

BOARD PAPER HA06/048

Report of the Independent Review into the Horton General Hospital Accident & Emergency Department

<p>Executive summary:</p> <p>On the 10th May 2006 a 23 year old staff nurse, Benjamin Geen received a prison sentence of a minimum term of thirty years. This followed his conviction for two counts of murder and fifteen of grievous bodily harm to patients while they were in the Accident & Emergency Department at the Horton General Hospital in Banbury, Oxfordshire. All the incidents took place during a period of two months from December 2003 to February 2004 while he was working as a staff nurse in the Emergency Department at Horton Hospital, Banbury.</p>
<p>Actions requested:</p> <ul style="list-style-type: none">▪ To note the contents of report and its recommendations.▪ To agree that NHS South Central takes a role in the performance management of the resultant action plan.▪ To agree that the report be circulated to the other nine SHAs in England and other NHS organisations locally to ensure that lessons can be learned from this incident.▪ To approve the monitoring arrangements
<p>Aim(s)/objective(s) supported by this paper:</p> <p>Following the conviction of Benjamin Geen, the former Thames Valley Strategic Health Authority commissioned an independent review.</p> <p>The aim of such reviews is to better understand why such events occurred, whether they could have been predicted or prevented and to learn the lessons in order to improve practice and reduce the risk of such events happening again.</p>
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<p>Lead Directors responsible for this area of work:</p> <p>Simon Tanner – Director of Public Health Olga Senior – Director of Communications & Corporate Affairs (Acting)</p>
<p>Date of paper:</p> <p>November 2006</p>

On the 10th May 2006 a 23 year old staff nurse, Benjamin Geen was convicted of murder on two counts and on 15 counts of grievous bodily harm to patients while they were in the Accident and Emergency Department of the Horton General Hospital in Banbury. All the incidents took place during a period of two months from December 2003 to February 2004 while Mr. Geen was working as a staff nurse in the Emergency Department at Horton Hospital, Banbury. Mr. Geen received a minimum prison sentence of 30 years.

Following his conviction the Thames Valley Strategic Health Authority commissioned an independent review into the events at the Horton General Hospital. The main reasons for commissioning the review were to understand thoroughly how Mr. Geen had managed to undertake his activities, why his actions were not identified earlier and what actions could be taken to reduce the likelihood of similar events occurring in the future.

Professor Pat Cantrill, a former senior civil servant at the Department of Health, and a holder of a number of senior nursing and other management positions was asked to chair the inquiry. Professor Cantrill was assisted by two other panel members, Darren Walter, a Consultant in Emergency Medicine and Clinical Director of the Emergency Department of South Manchester University Hospitals NHS Trust, and Rebecca Hoskins, a registered adult and children's nurse with 18 years experience in emergency care.

Key findings from the review

The review panel have examined a range of evidence and heard from a number of witnesses during their investigations. They make a number of recommendations that are intended to improve policies, structures and culture within the Trust. At the outset however, it is important to stress that the panel found that while there are improvements to be made, the responsibility for the deaths of two patients and the grievous bodily harm caused to 15 others rests with Mr. Geen, and that the actions of staff in identifying his activities prevented further injury and death.

- The findings of the report are not about blame, they are about identifying lessons to be learnt to improve the performance of services in relation to safeguarding patients in the future. The only person responsible for the death of two patients and the harm inflicted on a number of others was Ben Geen himself.
- The findings of the report highlight areas where some processes and procedures at the Horton Hospital can be improved upon.
- It should be recognised that it is very difficult to stop a Nurse or any other healthcare professional from betraying the trust of patients by harming them deliberately. However we can always improve processes and procedures to reduce the chances of a similar incident from happening again.

- The judge in the trial recognised the dedication of the medical and nursing staff in dealing with the patients, on occasion saving their lives. The report highlights the commitment and loyalty of Horton ED staff and recognises them as a group of outstanding individuals.
- The evidence showed that Ben Geen would have continued his activities and harmed more people had the staff at the Horton Hospital not identified Ben Geen earlier. Staff within the A&E department should be commended for their quick actions.

There are a number of clear messages from the report that can be used to further promote existing good practice and to improve practice in the future both clinically and corporately. Of those messages the key areas are:

- Whilst nothing could have been done to predict or prevent this incident, the report makes some recommendations on improving policies and processes which will help reduce the risk of a similar situation.
- Clinical governance policies, structures, systems and processes need to be strengthened.
- The identification of many areas of good practice that many other trusts can learn from.
- The report recognises the considerable work already undertaken in formally assessing the outcomes of the case.
- Work has already taken place since the incident to improve some of the processes relating to clinical governance.
- Ben Geen was effectively supervised throughout this period with staffing levels well above what is expected in an Accident & Emergency unit such as the Horton's.

Main recommendations

- Establish a Clinical Governance Framework incorporating an integrated clinical audit and effectiveness work programme
- Review and establish a systematic risk assessment in the Emergency Department
- Review the critical investigative infrastructure to better support the cycle for investigation, incident reporting forms being properly analysed and results used in service areas to inform staff and improve patient experience
- Review procedures for recruiting nurses straight from training, considering their progress, evidence of passed modules, outstanding modules and capacity to undertake the role for which they are being recruited
- Develop a standardised framework and guidance to enable the performance of staff to be recorded, particularly for all staff that undertake disciplinary interviews

- That controlled drugs are checked at every nursing shift change so that a robust audit system is in place if there should be a discrepancy found. Regular audits should be undertaken to ensure that controlled drugs are being used appropriately and all stock can be reconciled
- That packages of care should be established to meet the physical, emotional and mental health needs of patients who have been involved in a Serious Untoward Incident

Actions taken so far

Copies of the report have been circulated to the patients and relatives directly affected by Ben Geen's activities.

Copies of the report and a covering briefing note have been sent to the Department of Health Investigations Unit, the Ministerial Briefing Unit and the Chief Nursing officer. Oxfordshire Members of Parliament have also been briefed.

NHS South Central has already started discussions with the Oxford Radcliffe Hospitals NHS Trust (ORH) about the development of an action plan to implement the recommendations of the review. The review report will be formally considered by the ORH Board at their meeting in November 2006, following the SHAs approval of the recommendations.

Monitoring

The Director of Clinical Standards, will act as Lead SHA Director and Steve Appleton will be the designated SHA manager. A lead director and manager will be nominated by the Trust. The SHA will monitor progress on the action plan via biannual Board to Board performance meetings and by lead exec to exec meetings in between. The SHA lead manager will have monthly reviews with the Trust, with exception reporting to the Executive Team.

Work is underway to categorise and refine the recommendations, ensuring that there is a clarity about those actions where assurance is required through the presentation of evidence to the SHA .

Board action required

Following consideration of the report, the NHS South Central Board is asked:

- To approve the recommendations in the independent review report
- To instruct the Oxford Radcliffe Hospital Trust (ORH) to complete an action plan to demonstrate how it will implement the recommendations, and to agree that the SHA will performance manage the implementation of that action plan with the ORH
- To agree to circulate the report to other NHS South Central Trusts and PCTs. To distribute the report to the nine other English Strategic Health Authorities for them to disseminate to their organisations to ensure wider learning from this case
- To approve the monitoring arrangements

In conclusion

Fortunately incidents such as this are rare in the NHS. It is incumbent upon the NHS to ensure that governance is strengthened to ensure that robust checks and balances are in place to minimise the risk of any healthcare professional harming patients. The findings of this report will be used to build upon and improve clinical governance arrangements at the ORH and the lessons will be shared more widely with other parts of the NHS locally and nationally.

Steve Appleton
Head of Delivery and Service Improvement
November 2006

Erratum

Page 4 Paragraph 1.1.1 should read:

On the 10th May 2006 a 23 year old staff nurse, Benjamin Geen received a prison sentence of a minimum term of thirty years. This followed his conviction for two counts of murder and fifteen of grievous bodily harm to patients while they were in the Emergency Department at Horton General Hospital, Banbury. The incidents took place during a period of two months from December 2003 to February 2004 while he was working as a staff nurse in the Emergency Department at Horton General Hospital, Banbury.

Page 25 Paragraph 4.1.23 should read:

In May 2006 the trust was able to declare it's compliance with 40 of the 43 core standards within Standards for Better Health, with compliance on one standard already completed and two outstanding issues being worked towards.

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Thames Valley Strategic Health Authority

Confidential

**Horton General Hospital Emergency Department
Review Final Report**



**Produced by
Professor Pat Cantrill- Chair
Ms Rebecca Hoskins
Mr Darren Walter**

August 2006

Acknowledgments

Patients and Relatives

The External Review Team would like to thank patients and relatives for sharing their stories with us. They have spent over two years waiting for Benjamin Geen's criminal trial to take place and for their questions to be answered.

They have been at the centre of our thoughts as we have undertaken this review and we hope that it will answer some questions that remain for them. We cannot of course answer why Benjamin Geen did what he did or why he selected them or their relatives. We can however make sure that the stories they have shared help to inform others who plan and provide health services. The human side of this situation must not be lost.

The patients and relatives are a truly remarkable group of people who are striving to overcome a life changing experience.

Staff of Emergency Department and Horton General Hospital

Mr Justice Crane, the Judge at the criminal trial of Benjamin Geen said,

"It seems to me that I should first of all comment on something that must have struck anybody listening to the trial, and that is the dedication of the medical and nursing staff in dealing with these patients, and, of course, in more than two cases they not only revived but their lives were saved, and I think, if I may say so, the dedication of those other people, many of whom we heard give evidence, was extremely impressive and I think should be mentioned."

The External Review Team would like to express our gratitude to the staff of the Emergency Department, and the Senior Managers at Horton General Hospital for the honest and open way they have shared information with us. Like the patients and relatives, they have, waited a long time to share their stories and up to the time of the criminal trial had been unable to discuss with one another issues associated with the case because of the risk of affecting the outcome. They have experienced so much they have, questioned their judgement, their practice and have asked themselves if they could have done more. They are an outstanding group of individuals who as members of a close team have managed to handle the situation of coping clinically with the outcome of Benjamin Geen's actions and living with the knowledge that someone they have worked closely and shared social occasions with is someone who maliciously harmed people they were committed to care for. The Emergency Department team kept services running throughout the criminal trial, planning off duty and childcare around giving evidence in court. Their commitment and loyalty should not be underestimated.

Thames Valley Police

The Review Team would also like to thank the police officers that have been involved with the families and staff during the whole of this journey. Without exception everyone has expressed their gratitude for the support they have received at the most difficult of times.

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Section One

1.1 Reason for the report

1.1.1 On the 10th May 2006 a 23 year old staff nurse, Benjamin Geen received a prison sentence of a minimum term of thirty eight years. This followed his conviction for two counts of murder and fifteen of grievous bodily harm to patients while they were in the Emergency Department at Horton General Hospital, Banbury. The incidents took place during a period of two months from December 2003 to February 2004 while he was working as a staff nurse in the Emergency Department at Horton General Hospital, Banbury.

1.1.2 Responsibility for the murder and grievous bodily harm of the seventeen patients involved in this case rests with Benjamin Geen .At the point of sentencing Geen, Mr Justice Crane stated:

"It seems that you relished the excitement of that feeling of taking control, but you must have known quite well that you were playing with their lives. This was a terrible betrayal. You betrayed your nursing and medical colleagues and the vital profession of which you had been a member.

Most of all you betrayed the trust of the patients. They were in your care and you intentionally caused them huge damage."

1.1.3 There remain some questions still to be answered. Patients, relatives, local people, the staff of Horton General Hospital in particular, Oxford Radcliffe Hospitals NHS Trust and society generally need to have a better understanding of how Geen managed to undertake this activity, if his actions could have been identified earlier and what might be done to reduce the risk of this happening again.

1.1.4 An External Independent Review was commissioned by the Thames Valley Strategic Health Authority with the support of the Oxford Radcliffe NHS Trust. Following the publication of Commissioning a Patient Led NHS in July 2005, and a subsequent consultation, Thames Valley Strategic Health Authority has been merged with Hampshire and Isle of Wight Strategic Health Authority. On 1st July 2006 NHS South Central replaced those two bodies. The new Strategic Health Authority will receive the report and will manage the implementation of the recommendations with the Trust. The report will be placed in the public domain and it is anticipated that both the Oxford Radcliffe Hospitals NHS Trust and NHS South Central will use the report as a means of sharing learning and experiences across the wider health community.

- 1.1.5 This report should not be considered as a judicial opinion based on rigorous investigation of evidence as required in Civil or Criminal Courts. Any issues or concerns identified are a reflection of the evidence made available to us with benefit of hindsight and the application of foresight.
- 1.1.6 This report has been produced from analysis of information made available to us as a result of reviewing available documentation, management reviews of the performance of services and one to one interviews of key participants. We have additionally reviewed national policy documents of significance to this case. All of the information supplied has formed the basis for identification of key issues and subsequent recommendations to support the provision of best practice by services in future. See Appendix One for a list of documents and reports used as part of the review.

1.2 Terms of reference

The review team will: -

- Review the systems and processes in place in the Emergency Department of Horton General Hospital, Banbury prior to, during and following the incidents, which occurred from December 2003 to February 2004. The review should include: -
 - a. Risk management arrangements
 - b. Learning from untoward incident reporting
 - c. Record keeping systems.
- Review the systems and processes in place in the Emergency Department at the Horton General Hospital, as a consequence of the original internal investigation and how these are monitored. Determine if they were consistent with current policies, guidance, procedures and best practice.
- Review the management, provision and quality of healthcare in the Horton Emergency Department to keep patients safe in respect of medication administration.
- Review the management and support of patients and relatives once untoward incidents are identified
- Review the mechanisms in place to minimise the risk of a similar incident arising in the future.
- Identify the lessons to be learned from analysis of the review, provide clear conclusions and make any appropriate recommendations for continuing service improvement.

1.3 External Review Team Members

Professor Pat Cantrill, Independent Consultant and Chair of the External Review Team

Ms Rebecca Hoskins, Emergency care Nurse Consultant, Bristol Royal Infirmary

Mr Darren Walter, Emergency Medicine Clinical Director, Wythenshawe Hospital, South Manchester University Hospitals NHS Trust

For biographical details see Appendix one

1.4 Period covered by the review

November 2002 to June 2006

Section Two

2.0 Executive Summary

- 2.1 On the 10th May 2006 a 23 year old staff nurse, Benjamin Geen was convicted of two counts of murder and fifteen of grievous bodily harm to patients while they were in the Emergency Department at Horton General Hospital, Banbury. The incidents took place during a period of two months from December 2003 to February 2004 while he was working as a staff nurse in the Emergency Department at Horton General Hospital, Banbury.
- 2.2 In June 2006 the Thames Valley Strategic Health Authority with the support of the Oxford Radcliffe NHS Trust commissioned an External Independent Review. Subsequently Thames Valley Strategic Health Authority has merged with Hampshire and Isle of Wight Strategic Health Authority and has been replaced by NHS South Central.
- 2.3 The purpose of the External Review and the report is not to blame individuals or services but to identify lessons to be learnt to improve the performance of services in relation to safeguarding patients in the future.
- 2.4 As part of the review the External Review Team had discussions with all the patients and families who wanted to share their story. The major issue for many families was that while, the Trust made attempts to keep the patients and families fully informed the Trust did not meet their clinical and psychological needs. The Trust's contact with patients and families was adversely influenced by an anxiety that contact with the families might cause difficulties for the police investigations. This, alongside the lack of a fully developed communications strategy, led to some patient's and relative's feeling neglected by the Trust.
- 2.5 The External Review Team is very aware from conversations with patients, relatives and staff that three key questions needed to be addressed:
- How was he able to do it?
 - How did he manage to harm patients for so long?
 - How can this be prevented from happening again?
- 2.6 The External Review Team has attempted in the review to answer these questions and have used them with the terms of reference to frame the report.

How was he able to do it?

It is the External Review Team's view, as described in section 4 of the report, that a combination of factors provided an opportunity for Benjamin Geen to harm patients. These include the selection of vulnerable patients, the winter period and fact that he was the only person involved with all seventeen patients. As a Registered Nurse he was able to access drugs and deliver clinical care that provided an opportunity for him to harm patients

How did he manage to harm patients for so long?

The External Review Team has identified that whilst Benjamin Geen was criminally active for 64 days in fact he caused patients to deteriorate on 15 days spread over 64 days. While there is some change in the statistics with an increase from December 2003 in the number of patients who experienced a respiratory arrest, this increase could readily have been attributed to the winter months' variation. It must also be remembered that any data is being retrospectively analysed and significant evidence was only available at the beginning of February 2004. The rise in unexplained events in a department dealing with sick patients constantly appears to have been identified quickly. It is External Review Team's view after examining all the evidence that the clinicians identified there were problems as quickly as possible and took the required action.

- 2.7 In section four of the report, the major issues have been explained in detail and recommendations have been made which reflect not only on the Oxford Radcliffe Hospitals need to review some areas of their organisation and other health providers and commissioners of health care need to compare the findings against their own organisational structures and performance.
- 2.8 The External Review Team has made a number of recommendations that will strengthen clinical governance, medicines management and workforce issues in the Trust generally and specifically at Horton General Hospital. The issues raised, while important in reducing the risk of poor or malicious practice, will not on their own, prevent anyone with malicious intent from harming patients. It was the concerns of individual clinicians that led to identification of Benjamin Geen's activities rather than policies, systems and processes. The changes suggested are to strengthen the Trust's clinical governance, which will help to reduce the risk of a similar situation recurring.
- 2.9 The Emergency Department team and hospital managers must be praised for the way they kept services running throughout the trial, planning off duty and childcare around giving evidence in court. The planning for this to take place efficiently to maintain services and for staff to appear in court was logistically a great challenge. Guidance for

staff about appearing in court was developed and opportunity for staff to spend time in court familiarising themselves provided. There are positive lessons to be learned from the handling of this situation that should be used to inform others.

- 2.10 The External Review Team has examined carefully all the evidence in the case and feel that whilst there are improvements that can be made in policies, structures and cultures the responsibility for the murder and grievous bodily harm of the seventeen patients involved in this case rests with Benjamin Geen and that it is the skills and knowledge of the nurses and doctors at Horton General Hospital that quickly identified his activities and prevented the outcome of his actions from resulting in more deaths and injuries.

At the point of sentencing Geen, Mr Justice Crane stated:

"It seems that you relished the excitement of that feeling of taking control, but you must have known quite well that you were playing with their lives. This was a terrible betrayal. You betrayed your nursing and medical colleagues and the vital profession of which you had been a member.

Most of all you betrayed the trust of the patients. They were in your care and you intentionally caused them huge damage."

Section Three

3.0 Summary of the Case and Background to the report

3.1 The Oxford Radcliffe Hospitals NHS Trust

The Oxford Radcliffe Hospitals NHS Trust is one of the largest acute teaching hospital trusts in the United Kingdom. It consists of four hospitals :

- The John Radcliffe Hospital in Headington, Oxford
- The Churchill Hospital in Headington, Oxford
- The Radcliffe Infirmary in Central Oxford
- The Horton General Hospital in Banbury

The Trust provides general acute services to an Oxfordshire catchment population of approximately 626,000 as well as specialist regional and national services. The majority of the remainder of the Trust's activities serve populations in Northamptonshire, Buckinghamshire, Berkshire, Wiltshire and Gloucestershire. The volume of services provided for patients is approximately three times the English average for a trust. The Trust currently employs just under 10,000 people and has around 1600 beds. In 2005-6 the Trust had a turnover of £475 million.

The population

Oxfordshire has a population of 605,492¹. The population has a low level of deprivation as a whole and the age structure of the population is similar to the national picture. (Townsend, Carstairs and Jarman measures²)

National indicators show that the population of Oxfordshire has a fairly low rate of illness compared with the national average. The standardised permanent illness rate for women is approximately 60% of the national average and for men 50%. This indicates that for permanent illness in particular, the county experiences considerably better health than the country as a whole.

Banbury is a market town on the River Cherwell in Oxfordshire. It had a population of 42,802 at the 2001 census, but due to rapid expansion is now in excess of 50,000. Banbury is part of the Cherwell District in North Oxfordshire.

¹ Census data 2001. National Statistics

² DoE, Jarman, Carstairs and Townsend scores for wards in England and Wales (calculated using England & Wales as the population base.)

3.2 The Horton General Hospital

The Horton General Hospital was opened as Horton Infirmary on 17 July 1872, to serve the growing population in the area; there were two wards, men's and women's, and a total of twelve beds.

Over the years the hospital has extended and developed and is much loved by the local community it serves. The Hospital became a National Health Service Trust in April 1993 and was merged with the Oxford Radcliffe Hospitals NHS Trust on 1st April 1998.

The Horton General Hospital in Banbury serves the population in North Oxfordshire and surrounding areas. It has 236 beds and is an acute general hospital providing a wide range of services, including:

- emergency department
- general surgery
- acute general medicine with a medical assessment unit
- trauma & orthopaedics
- obstetrics and gynaecology
- paediatrics
- critical care unit used flexibly for intensive care
- coronary care
- cancer resource centre

The majority of these services have inpatient beds and outpatient clinics, with the outpatient department running clinics with visiting consultants from Oxford in dermatology, neurology, physical medicine, rheumatology, ophthalmology, radiotherapy, oral surgery and paediatric cardiology.

Acute general medicine also includes a short stay admissions ward, a medical assessment unit, a day hospital as part of specialised elderly care rehabilitation services, and a cardiology service.

In August 2006 orthopaedic services moved into a new independent sector treatment centre built on the Horton site managed by Capio. The Hospital employs 1,200 people, making it one of Banbury's biggest employers. The local community takes great pride in the Hospital and provides exceptional levels of volunteer support.

The Oxford Radcliffe Hospitals NHS Trust, as part of a performance improvement and cost reduction exercise, is undertaking a consultation process. The proposals recommended for Horton General Hospital include the maintenance of the Emergency Department at Horton General Hospital with:

- Additional consultant presence and service enhancement to meet out-of-hours cover to modern standards

- Higher grade resident out-of-hours cover
- Enhanced paediatric life support skills

Other changes proposed are identified at appendix 3

3.3 **The Emergency Department**

'Reforming Emergency Care 2001'³ provides a strategy for the development of emergency care based on six key principles

- *services should be designed from the patient's point of view;*
- *patients should receive a consistent response, wherever, whenever and however they contact the service;*
- *patients' needs should be met by the professional best able to deliver the service;*
- *information obtained at each stage of the patient's journey should be shared with other professionals who become involved in their care;*
- *assessment or treatment should not be delayed through the absence of diagnostic or specialist advice;*
- *and emergency care should be delivered to clear and measurable standards.*

Every area of a patient's journey, from the point of contact with the ambulance service or attendance at the emergency department to discharge or admission to hospital, was reviewed and the way services might be improved identified." See and Treat" services using a variety of models and skilled clinicians have been established throughout the country. The aim was improve services to enable a patient to move from one part of the health service to another without barriers or delays.

Whilst the changes have made a considerable difference to the delivery of emergency services planning and delivery, they remain challenging and an unpredictable area to work.

The emergency department of any hospital is different each and every day and can quickly shift from the quietest to the most hectic department in the hospital in literally a matter of minutes. The types of patients that come to the emergency department for care as well as the numbers of patients that attend hospital emergency departments often depend on situations like the weather, accidents, industrial accidents, and hundreds of other unfortunate incidents.

A doctor or nurse choosing to work in emergency care has to be able to cope with unpredictable workloads and complexity of cases and for patients of all ages. From a patient with a sprained ankle to a seriously ill patient as a result of a medical condition or serious accident, the service and staff have to be able to respond quickly, with a high level of

³ Transforming Emergency Care in England –Professor Sir George Alberti DH October 2004

competence, and not lose sight of the needs of individual patients and their families.

Horton General Hospital Emergency Department

The Emergency Department at Horton General Hospital faces the same challenges in the provision of services as any other. While small in size and in relation to the number of patients seen (35,000 attendances every year) it meets the needs of patients with minor injuries and illnesses and major accidents and illnesses. Patients requiring major trauma treatment, neurosurgical or vascular assessment are not currently brought to the Horton General Hospital Emergency Department but are taken to the John Radcliffe Hospital in Oxford. This has been the protocol for many years. Links are in place with the ED at the John Radcliffe Hospital and the two departments are managed together as part of the emergency medicine, acute general medicine and gerontology directorate of Division A.

The emergency department has implemented the key principles of *Reforming Emergency Care* with well - developed triage, and see and treat services in place supported by senior nursing staff with extended skills, including emergency nurse practitioners and a practice development nurse. The consultant nurse in emergency care also supports the emergency department.

The GP out of hours services is located adjacent to the emergency department.

Like any other emergency department it has to provide services that are flexible, highly competent and able to cope quickly when a patient presents with a life threatening condition. The key to efficient working in an emergency department is the ability to work as an effective team, each individual's skills, knowledge and competence used appropriately, each understanding his or her responsibilities and what they are accountable for. The team must reflect on its practice and performance and address clinical governance requirements. The Emergency Department at Horton General Hospital has a well established and experienced team who reflect these key principles.

3.4 Benjamin Geen

- 3.4.1 In October 1999 Benjamin Geen commenced a Diploma of Higher Education in Nursing at a University . For the next three years he was a student undertaking clinical placements in a variety of health and social care settings. While he received satisfactory reports from his clinical practice, Geen struggled with the academic part of the course that resulted in him having difficulty in attaining the required standards

to achieve the Diploma and therefore register as a First Level Nurse⁴. He attempted to secure a pass level twice before he left the University in October 2002 and twice as an associate student in January 03 and finally secured a pass at the fourth attempt in April 2003. Securing this final assignment meant he could register with the Nursing and Midwifery Council (NMC) as a First Level Nurse.

- 3.4.2 On October 10th 2002 he was interviewed for a post as Staff Nurse in the Emergency Department of Horton General Hospital and was offered the post, subject to satisfactory references, health clearance and NMC registration. He was advised that he would be paid at C grade until he had received his registration.
- 3.4.3 After receipt of satisfactory references and occupational health clearance, he commenced work at Horton General Hospital on 18th November 2002 as a Health Care Assistant whilst he waited for his examination results. He attended an induction to the Trust. As he had failed a modular assignment 'Work experience –aspect of care', he could not register with the NMC and was therefore continued to be employed as a Health Care Assistant. Although he received additional support from the Lecturer Practitioner who worked in the Department, he again failed to achieve the required standard in his assignment in January 2003. An agreement was made to continue his employment with the Trust as a health care assistant until 18th May 2003. He was informed that failure to register might result in termination of his contract. Geen was awarded the Diploma of Higher Education in Nursing at the University Board of Examiners held on 7th April 2003. This meant he could then register with the Nursing and Midwifery Council (NMC) as a First Level Nurse.
- 3.4.4 There was some early concern about Geen working beyond the level to which he had been employed as a health care assistant. This is discussed further in at 4.1.47
- 3.4.5 From April 2003 to February 2004 Geen undertook a number of professional development courses to equip him to extend his role as a staff nurse. He is said to have been a committed and enthusiastic member of staff. While there was concern that his confidence at first was far greater than his competence, the feeling is that gradually with experience this began to change. Senior nurses in the Emergency Department had discussed the fact that Geen preferred working in the areas of the department where the most ill patients were cared for, particularly the resuscitation room. Their concerns related to him getting sufficient experience of working with patients with minor illnesses or injuries so that he consolidated his training and had a breadth and depth of knowledge and experience of emergency

⁴ Statutory Instrument 2004 No. 1765 Nurses and Midwives (Parts of and Entries in the Register) Order of Council 2004

nursing. It is not unusual for nurses to have a preference to work in a particular area or with a specific client group and therefore his inclination to work with patients requiring a more major input or resuscitation was not a factor on its own that should have caused concern about any malicious intent.

3.4.6 During this period Geen, was also a Combat Medical Technician and after qualification he became Lieutenant in the Territorial Army Medical Services where he would have received training to deliver an extended role.

3.4.7 During Thursday 5th February 2004, two patients experienced unexpected respiratory arrests shortly after arriving at the Emergency Department at Horton General Hospital. One patient also exhibited a rapid but unexpected drop in blood sugar, recovering uneventfully following a period of mechanical ventilation and the provision of intravenous glucose.

3.4.8 This day was the point when the nurses, the consultant in the Emergency Department and consultants in medicine and anaesthesia from the hospital raised and discussed concerns about the unexpected and unexplained clinical pathway for the two patients while in the Emergency Department. The patients had health problems that should not have resulted in them experiencing a respiratory arrest. There was recognition that something was wrong, however, there was no clear indication at that stage of any malicious intent.

Separately, physicians and anaesthetists involved in the care of a number of patients who had experienced a respiratory arrest and required resuscitation and then intensive care were discussing what they felt was an increase in the incidence of patients requiring resuscitation, particularly unexpected and difficult to explain cases. On the morning of Friday 6th February 2004 they reported their concerns to the Head of Clinical Risk for the Trust and the Director of the hospital was informed.

3.4.9 The Chief Nurse, in her capacity as Executive lead for governance was contacted and a Serious Incident Investigation (SUI) was immediately initiated on 6th February 2004. The SUI team met to establish the position, reviewing patient case notes and also staffing records. It became clear that in those cases of the patients where there was concern, the consistent factor was that Benjamin Geen was on duty when the patients attended the Emergency Department. Discrete enquiries determined that Benjamin Geen had gone off duty because of illness that day and was off duty for the weekend of 7th and 8th February 2004. This reassured the SUI team that patient safety would not be an issue over the weekend and that further, more detailed investigation could take place.

3.4.10 Following extensive work over the weekend by medical, nursing and medical records staff, by Monday 9th February 18 patients had been

identified as having had an unexplained respiratory arrest and/or hypoglycaemia during the previous 8 to 10 weeks. After further consultant peer review of the 18 patient records, where all possibilities were considered, 10 remained unexplained. Although many of the patients were elderly and/or very unwell, most of these 10 patients were able to communicate when they arrived at the Emergency Department and their condition had rapidly and unexpectedly deteriorated.

3.4.11 There was some consistency in the clinical progress of these patients in that following nurse triage and intravenous cannulation, the patients developed some or all of the following:

- The patient's breathing rate became seriously depressed, even leading to respiratory arrest.
- In some cases their blood sugars appeared to fall rapidly.
- Some patients showed signs similar to opiate overdose.

3.4.12 As a result of the SUI investigation, the police were finally provided with the case notes of 25 patients as warranting further investigation. These patients had been in the Emergency Department in the period from December 2003, during January 2004 and the first week of February 2004.

3.4.13 Further review of staffing records in the Emergency Department identified that a single member of nursing staff, Benjamin Geen appeared to be the consistent factor in the care of all of the patients. On Monday 9th February 2004 Benjamin Geen was placed on special leave and arrested by Thames Valley Police.

3.4.14 Thames Valley Strategic Health Authority (TVSHA), the Nursing and Midwifery Council (NMC) and the Chief Nursing Officer for the Department of Health were informed. On 16th February the DoH procedure for issuing alert letters for health professionals was implemented. Subsequently the Nursing and Midwifery Council issued a temporary suspension of Benjamin Geen from the Register, preventing him from practicing legally as a qualified nurse.

3.4.15 The NMC imposed an Interim Suspension in the public interest for the protection of the public. This interim measure prevents a Practitioner from working as a nurse until their case has been completed or the Order is revoked at a review hearing.

3.4.16 On the 10th May 2006, Benjamin Geen received a prison sentence of a minimum term of thirty-eight years. This followed his conviction for two counts of murder and fifteen of grievous bodily harm to patients while they were in the Emergency Department at Horton General Hospital, Banbury. He was acquitted in the case of one patient. The criminal trial at Oxford Crown Court showed the probability that Geen injected the

patients with lethal doses of insulin, muscle relaxants and sedatives, which led to their clinical deterioration.

The Detective Superintendent who led the murder investigation, said:

"Ben Geen abused his position of trust. "We may never know what motivated him to select and poison his victims. "It is clear that he wanted to be the centre of attention and in order to fuel this desire, brought some of his patients to the brink of death and coldly murdered two of them."

3.5 Patients and Relatives

- 3.5.1 As identified at 1.1.1 Benjamin Geen was found guilty of two counts of murder and fifteen of grievous bodily harm of patients. His actions followed no specific pattern in relation to dates, days or frequency.
- 3.5.2 Of the seventeen patients, two were aged between twenty and forty-nine, seven between fifty and sixty nine and eight between seventy to eighty nine years. Eleven patients were male and six female. Twelve of the patients were brought to the Emergency Department by ambulance and five by car or taxi.
- 3.5.3 Attending an Emergency Department makes most patients vulnerable because of illness or injury and anxiety. Most of the patients' level of vulnerability increased because they were elderly and some had mental health problems.
- 3.5.4 Two patients subsequently died and the Home Office Pathologist made the connection of their deaths to BG's actions.

Section Four

4.0 Findings and Recommendations

The majority of health care providers, commissioners and practitioners will never be involved in a case of deliberate malicious poisoning by a health care professional during their working lives. As stated by Lord Clothier in the case of the nurse Beverly Allitt,

‘The idea of a nurse deliberately taking the lives of patients who they were responsible for is almost unthinkable. Individuals and organisations cannot plan for the truly extraordinary’⁶.

Benjamin Geen set out over a period of 64 days to cause the respiratory arrest of some of the most vulnerable patients admitted to the Emergency Department at Horton General Hospital. There is evidence to suggest that he would have continued his activities and harmed even more people if staff at the hospital had not identified him and his actions.

How was he able to do it?

One of the key issues raised by patients and relatives and the media has been “How was he able to commit his crimes and remain undetected?”

It is the External Review teams belief that a combination of factors gave him the opportunity to harm people, such as:

- He was a qualified nurse, giving him access to prescription only drugs. He used different agents and combinations of drugs and other substances, which made it less obvious in relation to both, drug usage and patient diagnosis.
- He was able to undertake procedures such as cannulation or venepuncture as a First Level Nurse who had achieved the appropriate level of competence.
- His selection of vulnerable patients.
- Events occurred during the winter period when there is normally an increase in the number of people with respiratory distress and anticipated increase in respiratory arrests.
- The number of different staff involved at the time of the respiratory arrest of patients meant that no other person was directly involved in all events. Geen was the only consistent

⁶ Independent Inquiry relating to deaths and injuries on the children's ward at Grantham and Kesteven General Hospital.
London: HMSO, 1994

member of staff involved; he was the only one with an overview of all seventeen patients.

- Benjamin Geen commenced work at the Emergency Department at Horton General Hospital on the 18th November 2002 and therefore had worked as a member of the team for over a year before he harmed the first patient.
- When a nurse or any other health care professional works as a member of a departmental or ward team, they work in a culture of trust, particularly in small units like the Emergency Department at Horton General Hospital. Some people have emphasised comments made by Geen and others about patients requiring resuscitation when he was on duty. With hindsight it is easy to reflect that this should have pointed to his activities, but it is not uncommon for this type of comment heard in hospitals.

How was he able to do it for so long?

This is the question most frequently asked and the External Review Team has considered it at length. As previously stated the period over which Benjamin Geen was criminally active was 64 days. In fact he caused patients to deteriorate on 15 days spread over 64 days. While there is some change in the statistics with an increase from December 2003 in the number of patients who experienced a respiratory arrest, this increase could readily have been attributed to the winter months' variation. It must also be remembered that any data is being retrospectively analysed and significant evidence was only available at the beginning of February 2004. Respiratory distress and or arrest are common in emergency care but sudden, unexpected and unexplained cases are rare. The number in December 2003 was six and this was only one more than in December 2002. Anyone monitoring the frequency on a monthly basis would not necessarily have perceived a cause for alarm. The key month was January 2004 because of the unprecedentedly high frequency of event incidence in two consecutive months. From an auditing perspective it would not necessarily have been known until the end of the month of January or even into February 2004.

The rise in unexplained events in a department dealing with sick patients appears to have been identified quickly, with clinicians bringing it to the attention of the Head of Clinical Risk in the first week of February 2004.

What can be done to stop this happening again?

The External Review Team has taken the first four areas identified in the terms of reference to formulate this section and has identified and incorporated the mechanisms that are now in place to minimise the risk of a similar incident as part of the issues covered.

- 4.1 Review the systems and processes in place in the Emergency Department of the Horton General Hospital, Banbury prior to, during and following the incidents, which occurred from December 2003 to February 2004. The review should include: -**
- a Risk management arrangements**
 - b Learning from untoward incident reporting**
 - c Record keeping systems.**

Background

- 4.1.1 The development and implementation of understandable and specific statements of standards of care expected of health services and from the professionals that deliver them is a challenge for health care. There is, however, a growing understanding of the whole issue of reducing risk to patients based on analysing and learning from errors and adverse events.
- 4.1.2 Patient safety is a high priority for the Government and professional and regulatory bodies, resulting in a number of Department of Health initiatives beginning with, “An Organisation with a Memory⁷” and the latest report, “Good doctors, safer patients⁸”.
- 4.1.3 Failures in standards of care can present in a variety of different ways, for example, sometimes they occur:
- as apparently completely unexpected events which result in harm to, or even the death of, a patient e.g. where the wrong drug or the wrong dose of drug is administered;
 - as poor or unsatisfactory outcomes of care from a service performing below standard.
 - when patients are put at risk by a practitioner whose performance is impaired due to inadequate knowledge, skills, ill health or dysfunctional conduct or
 - when a practitioner deliberately sets out to harm or kill patients.
- 4.1.4 Currently in the UK there are clear, comprehensive frameworks, which guide the NHS to embed quality assurance, quality improvement and patient safety in all day-to-day activities and enable their performance to be measured. They are “*Standards for Better Health*” and Clinical Governance.

⁷ An organisation with a memory- Department of Health Expert Group (Chairman, CMO) 13/06/2000

⁸ Good doctors, safer patients- Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients. Department of Health July 2006. *A report by the Chief Medical Officer*

4.1.5 In April 2005 a new performance framework for the NHS was introduced, “*Standards for Better Health*”⁹, the standards of care expected of all organisations. The Standards describe the level of quality that healthcare organisations, including NHS Foundation Trusts, and private and voluntary providers of NHS care, *will be expected to meet in terms of safety; clinical and cost effectiveness; governance; patient focus; accessible and responsive care; care environment and amenities; and public health.* Trusts were expected to prove compliance with these standards by April 2006.

4.1.6 The purpose of clinical governance is to ensure that patients receive the highest quality of NHS care possible. It covers organisational systems and processes for monitoring and improving services, including:

- consultation and patient involvement
- clinical risk management
- clinical audit
- research and effectiveness
- staffing and staff management
- education, training and continuing personal and professional development
- the use of information about the patient experience, outcomes and processes.

Effective clinical governance should therefore ensure:

- continuous improvement of patient services and care
- a patient centred approach
- a commitment to quality,
- health professionals that are up to date in their practices and properly supervised where necessary
- the prevention of clinical errors wherever possible and the commitment to learn from mistakes and sharing that learning with others

4.1.7 In “Good doctors, safer patients”¹⁰, the Chief Medical Officer identified that the major challenge is establishing:

“A more rigorous approach is needed to implementation, because the framework still falls short of its full potential. For example, clinical governance is a strong feature of some services but largely lacking in others; the size of the problem of unsafe care is well documented but

⁹ Section 46 of the Health and Social Care (Community Health and Standards) Act 2003 sets out the legislative basis for the Healthcare Standards.

¹⁰ Good doctors, safer patients- Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients. Department of Health July 2006. A report by the Chief Medical Officer

there are few instances yet where risk has been systematically reduced; and few chief executive officers of health organisations match the depth of their fear of missing budgetary and productivity targets with the strength of their passion to improve quality and safety of services for their consumers.

In the best healthcare organisations in the world, the ‘business plan’ and the ‘quality plan’ are one and the same.”

4.1.8 As identified by the Chief Medical Officer,

Ironically in contrast, standard setting by professional bodies has a long and strong tradition and has made a very important contribution to improving the quality of professional practice and training.²

4.1.9 There are 680,000 registered nurses, midwives and health visitors practicing in the United Kingdom, the vast majority of whom provide care of a high standard, but a small proportion will provide care that is not acceptable, because of a lack of knowledge or required skills, insufficient support, ill health, lack of motivation, or, on rare occasions, malice. The Nursing and Midwifery Council regulates the practice of nurses and midwives.

The Nursing and Midwifery Council (NMC) is the organisation established by Parliament to protect the public by ensuring that nurses and midwives provide high standards of care to their patients and clients. The Nursing and Midwifery Order 2001(SI 2002/253)¹¹ prescribes the function of the NMC.

To achieve its aims, the NMC: maintains a register of qualified nurses, midwives and specialist community public health nurses and sets standards for conduct, performance and ethics .It provides advice for nurses and midwives and considers allegations of misconduct, lack of competence or unfitness to practise due to ill health.

4.1.10 Clinical audit forms a key pillar of clinical governance. Comparing measured performance against agreed standards, it aims to identify where improvements in patient care can be made and how they can be achieved. The clinical audit cycle includes; setting/agreeing standards of care, examining current practice, comparing practice to the standards and implementing change. The cycle is closed by reassessing to ensure that the change has produced an improvement, if not achieved full compliance. It is a continuous process. Clinical audit should facilitate the change in culture towards more evidence-based practice. Clinical audit can also be used to measure the outcomes of care including patient satisfaction.

4.1.11 Managing risk is also a key facet of the clinical governance agenda and the strategic management of all health care commissioners and providers. It is by managing risk that the safety of patients, the public

¹¹ The Nursing and Midwifery Order 2001(SI 2002/253)

and staff can be assured. It is the process by which the risks attaching to any activity are identified and addressed with the goal of achieving effective outcomes within each activity and across the portfolio of all activities. The challenge for a Trust like the Oxford Radcliffe Hospitals is for risk management to be consistent and constant throughout the organisation's culture, its strategy and the implementation of that strategy.

A Risk Management Standard ¹² should:

- Be integrated into the culture of an organization
- Support performance development and management
- Address methodically all the risks associated with activity, past present and in the future
- Provide a framework to enable future activity to take place in a consistent and controlled manner
- Improve decision making, planning and prioritisation
- Contributing to more efficient use of resources
- Develop and support staff.

Oxford Radcliffe Hospitals NHS Trust and Horton General Hospital

4.1.12 The External Review Team examined a number of reviews and reports associated with development of clinical governance at the Trust to establish the environment prior to, during and after the serious incident.

4.1.13 The Healthcare Commission¹³ publishes performance ratings for NHS organisations each year and, up to the year ending 31 March 2006, used a star rating. They assessed areas associated with, waiting times for hospital treatment, access to GPs and response times of ambulances, as well as the management of finances and the handling of patients and staff. The Oxford Radcliffe Hospitals NHS Trust has scored:

Performance rating 2005: two stars

Performance rating 2004: two stars

Performance rating 2003: one star

In the first Annual Health Check, published in October 2006 the Trust received a rating of good for quality of services and weak in the use of resources

The Trust has also achieved a level 1 rating for its general services from the Clinical Negligence Scheme for Trusts (CNST) and, in October 2006 was awarded CNST level 2 for its maternity services.

4.1.14 In 2000 an external review of cardiac services at Oxford Radcliffe Hospitals NHS Trust recommended an early Commission for Health

¹² A Risk Management Standard 2002 .IRM,AIRMIC and ALARM

¹³ The Commission for Health Improvement became the Healthcare commission in April 2004

Improvement review. A clinical governance review¹⁴ was conducted between April 2001 and August 2001. The major issues at that time were identified as:

- *feedback to areas on reported incidents is inconsistent.*
- *incident reporting forms were described by one member of staff as 'disappearing into a black hole'.*
- *the way the trust had responded to some incident reporting forms did not support 'a no blame culture' .*

4.1.15 Key areas for action were said to be that the Trust needed to:

- *identify how the separation of clinical and non-clinical risk will be managed in readiness for the pending convergence.*
- *provide appropriate risk management training for all disciplines and grades of staff to ensure employees are aware of their individual and collective responsibilities.*
- *ensure that all incident reporting forms are properly analysed and results are used in service areas to inform staff and improve patient experience.*
- *raise staff awareness, at strategic and operational levels, of its responsibility to achieve substantive compliance against the 19 standards within controls assurance.*
- *produce an annual audit programme that takes into consideration trust wide data and information and local need.*

External Review

Clinical Governance

4.1 .16 As we were requested to; "*Review the systems and processes in place in the Emergency Department of the Horton General Hospital, Banbury prior to, during and following the incidents, which occurred from December 2003 to February 2004*", we have spent some time assessing the clinical governance structures in place during this time frame.

4.1.17 While we do not believe that this was a significant factor in relation to this incident, we have identified below what we feel are key issues and subsequent recommendations. It was the concerns of individual clinicians that led to identification of Benjamin Geen's activities rather than policies, systems and processes. The changes suggested would strengthen the Trust's clinical governance, which will help to reduce the risk of a similar situation recurring.

4.1.18 What is clear from reports and reviews and in discussions with staff in the Trust, is that Clinical Governance policies, structures, systems and

¹⁴ Report of a clinical governance review at Oxford Radcliffe Hospitals NHS Trust December 2001 Commission for Health Improvement

processes need to be strengthened .The report undertaken by the Commission for Health Improvement in December 2001¹⁴ identified the key areas requiring improvement (4.1.14 and 4.1.15).

- 4.1.19 The Trust needs to develop a clear Clinical Governance Framework, which reflects the needs of the Trust as a whole and those of Horton General Hospital in particular, supporting staff to identify with the principles of clinical governance and recognise the policies, structures and systems in place. There needs to be a system, effective throughout the organisation, with demonstrable horizontal and vertical integration to capture Directorate and Divisional activity within a whole trust strategy.
- 4.1.20 As it is the Divisional and Corporate teams that appear to provide the steer for developments in governance, it is difficult for Horton General Hospital staff, without a framework and at a distance, to understand the requirements placed upon them and to be actively involved in Trust-wide audit cycles and incident reviews. There are a number of factors that have led to this position these include, staffing changes and a reduction in the resource available across the Trust and so capacity in the clinical governance team. These are issues also identified by the Commission for Health Improvement.
- 4.1.21 The Trust recognised some weaknesses, particularly in linkages within the clinical areas and in the integration of governance. This resulted in some changes taking place in the last eighteen months in the organisation and management of governance, risk and quality. The Chief Nurse was designated as the executive lead for governance and risk in 2004, non clinical and clinical risk were brought together and a new appointment of Assistant Director of Quality and Risk was made in October 2005. This appointment has the potential to provide a focus for strategic and operational initiatives if he receives the support of Divisional and Directorate managers and clinicians and may start the cultural shift towards a more fully integrated system.
- 4.1.22 The Trust has already reviewed the terms of reference for the Governance Committee, the Quality and Risk Committee and regular reports are made by the QRMC to the Executive Board, particularly highlighting serious incidents and the follow up of complaints.
- 4.1.23 In May 2006 the Trust was able to declare its compliance with 41 of the 43 core standards within Standards for Better Health, with compliance on the two outstanding being achieved by the end of June 2006.

Audit

¹⁴ Report of a clinical governance review at Oxford Radcliffe Hospitals NHS Trust December 2001 Commission for Health Improvement

4.1.24 In December 2001 the Commission for Health Improvement ¹⁴ identified in their report of the clinical governance arrangements at the Oxford Radcliffe Hospitals NHS Trust that:

- *The trust has no formal annual audit programme.*
- *There was also little evidence that audit topics were a result of complaints, patient views or high quality impact analysis.*
- *Audits that are undertaken are usually locally driven by clinicians*
- *Across the Trust CHI found a low level of patient involvement in clinical audit.*
- *There is little evidence of multidisciplinary audit within the trust; apart from infection control and maternity services CHI found that the majority of audits were medically driven*
- *Feedback to areas on reported incidents is inconsistent. Incident reporting forms were described by one member of staff as 'disappearing into a black hole'.*
- *Although during some interviews the Trust was described as having 'a no blame culture' CHI were told that the way the Trust had responded to some incident reporting forms did not support that culture*

4.1.25 There is evidence to suggest that, following the Commission for Health (CHI) Improvement Report; progress was made in relation to the clinical governance agenda, led by the Director of the Clinical Governance Support Unit, the Assistant Medical Director (working to the Medical Director and the Chief Nurse).

The Trust developed a detailed action plan in response to the CHI Clinical Governance Review and implementation of its recommendations was monitored by TVSHA, the Executive Board and the Governance Committee. The action plan covered all the points raised by CHI including the co-ordination of clinical and non clinical risk, a unified incident reporting procedure (with associated training), the development and agreement of the SUI process, establishment of a trust-wide audit programme, the review of incidents, comments and complaints by directorates and divisions, and the provision of quarterly analyses on these by the clinical information team. In addition, a trust-wide database of audits was in place. The action plan was signed off by the TVSHA in February 2005, as noted formally by the Governance Committee in March 2005. The implementation of the action plan was significantly affected when the Assistant Medical Director left and the support unit was reorganised with the level of staffing reduced substantially as a result of significant financial pressures across the Trust. The Trust has placed emphasis and transferred resource into the three Divisional structures. The appointment of clinical governance

¹⁴ Report of a clinical governance review at Oxford Radcliffe Hospitals NHS Trust December 2001 Commission for Health Improvement

coordinators for each Division has continued although there have been periods when the posts have not been filled which has impacted on clinical governance activity. (See Appendix 3 for Divisional structures).

4.2.26 Divisions are responsible for their audits and audit plans and for taking account of outcomes of audits. Clinical governance co-ordinators and other staff support and facilitate this work. The Divisional activity needs to feed into a coherent Trust agenda and audit programme and therefore a consistent collection of information. There is a requirement for a standardised approach to audit across the Trust and for a central capacity to inform Trust wide performance development, implementation and management, particularly to support Horton General Hospital. Presently there is only capacity to provide a reactive service with 0.75 WTE clinical audit person in place in the corporate clinical effectiveness team. There is an expectation that those conducting the audit will disseminate results and good practice throughout their own Directorate and the Trust. A clear mechanism needs to be in place for doing this. There is a Trust intranet available with reasonable access for staff, but no system currently in place to display audit results.

4.1.25 A Clinical Audit and Effectiveness Work Programme is in the process of development and the Clinical Effectiveness team intends to roll out a new process for clinical audit in 2006-07. This will involve use of Directorate Annual Audit Plans.

Working with the Clinical Effectiveness team, each Division will produce an Annual Audit Plan, which will detail all national, priority, NICE and other audits to be undertaken during the year. It will provide a permanent record of progress with each project. Audit activity will be reported through new Quality Reports and will also provide a structure for keeping audit reports, as evidence for compliance with NICE, Standards for Better Health, Peer Review and external investigations.

4.1.26 The Annual Audit Plans are designed to provide a structure to the current system of clinical audit in the Trust. In many areas this will tie-in with current practice on clinical audit. The new system will also allow a record to be kept of what audits are being conducted. In future, it is hoped to extend this project to incorporate patient surveys.

4.1.27 The recommendations made in this section of the report reflect those identified by the Commission for Health Improvement 2001.

Recommendations 1 to 4

The Trust should:

- 1 Establish a Clinical Governance Framework incorporating an integrated clinical audit and effectiveness work programme.**

- 2 Produce an annual audit programme and a new process for clinical audit that takes into consideration a Trust wide data and information agenda, local need, the result of complaints, patient views and involvement and high quality impact analysis.**
- 3 While the value of uniprofessional audit of practice is accepted, the issue of multi professional formal discussions about clinical processes and outcomes of care in the Horton General Hospital Emergency Department, linked with the John Radcliffe Hospital Emergency Department, should be reviewed, strengthened and further developed. Changes in clinical practice necessitate a wider boundary for audit than solely medical practice.**
- 4 Address the continuing difficulty surrounding the proportionate involvement of doctors from Horton General Hospital attending the emergency care clinical meetings.**

Risk Management Arrangements

- 4.1.28 As identified earlier the challenge for a Trust like the Oxford Radcliffe Hospitals is for risk management to be consistent and constant throughout the organisation's culture and strategy. The Trust is in the early stages of reviewing risk assessment processes to support implementation and performance management throughout the organisation.
- 4.1.29 In relation to the Emergency Department at Horton General Hospital, as with other parts of the Trust, there is not a systematic risk assessment in place. This is something that requires review.
- 4.1.30 The Trust has in place a programme of risk management and incident mandatory training. However, this training is said to be poorly attended.

Serious Untoward Incidents

- 4.1.31 While the Serious Untoward Incident procedure are excellent and an example of best practice, the application of the procedure needs to be consistent. Managers need to take responsibility for ensuring action points are carried out and for the final signing off of incidents. There is a need to strengthen the links between the Divisions and Directorates systems with processes for managing clinical governance, clinical risk and learning from incident reporting. There needs to be greater focus on incident and risk management to refocus what appears to be the current emphasis on coding incidents.

4.1.32 In this case the Serious Untoward Incident Procedures was activated promptly and followed effectively. This was a substantial test of the policy and procedures and the SUI team quickly identified that there was a requirement to contact the police because of what were felt to be criminal acts. In evaluating efficiency of the policy there are some issues that need to be considered by the Trust and other organisations that might find themselves in this or a similar situation.

- Trusts should develop a relationship with their local police force to establish a plan for handling a situation where criminal activity is suspected. The recent joint agreement for the investigation of *“Patient safety Incidents involving unexpected death or serious untoward harm”* should be incorporated into SUI policies.
- There also needs to be in place an agreement about handling the human resource part of the type of situation. If the Trust had suspended Geen on the 6th February it might have provided an opportunity for him to destroy evidence that was valuable to the case.
- The Trust needed to establish a detailed communications strategy as part of the SUI, which reflected the need to address both internal and external requirements in the short, medium and long term. This included; patients, relatives, the public, the media, staff in the emergency department, staff of Horton General Hospital and the Oxford Radcliffe Hospitals, other health and social care providers and commissioners, politicians, the Department of Health and many other stakeholders. The fact that the Horton General Hospital is a small hospital enabled the sharing of information much easier in some respects but also created difficulties in managing the information that should be shared.
- While the Director of the Hospital briefed senior managers with appropriate information, the view of some staff is that the managers outside the Emergency Department with responsibility for other areas of the Hospital could have provided more support for the staff working in the Emergency Department.
- Substantial efforts were made to support all staff in Emergency Department both during the SUI investigation and associated events and during the criminal trial.

4.1.33 It is the External Review Teams view that in relation to nursing practice in the Emergency Department at Horton General Hospital, there have been considerable advances in discussing and formally assessing the outcomes of care and clinical practice.

4.1.34 Nursing clinical incidents appear well managed within the

Emergency Department at Horton General Hospital. All clinical incident forms are reviewed, investigated and actioned by the senior nurse within the Department. Issues arising and action points made are fed back to the nurses at weekly meetings and salient learning points from all clinical incidents are shared between the Horton and John Radcliffe Hospital Emergency Departments.

- 4.1.35 The medical staff also have a well developed local system to review clinical practice and outcomes. A letter is produced for every patient who attends the Emergency Department and is used to review patient condition and their care. If there are any concerns, the patient's clinical record is reviewed. Laboratory and xray reports are screened. Concerns and areas for learning are relayed back to the clinical team and used in an anonymised way at teaching sessions. Apart from deaths of patients within 24hours of attending the Emergency Department, information, trends and analysed themes or analysis of clinical incidents are not collated and shared across the Directorate.
- 4.1.36 The difficulties that clinicians from the Horton General Hospital have in attending the Oxford Radcliffe Hospitals for morbidity & mortality meetings and the lack of clear integration of the governance information between the two sites is an area of concern. Increased cross-site working by the consultants in emergency care will support this as will the video conferencing facility now available. While this may also be addressed by the introduction of a common Directorate annual audit agenda, the need for additional local analysis and opportunities for shared learning are not being met at present and leave a significant area of risk.
- 4.1.37 The Trust has now reviewed its SUI process, focusing particularly on the timetable for the closure of the investigations and the monitoring of completion of recommendations and actions arising. Reports are now made routinely to the Executive Board on SUIs and divisional directors and chairs are kept up to date throughout. The Incident, Complaints and Claims Committee now has responsibility for ensuring proper sign off of SUIs within the agreed timetable. Reports to TVSHA on SUIs continue to be made and the trust's performance is also monitored by TVSHA. Reports are also made to the Governance Committee so that it can be assured on the completion of actions within the agreed timeframes.

Recommendations 5 to 11

The Trust should:

- 5 Complete the review of risk management processes.**
- 6 Review risk management and incident training to**

ensure its availability for and completion by all disciplines and grades of staff to ensure employees are aware of their individual and collective responsibilities.

- 7 Review and establish a systematic risk assessment in the Emergency Department.**
- 8 Emergency Department information, trends, and themes and analysis of clinical incidents should be collated and shared across the Directorate.**
- 9 Review the serious investigative infrastructure to better support the cycle for investigation, incident reporting forms being properly analysed and results used in service areas to inform staff and improve patient experience and to stop the process 'disappearing into a black hole'.**
- 10 Further development is required to establish 'a no blame culture' in responding to incident reporting forms.**
- 11 Trusts should establish a relationship with their local police force to establish a plan for handling a situation where criminal activity is suspected. The recent joint agreement for the investigation of "*Patient safety Incidents involving unexpected death or serious untoward harm*" should be incorporated into SUI policies.**

Record Keeping systems

4.1.40 Internal review of the Serious Untoward Incident (SUI 219) following identification of the situation, established a number of areas for improvement related to record keeping.

These included;

- The legibility of writing on clinical records and the use of blue or black ink.
- The completeness of records, particularly that anyone writing in the patient record should print their name, and add the date and time of entry.
- The police investigation highlighted that results of blood gas analysers written in the clinical notes did not match data held on Radiance (part of the electronic patient record).
- That design of the casualty card should be reviewed to make it explicit, which data entry boxes are obligatory to complete and which are discretionary.

- The archiving of historical records of nursing and medical rotas, including any late amendments or changes and the presence of agency nurses and doctors.
- Each doctor's responsibility for informing the telephone exchange and their speciality co-ordinator of any changes made to rotas.

4.1.41 A detailed account of the action taken from SUI 219 and a further audit by Central England Audit and Consultancy December 2005 (CEAC) is provided at 4.2.

Recommendations 12 and 13

- 12 That the frequency of audit of records is increased to reflect change in doctors on a quarterly basis and to support speedy feedback to doctors of their own documentation prior to change over.**
- 13 Blood gas results should be written in the notes and the print out attached to the patient's record.**

Workforce issues

Recruitment

4.1.42 A number of recent reports have been critical of processes used by some organisations to recruit staff¹⁵. Reports have emphasised the value of employers always reviewing references and advised employers to check facts such as qualifications gained and previous jobs held. The level of CV fraud ranges from inaccurate dates in an applicant's employment history, to false claims about qualifications and forged references. Yet many employers do not have the time to run sufficient checks. Of those that do, a quarter said they have withdrawn at least one job offer in the last year after discovering an applicant had lied on their application form.

4.1.43 The decision made by the senior nursing team to short list and employ Benjamin Geen as a staff nurse in the Emergency Department at Horton General Hospital was made on the basis of, his educational qualifications, the fact that he was waiting for the results of his Diploma of Higher Education in Nursing, and on the basis of satisfactory occupational health checks, satisfactory references and finally his performance at interview.

¹⁵ Chartered Institute of Personnel and Development. (2005) *Recruitment, retention and turnover 2005*. London: CIPD.

4.1.44 The External Review Team was informed that it was unusual for newly qualified nurses to be employed in the Emergency Department but it was difficult to recruit at that point. More importantly, the considered view was that as there was an established and experienced nursing team in the Department. There was well developed mentoring and educational support for a newly qualified nurse, particularly one committed and enthusiastic to learn and therefore he would receive the support required. Benjamin Geen's involvement in the Territorial Army Medical Services provided additional support to the belief that he would be able to cope in a challenging environment.

What was not available to the interview team is that:

- He was struggling to complete required assessments and had already had to resubmit a modular assignment twice and was waiting for the results of a resubmission when he applied for the post .He was aware that he had failed to achieve the required level to register as a qualified nurse successfully for a second time when he commenced work at Horton General Hospital. He was employed as a health care assistant and therefore did not practise as a registered nurse until he eventually completed the Diploma and his NMC registration on 14th May 2003. It is debatable if he would have been employed if the interview panel had been aware of these factors. There would have been an increased risk associated with his employment in an area that requires a great level of individual integrity and ability to be able to critically analyse situations rapidly.
- As identified earlier, a key component of the judgement made about employing Benjamin Geen was the references provided about him. At the time of interview the interview team had received a reference given by a qualified nurse who had worked with Benjamin Geen for six months over two periods during 2001 and 2002 and a reference from the University. It is obviously difficult in the early stages of anyone's career to provide referees that have a detailed knowledge of the individual's ability. The reference from the University is crucial in the case of individuals who have undertaken training as a nurse, in that they have an overview of the individual's clinical and theoretical performance as well as their personality and integrity over a three year period.
- A more cautious approach from people and organisations giving references has resulted from growth in case law. The important factor is that all data given in a reference must be based on fact or capable of independent verification. Referees need to be cautious about giving any subjective opinion about an individual's performance, conduct or suitability which they cannot substantiate with factual evidence.

- It is the view of the External Review Team that the reference, whilst consistent with the practice of most Universities, does not clearly identify the fact that Benjamin Geen was having some difficulties completing the final modules of the Diploma and therefore registering as a First Level Nurse. The use of a standardised summary of training needs to be considered at a national level.

Recommendations Number 14 and 15

- 14 Academic claims made in application forms should be confirmed by checking certificates to support claims.**
- 15 Consideration needs to be given by Universities to the quality of information supplied to employers to enable them to make an informed decision about the capability of an individual to undertake a specific role. An agreed summary of training, developed for all students to a legally approved format to better inform potential employers, should be considered.**

4.1.45 While lessons need to be learnt about employment processes it must be emphasised that he was employed as a health care assistant and he was supervised closely at that level. It was only after registering as a nurse that he was able to undertake the activities delegated to a Registered Nurse.

4.1.46 Benjamin Geen had been working at the Emergency Department at Horton General Hospital for more than a year before he started to harm people. The staff had got to know him well. There are mixed views about him, with some staff stating that they found him overly confident and others that he was simply a committed Emergency Department nurse.

4.1.47 There were some concerns about Geen working beyond the level to which he had been employed as a health care assistant.

- On 28th November 2002, Geen received a warning for wearing staff nurse epaulettes and name badge. He had been allocated the uniform on employment and stopped wearing it once approached.
- On December 11th 2002 he received a warning in relation to:
 - Evidence suggesting that he was telling people he was a qualified nurse and was waiting for his NMC registration number before he could practise as a Registered Nurse,
 - For not working in accordance with local policy that all staff learning a procedure are required to get their work checked. He

had failed to get a plaster on a patient's arm checked before discharge.

- He was felt at first to be more confident than was acceptable for his level of competence, but this changed as he gained more experience.
- He showed a greater interest in resuscitation and major areas of work, a factor that the senior nurses were concerned about. They wanted him to have experience of the breadth and depth of Emergency Department nursing only achieved by working in all areas.

These issues, in hindsight, might have been an indication of deeper problems, but it is the External Review Team's belief that at the time they were incidents that he should have been warned about, which he was, and they were not repeated. Therefore the required action was taken.

Staff in the Emergency Department

4.1.48 Nursing

There is strong nursing leadership within the Emergency Department at Horton General Hospital and consistency with the John Radcliffe Emergency Department. They are a very united and committed team whose practice is at a high level. It is all the more upsetting that they should find themselves at the centre of this situation because of Benjamin Geen. The staff (especially senior nurses) now think the unthinkable when things go wrong, and that malice may play a part. There are many areas of good practice that many other Trusts could learn from.

As stated by the Judge, it is a testimony to the team's skills and knowledge that more people did not die as a result of Benjamin Geen's actions.

We have examined a number of areas to make a judgement about nursing in the Emergency Department at the time of the incident and the subsequent changes.

Skill mix has been defined as:

The balance between trained and untrained, qualified and unqualified and supervisory and operative staff within a service area as well as between staff groups...optimum skill mix is achieved when the desired standard of service is provided, at the minimum cost, which is consistent with the efficient deployment of trained, qualified and supervisory personnel and the maximization of contributions from all

*staff members. It will ensure the best possible use of scarce professional skills to maximize the service to clients.*¹⁶

Whilst guidance has been published on the minimum safe medical staffing levels required within Emergency Departments¹⁷, providing national guidance for minimum safe staffing levels for the nursing workforce has proved more challenging. The issues have also been more difficult to quantify in light of advancing nursing roles such as Nurse Practitioners who have taken on some of the Emergency Department workload traditionally managed by medical staff.

The Royal College of Nursing (RCN) published guidance in 2003¹⁸ which suggested that the ratio of trained nurses to patients in the Emergency Department should be 1:3 with the addition of a nurse in charge of a shift and a triage nurse each shift. This guidance can be difficult to interpret and apply in light of the changing numbers of patients in the Emergency Department on an hour by hour basis, but an average can be calculated.

A more informal staffing level calculation has been accepted as a minimum nursing staff level of 1 WTE registered nurse per 1,000 new patients seen per year in an Emergency Department. Using this guidance, the Horton General Hospital Emergency Department meets the recommended requirements.

New guidance from the RCN Emergency Care Association is expected to be published in November 2006. This will identify optimum skill mix in Emergency Departments.

The External Review Team has examined carefully the nursing establishment at Horton General Hospital Emergency Department during the period of the serious untoward incident from December 2003 to February 2004 and at June 2006. (See Appendix 5)

In 14 of the 19 shifts when an incident occurred when Benjamin Geen was on duty, the staffing and skill mix was above the agreed baseline skill mix. In only one episode, an E grade nurse was in charge, otherwise the nurse in charge was an F grade or above.

It is our view that the qualified /unqualified nursing staffing levels and the skill mix were appropriate in December 2003 and have subsequently been refined in order to meet the needs of the service, for example; an Emergency Nurse Practitioner is now on duty on both an early and late shift.

¹⁶ Bevan, S. (1991) *Choosing an approach to reprofiling and skill mix*. NHSME/Personnel Development Division: London

¹⁷ The Way Ahead. http://www.emergencymed.org.uk/temp/1375-pubs_way_ahead_2005.pdf (accessed 24/08/06)

¹⁸ RCN (2003) *Setting safe nurse staffing levels*. RCN: London

We did not find any evidence to suggest that Benjamin Geen had not been effectively supervised or was requested to work outside his level of competence. The incidents, where there were issues are identified at 4.1.47.

Education and Training in the Emergency Department

4.1.49 Nursing

Nursing staff working within an Emergency Department are required to undertake a variety of assessments and technical skills in caring for patients who present within a wide spectrum of acuity over a 24 hour period.

Horton General Hospital Emergency Department has well evidenced training and education packages and assessment of competence processes in place for a wide variety of core skills for example venepuncture, cannulation, application of plaster of Paris and triage training. A chart identifying what competencies each member of staff has completed is available for the nurse in charge of the shift, to ensure that people work within their skills and receive required support.

There are excellent educational resources and support to the nursing staff in the form of a Nurse Consultant who works in the Department one day a week, two Lecturer Practitioners who each work in the Department one day a week and a Practice Development Nurse who works in the Department three days a week.

There are comprehensive and up to date training records for all members of nursing staff covering statutory mandatory training as well as competence in more advanced skills.

There is a good mentorship and buddy system in place for new staff to the Department and this was in place at the time Benjamin Geen worked in the Emergency Department. (See Appendix 6)

Police investigations and our discussions with staff have identified an issue in relation to the recording of informal matters raised on the performance of staff and the lack of a recognised appraisal system across the wider Trust. (See 4.1.47)

4.1.50 Medical

The medical staffing of the Emergency Department at Horton General Hospital at the time of the incidents consisted of a single-handed Consultant in Emergency Care with a supporting Associate Specialist, four middle-grade doctors working from 09:00 to 23:00 each day and five Senior House Officers (SHOs) on a full shift schedule.

Under the "Way Ahead" guidance from the British Association for Emergency Medicine, a department of the size of Horton General Hospital should have a medical staffing complement equivalent to 12 workload units (wlu). Currently in post medical staff equate to 10.25 wlu's, to which can be added the nurse practitioner pool, making the department medically staffed to the recommended level.

The SHOs were rotated from the John Radcliffe Emergency Department pool for 2 months at a time. The senior staff provide an induction training period for new medical starters but there was no formal competency assessment framework for confirming their fitness. This mirrors many other departments in the UK.

Since 2004, there has been recruitment of an extra middle-grade to reduce the need for locum cover for leave periods and a move from SHOs to Foundation Year 2 trainees spending only 4 months in Emergency care, but all of that in the Horton General Hospital.

This level of staff changeover is difficult to sustain and support and Trust management advised the Review Team that plans were being developed to recruit a second Consultant in Emergency care for the Horton General Hospital. This would have a significant positive impact on the level of supervision and clinical support to the department and is very much welcomed by the Review Team.

Appraisal and professional support for the senior clinicians is provided from within the wider Directorate from the John Radcliffe consultant body and is reported to be fully up to date. Supervision of junior medical staff is provided internally. Of concern was the suggestion that the study leave budget has been withdrawn as part of the cost improvement programme.

The links between the Horton General Hospital and John Radcliffe Emergency Department medical staff felt tenuous and need to be reviewed. The recruitment of a second consultant will increase the capacity for staff to travel to meetings at the other site and allow for relations and clinical managerial contact to be strengthened.

4.1.51 Working as a Team

The staff in the Emergency Department at Horton General Hospital are an outstanding group of individuals, who as members of a close team have managed to handle the situation of coping clinically with the outcome of Benjamin Geen's actions and living with the knowledge that someone they have worked closely and shared social occasions with is someone who maliciously harmed people they were committed to care for.

The Emergency Department team kept services running throughout the criminal trial, planning off duty and childcare around giving evidence in court.

The planning for this to take place efficiently to maintain services and for staff to appear in court was logistically a great challenge.

Guidance for staff about appearing in court was developed and opportunity for staff to spend time in court familiarising themselves provided. The Legal Services Advisor from the Legal Services Department within the Trust, provided advice and support to the staff and was present in court throughout the criminal trial. This was appreciated by the staff and invaluable for communications.

The Emergency Department staff have chosen to not to accept offers of additional support and counselling as they have chosen to support one another and to use primary care services. The Trust should review their needs following the issue of this report.

Recommendations 16,17, 18,19, 20, 21,22 and 23

- 16 Ensure that staff nurse uniforms and badges are not given to staff that are recruited before registration.**
- 17 Review procedures for recruiting nurses straight from training, considering their progress, evidence of passed modules, outstanding modules and capacity to undertake the role for which they are being recruited.**
- 18 The Trust should compare existing nursing staffing levels and skill mix in the Emergency Department at Horton General Hospital with the new guidance from the RCN Emergency Care Association.**
- 19 Develop a standardised framework and guidance to enable the performance of staff to be recorded, particularly for all staff that carry out disciplinary interviews e.g. formal warnings, details of discussions, and actions taken.**
- 20 A robust staff appraisal system needs to be implemented for all personnel in the Emergency Department, whatever their clinical background.**
- 21 Review and strengthen the links between Horton General Hospital and John Radcliffe Emergency Department medical staff. The appointment of a second consultant for the Horton General Hospital would facilitate this.**
- 22 The Oxford Radcliffe NHS Hospitals Trusts should make available to other Trusts the guidance that they produced for staff when giving evidence in court, as it is an example of best practice.**

23 The Trust should review the needs of the Emergency Department staff following the issue of this report.

Conclusion

In this section the External Review Team have made a number of recommendations that will strengthen clinical governance in the Trust generally and specifically at Horton General Hospital. The issues raised, while important to reducing the risk of poor or malicious practice, will not on their own prevent someone with malicious intent from harming patients.

It is our view after examining all the evidence that the clinicians identified that there were problems as quickly as possible and took the required action.

4.2 Review the systems and processes in place in the Emergency Department at the Horton General Hospital, as a consequence of the original internal investigation and how these are monitored. Determine if they were consistent with current policies, guidance, procedures and best practice.

- 4.2.1 In June 2004 the Chief Nurse commissioned a serious untoward incident (SUI 219¹⁸) interim report of incidents at the Emergency Department at Horton General Hospital. The interim report was produced in July 2004 and presented to the Clinical Risk Management Committee (CRCM) in September 2004. Subsequently, following further discussions at the CRMC and the Governance Committee in December 2004, July and September, 2005, the Trust's internal auditors Central England Audit and Consultancy¹⁹ (CEAC), were asked to undertake an audit on implementation of and actions taken on the recommendations made in this report. This audit was reported in draft to the Governance Committee in December 2005, together with an update on recommendations from the ORH's SUI report. The final CEAC report was received in January 2006.
- The first part of this section highlights the areas of SUI 219 and CEAC reports that have still to be fully actioned and the second part is a chart, which identifies the areas that have been implemented.

¹⁸ Serious Untoward Incident 219 Internal Report ,September 2004

¹⁹ Central England Audit and Consultancy December 2005.

Both reports have been quoted directly in the content of this section.

The serious untoward incident interim report (SUI) 219 made a number of recommendations, which addressed four major areas:

- Risk management arrangements
- Patient Records
- Staff issues
- Medicines Management

Risk management arrangements

4.2.2 SUI 219 Recommendation 13 and 14

“In light of this inquiry, arrangements for formally discussing clinical processes and outcomes of care in the Horton General Hospital Emergency Department, linked with the John Radcliffe emergency department should be reviewed and strengthened. This should also take into account recommendations made in later section of this report (e.g. Patient records, Staff Rotas and Medicines Management) “.

“Regular informal communication and information-sharing mechanisms should be recognised and used to compliment more formal clinical audit processes.”

4.2.3 CEAC Audit of Recommendation 13 and 14

The Emergency Departments (EDs) at both the John Radcliffe Hospital and the Horton General Hospital participate in monthly Morbidity and Mortality meetings. These meetings have been taking place since long before this incident. At the meetings Senior House Officers present cases where the patient has died within 24 hrs of arriving at the ED. If Horton General Hospital has any cases, then a doctor from Horton General Hospital will attend the meeting (at the John Radcliffe Hospital) and present the cases. If there are no Horton General Hospital cases, the Horton General Hospital doctor will often not attend due to pressures of work.

This results in John Radcliffe Hospital doctors always being informed about Horton General Hospital cases, but not vice versa. More resources would be needed in order to release a staff member monthly, or remote participation via a telephone link. The cost effective solution would be to ensure that presentation slides of John Radcliffe Hospital cases are always emailed to Horton General Hospital doctors for local circulation.

As a result of the audit CEAC made additional recommendations as they found that it was still not always possible for Horton General Hospital Emergency Department to send a doctor to the Morbidity and Mortality meetings, held monthly at John Radcliffe Hospital. The recommendations were:

- Trust to consider making resources available to release a doctor to attend, or to arrange remote participation.
- If unable to attend the slides of the John Radcliffe Hospital presentations should be emailed to the Horton General Hospital ED clinical lead for dissemination.

Regular informal communication has been strengthened due to the fact that many Emergency Department doctors work between both sites, and further evidenced by the level of email communication between Emergency Department doctors. The Morbidity and Mortality meetings support this initiative as they also give opportunity for informal communication.

4.2.4 External Review Conclusions 13 and 14

In section 4.1 we have identified the key issues for the Trust associated with auditing clinical practice and the recommendation can be found in that section. As this recommendation stands, further work needs to take place in relation to:

- A unified audit strategy across the Trust feeding from and into the local audit agenda.
- It is our view that in relation to nursing practice there have been considerable advances in discussing and assessing formally the outcomes of care and clinical practice. There does not, however, appear to be the same advances in relation to a coherent approach for the medical staff. It is a challenge for the John Radcliffe Emergency Department to ensure that they work in partnership with colleagues at Horton General Hospital recognising the differences and ensuring that audit activity reflects their needs.
- There is still difficulty in relation to doctors from Horton General Hospital attending the morbidity and mortality meetings.
- Whilst the value of uniprofessional audit of practice is accepted, the issue of multi professional formal discussions about clinical processes and outcomes of care in the Horton General Hospital Emergency Department, linked with the John Radcliffe Emergency Department also should be reviewed and developed. Changes in clinical practice necessitate a wider boundary for audit than solely medical.

4.2.5 SUI 219 Recommendation 15

“With support from biochemistry/clinical measurement, outputs from blood gas analysers should be included within standard clinical audits.”

4.2.6 CEAC Recommendation 15

Following communication with Clinical Risk, Clinical Effectiveness, Clinical Biochemistry and Clinical Measurement we confirmed that all clinical audits are initiated by local requirements, and that they do not follow a “standard” procedure. The use of a standard clinical audit report template would encourage clinicians to report in the same format for easy central analysis. There is no specific advice to include outputs from blood gas analysers in the intranet guidance “How to conduct a clinical audit”. Clinical Effectiveness would like to hold a centralised database of clinical audits and a centralised annual plan, but is now a much-depleted team with limited resources.

Examination of the Morbidity and Mortality meetings reports indicate that the Emergency Department presentation slides do refer to “bloods” but are not sufficiently detailed for us to determine to what level blood gas analysis results are scrutinised.

It was police investigation that highlighted the results of blood gas analysers in the clinical notes did not match data held on Radiance. However, it seems likely that there was malicious intent to deliberately write incorrect information onto the notes. If the Trust insisted that the printed results from the ward based blood gas analysers were attached securely to the clinical notes, rather than handwritten, this would reduce the likelihood of error. If required, this could later be checked against Radiance.

As a result of the audit CEAC made additional recommendations that the Trust consider making resources available for clinical effectiveness to hold a centralised database and annual plan of clinical audits

- Trust to consider a standard template for a clinical audit report, copies of completed reports to be sent to Clinical Effectiveness Support Team.
- Printouts from the blood gas analysers should be securely attached to the medical notes – and ensure patient and user ID are input.

4.2.7 External Review Conclusions 15

The CEAC report covers two major areas in this recommendation. Firstly in relation to clinical effectiveness we have covered this in detail in section 4.1 and have found little change from the comments made by CEAC.

Secondly the CEAC report states that it seems likely that there was malicious intent to deliberately write incorrect results of blood gas analysers information on patient notes. The Emergency Department agrees with this comment, as its view is that the practice recommended is already part of departmental processes and procedures. The blood gas results along with other reports are inserted into a pocket in the Emergency Department notes that is part of the patient record. Usual practice is that blood gas results would be written in the notes and

attached to the patients record. The External Review Team note the process in place within the Trust: All blood gas machines require user ID which is a unique password given at training and a barcode on their hospital ID badge. Patient ID is required in order to process the sample. Filing of paper results is at the local level and all staff are advised at training of the need for accurate filing in the patients notes.

The Patient Record

4.2.8 SUI 219 Recommendation 20

“The Oxford Radcliffe Hospitals standards on clinical documentation and record keeping should be implemented more fully. In particular:

- 20.1. Departmental clinical audits should review handwriting legibility.*
- 20.2. Only black or blue ink should be used in the Patient record.*
- 20.3. All clinical events being entered in the patient record must have a time entry.*
- 20.4. Anyone writing in the Patient Record must print their name, and add the date and time of entry.”*

4.2.9 CEAC Audit of Recommendation 20

20.1 There is an annual Health Records Audit undertaken by the senior nursing team. Our audit work included looking at a sample of casualty cards and we found the front covers to be legible on all. The new doctors’ induction also covers this in some detail.

20.2 We can confirm this was satisfactory on the sample of casualty cards examined. We note, however, that when notes are copied for lawyers that blue ink does not copy so well and the guidance should now be black ink only. Medical induction slides are already being changed to reflect this advice.

20.3 Results relating to this were less satisfactory. 36% of the records examined in the annual Health Records Audit were timed. From our sample of casualty cards, only 40% of doctors at John Radcliffe Hospital and 90% of the doctors at Horton General Hospital timed their entries, whilst 100% of nurses timed theirs. Medical induction slides are very clear that entries need timing and dating. Perhaps there needs to be more responsibility taken from the results of the health records audit by clinical leads in improving compliance.

20.4 We found that in our sample of casualty cards, 20% from John Radcliffe Hospital had no doctor’s name on the front, the remainder had the name printed or stamped, and the time identified. Whereas 100% of Horton General Hospital cards examined showed a doctor’s name printed or stamped clearly.

As a result of the audit CEAC made additional recommendations that the Trust could further improve the standard of clinical notes by:

- Reminders to be sent to all medical staff regarding the standard of clinical notes, plus a special reminder to use only black ink and to use their self-inking stamp.
- Results of clinical notes audits should be distributed to clinical leads
- Clinical leads to use results of medical notes audits to continually reinforce to their medics the importance of high standards of clinical notes

4.2.10 External Review Conclusions 20

The position at Horton General Hospital regarding clinical record keeping is that all medical staff commencing work in the Emergency Department receive a handbook, which contains reference to clinical record keeping, and its importance is emphasised by the Consultant.

Clinical notes are being audited and the outcome reported to clinical leads. We would recommend that the frequency of the audit be increased to reflect the change in doctors on a quarterly basis direct feedback to doctors on their own record keeping. Indeed, as part of the Modernising Medical Careers initiative, the Senior House Officers should have regular review of their own note keeping as part of the supervision process. The Trust's medical director has written to all clinical directors about the need for clinical audit and the importance of good clinical record keeping.

Medicines Management

The major issues and recommendation regarding medicines management are in section 4.3.

4.2.11 SUI 219 Recommendation 38

“The prescribing and administration of medicines, including amount, timing and individuals involved must always be recorded on the drug chart or the relevant section of the Casualty card.”

4.2.12 CEAC Audit of Recommendation 38

Evidenced by letter from Medical Director, Chief Nurse and Chief Pharmacist included in doctors' induction dated 24th January 2005. The Pharmacy Directorate plans to audit 100 casualty cards at random for compliance during December 2005.

4.2.13 External Review Conclusion 38

Audit of 100 cards completed in January 2006. This showed that of the 39 patients that required medication the majority had completed details. The report is yet to be completed and we would recommend that this is done and the learning shared.

4.2.14 SUI 219 Recommendation 39

“The procedure for dealing with and recording the disposal or return of part used and expired controlled drugs must be adhered to.”

4.2.15 CEAC Audit of Recommendation 39

The Board approved a new Controlled Drugs Policy in May 2005. Every nurse is obliged to complete training and self-assessment from the intranet by the 31st December 2005, with full implementation by mid January 2006. The controlled drugs cupboards are checked daily in the ED. Key security is compliant with policy.

4.2.16 External Review Conclusion 39

The changes implemented are as described above. The policy and subsequent processes were assessed in December 05. The change to new combined record/order books and three monthly ward controlled drug checks has been implemented led by a designated pharmacist. Daily controlled drugs checks are in place in the Emergency Department at Horton General Hospital. There is a separate policy for patient's own controlled drugs. A medicines safety nurse has also been identified within the Trust. All nurses have completed training and ward managers maintain training records. The Audit Commission's review of medicines management 2005/06 ²⁰ (part of the Healthcare Commission's Annual Health Check) gives an overall assessment for the Trust of "Good" in relation to the effectiveness of their medicines management but areas for which they received a poorer score is controlled drug management and audit.

4.2.17 Distribution of Serious Incident Reports

During the CEAC audit it was apparent that one responsible officer had not received a copy of the serious incident report and therefore had not been able to implement the recommendation until informed about it by internal auditors. They recommended the Trust to appoint a monitoring officer to ensure that the implementation of recommendations was managed.

4.2.18 External Review Conclusion

²⁰ Audit Commission Acute Hospitals portfolio Medicines Management. Annual Health Check Healthcare Commission 2005/2006.

A monitoring officer has been appointed who is monitoring performance against the recommendations.

Conclusion

The majority of the recommendations made in the original SUI 219 Internal Review and subsequent CEAC investigation have been met. There remain important areas however that need to be addressed associated with clinical governance and medicines management. We have identified our recommendations in 4.1 and 4.3 respectively.

Recommendations made in	Recommendations made in CEAC report	Observation/Comment by External Review Team
<p>Consideration should be given to issuing all doctors with self-inking identification stamps, which include a space for date and time. Over time these should be issued to other staff groups.</p>	<p>We found that all medics in Emergency Department had been issued with self-inking stamps, and that Horton General Hospital had two available for locums. Only 50% of the doctors at John Radcliffe Hospital Emergency Department were, however, using them. This test was not completed at Horton General Hospital.</p> <p>All new junior doctors will be issued with self-inking stamps at the next induction February 2006. This was formerly the procedure, but had been stopped in recent times due to financial constraints. The Trust may wish to issue stamps to medics still with the Trust.</p> <p>As a result of the audit CEAC made an additional recommendation that the Trust should consider if all doctors should be issued with a self-inking stamp.</p>	<p>This recommendation has almost been implemented. The review team feel that the issue is to ensure that doctors print their name and designation date and time on records rather than an emphasis on self-inking stamps</p>
<p>The design of the casualty card should be reviewed to make it explicit, which data entry boxes are obligatory to complete and</p>	<p>There has been extensive consultation on this topic in order to get the end result right due to the costs involved if a reprint is needed.</p>	<p>A new Emergency Department patient card has been developed and will be introduced once the old cards have been used.</p>

<p>which are discretionary.</p>	<p>Layouts have now been received and a decision is soon to be made and a print run ordered. However, they do plan to use up existing stocks to avoid wastage. Two versions of the front card will be printed, as they need to capture different information for the separate systems that exist at the two sites, the reverse side is the same for both sites.</p>	
<p>Historical records of the nursing rotas, including agency staff should be held under lock and key in the main office on each ward or groups of wards, for duration of 2 years.”</p>	<p>Testing was undertaken in both EDs and in four other wards chosen at random in John Radcliffe Hospital. All were found to retain nurses’ rotas for at least two years under satisfactory security. If not already included in induction or procedures for senior nurses, it should be. As a result of the audit CEAC stated that although the sample areas were retaining nursing rotas longer than 2 years they were not able to obtain a copy of any instruction circulated to nurses on this topic. An additional recommendation is that the Trust should, if not already in procedures or induction for senior nurses, include rota retention in both.</p>	<p>The recommendations have been fully implemented.</p>

<p>29</p>	<p>Historical records of the doctor's rotas, including agency staff should be held under lock and key in the main office of each speciality for duration of 5 years</p>	<p>The Medical Director has written to all Directorate Managers on the 7th December 2005 advising them of this requirement. Testing showed that John Radcliffe Hospital Emergency Department retained their rotas back to 1997. Horton General Hospital Emergency Department has previously only been retaining for one year, but is now on track; L7 Vascular Surgery is retained back to 1991. All under satisfactory security.</p>	<p>The recommendations have been fully implemented</p>
<p>30</p>	<p>Each doctor concerned is responsible for informing the telephone exchange and their speciality co-ordinator of any changes made to the rotas</p>	<p>All Directorate and Divisional managers, and the telecoms manager were informed by email from the Director of Planning and Information on the 1st December 2005, and by letter from the Medical Director on the 7th December. As a result of the audit CEAC identified that information about changes to rotas to the specialty co-ordinator and to switchboard were not included in medical induction. They recommended inclusion of the process required in the event of a change in rota to be included in medical induction.</p>	<p>The recommendations have been fully implemented.</p>

31	Any last minute changes made by the doctor rotas held by the telephone exchange must be fed back to the main specialty the next working day and these changes recorded on the master record	The Director of Planning and Information had not been aware of this recommendation until CEAC brought it to his attention.	The recommendations have been fully implemented.
32	The name of the individual clinician must always be recorded in the medical record (it is not enough to record the number of the bleep held by the doctor in question)"	This is covered in the new doctors' induction, and was covered in a letter from the Medical Director to all doctors (27 th August 2002) "keeping good medical notes".	The recommendations have been fully implemented
40	The procedure for dealing with and recording patients own medicines must be adhered to including options for continuing use, returning to the patient on discharge, or disposal via the pharmacy department	The procedure for dealing with patients' own medicines was ratified in November 2005. The same sealed bags used for controlled drugs will also be used for patients' own medicines; a successful trial had been completed at the Horton General Hospital.	The recommendations have been implemented in the emergency department but not across all of the Trust. Patient's own drugs are placed in a sealed bag and recorded as soon as they arrive at the Emergency Department. A position statement is being presented to the Executive Board.
41	Staff must never take medicines home that belong to patients or to the hospital. The only exception is those medicines that are properly prescribed for staff member concerned	The self-prescribing policy is currently in draft form and expected to be final before the 31 st March 2006. NMC guidelines have always been very clear about theft of medicines, and all registered practitioners will be aware of this.	There is no evidence to suggest that apart from Benjamin Geen the staff in the ED remove drugs from the Department. A Trust wide policy is in process of being developed and will be presented to the Health and Safety Committee. This needs to be completed as a matter of urgency.

42	Valuables must not be stored in the Controlled Drug Cupboard. Wherever possible the patient should be encouraged to ask a relative or friend who is accompanying them to look after their valuables for them. Where there is no alternative a simple locking cabinet should be provided in the emergency department for the storage of patient's valuables.	Both Emergency Departments were tested and found to be compliant. New lockable cupboards had been purchased for both areas and were in use.	The recommendations have been fully implemented.
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4.3 Review the management, provision and quality of healthcare in the Horton General Hospital Emergency Department to keep patients safe in respect of medication administration.

- 4.3.1 Medicines management describes a system of processes and behaviours within an organisation that determine how medicines are used by patients and by the NHS. At the centre of effective medicines management is the patient as the focus to delivery of better targeted care and to ensure that they are better informed.
- 4.3.2 A considerable amount of work has taken place in the health service to establish systems and practices in relation to managing medicines that are designed to withstand human error and increase staff openness so that any errors are recorded, analysed and used to improve processes. Attention is paid particularly to the use of controlled drugs because of the potential for individuals to criminally misuse these drugs.
- 4.3.3 Deliberate criminal poisoning is said to be rare or rarely detected. Serial poisoning is exceedingly rare. In the last 15 years there have been three cases of health professionals being convicted. Beverly Allitt, a nurse, murdered four children and injured many others. Harold Shipman, a doctor, used diamorphine to murder more than two hundred patients. Benjamin Geen used morphine-based painkillers, anaesthetics, oxygen and muscle relaxants to make his victims have acute respiratory problems and require immediate emergency resuscitation.
- 4.3.4 Lord Clothier ²¹stated
"A determined and secret criminal may defeat the best regulated organisation in the pursuit of his or her purpose".
- 4.3.5 The Shipman Inquiry, produced its Fourth Report in July 2004 .It made a number of recommendations to strengthen the prescribing of controlled drugs and for monitoring their movement from prescriber to dispenser to patient. In December 2004 the Government's response Safer Management of Controlled Drugs²² was published. The response accepted that current systems could be strengthened provided that this does not hinder the use of controlled drugs to meet patients' needs.
- 4.3.6 The Misuse of Drugs Act 1971 is the main piece of legislation covering drugs. The law places drugs into three different categories, known as Class A, B and C. Drugs regulated in this way are known as 'controlled'

²¹ Independent Inquiry relating to deaths and injuries on the children's ward at Grantham and Kesteven General Hospital. London: HMSO, 1994

²² Safer management of controlled drugs: (1) Guidance on strengthened governance arrangements DoH March 2006

substances. Class A drugs are those considered to be the most harmful, while drugs classified C are those considered not as harmful.

- 4.3.7 Primary Care Trusts, NHS Trusts, Foundation Trusts and the independent sector are accountable for the monitoring of all aspects of the use and management of controlled drugs by all healthcare professionals they employ.
- 4.3.8 It is important to remember that it is the responsibility of each individual Registered Nurse to manage and administer drugs safely as laid out in the Nursing and Midwifery Code of Professional Conduct. Further guidance is also given to nurses in the form of a publication from the Nursing and Midwifery Council (NMC) on 'Medicines Management'. NMC Code of professional conduct for registered nurses states:
- To practise competently you must possess the knowledge, skills and abilities required for lawful, safe and effective practice without direct supervision. You must acknowledge the limits of your professional competence and undertake practice and accept responsibilities for those activities in which you are competent.*²³
- 4.3.9 The use of controlled drugs is an essential part of emergency clinical care. They are used to treat a wide variety of clinical conditions in patients requiring emergency care. The establishment of systems and processes to manage medicines is a challenge in many clinical areas but is made more complex by the pace and variety of activity in an emergency department. Due to the nature of emergency care, it is essential that Registered Nurses and medical staff have immediate access to emergency drugs so that patients can be treated in an appropriate and safe way.
- 4.3.10 Traditionally some emergency drugs, which are required to be kept at a cool temperature, are stored in an unlocked drugs fridge within the resuscitation room so staff have immediate access to them in an emergency situation. Staff working within emergency departments require access to a wide range of drugs including controlled drugs, anaesthetic drugs and anticonvulsant drugs in order that patients can be treated quickly and safely.
- 4.3.11 Routine monitoring of the use of controlled drugs helps to drive up the quality of medicines management as well as detect potential concerns. If patient safety is thought to be at risk, immediate action should be taken. NHS bodies should follow their local serious untoward incident (SUI) procedures. Immediate referral to the relevant regulatory body must be considered where there are serious concerns about an individual's fitness to practise.

²³ NMC Code of Professional Conduct : standards for conduct ,performance and ethics

4.3.12 The Healthcare Commission has conducted an annual health check-medicines management 2005/06 ¹⁹ and gives an overall assessment for the Oxford Radcliffe Trust of “Good” in relation to the effectiveness of their medicines management but an area that receives fair is controlled drug management. This relates to audit of controlled drugs.

There are a number of legal requirements and best practice arrangements relating to the management of controlled drugs. Significant numbers of controlled drugs are held in a number of locations within hospitals. It is important that there are regular audits to ensure that these are being used appropriately and all stock can be reconciled. It is a legal requirement that an eligible person witnesses all destruction of controlled drugs from within the pharmacy.²⁴

4.3.13 Several changes in practice have been introduced in the storage and management of drugs in response to this serious incident.

4.3.14 The pharmacy department has introduced three new systems in order to strengthen the robust storage and management of drugs:

- A new system of combined controlled drugs ordering and register books has been introduced throughout the Trust so that there is a good correlation to drugs ordered and used in the department. This is an excellent example of managing the ordering and storage of controlled drugs.
- A new system has also been introduced Trust wide of a separate controlled drugs record book for all patient’s own controlled drugs which are brought into hospital with the patient. This ensures that all drugs are recorded and a transparent trail is made. This is also seen as an example of good practice.
- Sealable, tamper proof pharmacy bags have been introduced into the Emergency Department at the Horton General Hospital. Patients’ own drugs are put into the sealed pharmacy bag on admission to the Department. The drugs are then checked and listed at a later time. This system means that patient drugs are less likely to be mislaid or misappropriated. The system is working so well that it is to be introduced in to the Emergency Department at John Radcliffe Hospital.

4.3.15 The amount of controlled drugs kept in the controlled drugs cupboard are checked daily in all wards and departments to make sure they tally with the controlled drug register.

²⁴ Annual health check medicines management. Acute hospital portfolio. Healthcare Commission 2005/2006.

- 4.3.16 An on-line training programme in the storage and management of controlled drugs has been introduced for all registered nurses, midwives and operating department practitioners. This is mandatory training for all registered nurses in the Trust.
- 4.3.17 Benjamin Geen used some drugs that are not controlled drugs but are in schedules 3, 4 and 5 of the Misuse of Drugs regulations such as Midazolam (an injectable benzodiazepine). These drugs are supplied as stock to wards and departments at the Oxford Radcliffe Hospitals. No records are legally required in the controlled drugs record books, either in Pharmacy or departments or on the wards. The Pharmacy computer system records the issue of all drugs. When there have been concerns on a specific ward or clinical area that usage of drugs liable to misuse, such as Midazolam, is higher than would be expected, tighter procedures are introduced. This may include treating the drug as full controlled drug for a limited period of time in order to monitor its issue and use. This most frequently happens with, for example, codeine or dihydrocodeine tablets.
- 4.3.18 Midazolam is defined as a Schedule 4 drug under the Misuse of Drug Regulations 2001 and, as such, is not liable to any special safe custody requirements. As an injectable benzodiazepine, midazolam is potentially vulnerable to misuse. If a named individual is responsible for regularly ordering resupply of medications prone to misuse, large variations in usage are more likely to be noted and questions asked as to why, even without the necessity of tracking use and reconciling prescriptions.
- 4.3.19 The Oxford Radcliffe Hospitals, in common with most hospitals, uses pharmacy top-up assistants to identify and supply stock drugs required by wards and departments. They are in a position to raise concerns about increased usage with the pharmacist. The pharmacist may identify a genuine clinical reason for the increased use; e.g. a changed patient case mix or new prescriber with different prescribing preferences. If this identifies a potential diversion or inappropriate use of the drug, the pharmacist will escalate through the incident reporting procedure and the necessary actions would be taken.
- 4.3.20 The External Review Team looked retrospectively at the issues of Midazolam in the Horton's emergency department and identified that there was an increased use of midazolam in the Horton General Hospital Emergency Department during January 2004. Analysis of the annual consumption figures does suggest that there is a fairly steady and predictable level of use of midazolam in the department. The year of 2004 is a slight outlier and with the benefit of hindsight, the excess from median consumption (130) is 40 units. Whilst an increase, the small overall quantities involved suggest it may have taken some time to be identified.

4.3.21 The Pharmacy department has spent some time considering if the Bedford pharmacy system could generate reports that would automatically alert pharmacists to the possibility of inappropriate increase in the issue of drugs liable to misuse. The conclusion is that, with the current system, the data to be reviewed would be very cumbersome and not user friendly. It would involve the pharmacists reviewing many different cost centre reports for an individual department such as the emergency department, radiology, and theatres etc.

4.3.22 There are a number of systems available that support more effective medicines management and can identify the access to drugs by staff. These include:

- A swipe access system to the clinical room, which stores all drugs in the Emergency Department, used outside the resuscitation room. This system is in place in the Emergency Department at John Radcliffe Hospital and has been shown to work well.
- An electronic record of all staff accessing drugs gives another robust audit system. It also removes the need for numerous drug keys, which can be mislaid.
- An automated medication management system in the Emergency Department, which has potential to reduce the risk of medicine mismanagement.

4.3.23 Development of IT systems that can identify significant increases in issues of drugs with potential for misuse should be taken forward as a national initiative, possibly linked to electronic patient records and the response to The Shipman Inquiry, Fourth Report in secondary care.

4.3.24 The pharmacy department have worked with the nursing staff and identified priorities for improved medicines management covering education, clear accountability and team working both within nursing and pharmacy and between the two disciplines. The work covers the following:

- Staff education to emphasise that ward sisters / charge nurses are responsible for all aspects of medicines use on their ward, including safe and secure storage and local stock control.
- Ward pharmacists to be clear that, as well as advising on clinical use of medicines, they have a responsibility to work with pharmacy top-up assistants, technicians and ward managers to advise on and ensure safe and secure storage and stock control of medicines.
- The ward sister / charge nurse and ward pharmacist regularly undertake a documented review of medicines usage and storage and update the ward stock list, reviewing both the medicines held as stock and the stock levels. Unused stock is returned to the Pharmacy.

- Regular review and update of medicines management policies and ensuring implementation includes training and competency assessment.

4.3.25 In some organisations, medications prone to misuse, even falling outside the scope of the Misuse of Drugs Regulations 2001, are classified as 'Accountable'. Such drugs are managed in a way similar to controlled drugs, in that drugs are stored in locked cabinets, stocks are noted in registers, each issue is noted with patient details and regular checks are conducted to look for discrepancies.

4.3.26 Changes made in Horton General Hospital Emergency Department include;

- The main drug keys for the Emergency Department are carried by the nurse in charge of the unit and only given to trained nurses when access to the drug cupboards is required and then returned to the nurse in charge.
- The most commonly used anaesthetic drugs are now kept in a drug box in the resuscitation room fridge. The resuscitation room fridge is now locked.
- The box containing anaesthetic drugs is handed to the anaesthetist when required in order that the clinician can prepare anaesthetic drugs instead of nursing staff.

Recommendations 24,25,26,27,28,29 and 30

24 That controlled drugs are checked at every nursing shift change so that a robust audit system is in place if there should be a discrepancy found. This means that the drugs will be checked every 8-12 hours and any discrepancies can be traced, followed up and investigated in a timely manner.

25 Regular audits should be undertaken to ensure that controlled drugs are being used appropriately and all stock can be reconciled.

26 The Trust should consider the introduction of a swipe access system to the clinical room, which stores all drugs in the Emergency Department, used outside the resuscitation room.

27 The Trust should review the potential to use an automated medication management system in the Emergency Department, which has potential to reduce the risk of medicine mismanagement.

28 Development of IT systems that can identify significant increases in issues of drugs with potential for misuse should be taken forward as a national initiative, possibly linked to electronic patient records and the response to The Shipman Inquiry, Fourth Report in secondary care.

29 That the locking of the emergency drug fridge in the resuscitation room is revisited in light of the need for emergency access to drugs during resuscitation. This is not common practice in many other Emergency Departments.

30 The 3 systems introduced by the pharmacy department are recommended as examples of good practice and all Trusts should consider the introduction of these systems.

Conclusion

A number of significant changes have been made in medicines management across the Trust and in the Emergency Department at Horton General Hospital. The Audit Commission's medicines management review as part of the Healthcare Commission's Annual Health Check for 2005/06¹⁹ gives an overall assessment for the Oxford Radcliffe Hospitals of "Good" in relation to the effectiveness of their medicines management. There are areas where further change is required particularly in relation to having in place a robust audit system for controlled drugs and an action plan is being formulated.

4.4 Review the management and support of patients and relatives once untoward incidents are identified

"The operation of a health service depends upon a complex interaction between the patient, the environment in which care is provided and the people, equipment and facilities that deliver the care." Donaldson²⁵

4.4.1 As part of the review the Team has had discussions with all the patients and families who wanted to share their story. Seventeen took that opportunity and we are very grateful for their support. There is a level of consistency in the issues they raised with us. We do not underestimate that for most this meant reliving one of the most difficult periods of their lives.

4.4.2 After incidents like this we often do not hear of the tragedy that lies behind the brief newspaper story, item on the television news or

²⁴ Annual health check medicines management. Acute hospital portfolio. Healthcare Commission 2005/2006.

²⁵ Liam Donaldson writing in Medical Mishaps: Pieces of the Puzzle. Rosenthal M M, Mulcahy L and Lloyd-Bostock S (Eds). Open University Press, February 1999

reports of court proceedings. Behind all the stories are human beings whose lives have been affected by a criminal act. Many have waited for over two years until the criminal trial of Benjamin Geen to be able to express their views.

- 4.4.3 It is difficult for anyone who has not experienced being maliciously harmed by someone to fully comprehend the impact it can have on an individual's ability to trust others. The patients and relatives affected by the actions of Benjamin Geen have to live with the fact that the trust they placed in a nurse resulted in physical harm and in some cases death.
- 4.4.4 As a result of the Healthcare Commission's patient surveys in 2004/05 covering the emergency departments, the ORH received positive feedback and comment in a number of areas, including reception, the approach of doctors and nurses, privacy and dignity, information giving and explanation for tests, and in overall satisfaction. The action plan in place to address areas for improvement covers the need to manage pain for patients and the provision of more advice for patients on leaving the department. These results support the earlier finding of CHI in 2001.
- 4.4.5 Our conversations with members of the Oxford Radcliffe Hospitals Patients Forum have also identified the willingness of the Trust to provide information and support to enable the Forum to be effective. The Forum was not informed about the Geen incident prior to it being in the media but were kept updated with information that was appropriate at their meetings.
- 4.4.6 A Patient Advice and Liaison Service (PALS) was not available at the time of the incident, as the service was not fully established until 2005. The Trust now has in place a Patient Advice and Liaison Service in each of the hospitals to:
- Act on behalf of their service users when handling patient and family concerns.
 - Liaise with staff, managers and, where appropriate, other relevant organisations,
 - Negotiate speedy solutions and to help bring about changes to the way that services are delivered.
 - Refer patients and families to local or national-based support agencies, as appropriate
- 4.4.7 The Horton General Hospital is much loved and supported by the local population and this is clearly reflected in the support that the hospital and staff received at the point of the media breaking the story of the arrest of Benjamin Geen, and then the publicity during and after the criminal trial.

- 4.4.8 Comments made to the Review Team reflect this in that there is sympathy for the staff in the Emergency Department and the hospital and the belief that the action of Geen should not reflect negatively on their hospital. Many expressed their gratitude for the skills of the doctors and nurses. They recognise that without them many more people may have died as a result of Geen's actions.
- 4.4.9 Geen harmed the first patient on December 4th 2003 and it was on February 6th 2004 that the concern about inconsistent patient case histories was identified and the complicated process of identifying other patient who might have been harmed by Geen commenced. For most patients it was a week later when they were notified of the situation and as patient clinical records were analysed further patients were identified and informed. For some it was the publicity about the suspension of Geen that resulted in them contacting the hospital to identify their or their relative's potential involvement.
- 4.4.10 As part of the application of the Sudden Untoward Incident Procedure associated with the Geen incident, discussions took place regarding the handling of the media and communication with patients and relatives. It was reasonable that the intention of the Trust was to ensure that they had a better understanding of the situation and also to enable the police to be able to progress their investigations before they started to contact patients and or their relatives. Unfortunately the press received information from an unknown source, which necessitated the Director of the Hospital speedily contacting the patients or relatives they were aware of at that stage before the press published the story.
- 4.4.11 Despite the best efforts of the Trust because of the staggered identification of the patients involved, some learned of the situation from media coverage. For others it was the publicity that led them to consider they or their relatives might have been cared for by Geen in the Emergency Department at Horton General Hospital.
- 4.4.12 As part of the SUI, the Trust attempted to communicate with the patients and relatives at key points.

This included:

- Patients and relatives contacted either by telephone, or home visit and follow up letter.
- Press conferences to reassure local people.
- Patient contact to get permission to release notes to the police.
- All further patient or relative concerns investigated and responded to.
- A procedure for handling calls was developed and implemented with trigger points to identify the requirement for the establishment

of a rapid response line. Only 10 calls from the public were received.

- A letter about police investigations with the result that the Trust would no longer be involved with the patients and their relatives.
- Contacting patients and relatives after the criminal trial to apologise formally.

4.4.13 The Trust, as a result of being concerned about adversely effecting the police investigation, handed over support of the patients and families to the police. This resulted in considerable frustration for the relatives, patients and hospital staff at not being able to provide or receive support from the hospital. The recurring theme is that some of the patients and relatives felt 'abandoned' by the hospital and unsupported. The involvement of victim support earlier would have provided some of the additional support required.

4.4.14 Without exception the patients and their relatives expressed their gratitude to the police service for the support they received for more than two years during a very difficult period of their lives.

4.4.15 This is an unusual situation for any Trust and there is not a blueprint that might be used but the External Review Team has some concerns about the care management and patient support. Many of the patients, as stated earlier, already had long-term health needs, for some physical and some mental health problems, prior to this incident. Additionally they had to adjust to the changes in their lives resulting from the physical, mental or emotional impact of:

- Deterioration in physical or mental health.
- The investigation and stress of the criminal trial.
- Using hospital services, particularly the Emergency Department.
- Relatives attending the hospital for treatment.

4.4.16 It is External Review Teams view that the Trust needed to have in place a communications strategy that was wider than dealing with the response to the media and the key points during the case. An important part of the strategy was establishing a well thought through approach for working with the patients and relatives. Many had clinical requirements that were never assessed by the Trust. Some needed additional support but were left to handle the change in their physical or mental state without the information that was required to better understand how their care might be managed.

4.4.17 Clinicians outside the Oxford Radcliffe NHS Trust were providing the continuing care of some of the patients, particularly in relation to general practice and mental health services. There was no attempt to contact general practitioners or other Trusts to provide information they were able to about the impact of the incident on the patient and enable

additional support to be offered. Some families feel that they were not able to understand and provide support to their relatives effectively because they did not have the full facts. This has added to their distress.

4.4.18 There are however examples where this additional support was given, particularly in the case of one patient who had a long-term respiratory problem. The care he received whilst in hospital but specifically from the Specialist Respiratory Nurse at home provided the support that was required both physically and emotionally.

4.4.19 Other issues raised by some patients and their relatives are:

- The lack and delay in providing information to relatives while the patients were being treated in the Emergency Department. This was distressing for some, as they had to wait a considerable amount of time to learn if their relative had survived or died as a result of the deterioration in their condition.
- A number of patients and relatives expressed concern that they had attempted to draw attention to dramatic changes in their or their relative's condition after having an injection. At the time they wondered if the wrong dose or drug had been given and they felt that the doctors had not taken their concerns seriously.
- While not part of the terms of this review, the External Review Team feels a responsibility to identify that some expressed their dissatisfaction with the quality of care received by their relatives after the incident whilst they were on the wards. This particularly related to the care of older people. Some relatives have already received an apology for the issues they have raised and the concerns have resulted in some changes.

4.4.20 In February 2006 a protocol between the National Health Service, Association of Chief Police Officers and Health & Safety Executive set out a joint agreement for the investigation of "*Patient safety Incidents involving unexpected death or serious untoward harm*" to support liaison and effective communications. One of the key principles of the protocol was that in taking forward investigations recognition that the safety of the public and of patients should be the first priority and to achieve this requires a collaborative approach.

The protocol advises, from the following sections:

Section 7. Supporting those harmed, patients, relatives and NHS staff

7.1. In the event of a patient safety incident it is important that the NHS, police and/or HSE work together to keep patients, relatives,

injured parties and NHS staff informed and to provide support as appropriate.

The organisations should therefore, as far as possible, agree and follow a liaison strategy for each incident. Such a strategy should be agreed at the first meeting of the Incident Coordination Group and as necessary at subsequent meetings.

Section 8. Handling communications

8.1. A communications strategy needs to be agreed for dealing with patients, relatives, other organisations and the media. Where possible, the three organisations need to take a common approach to communications although in the event of legal proceedings this may not be practicable. Specialist help and advice should be sought as necessary.

- 4.4.21 The Trust needs to consider the content of the protocol and reflect it in the Serious Untoward Incident Investigation Procedure.

Recommendations 31,32,33,34,35 ,36 and 37

- 31 That packages of care should be established to meet the physical, emotional and mental health needs of patients who have been involved in a Serious Untoward Incident.**
- 32 A national system of identifying an objective' member of hospital staff is required to ensure that evidence is not jeopardised but patients and relatives receive the support they need from the hospital. This should be established in close cooperation with victim support.**
- 33 The Trust should annotate records to enable patients that have experienced a Serious Untoward Incident to be readily identified if admitted to the Emergency Department or onto a ward.**
- 34 The Emergency Department should support witnessed resuscitation, in association with patient and relatives' wishes.**
- 35 The Emergency Department should consider the processes they have in place to keep relatives informed of the patient's condition while in the Emergency Department.**
- 36 The Trust needs to apply the Incident Coordination Committee 2006 protocol to the Serious Untoward Incident Investigation Procedure.**

37 The Trust should ensure that a comprehensive communications strategy is established in the case of a serious untoward incident, which reflects the needs of all stakeholders.

Conclusion

The relationship between a patient and a health professional is a unique one. Whilst all successful human relationships are founded on mutual respect, in the healthcare setting patients can feel vulnerable in ways, which do not exist in other areas of life.

While the Trust made attempts to keep the patients and families fully informed, their ability to meet the clinical and psychological needs of those involved was adversely influenced by an anxiety that contact with the families might cause difficulties for the police investigations. This alongside the lack of a fully developed communications strategy led to the patient's and relative's feeling neglected by the Trust.

Overall Conclusion

This report has attempted to capture the key findings and issues associated with the provision of services at Horton General Hospital at the time and following the incidents associated with Benjamin Geen. It is not about blaming individuals or services but identifying the lessons to be learnt to improve the performance of services in relation to safeguarding patients in the future. The External Review Team has examined carefully all the evidence in the case and feel that whilst there are improvements that can be made in policies, structures and cultures the responsibility for the murder and grievous bodily harm of the seventeen patients involved in this case rests with Benjamin Geen and that it is the skills and knowledge of the nurses and doctors at Horton General Hospital that quickly identified his activities and prevented the outcome of his actions from resulting in more deaths and injuries.

Documents used in preparing this report

Appendix 1

- Census data. National Statistics. 2001
- Scores for wards in England and Wales .Jarman, Carstairs and Townsend
- Transforming Emergency Care in England –Professor Sir George Alberti DH October 2004
- Statutory Instrument 2004 No. 1765 Nurses and Midwives (Parts of and Entries in the Register) Order of Council 2004
- Independent Inquiry relating to deaths and injuries on the children's ward at Grantham and Kesteven General Hospital. London: HMSO, 1994
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- Section 46 of the Health and Social Care (Community Health and Standards) Act sets out the legislative basis for the Healthcare Standards. 2003
- Good doctors, safer patients- Department of Health.A report by the Chief Medical Officer . July 2006
- The Nursing and Midwifery Order 2001(SI 2002/253)
- A Risk Management Standard -IRM,AIRMIC and ALARM. 2002
- Report of a clinical governance review at Oxford Radcliffe Hospitals NHS Trust. Commission for Health Improvement. December 2001
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- Serious Untoward Incident 219 Internal report. Oxford Radcliffe NHS Trust, September 2004
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- Coulter A, The Autonomous Patient: Ending Paternalism in Medical Care (London: The Nuffield Trust, 2002).
- Wanless D Securing Our Future Health: taking a long term view *The Wanless Report. London: MH Treasury. 2002*
- NMC Code of Professional Conduct - standards for conduct-performance and ethics. 2004
- Numerous documents provided by the Oxford Radcliffe NHS .

Professor Pat Cantrill

Pat is Registered Nurse and Health Visitor and was a senior civil servant at the Department of Health, providing Ministers, the Permanent Secretary, Chief Executive and other Executive Directors and wider department with expert, informed, advice and support. As Assistant Chief Nursing Officer, (DoH England) for Clinical Practice and Regional Nurse Director, Pat developed leadership qualities and professional credibility nationally. She held two of the most senior nursing posts in the country, both of which have demanded a high public profile. As Regional Director of Workforce Development Pat had the responsibility for medical and non-medical education and training for all staff in the then Trent Region.

She has a proven academic track record holding an MSc in Race Relations and Community Studies and a BA (Hons) in Social Studies and she is a qualified teacher with experience as a Senior Lecturer at the then Sheffield Polytechnic. Pat is a Visiting Professor at Sheffield Hallam University and Adjunct Professor at the University of Lethbridge, Alberta, Canada.

She has led a number of high profile reviews of serious untoward incidents and safeguarding children overviews. Pat now is Company Director of her own limited company.

Rebecca Hoskins

Rebecca is a Registered adult and children's nurse. She has worked in emergency care for 18 years. She has experience of working in a variety of A&E departments during this time. Previously she has worked as a clinical nurse manager/matron in 2 A&E departments, being responsible for leading a large team of nurses and delivering an A&E service. She has also worked as a lecturer-practitioner in emergency care as well as an emergency nurse practitioner.

In her current role as a consultant nurse and senior lecturer in emergency care, Rebecca works clinically in order to deliver an A&E service as well as taking part in strategic planning for the future of emergency services. At the University of the West of England she manages a post registration emergency care course and contributes to courses educating emergency nurse practitioners and emergency care practitioners. She has also taken part in delivering aspects of the pre -registration curriculum for student nurses.

Her practice is underpinned by educational qualifications including a BSc (Hons) in Critical Care and a MA in Education and she has had several papers published in emergency care.

Mr. Darren Walter

Darren is a Consultant in Emergency Medicine and currently Clinical Director of the Emergency Department at South Manchester University Hospitals NHS Trust. He is an Honorary Lecturer with the University of Manchester School of Medicine and also an Associate Medical Director of the Greater Manchester Ambulance Service NHS Trust.

During higher medical training, his areas of specialist interest were EMS (Emergency Medical Services) and Disaster and Emergency Planning. He is an elected Board Member of the Faculty of Pre-hospital Care at the Royal College of Surgeons of Edinburgh and of the World Association of Disaster and Emergency Medicine. He is also Chairman of the International Committee of the British Association for Immediate Care (BASICS) and actively involved in developing international relations with EMS across the globe.

He is currently an advisor to the Emergency Planning Division at the Department of Health on a number of key work streams and also an Associate with the Healthcare Commission.

He remains committed to grass roots provision of pre-hospital care and spends rather too many dark and rainy nights getting his hands "dirty" at the sites of road traffic incidents and medical emergencies with the ambulance services in Manchester and Cheshire.

Performance Improvement & Cost Reduction

Proposals for changes at Horton General Hospital

- Maintaining the core of the hospital – the Emergency Department and Acute General Medicine.
- Improving care for older people, including provision of community beds, at the Horton General Hospital, to enable elderly patients to recover locally with easy and rapid access to assessment and diagnostic services, such as x-ray and CT imaging.
- Delivering the majority of routine surgery for the population of North Oxfordshire, South Northamptonshire and parts of Warwickshire at the Horton General Hospital.
- Delivering the majority of emergency surgery in scheduled emergency operating lists at the Horton General Hospital, with rapid access to theatres in Oxford for the few cases that still require emergency surgery out-of-hours.
- Providing access to the fullest range of diagnostic tests and equipment which can be provided cost-effectively in Banbury.
- Providing maternity services, including the large number of normal births, at the Horton General Hospital, in a new configuration linked with the Women's Centre in Oxford.
- Providing children's services in a consultant-led Horton Childrens' Day Centre, in a new integrated children's service covering all of Oxfordshire.
- Providing access to the many specialist (tertiary) services provided by the Trust, with as many as possible being delivered through clinics at the Horton.
- Integrating services across the Trust so that they are delivered to consistently high standards, by a single team of clinicians, with a common approach, ensuring equal access to the generalist and specialist expertise of the Trust for all patients.

Divisional Structure Clinical and Clinical Support Services

Services are grouped into three Divisions, each with a number of directorates. The directorates include those with services on more than one site, such as general surgery and women's services, and those based on a single site, such as cardiac services and neurosciences.

1.0 Division A

- **Acute and emergency medicine and gerontology** – acute general medicine, Horton medicine, emergency departments in Oxford and Banbury, gerontology.
- **Emergency access** - operational managers, emergency admissions, emergency access teams
- **Cardiac services** - cardiology, cardiothoracic surgery, technical cardiology, and cardiac investigative and diagnostic services
- **Renal services** - urology, renal medicine and dialysis, transplantation
- **Specialist medicine** - dermatology services, Oxford Centre for Diabetes, Endocrinology and Metabolism, haemophilia unit, clinical immunology, infectious diseases, respiratory medicine.

2.0 Division B

- **Cancer services** - medical and clinical oncology, clinical haematology, pain relief unit and palliative care
- **General surgery, vascular and trauma** - emergency surgery, gastrointestinal medicine and surgery, endocrine surgery, breast surgery, trauma surgery and orthopaedic surgery
- **Critical care, anaesthetics and theatres** - intensive care unit, neuro-intensive care unit and Horton critical care unit. Anaesthetics provide a service not only within the Trust but also to all other Trusts in Oxford
- **Specialist surgery and neurosciences** - ENT, cleft lip and palate surgery, plastics and reconstructive surgery, ophthalmology, oral and maxillofacial surgery, neurosurgery, neurology, neuropathology, neuropsychology and neurophysiology.

3.0 Division C

- **Children's services and clinical genetics** - paediatric medicine, paediatric surgery, specialist children's services, community paediatrics, neonatal, paediatric intensive care, and clinical genetics
- **Women's and sexual health** – obstetrics and maternity services, gynaecology and genitourinary medicine
- **Laboratory medicine and clinical sciences** - cellular pathology, biochemistry, haematology, microbiology, immunology and genetics

- **Radiological sciences** - general radiology, CT, MRI, medical physics & clinical engineering, neuroradiology and nuclear radiology
- **Pharmacy and therapies** - pharmacy, physiotherapy, dietetics, speech and language therapy, and occupational therapy.

4.0 **Corporate Services**

- Chief Executive's Department
- Medical Directorate
- Nursing Directorate
- Human Resources
- Finance and Procurement
- Planning and Information
- Estates and Facilities

Nursing Staffing in the Emergency Department at Horton General Hospital

Whole Time Equivalent Dec 2003	Whole Time Equivalent June 2006
Nurse Manager I grade 1.0 WTE Lecturer Practitioner I grade 1.0 WTE	In addition in June 2006 across the Horton and John Radcliffe Hospital sites on average at the Horton General Hospital Practice Development Nurse 0.6 WTE Lecturer Practitioners 0.2 WTE Nurse Consultant 0.2 WTE Matron 0.4 WTE Adding 1.4 WTE of senior nurse time to the June 2006 figures
1.71WTE G grade	1.0 WTE Band 7 (G grade)
8.56 WTE F grade	9.3 WTE Band 6 (F grade)
8.26 WTE E grade	18.6 WTE Band 5 (D & E grade)
11.26 WTE D grade	
8.58 WTE A/B grade	10.02 WTE Band 2/3 (A/B grade)
Total 40.37 WTE	Total 38.92 WTE

Training strategy for A&E (Horton General Hospital).

All qualified nurses

• **Compulsory annual training:**

Manual handling refresher
Fire lecture
Glucometer refresher
Paediatric and Adult life support skills refresher at appropriate level

• **Life Support training**

Adult Life Support

Hospital Life Support (HLS) New D grades during first year in A&E

Intermediate Life Support (ILS)	Minimum level for all other nurses
Advanced Life Support (ALS)	Desirable for F grade and above

Paediatric Life Support

Paediatric Hospital Life Support (PHLS)	New D grades during first year in A&E
Paediatric Intermediate Life Support (PILS)	Minimum level for all other nurses
Paediatric Advanced Life Support (PALS)	Desirable for F grade and above

Advanced Trauma Life Support (ATLS)

Lunchtime training in A&E	New D grades during first year in A&E
ATLS Observer course (ATLS(O) or helping with ATLS course in Oxford	
Minimum level for all other nurses	
Advanced Trauma Nursing Course (ATNC)	Desirable for E grade and above

Recertification when due:

ALS 3 years
ATNC 4 years
PALS 3 years

Please inform your team leader about the resuscitation and fire training you are going to organise for yourself each year.

All staff must have attend the following training

Accountability & scope of practice
Managing threatening behaviour
Awareness of non accidental injury in children

New staff

- **Core A&E technical skills**
(Achieved through Buddy scheme, within 6 months of starting)

PAS computer

LIMS (Pathology results) computer (contact -----ext'n 29231 bleep 538)
Glucometer
12 lead ECG recording
Triage
Plaster casting
IV drug administration
Suturing
Venepuncture
Cannulation

- **After 6 months your ongoing development will be based upon your annual appraisal. This may include the following:**

D grade development course
Mentor preparation
Breaking bad news
Issuing emergency contraception
Male catheterisation
A&E Certificate (ENB199)
E grade development course
Teaching and assessing in clinical practice course (ENB 998 / 730)
Stand alone modules at Brookes University e.g. Research, Trauma care, Pain...
Nurse Practitioners course (ENB A33)
Children's Nursing or Mental Health Nursing courses
Appraisal training
Managing sickness

- **Health Care assistants**

Adult basic Life Support for HCA's
Paediatric Hospital Life Support
Clinical practice development for HCA's (2 days)
Basic life support for HCA's
PAS computer
LIMS (Pathology results) computer
Glucometer
12 Lead ECG recording

Lecturer-Practitioner May 2001

Welcome.

This information is designed to help you settle into the A&E Department and to help you become a confident member of the team. If at any time you feel unsure of anything (however trivial) then always ask.

Your buddy will be :

Buddy system

First day

Hospital induction on first day (usually 10am – 11.30am)

Hospital life support + manual handling + fire training dates organised by training dept

Come to A&E dept to meet “buddy” and organise first day practicalities (see list)

It is your buddies responsibility ...

to help you feel a part of our team in a social sense as well as just as a colleague.

To encourage and monitor you while you practice the core A&E technical skills and judge when you are competent to use them without supervision (see attached list).

You are supernumerary for 2 weeks during which there is:

- Learning objectives (equipment, policies etc) which needs to be completed.
- A discussion with your buddy to assess your current skills and plan initial training.
- At end of the first week an informal discussion with your buddy to discuss progress
- At end of the second week another informal discussion with your buddy to discuss your progress

At end of the fourth week a confidential meeting with your buddy using the following structure:

- Buddy to write 2 things you do well and 2 things you could develop
- Your buddy *must* give specific examples to illustrate what they mean. For the areas where development would help, they *must* explain practical and specific ways to achieve this. If they cannot do this then these areas cannot be included.

This written feedback is confidential copies are to be kept by your buddy and yourself. These do not have to be shown to anyone but you are welcome to discuss it with whoever you wish, including LP or A&E Manager.

This meeting also includes a review of your progress with the learning objectives which were set in the first two weeks.

At end of the second month a confidential meeting with your buddy using the following structure:

Build upon the previous discussion and assess progress.

Your buddy adds 2 further things you do well and 2 more things requiring development.

This process needs to be documented but remains confidential.

Also review progress with your learning objectives which were set in the first two weeks.

At end of the fourth month a confidential meeting with your buddy using the same structure.

Your buddy will also organise a day at the A&E dept JRH – Through Liz Sibley or Alison Aberdeen (ext'n 20224/7/8 – the goldfish bowl in A&E major side) who organise buddies there. They will be able to organise a mentor for the day.

At the end of the sixth month you will meet with the A&E Manager for your first appraisal

You will need to give a copy of your completely signed “Core A&E technical skills competence record” to your appraiser and the A&E Lecturer – Practitioner. This means that you are expected to have achieved them all by this time. Information from the private meetings with your buddy can be used in this meeting if you wish but this is optional. The appraisal will include identifying your strengths and areas of interest, which can be developed to the mutual benefit of the A&E department and you

