From: Andrew Browne
Safety & Quality Unit

COR/572/2010

Date: 1 June 2010

To:

1. Dr Jim Livingstone (**Approved 1/6/10**)
2. Dr Paddy Woods – **Agreed PW 3/6/10**
3. Michael McGimpsey

RQIA FOLLOW-UP REVIEW: REDUCING THE RISKS OF HYPONATRAEMIA WHEN ADMINISTERING INTRAVANEOUS INFUSIONS TO CHILDREN

Summary

Issue: Ian Carson wrote to you on 19 May enclosing the final RQIA report of the follow-up review on the application of *NPSA Safety Alert 22: Reducing the Risk of Hyponatraemia when Administering Intravenous Fluids to Children.*

Timing: Routine.

Presentational Issues: Trevor Birney (journalist) has made recent enquiries about the start date for the public hearings for the Hyponatraemia Inquiry but there has been little other media interest.

FOI Implications: Fully disclosable.

Financial Implications: None

Special Adviser's Comments:

Recommendation: That you note the key findings of the report and approve its publication by placing on the RQIA website.

Background

1. The RQIA wrote to you on 19 May 2010 enclosing the final report of its follow-up review into the application in Northern Ireland of *NPSA Safety Alert 22: Reducing the Risk of Hyponatraemia when Administering IV Fluids to Children*. A previous review, which had been commissioned by the Department, was carried out by the RQIA in 2008. That report made 16 recommendations and in February 2009 a joint letter from the Chief Medical Officer, Chief Nursing Officer and the Chief Pharmaceutical Officer was sent to HSC Trusts and independent hospitals requiring full implementation of the 16 recommendations. At that time you requested that the RQIA undertake a further review of the measures in place in HSC Trusts and independent hospitals to reduce the risk of hyponatraemia in Northern Ireland, specifically in terms of the recommendations made in the 2008 RQIA report. You asked that the follow-up review should pay particular attention to the reporting of incidents and the treatment of children in adult wards.

2. This submission sets out the key findings and recommendations of RQIA's follow-up review.

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. In all the areas visited by the review team there was evidence of improvement and commitment to achieving full compliance with the recommendations made in NPSA Patient Safety Alert 22 and in the RQIA Hyponatraemia Review 2008. **The Review Team concluded that trusts and independent healthcare facilities in Northern Ireland have good operational control of the administration of intravenous fluids to children and that compliance with NPSA Alert 22 has been substantially achieved.** The RQIA also commented that Trusts and independent hospitals had provided reviewers with evidence to demonstrate that patient safety was a priority when prescribing, administering and monitoring of intravenous infusions to children.

Key findings

Use of Sodium Chloride No.18 solution

4. All hospitals have completely removed No.18 solution from clinical areas where children are treated and its use across all trusts and independent hospitals was negligible. A small number of hospitals

have retained limited stocks in pharmacy departments for use in specialist areas such as critical care, renal, liver and cardiac units.

Clinical Practice

5. There is good compliance with the display of, and staff awareness of, the Clinical Guidelines in the form of the Paediatric Parenteral Fluid Therapy wall charts issued by the Department in October 2007. The majority of trusts and independent hospitals had written policies for the administration of intravenous fluids to children.

Staff Training

6. RQIA found that there was evidence to show that nursing staff have attended training events on the administration of fluids to children and there is good uptake of the BMJ E-learning module on hyponatraemia by doctors in training.

7. Some children continue to be treated in adult wards, but all hospitals have measures in place to identify the location of patients aged 14-16. There is however, a continuing potential risk associated with the administration of intravenous fluids to children treated on adult wards and clinical areas.

Reporting of hospital-acquired hyponatraemia

8. The review team found there is good evidence of staff awareness of incident reporting systems but there is limited evidence of robust systems for putting the learning from incident reporting into practice.

Recommendations

9. RQIA's report makes 8 further recommendations, all of which have been accepted by the Department. These centre around:

- the complete removal of No.18 solution;
- the development of a competency assessment tool on the administration of intravenous fluids;
- the development of a strategy to ensure there is collaborative clinical management between paedatric and adult clinicians for the administration of intravenous fluids to children in adult wards;
- training and assessment of staff in the administration of intravenous infusion to children and
- dissemination of learning from adverse incidents.

10. The 2008 RQIA report highlighted the need for training and awareness-raising about hyponatraemia among staff involved in the care of older children in adult wards. At that time the Department advised that recent guidance had been issued and this applied to all children aged between one month and 16 years regardless of ward setting. It was recognised, however, that the guidance as it applied to adults may need to be revised and this was to be taken forward by the Guidelines and Audit Implementation Network (GAIN). GAIN subsequently revised the guidance on Hyponatraemia in Adults, which was published in February 2010.

11. With regard to the reporting of adverse incidents, a review of the current system was undertaken with the aim of ensuring 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. The review has now been completed and recommendations arising from the review were accepted by Minister in February 2009. Work is ongoing to implement a new Regional Adverse Learning and Incident system (RAIL).

Handling strategy

12. As this report was commissioned by the Department it is for the Department to agree the publication date in line with existing protocols. This is normally to publish the report within 4 weeks of submission to the Department. Once the report is cleared for publication, the Director of SQSD will write to the Chief Executive of the RQIA advising him that the report may now be placed on their website. As this is a second review report it is not envisaged that a press release or other "launch" should accompany publication of the report.

13. It is also intended to write to Trusts and independent hospitals to ask them to take forward the recommendations made in the report. The RQIA will assist independent hospitals take forward the

recommendations and will monitor progress on implementation through its annual programme of inspections.

Inquiry into Hyponatraemia-related Deaths

14. As you are aware, the public hearings are scheduled to commence in March 2011. John O'Hara will have an interest in this report and it is therefore encouraging to note that considerable progress has been made since the previous RQIA review in 2008. A copy of the final report will be sent to the Inquiry.

Recommendation

15. That you note the key findings of the report and approve its publication on the RQIA website.

Andrew Browne
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cc: Dr Andrew McCormick
Dr Michael McBride
David Galloway
Dr Heather Livingston
Dr Martin Donnelly
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