

Quality care – for you, with you

BOARD REPORT SUMMARY SHEET

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| Meeting: Date: | Trust Board 26 th September 2019 |
| Title: | Inquiry Report into Hyponatraemia related Deaths update |
| Lead Director: | Dr M O’Kane - Medical Director Mrs Heather Trouton – Interim Executive Director of Nursing, Midwifery and AHP’s |
| Purpose: | Assurance |
| <p><u>Key strategic aims:</u></p> <p>To ensure the Trust meets the recommendations of the report on Hyponatraemia related deaths</p> | |
| <p><u>Key issues/risks for discussion:</u></p> <ul style="list-style-type: none"> • Compliance with Fluid Prescribing and Monitoring Documentation • Compliance with Clinical Recommendations (10-29) • Review of and progress with 96 recommendations | |
| <p><u>Summary of SMTdiscussion:</u></p> <ul style="list-style-type: none"> • Management of Fluid Balance and Plan to address. | |
| <p><u>Human Rights/Equality:</u></p> | |

The Inquiry into Hyponatraemia Related Deaths – 2018

1. Purpose of Paper

On the 31st January 2018 the Hyponatremia Inquiry released its final report, complete with 96 recommendations. The purpose of this paper is to provide the Senior Management Team with an update on the Trust's responses and oversight arrangements in respect of the Hyponatraemia Inquiry report and accompanying recommendations.

2. Correspondence and Work streams

The Trust records all external communication on the Hyponatraemia SharePoint Site. There have been 2 update reports received in December 2018 and March 2019. An addendum report was received in June 2019 in relation to the Investigation Report on a Whistle Blower's concern in relation to searches and evidence relevant to the Hyponatraemia Inquiry.

The SHSCT contributed to a Consultation exercise in April 2019, on the "Statement of what you should expect in relation to a Serious Adverse Incident."

The SHSCT is represented on the following Work streams; all papers received for these work streams are recorded on the Hyponatraemia SharePoint Site:

- Duty of Candour – Being Open - Geraldine Donaghy and Dr Tracey Boyce
- Death Certification Implementation Working Group – Stakeholder Group for Preparing for Inquests – Lynne Hailey
- Duty of Quality – Clinical and Social Care Governance and RQIA Subgroup – Trudy Reid
- Duty of Quality – ALB Board Effectiveness – Vivienne Toal and Martin McDonald
- Paediatric Clinical Collaborative – Dr Bassam Aljarad, Bernie McGibbon and Eileen Mullan
- Regional Oversight Committee – Trudy Reid and Grace Hamilton

3. Trust Oversight Group

The Trust Oversight Group has met in February, March, April, June and August 2019. Regional Work streams are progressing, with Regional direction from the DoH on how the Trusts can ensure compliance with the Recommendations. There is an agreed Communication Strategy from the DoH to ensure all Trusts receive the information in the same way. All of these pieces of correspondence will be tabled at the Oversight Group.

The initial focus was on the Clinical Recommendations, with a number of task and finish groups convened in relation to clinical recommendations. As the Trust moves through the journey of implementing recommendations; the oversight committee is reviewing and progressing work in relation to other recommendations such as the duty of candour (Being Open Group has been convened, Peter McBride, chair of the Being Open work stream joined the group to share the ongoing Regional position) and education. The oversight committee continues to follow Regional

direction from the work streams, while progressing locally.

4. Fluid Management in Children

A report on the Regional Paediatric IV Fluid Audit Implementation Tool (PIVFAIT) is presented at each Oversight Group. This tool is not used to audit fluid prescribing and administration in theatres, and so to provide assurance to the oversight group the Trust has developed an audit tool for theatres and reports will be shared with the oversight group.

100 % compliance remains challenging and the oversight group continues to work with operational directorates to improve compliance in fluid prescription and monitoring of fluid balance.

5. Paediatric Clinical Recommendations 10-29

Work continues to progress in relation to the Paediatric Clinical Recommendations 10-29.

Patient placement –

Paediatric patients will be nursed in paediatric wards in Craigavon Area Hospital and Daisy Hill Hospital with exceptions where specialist care is required, in this circumstance 14-16¹ year old patients will be cared for in adult wards. These designated wards/departments are Emergency departments, Trauma and Orthopaedic wards, Obstetrics and Gynaecology wards and some theatre departments.

A report is presented to the group regarding the 14-16 year olds admitted to Adult Wards.

The purpose of this report is to provide the oversight committee with assurances that patients up to their 16th birthday are cared for in either a paediatric ward or an adult ward which is designated to care for 14 -16 year old children.

If children are cared for outside designated wards, the operational teams review these incidences for learning and to prevent patients being allocated to undesigned wards.

Compliance with Recommendations 10-29

The oversight group requested a review of the implementation of recommendations 10 to 29, within CYPS and Acute wards where 14-16 year old patients will be care for to establish the current position with these recommendations. This self-assessment showed gaps in implementation, which require further action.

An in depth independent audit has now been commissioned by the oversight group to identify compliance with recommendations and to inform any areas for improvement. A short life working group is developing the audit tool and support to the audit process.

¹ Patients aged 15yrs and 364 days (prior to their 16th birthday)

Compliance with all 96 Recommendations

As it is now 18 months since the publication of The Inquiry into Hyponatraemia-related Deaths Report the oversight group plan to facilitate a workshop to review and update the Trust base line assessment on all 96 recommendations.