paediatric staff caring for older children on adult wards was poor across all organisations.

Reporting of hospital-acquired hyponatraemia

7. The review team found little evidence of a reporting culture for incidents relating to intravenous fluids and hyponatraemia. It does not consider that appropriate systems are in place for hospital staff to report, analyse and learn from such incidents.

Recommendations

8. RQIA's report makes 16 recommendations in total. These centre around,:
    - the availability of No.18 solution;
    - the need for continued work on the dissemination of clinical guidelines;
    - the requirement to display only the most recent version of the fluid therapy wallchart;
    - training and assessment of staff in the administration of intravenous infusion to children;
    - the treatment of older children on adult wards;
    - incident reporting, and;
    - the need for a regional audit tool.

Handling strategy

9. It has been agreed with RQIA that the Department will issue this report. A draft letter for issue to RQIA prior to formal publication of the report is attached at **TAB B.** A draft press release (which has been agreed with Information Office and the RQIA) is attached at **TAB C.**

10. A draft letter for issue to the service is attached at **TAB D.** This includes the requirement to implement the recommendations of RQIA's review, in addition to the recommendations contained within NPSA Alert 22, by March 2009. It also provides notification that RQIA will repeat its review in June 2009 to assess the extent to which all recommendations have been implemented.

11. One of the major issues highlighted by the RQIA's review is the need for training and awareness-raising in the risk of hyponatraemia among staff involved in the care of older children in adult wards. This concern has also been raised in a letter from Dr Tony Stevens to CMO dated 17 July. In the response to Dr Stevens, we advised that the most recent guidelines

apply to all children aged between one month and 16 years, regardless of ward setting. However, we recognised the need to reconsider guidance as it applies to adults. The attached draft advises that the Guidelines and Audit Implementation Network (GAIN) is reviewing the 2003 CREST guidance on this issue. We expect revised guidance to be available early next year.

12. RQIA recommends that an audit tool which, as a minimum, would address aspects of NPSA Alert 22 should be developed and used at least annually by trusts, and that trusts should continue to seek approval and funding for a regional audit on the uptake of the Paediatric Parenteral Fluid Therapy guideline and potential unexpected clinical consequences of the guideline. The Department is currently working with GAIN and the service to facilitate the development and use of this audit tool.

13. With regard to the reporting of adverse incidents, we are very concerned that RQIA notes little evidence for a culture of reporting and considers that appropriate systems are not in place. HSC organisations are required to have an agreed process in place for the reporting, managing, analysing and learning from adverse incidents. In July 2004, the Department established an interim Serious Adverse Incident reporting system. This was introduced at a time when there were concerns about information on hyponatraemia in children being known to the Department.

14. The Department recognises that there is room for improvement in the current system. A review project is underway to ensure that appropriate and effective HSC-wide reporting systems for adverse incidents are in place that meet the needs of HSC organisations, the Department and other relevant bodies. These systems must include early feedback to ensure learning from adverse incidents, facilitate the regional sharing of learning and provide assurance that learning has been implemented in

order to improve quality of services and minimise risk or reoccurrence. The system must also facilitate early warning of critical events as they occur in the HSC in particular those that are likely to give rise to public concern. It is anticipated that this review will be completed by 31st December 2008, with a phased implementation of any agreed new process thereafter.

Recommendation

15. That you note and agree:
    - the key findings and recommendations of RQIA's review
    - suggested handling strategy
    - lines to take **(TAB A)**
    - draft press release **(TAB C)**

16. That you note:
    - Draft letter to RQIA **(TAB B)**
    - Draft letter to HSC **(TAB D)**

Andrew Browne
Safety & Quality Unit
Ext [redacted]

cc: Secretary
Dr Miriam McCarthy
Dr Carolyn Harper
Dr Heather Livingston
Dr Martin Donnelly
Sean Scullion
Mark Timoney
Diane Taylor
Philip Robinson
Elaine Lawson
Billy Baird
Nicola Porter

Clare Baxter

Lines to Take

I am grateful to RQIA for carrying out this independent assessment of measures in place to reduce the risk of hyponatraemia in children. I fully accept the report's recommendations and will ensure that they are acted upon.

I am pleased to note that the RQIA found that significant work has already been done to reduce the risk of hyponatraemia in children, building on guidance and wallcharts issued by the Department.

There is still some way to go before NPSA recommendations are fully implemented. I have written to Trusts and independent hospitals requiring them to implement all the actions outlined in the NPSA Safety Alert and the RQIA's report by March 2009.

I have commissioned the RQIA to repeat their review next year. It is likely that this will commence in June 2009.

TAB B

From the Chief Medical Officer
Dr Michael McBride

Alice Casey
Interim Chief Executive
Regulation & Quality Improvement Authority
9th Floor, Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Castle Buildings
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Belfast BT4 3SQ
Tel: [redacted]
Fax:
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Our Ref:
Date: December 2008

RQIA REVIEW INTO APPLICATION OF NPSA SAFETY ALERT 22

Dear Alice

Thank you for your letter of 14 October to Jim Livingstone, enclosing the above report, amended to take account of the Department's earlier comments.

I can confirm that we have reviewed this latest version and are content that the report now takes account of the vast majority of our comments. I understand that you have agreed to the Department issuing the report to the service, which will be done on Wednesday 3 December. A press release will follow on Thursday 4 December.

I am grateful to RQIA for agreeing to repeat its review again in June 2009. Perhaps we can finalise the detail of this second study in due course.

I trust that you are content with this approach.

Yours sincerely

DR MICHAEL McBRIDE
Chief Medical Officer

TAB C

Press Release **4 December 2008**

INDEPENDENT REVIEW OF MEASURES TO REDUCE THE RISK OF HYPONATRAEMIA IN CHILDREN PUBLISHED

Health Minister Michael McGimpsey has welcomed the publication of an independent review of measures in place in Northern Ireland to reduce the risk of hyponatraemia in children.

The Regulation and Quality Improvement Authority investigated the application in Northern Ireland of the National Patient Safety Agency's recommendations to reduce the risk of hyponatraemia when administering intravenous fluids to children in hospital.

The Review concluded that HSC Trusts and independent hospitals have undertaken considerable work to reduce the risk of hyponatraemia when administering intravenous fluids to children, and it highlights a number of good practice initiatives. It also makes 16 recommendations that should be fully implemented before full compliance with NPSA Safety Alert 22 is fully achieved.

Commenting on the publication of the review, the Minister said: "**The RQIA's independent assessment of steps being taken in Northern Ireland hospitals to prevent hyponatraemia in children is extremely helpful. I am committed to ensuring safe, high-quality services for all patients here and reducing the risk of hyponatraemia in children is a key element of this.**

"The finding that hospitals in Northern Ireland have already made significant progress is encouraging, but I note that further improvements

can still be made, particularly in the reporting of incidents and the treatment of children on adult wards.

"I have written to Trusts and independent hospitals requiring them to implement all of the RQIA's recommendations by March 2009. I have also asked the RQIA to repeat its review later in 2009, and I expect to see evidence of significant progress when this is complete."

Notes to editors:

- Hyponatraemia is a disorder of sodium and water metabolism and is the most common electrolyte abnormality in hospitalised patients.

- RQIA's review into the application of *NPSA Safety Alert 22: Reducing the Risk of Hyponatraemia when Administering Intravenous Fluids to Children* is published today (DN: Insert date) and is available on its website at [DN: Information Office to insert link].

- A copy of the report has been issued by DHSSPS to all hospitals in Northern Ireland, with a requirement to implement the relevant NPSA and RQIA recommendations by March 2009.

- The Department has commissioned the RQIA to repeat its review in 2009. It is expected that this will be carried out in June 2009.

- *NPSA Safety Alert 22: Reducing the Risk of Hyponatraemia when Administering Intravenous Fluids to Children* can be accessed through the NPSA website at http://www.npsa.nhs.uk/nrls/alerts-and-directives/alerts/intravenous-infusions/

- John O'Hara QC is currently chairing a public inquiry into hyponatraemia-related deaths in Northern Ireland, which is expected to report towards the end of 2009.

TAB D

From:

Chief Medical Officer	Chief Nursing Officer	Chief Pharmaceutical Officer
Dr Michael McBride	**Mr Martin Bradley**	**Dr Norman Morrow**

For Action:
Chief Executives of HSC Trusts

Independent hospitals, hospices and relevant regulated establishments

Castle Buildings
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Tel: [redacted]
Fax:
Email: qualityandsafety[redacted]

Our Ref:
Date: January 2009

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

Dear colleagues

You will be aware that the Regulation and Quality Improvement Authority has recently completed its review into the application of NPSA Safety Alert 22 in hospitals in Northern Ireland. The final report of this review is attached.

RQIA notes in its review that HSC Trusts and independent hospitals have undertaken considerable work to reduce the risk of hyponatraemia when administering IV fluids to children. However, it also highlights areas where further work is required and makes a number of recommendations around, for example, the use of No. 18 solution, staff training, and reporting of adverse incidents.

Circular HSC (SQS) 20/2007 required Trusts to implement the actions outlined in NPSA Safety Alert 22 by 30 September 2007. RQIA's findings would suggest that this work is not yet complete. We would therefore ask that you review the recommendations contained in RQIA's report and take whatever action necessary to ensure that these, along with the recommendations set out in NPSA Safety Alert 22, are implemented by **31 March 2009**.

We would emphasise the importance that the Minister and the Department places on this issue. To this end, we have asked RQIA to repeat its review next year to assess the extent to which its recommendations and those of NPSA Safety Alert 22 have been implemented. It is anticipated that RQIA will undertake this further review in June 2009 and we would expect it to find evidence that significant progress has been made.

RQIA highlights the need to develop an audit tool which could be used by Trusts to measure the implementation of NPSA Safety Alert 22. The Department is working closely with the Guidelines and Audit Implementation Network (GAIN) to facilitate the development of such an audit tool as soon as possible.

RQIA also raises concerns about the systems in place for reporting and learning from adverse incidents. You may be aware that the current system is already under review to ensure that appropriate and effective HSC-wide reporting systems for adverse incidents are in place. It is anticipated that this review will be completed by 31st December 2008, with a phased implementation of any agreed new process thereafter. In the meantime, however, we would stress the need for all staff to be made aware of the current system and of the importance of ensuring that all adverse incidents are reported and managed appropriately.

We should be grateful if you would ensure that RQIA's report is made available to all relevant staff in your organisation, and take every effort to ensure that RQIA's recommendations are implemented as a matter of urgency.

Yours sincerely

Dr Michael McBride
Chief Medical Officer

Dr Norman Morrow
Chief Pharmaceutical Officer

Mr Martin Bradley
Chief Nursing Officer

cc:
Chief Executive, RQIA
Chief Executives, HSC Boards
NI Medicines Governance Team
Hugh Mullen, Director of Performance and Provider Development, Service Delivery Unit
Directors of Pharmacy, HSC Boards/ HSC Trusts
Medical Directors, HSC Trusts
Medical Director, NIAS
Directors of Public Health, HSC Boards
Chair, Guidelines and Audit Implementation Network
Head of School of Medicine and Dentistry, QUB
Dean of Life and Health Sciences, UU
Head of School of Nursing and Midwifery, QUB
Head of School of Nursing, UU
Staff Tutor of Nursing, Open Nursing
Professor David Cousins, NPSA
Chief Executive NIMDTA, NICPLD, NIPEC