Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

Safety, Quality & Standards Directorate
Office of the Chief Medical Officer

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

Room C3.8
Castle Buildings
STORMONT, BT4 3SQ
Tel:
Fax: [redacted]
Email:
maura.briscoe[redacted]

Your Ref:
Our Ref:
Date: 22 May 2008

Dear Alice

RE: NPSA ALERT 22 – REDUCING THE RISK OF HYPONATRAEMIA WHEN ADMINISTERING INTRAVENOUS FLUIDS TO CHILDREN

The purpose of this letter is to share with RQIA the further communication between the Department and the five Trusts in respect of the audit checklist relating to NPSA Alert 22 on reducing the risk of hyponatraemia in children.

Attached are:

1. Letters to each of the Trusts from Dr McBride (dated April 2008) – Annex 1.
2. Individual Trusts' responses to Dr McBride's letter – Annex 2.
3. Preliminary Departmental analysis of these responses – Annex 3.

As you can see from Annex 3, it is our view that there remain some outstanding areas (amber) regarding completion of the checklist with specific reference to the questions documented in Dr McBride's letters to individual Trusts. However, it may well be that RQIA's recent review on hyponatraemia has already unmasked these answers. I should, therefore, be grateful for your view as to whether these "amber" areas should be converted to green, based on the information held by RQIA? In addition, it would be helpful to confirm that the "green" areas on the table are, in fact, appropriate given the recent RQIA independent findings.

Following an RQIA response, if there remains any areas of uncertainty regarding completion of the actions as outlined in the CMO's letter of April 2008, the Department would intend to clarify this further with the Trusts. We would, of course, share this with RQIA.

Very many thanks for your help. I know that we all have a common goal to ensure that as much as possible is being done to reduce the risk of hyponatraemia. To this end, the Department has asked GAIN to review its guidance on the management of hyponatraemia in adults as there may be some confusion in the Service now between this guidance and the recent paediatric parenteral fluid therapy chart.

Yours sincerely

Maura Briscoe

DR MAURA BRISCOE
Director, Safety, Quality and Standards Directorate

cc: Dr David Stewart, RQIA
Mr Phelim Quinn, RQIA
Dr Mc Bride
Dr Harper
Mrs Elaine Lawson

Annex 3

DHSSPS

AUDIT OF NPSA PATIENT SAFETY ALERT 22: REDUCING THE RISK OF HYPNATRAEMIA WHEN ADMINISTERING INTRAVENOUS FLUIDS TO CHILDREN

RESPONSES FROM TRUSTS TO CMO'S FOLLOW-UP LETTER IN APRIL 2008

CONFIRMATION SOUGHT ON:	BHSCT	SHSCT	WHSCT	SEHSCT	NHSCT
Removal of Sodium Chloride solution from general areas that treat children	Removed				
Distribution & implementation of Regional Guidelines to areas that treat children	Cascaded through Trust and placed on intranet	Actions still outstanding on roll out of clinical guidelines.			
Display of new Regional Paediatric fluid wall chart and replacement of 2002 wall chart	Displayed and 2002 version replaced		Displayed and 2002 version replaced	Displayed and 2002 version replaced	Displayed, although no confirmation that 2002 version replaced
Review and improvement to Fluid Prescription forms	Still under design – to be rolled out from June 2008				
Undertake training for relevant staff	Underway in RBHSC. E-learning module available to	Underway. Arranged for nurses working with children			

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CONFIRMATION SOUGHT ON:	BHSCT	SHSCT	WHSCT	SEHSCT	NHSCT
	staff in adult areas				
Establishment of incident reporting system	Established				
Implement fluid calculation sheet in areas treating children		Fluid balance sheet updated and commonly adopted across Trust. To be implemented in adult wards once training of relevant staff completed			
Detail 'triggers' for incident reporting in prescribing fluids for children	Not provided	Not provided, although one 'trigger' mentioned in minutes of meeting (ie. sodium below 130)	Triggers not detailed although policy for prescribing IV fluids to children provided	Provided – covers (i) choice of IV fluid; (ii) biochemical abnormalities; and (iii) assessment	Provided – covers (i) choice of IV fluid; (ii) biochemical abnormalities; and (iii) assessment
Investigation of Adverse Incidents reported and learning disseminated across Trust			Confirmation received		

- Grey shading indicates that Trust did not have to respond to the particular question posed.