MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON TUESDAY, 27TH JUNE 2023 - DAY 53

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THE INQUIRY RESUMED AT 10:00 A.M. ON TUESDAY, 27TH JUNE 2023, AS FOLLOWS:

CHAIRPERSON: Good morning, thank you.

MS. KILEY: Good morning, Chair, Panel. This morning's witnesses are Mr. Stephen Guy and Ms. Deirdre Murray, who are giving evidence on behalf of the Belfast Trust in relation to a statement made by Mr. Guy and Ms. Brona Shaw on the broad issue of PRN medication, and that arises from our Module 3(e). So I'll say something about that with the witnesses whenever they come out. But if the Panel is ready, the witnesses are ready. 10:03 10:03

CHAIRPERSON: Yes, absolutely. Thank you very much. 10:04

MR. STEPHEN GUY AND MS. DEIRDRE MURRAY, HAVING BEEN SWORN, WERE QUESTIONED BY MS. KILEY AS FOLLOWS:

CHAIRPERSON: Good morning both, thank you very much indeed for coming to assist the Inquiry, thank you. 10:05

Q. MS. KILEY: Good morning, Mr. Guy and Ms. Murray. We met briefly this morning. As you know, I'm Denise Kiley, I'm one of the Inquiry's counsel team and I'm going to take you through your evidence this morning. So I'll just say a little bit first of all about how that will run and perhaps we'll start with introducing both of you. 10:05

So if we can start with you, Mr. Guy. You were the

former lead pharmacist for the Belfast Trust, is that right?

A. That's correct. I'm Stephen Guy, I qualified as a pharmacist in 1986 and I spent the first part of my career in community pharmacy. Up until 1999 I ran a community pharmacy business of my own for seven years during that period. I decided on a career change and moved into hospital pharmacy in 1999, actually directly into mental health in Knockbracken Health Care Park as part of the old South East Belfast Trust before the Trusts merged. So then I've stayed within that role and expanded that role and developed over those years. And after the Trust merged in 1997, I think it was, I then took on the responsibility for the Mater Hospital. We had some indirect responsibility for Muckamore as part of the old South Eastern Trust on a service level agreement, but it was mostly supply of medication and not clinical function. Then I took on the responsibility for the City Pharma - the City, Windsor House at that point, the Mater Hospital, so sort of taking the lead role for mental health within the Belfast Trust.

I'm an accredited member of the College of Mental Health Pharmacy and a Fellow of the college, and I was President of the college from 1998 until 2012.

Q. MS. KILEY: Mr. Guy, you have made a statement jointly in fact with Brona Shaw in respect of PRN medication, isn't that right?

A. That's correct.

2 Q. I'm going to take the opportunity to bring that up on the screen please, STM-122. And you may be aware, Mr. Guy, the Inquiry is looking at a number of modules and you can see there in the title of your statement it refers to Module 3, Policy and Procedure, and your statement addresses an issue that arises from Module 3E. Module 3E relates to policies and procedures relating to medication and the auditing of medication. And the Inquiry has already heard from the Trust's medical director, Mr. Chris Hagan, about that topic broadly, but your statement addresses a more specific issue. So if we can just scroll down to see paragraph 1 and pause there, you can see the issue which your statement addresses and which I'm going to ask you to address today, and that is "Policies or procedures relating to the administration of PRN sedation, including how staff were assessed as competent to make decisions about using PRN and processes in place for assurance that PRN was being used properly". 10:07 10:07 10:08 10:08

A. Okay.

3 Q. Mr. Guy, can I ask you, do you wish to adopt this statement as the basis of your evidence before the Inquiry? 10:08

A. Yes.

4 Q. Thank you. And, Ms. Murray, can I come on to you then. You're presently the clinical pharmacist at Muckamore Abbey Hospital, isn't that right?

A. MS. MURRAY: Yes, that's correct. I qualified in 2008 as a pharmacist. I worked in community pharmacy and then made a career change into the hospital. I went to Musgrave Park Hospital. I subsequently left there to take up a new role as a GP practice pharmacist, where I qualified as an independent prescriber. And in 2018, the September of 2018, I joined the Muckamore Abbey Hospital as their clinical pharmacist.

5 Q. Can you tell the Panel a little bit about what your roles and responsibilities are at Muckamore as the clinical pharmacist? 10:08 10:09

A. Yes. As their clinical pharmacist, my role would be to attend MDT meetings as part of a team of doctors, nurses and occupational therapists and other people that would be present as multidisciplinary role. I consult on dosages, formulations of medications. I would advise on correct administration of medication and any monitoring requirements that are necessary. I work alongside the MDT to review treatments. I encourage adherence to policies and guidelines. I would be a link to the ward, between the ward and the dispensary, as we have no dispensary on site. I clinically check prescriptions for patients who are being discharged and going on home leave. I would advocate for medicines optimisation and provide advice and training when asked by staff. 10:09 10:10 10:10

6 Q. You've touched on some roles there that we will delve into a little deeper as we go through your evidence, and particularly your role in the multidisciplinary

team and providing advice on the administration of medication and the monitoring of that. So I'll ask you a little bit more about that in due course.

A. Okay.

CHAIRPERSON: Could I just ask, I'm so sorry. You've got some notes in front of you, and that's absolutely fine, but this is being live streamed so it's important that everybody understands what it is that you're reading from. 10:10

A. Oh. 10:10

CHAIRPERSON: Are those just your personal notes made to remind you?

A. Yes, they're just personal notes, yes, just to remind me of where I am as different topics arise.

CHAIRPERSON: Alright. And no-one else has had a hand in those? 10:11

A. Oh no, no, these are just some handwritten notes beside evidence that we have here.

CHAIRPERSON: That's absolutely fine, thank you.

7 Q. MS. KILEY: Thank you, Chair. Ms. Murray, you haven't made a statement yourself on this particular topic but you have contributed to the statement made by Mr. Guy and Ms. Shaw, is that right? 10:11

A. Yes.

8 Q. And have you had an opportunity to read over that before today? 10:11

A. Yes.

9 Q. And I'm going to ask you then some questions that arise from the statement. So in terms of procedure, I'll

direct questions to both of you throughout the course of this morning's evidence session. And as I explained whenever we met briefly this morning, whenever I ask a question I'm going to identify one of you who I think is perhaps best placed to answer the question. And I'd ask that person to be the primary witness and answer that question first of all. If either one of you feel that you have something to contribute after that, please feel free to do so. As you can see, we have a stenographer keeping a record of the evidence that is given, so if you are going to add something in that way, please just wait for the first person to finish. And it's also helpful if you can remember to identify yourself before you give evidence, just give us your name so that the stenographer can record that, okay.

10:11 10:12 10:12

So the first topic that I want to deal with is just to try and understand what is PRN. And, Mr. Guy, you explain this in the statement, so I want to read out in fact some of the paragraphs of the statement rather than have you repeat them, to provide us with a little bit of context. And then I'll ask you some questions about it. So if we can turn to paragraph 7 please on page 3. And you say here:

10:12 10:12

"PRN is an abbreviation of the Latin term pro re nata, which means "when needed". The acronym is used in relation to a wide range of prescribed medication that is to be taken or administered when needed. It is not

confined to medications that may be administered to a patient by intramuscular injection. It also encompasses oral medications. The PRN acronym is used to refer to a type or basis of prescription rather than to any particular medication. There are many different prescribed medications that may form part of the class or group referred to as PRN medication. PRN medication is used in a very wide variety of contexts across the health and social care system, primary, secondary and community care. It is not confined to use in a learning disability hospital or for the management of acute disturbed behaviour." 10:13 10:13

And if we move down to paragraph 12 then:

10:13

"In the context of mental health and learning disability care, the term PRN is commonly used in the context of the management of acute behavioural disturbance. In this context, the use of PRN medication is generally part of a strategy to deescalate or prevent situations of patient agitation, aggression and violence. It is a pharmacological strategy which may be used as part of a continuum of interventions including non-pharmacological techniques to manage instances of acute behavioural disturbance, the symptoms of which may range from agitation and distress to actual aggression or violence. In the context of mental health and learning disability care, the use of PRN can refer to the use of oral medication 10:14 10:14

utilised as part of a deescalation strategy..."

And you refer to that in the statement as "oral PRN deescalation".

10:14

"...through to intramuscular or IM medication administered to achieve rapid tranquillisation during an episode of violence or aggression."

So just pausing there, Mr. Guy. You've explained PRN and we can see there in the final paragraph that I've just read out, you have explained that there is a difference between what is described as "oral PRN deescalation" and "rapid tranquillisation". Can you explain the difference?

10:15

10:15

A. MR. GUY: Again, I have just some notes of my own which I've made to try and help me to remember the bits and pieces between that. Could you repeat your question again just so I'm clear on it please.

10 Q. It's really I read out the context of what you described as PRN, but you said in the final paragraph that I read that there's a difference between PRN administered for deescalation and rapid tranquillisation.

10:15

A. Okay.

10:15

11 Q. Can you help us understand what the difference is?

A. Yeah, I think the difference is down to what is defined as rapid tranquillisation, and that has changed a little bit over the years from the original NICE

guideline which did consider the CG25 guideline published in 2005. It did have a statement in it saying that all medication administered, including oral PRN medication, should be considered as part of rapid tranquillisation. The evidence - NICE create their evidence recommendations and that was created as an evidence recommendation level D, which is the lowest grade of evidence in NICE guidelines, and essentially it's expert consensus opinion. Many clinicians felt that including oral medication as part of a definition of rapid tranquillisation didn't really fit clinical practice, because oral medication is not rapid, it doesn't work quickly, it won't have the same speed of onset as medication given by intramuscular injection, so if you need a rapid response, you have to use the intramuscular medication. NICE have changed their definition of rapid tranquillisation in the 2015 guideline. 10:16 10:16 10:17

12 Q. Yes, I'm going to come on to that actually and look at those, so it may be appropriate to pause there and take that up whenever we look at the guidelines. But in terms of the difference, am I right in saying that oral PRN for deescalation are tablets administered orally? 10:17

A. Yes.

13 Q. Is that right? But rapid tranquillisation isn't administered orally, is that right? 10:17

A. No, rapid tranquillisation would be administered by intramuscular injection. And it may well be the same medication that might be administered. It could be -

For example, Haloperidol can be given both orally and intramuscularly. The effect will be different when it's given intramuscularly, it will be faster, it will be more - you know, it will have a quicker onset and, you know, there will be a more obvious onset, whereas if it's given oral, the onset will be delayed. So that's really why the sort of term rapid tranquillisation is different from oral PRN. And the oral PRN is there as part of that - one part of a deescalation strategy to try and reduce that sort of risk of some sort of mild agitated behaviour developing up to a full point where the person might require IM medication. So what you're trying to do is avoid the use of a more restrictive intervention by using a less restrictive option at the beginning. 10:17 10:18 10:18

14 Q. So is it right to say then that oral PRN is considered a less restrictive intervention than rapid tranquillisation?

A. I would say yes.

15 Q. Okay. We will see some of this in the outworkings of the policy, so I want to turn to look at those now, and you address the policies at paragraph 23 onwards in your statement. If we could turn up page 7 please. So we can see a list of policies and guidelines at paragraph 23. Is it right, Mr. Guy, that the Belfast Trust's first own policy on rapid tranquillisation was that in 2012? 10:18 10:19

A. That's correct.

16 Q. And that's the policy that's listed at 23B there, is

that right?

A. Yes, that's correct.

17 Q. Are you able to tell the Panel what guidance applied in the Belfast Trust before the 2012 policy?

A. I can't. I don't know exactly what guidance would have applied before that time. There wasn't - to the best, there wasn't a single unified Belfast Trust policy. I can't actually remember whether the legacy trusts had their own policies or not, and I think that the Trust Panel Team were trying to find that information out. But I can't remember or know, and certainly I don't think I would've ever had knowledge of whether Muckamore had a policy at that point. 10:19 10:20

18 Q. Okay.

A. So, yes, that would have been the first Belfast Trust policy and I'm not aware of a previous policy before that. 10:20

19 Q. Yes. There is reference at 23A there to February 2005, NICE Clinical Practice Guidelines. Were the Trust applying them pre-2012, do you know? 10:20

A. I couldn't say, I couldn't answer that for certain because I don't know whether they would have been or not. I think people would have been aware of those guidelines and would have been taking cognisance of those guidelines. I'm not sure when Northern Ireland actually was required to accept NICE guidelines. It was at some point but I'm not sure when that would have been, and it generally comes out from the Department, 'This guideline has now been approved for 10:20

use within Northern Ireland', but I don't know whether that would have applied to the CG25 or not. But that guideline, clinical staff would have been aware that that guideline would have been published.

20 Q. Yes. But is it right to say that it may be that the reliance was on clinical staff knowing that rather than there being a Trust policy requiring it to be followed, is that right? 10:21

A. I would say that's correct because, effectively, the policy which was written was to implement that guideline. 10:21

21 Q. Yes, and we can see that in the 2012 Trust policy. In fact I think you say that at paragraph 31, that the purpose of the 2012 policy was to implement the 2005 NICE guideline. If we could turn to look at the 2012 policy then. It appears at page 179. If we could bring that up please. You can see on the screen there, Mr. Guy, the first page of the 2012 policy, and in fact under "authors" you are named as the author in your role as Senior Clinical Pharmacist then. 10:21 10:22

A. That's correct.

22 Q. You mentioned earlier a divergence in the definitions of PRN and rapid tranquillisation --

A. Yes.

23 Q. -- with reference to the 2005 NICE guideline. What approach did the 2012 policy take to the difference between PRN and rapid tranquillisation? 10:22

A. Just bear with me one second because I think I might have something which would -- If you look at the NICE

2005 guideline, it does have a section about deescalation but it seems to be separate from the use of medication. It then goes on to actually mention a step-wise approach using oral medication as the first stage and then it goes on to mention using intramuscular medication as a further stage. We did sort of try and build that into the guideline and if you look on page 189 of the 2012 one, you'll see the flow chart. Actually, that's the (inaudible) one. 188 has the flow chart for adults and the Level 1 -- 10:23

24 Q. Just pause there a little second. If we could get that up please, 188. This I think is Appendix B to the 2012?

A. Yes. Yeah, so this is for adults over 18 and if you look at that, you'll see the green box is Level 1 medication, that is all oral medication. So that's trying to following that step-wise approach within the CG25 guideline. Although they're saying that's still a rapid tranquillisation, we're still putting that into this sort of lower level intervention within our own guideline. And then Level 2 moves in towards the use of intramuscular medication, which would be the next stage within CG25. 10:24 10:24

25 Q. Yes.

A. So we've tried to keep within that, although we're not sort of saying that the oral is rapid tranquillisation. 10:24

26 Q. Yes, okay.

A. We're sort of fitting that more as part of a deescalation strategy, even back at that point,

whenever that was not what NICE's definition was, but most clinicians at that point. I think the difficulty is if you have somebody who is not mildly anxious and you give them some oral medication, most clinicians would never have considered that to be rapid tranquillisation and there's very, very little likelihood that that would ever have proceeded to rapid tranquillisation even if you hadn't given them the oral medication but you'd given the oral medication to reduce their anxiety and their distress. And I think that is sort of where we've tried to keep sort of the oral separate from the intramuscular in that part of the guideline. 10:25 10:25

27 Q. And just looking at the three levels then. Is it right to say that in the context of a graduated style of approach, broadly PRN falls into Level 1, the green category? 10:25

A. Yes.

28 Q. And rapid tranquillisation falls into Level 2, the amber category? 10:25

A. Yes, and into Level 3.

29 Q. 2 and 3?

A. Yes.

30 Q. Okay. If we can go back up to page 180 of the policy please, in fact page 179, the first page please. 10:25 We can see there, Mr. Guy, the box setting out date version, author and comments and we can see at the top of that that the first version was authored by you, the first draft was authored by you on 15th of May 2009?

A. Mhm-mhm.

31 Q. But if we look up to the upper box on the right-hand side, we can see there's an approval date of the 29th of March 2012. Why was there a delay in the approval of the policy? 10:26

A. It's not necessarily a delay in the approval of the policy, it was a delay in the drafting of the policy. You know, the policy was not submitted for approval until probably some time in 2012, the earlier part of 2012 probably. I couldn't say for sure, but it usually 10:26 takes the internal process a couple of months to actually come out with the approved document. It would have gone through -- You know, you've seen several drafts have gone through there and it has fitted in with other work that's gone on and sometimes you just 10:27 don't get back to it in a timely enough manner to keep it going quickly.

32 Q. If we can move down to page 180 please and scroll down to - If we just pause there please.

DR. MAXWELL: Just before you move to that. Would you 10:27 consider it normal to take three years to draft a policy?

A. In this circumstance it did take that. I can't speak as to why. It's so long ago I can't remember why it took that length of time. 10:27

DR. MAXWELL: So would it be unusual to take three years to draft a policy?

A. I couldn't - I can only speak for policies that I have done and I can't speak for other ones.

DR. MAXWELL: But for the policies that you have drafted in your -- So you've mentioned that you're a Fellow of an institute for --

A. College of Mental Health Pharmacy.

DR. MAXWELL: Yeah, and you were the President, so you've obviously got experience in this area. In your personal experience of drafting policies, is three years an outlier? 10:28

A. Three years probably would be an outlier. As time would have went on, it would have got shorter than that. 10:28

DR. MAXWELL: And what would be the normal range then?

A. I couldn't actually give you a normal. It depends very much on - it depends to a certain extent on other work that you have, it depends to a certain extent on how quickly you get stuff back from other people to comment on. So it can take you -- If somebody comes back with stuff, you ask them to comment, you have to prompt them to get some comment back, and then it has to be circulated around other groups to try and get, you know, inclusion from nursing staff, inclusion from medical staff. It would go to the Trust's Drugs and Therapeutics Committee for approval and then it goes through to the Standards and Guidelines Committee for approval. So I would say it probably would take around a year to try and probably get something through from starting from scratch to something which is approved. 10:28 10:28 10:29

DR. MAXWELL: Thank you.

A. Okay.

33 Q. MS. KILEY: I want to look at the scope of the policy, so if you look at the page on the screen in front of you, 180 under Section 2. There is the title "Definition scope of policy". If we just pause there. And you can see in the second paragraph there it says: 10:29

"It is expected that this guideline will be used primarily in mental health settings but it may be applicable for the acute management of known or apparently disturbed mental states in other settings. 10:29 In these situations, clinicians may wish to seek further advice on management from a psychiatrist."

And if we scroll down then to look also at page 181, paragraph 5 please. Just pause there. You can see at 10:30 5.1 it says:

"This guideline is applicable in all mental health in-patient units within the Belfast Trust. All medical and nursing staff working in mental health in-patient 10:30 units should be aware of this guideline. Further consultation is required before this guideline is fully implemented outside mental health units."

So in 2012 did this guideline apply in learning 10:30 disability units?

A. It doesn't appear within the guideline as a statement that it applies but I do know that it was being used within the learning disability units.

34 Q. How do you know that?
A. Because of the statement from one of the other contributors to the statement, which was Damien Hughes, Dr. Damien Hughes, and he said that the guideline had - the flow charts were on the clinical room walls of the guideline and that they were aware of it in Muckamore and were following the guideline.
35 Q. You can see there though that there's a comment:

"Further consultation is required before this guideline is fully implemented outside mental health units."

Did that --
A. That was -- Sorry for interrupting. That was intended outside mental health entirely, outside into acute medicine, not with other mental health areas, including learning disability. That would really be for use within Accident & Emergency Departments or within general medical wards, because the NICE CG25 guideline did say that it could be used in other areas but we had not consulted on this version of the guideline in areas outside mental health.
36 Q. So whenever you're using the term "mental health" and when the policy uses that term, is the Panel to take it that it includes learning disability?
A. I think that's a fair comment.
37 Q. Okay. If we scroll down then to page 192, Appendix F. We can see that there's a training needs analysis for the rapid tranquillisation element of the policy and

you can see this table sets out the training needs analysis for all staff groups, identifying which groups of staff require training and the level and frequency required, and you can see on the left-hand side of the column that the staff group is identified and the level of training is identified in the other columns. So if this applied in the learning disability context, is it fair to say that one would expect there to be records of staff in Muckamore Abbey Hospital, the staff that fall into those groups having received this training? 10:32 10:33

A. I had no responsibility for delivering the training for Muckamore at that time and I don't know that I have the knowledge to answer that question directly. I think that would have to be answered by some of the Muckamore team. 10:33

38 Q. But just looking at the policy, is it right that this table sets out the staff groups that are expected to be trained under the policy?

A. Yes. 10:33

39 Q. And so one would expect that any unit applying the policy would have their staff trained in accordance with this appendix, is that a fair general statement?

A. That's a fair general statement.

40 Q. We've already looked at the flow chart at Appendix B, 188. If we just bring that up again please. So you've already described to us the various levels -- 10:33

A. Yep.

41 Q. -- within the policy, and if we scroll down two pages

please to page 190. We can see a further appendix. Appendix D sets out post rapid tranquillisation monitoring guidelines, and we can see - I won't go through it all but this sets out the observations that are required after the administration after rapid tranquillisation. Under this policy, were those same observations required after the administration of oral PRN for deescalation?

A. No, and it says that in the first box at the top after the heading "Rapid tranquillisation monitoring". 10:34

"After any parenteral drug administration..."

which means by injection.

"...for rapid tranquillisation or clinically necessary with oral medication, patients require to be monitored as below."

So there was no imperative to monitor after oral medication unless there was a clinical reason, that it was a concern of some reason that they needed to do that. But they should do it after intramuscular medication. 10:35

42 Q. What was the rationale behind having that difference? I'm thinking in particular -- You said earlier that sometimes the same medication can be used for oral PRN. 10:35

A. Okay, well again, the difference would -- Well, part of it is the NICE guideline said that after IM medication

was given, you should do the monitoring. So it was following that part of it. But there is a difference in the clinical effect and there's a difference in the risk between oral medication and intramuscular medication. You're more likely to get sedation with intramuscular medication, you're more likely to get respiratory depression with intramuscular medication. So the risk is higher. So that was why the emphasis was on monitoring after IM medication and only to do it after oral medication if there was a clinical reason. The oral medication given in PRN, quite often this person may get that - a person may get that medication as regular medication and there would be no requirement to monitor that on a regular basis after each dose. So it would be similar in that circumstance. 10:35 10:36 10:36

43 Q. The appendix there sets out particular observations that need to be recorded and particular timeframes. Where would you expect those observations to be recorded?

A. Now they will be recorded on the MEWS chart, the neurological early warnings course chart. I can't speak as to whether that chart was being used in Muckamore at that time. I don't know when it was implemented there. If it was not recorded on the MEWS chart, it would be recorded in the person's notes. 10:36 10:36

CHAIRPERSON: I'm sorry. Would the MEWS chart also become part of the patient notes?

A. Yes.

CHAIRPERSON: Or is that kept separately?

A. Yes, it would be filed with the person's notes, yes.

44 Q. MS. KILEY: And generally then in respect of this policy, after it was drafted approved, how were families of patients made aware of the Trust's policy?

A. I couldn't speak to that at this point because I don't -- There was no direct consultation with families for the policy at the time and I'm not aware of any direct consultation with families for any Trust policy in that sense. There is an equality impact assessment completed on the Trust policies and that's really looking at whether any of the affected groups within the Northern Ireland Order are treated differently within the policy. And the policies generally tend to be screened out because they're clinical in nature and they apply to all people equally. So I can't give you any more information than that. 10:37 10:37 10:38

45 Q. Okay. Are you aware of how staff were informed of the policy?

A. I'm not directly aware of how staff were informed of the policy, but it would have gone down through various line management structures within the Trust. It would be published on the Trust hub, and so there would be a version of it on the Trust hub which could be downloaded by any staff member and read. And it would have gone down through the line management sections within the different clinical directorates to disseminate. 10:38 10:38

46 Q. If we return to look at paragraph 23. At page 7 we can see that following this 2012 Belfast Trust policy,

there was then in May 2015 a new NICE guideline on violence and aggression, short-term management in mental health and community settings. And then there is reference to a further Belfast Trust policy dated February 2017. Is there a connection between the updated NICE guideline and the requirement for the updated Trust policy there? 10:39

A. Yes, yes.

47 Q. What were the -- Were there changes, significant changes in the 2015 NICE guideline? 10:39

A. There were some changes which I would consider significant. The main change was a very clear statement that rapid tranquillisation was the use of medication by injection, most commonly intramuscular. But they also allow intravenous, which would never be used within mental health units but might be used within Accident & Emergency Departments. But there's a very clear change in direction, to the extent that the guideline did not mention oral medication at all other than a statement that oral medication could be used as part of a deescalation strategy but that the use of oral PRN medication on its own was not considered deescalation, that they would need to do something in addition to that as well. So that would be the one major change in terms of definition. 10:40 10:40

In terms of implementing that part of it, I don't think it actually changed our implementation of the guideline terribly much because we felt that the guideline had to

still include the oral medication within it, because it's there to provide guidance to staff. We felt if we didn't include the oral medication section in it, you would have potentially variation in practice between different units, between different clinicians, because there was no framework to work with. So it didn't change that part of it terribly much, but it just changed the definition of it.

The only other change, which was significant which we really needed to implement, was a change in one of the medication recommendations for intramuscular injection, to move to using Haloperidol within another medication called Promethazine in combination, because NICE had found evidence that it reduced the risk of side effects with Haloperidol on its own. And that was a significant change in clinical practice. So those would be the two major changes within the actual guideline. If you actually track through the two guidelines side by side, you'll find that many of the statements are the same between them. And the flow charts have changed and if you look within the flow charts again, for example on page 272, we've sort of tried to clarify the flow --

10:41

10:41

10:41

10:41

48 Q. If we just pause and we'll bring this up on the screen. 10:42
This is the flow chart that accompanies the 2017 Belfast Trust policy, is that right?

A. Yes, so this is Appendix B.

49 Q. Yes, and this is the equivalent of the appendix that

you showed us previously in relation to the 2012 policy?

A. Yes. Yes, so we've tried to make it a wee bit more clear, sort of, you know, the layout wise to try and make it easier to follow. So we still have Level 1, which would now be the use of oral PRN as required medication as part of a deescalation strategy and to try and reduce the risk of having to move towards a higher level intervention. And then you've got Level 2, which is using the two equal first choice options in the NICE guidelines, which is either Lorazepam on its own or Haloperidol combined with Promethazine. So that's an equal first choice and it's down to the prescriber as to what they feel is the most appropriate for the individual. And then Level 3 is, when that sort of has failed you move on to the next step. And where we have -- We've kept within the NICE guidelines completely until the last of the five bullet points within Level 3. 10:42 10:42 10:43

50 Q. Yes. 10:43

A. Because at that point you've done all the things NICE recommend. You've either given a Level 1 intervention and potentially repeated that. Sorry, we call it a Level 2 intervention and potentially repeated that once. Or you've given the other Level 2 intervention if the first one didn't work, and that's all that NICE recommends. But there will be circumstances where people may still need something else at that point, so that's where they've drawn on clinical experience to 10:43

produce the options further down.

51 Q. Yes. So in terms of the Belfast Trust policies then, if we were to compare the 2012 policy with the 2017 policy, in fact the methodology was really the same, is that right, in terms of having three graduated levels on approach? 10:44

A. Yes, yes.

52 Q. Okay. And then if we could scroll down while we have this up to page 274, to look at the monitoring that was required after rapid tranquillisation. 10:44

A. Yes.

53 Q. Again, we looked at this document in respect of the 2012 policy. Was the approach in the 2017 policy the same, i.e. that the monitoring was automatically required for rapid tranquillisation but not for oral deescalation? 10:44

A. Yes, yes.

54 Q. Yes, okay.

A. And the only other change within that monitoring is the change in the time from 10 minutes to 15, and that was purely based on the NICE guideline changed. So, you know, it extended it out to an extra five minutes between the observations. 10:44

55 Q. So if you're a member of staff on the ground in the Belfast Trust applying the 2012 policy and the 2017 policy, is it fair to say that they were broadly the same? 10:45

A. They're broadly the same.

56 Q. Then at paragraph 26 you go on to refer to the first

ever regional guideline on the management of acutely disturbed behaviour through pharmacological deescalation and rapid tranquillisation. That was published in 2022 by the HSCNI. And I think you were a member of the group that published that guidance, is that right? 10:45

A. I was part - I came into it late, I wasn't in the original sort of earlier stages of it. But again, there has always been sharing of guidelines within, you know, the development of guidelines. I'd shared the 2012 Belfast Trust guideline with my colleagues in other trusts and the 2015, and a few of them had adopted a very similar style in terms of the three-level flow charts. The genesis of the regional guideline was two-fold. One was to -- We'd been sort of advised that with Encompass coming along and the new system, that we needed to try and harmonise as much as possible policies and guidelines so that all trusts could be using something similar. But also looking at it, the guidelines between the individual trusts were very, very similar and yet staff were moving between trusts. You know, trainee medical staff move on a regular rotation between trusts and it made sense for all trusts to be using a similar policy, you know, to make training simpler. That if they'd been trained in one Trust policy, then they will be using the same policy in another Trust. 10:45 10:46 10:46 10:46

57 Q. And are there differences between the Belfast Trust's own policy and the regional guideline now?

A. There may be some differences in sort of the background text. The background text has got quite a bit bigger within that part. I can't speak -- I thought this policy was slightly outside the remit, so I haven't actually looked, compared it, but the flow charts are essentially the same.

58 Q. The flow charts that we've been looking at?

A. Yes.

59 Q. Those three levels?

A. Yes. The flow charts were essentially the same. They've been tweaked a wee bit with some additional information put in them. But the medicines choices within them, because it's based on the same guideline, the NICE NG10 guideline, the medicines choices are not going to change and the monitoring isn't going to change because it's based on the same guideline.

60 Q. Okay. Before we leave the issue of policies, I just have one further specific question. Benzodiazepines are used for anxiety, is that right, on some occasions?

A. That's one of their indications, yes.

61 Q. And if that is administered, does that fall under the classification of PRN medication for deescalation?

A. If it's oral?

62 Q. If it's oral, yeah.

A. It could do, it could do that. I think the difficulty is the broad scope of acute behavioural disturbance. You know, I did sort of look at this to try and sort of get a background within that and the British Association for Psychopharmacology has a --

I'm just trying to sort of find my notes on this to see where it actually is. Yeah, they use the term and we've referenced the AP guidelines in tab 0307 of the Trust submission. They use the acute disturbance as a composite term, to include concepts of agitation, aggression and violence in the context of acute mental state. And the guideline further states there is no commonly accepted definition for any of these concepts. So it's a very broad spectrum, from someone who is maybe mildly agitated to someone who is on the verge of an acute outburst, and it's trying to sort of gauge what you're trying to treat within that. So is that deescalation? Yes, it could be, but that person may or may not have gone on to escalate whether they were given medication or not. It's hard to say. 10:49

63 Q. Well, if Benzodiazapine is administered for that purpose, for a deescalation, does the prescription and administration of that fall under the policies that we have just looked at, the Belfast Trust policies on rapid tranquillisation or is there something else that it falls within? 10:49

A. It falls within the Trust policy as part of the deescalation, yes.

64 Q. Okay, so it would fall under that Level 1 --

A. It would fall within that Level 1 part of the flow chart, yes. 10:50

DR. MAXWELL: Can I just clarify. So as you say, there's a wide range of behaviour. There are some people who are anxious and the risk of them becoming

violent or aggressive is tiny.

A. Yes.

DR. MAXWELL: Would there be different considerations for the use of PRN, benzodiazepines, for somebody who was regularly anxious but there was no expectation that this would progress to violent or aggressive behaviour? 10:50

A. I think that's a very, very fair comment. I think that is probably what happens in practice and I think trying to sort of pin all of this under acutely disturbed behaviour is very very difficult. You know, to give you an example. A patient who maybe is going out on a shopping trip from the ward, who becomes mildly anxious and agitated before they get on the bus, may themselves ask for their PRN medication to calm themselves so they can get onto the bus and enjoy their shopping trip. Is that deescalation? I'm not sure that that is, but where does it fit? 10:50 10:51

DR. MAXWELL: So that's my question really. Given that there are two different scenarios, one is not deescalation, it's therapeutic for the patient, for them to manage social interactions. Is there a different policy to cover the use in that scenario? 10:51

A. No.

DR. MAXWELL: There isn't?

A. No. 10:51

DR. MAXWELL: So if a member of staff was considering either prescribing or administering Benzodiazepine in a PRN context in that scenario, they would be using their professional judgment, there is no guidance?

A. They would be using their own clinical judgment, and it's likely the person may have some PRN medication prescribed on their Kardex, so they will be using their clinical judgment in that circumstance to decide whether to give that medication or not. 10:51

DR. MAXWELL: And so a simple review of a medication chart wouldn't necessarily tell you which scenario it had been used for?

A. Not unless that was recorded in the patient's notes.

DR. MAXWELL: Thank you. 10:52

65 Q. MS. KILEY: Okay. I want to move on from policy now and focus more on the prescription of medications for these purposes, and you deal with this at paragraph 42 of the statement, Mr. Guy. I'll just read what you say there. If you bring up page 13 please. It says: 10:52

"In the case of both oral PRN deescalation and intramuscular rapid tranquillisation, medication may be prescribed only by a qualified prescriber. Generally, this means a doctor. However, it could also mean other 10:52 non-medical professionals approved and registered within the Belfast Trust as a non-medical prescriber NMP."

I'll pause there because we'll come back to the topic 10:53 of NMP. But if we look at paragraph 48 please. You can see it says:

"As to the form of prescription, all medication must be

prescribed on a Kardex that relates to each patient. The Kardex relating to the individual patient then forms part of the patient material. The prescription of oral PRN deescalation or intramuscular rapid tranquillisation is recorded on the page entitled "as required medication" with the prescribing clinician completing information on the left column and the prescription start date."

And you have provided a sample Kardex, so I want to look at that please at page 630. So we can see there it says this is an example of how to write up rapid tranquillisation. Ms. Murray, I'll direct my questions on this to you, if I may.

A. MS. MURRAY: Yes.

66 Q. You can see there that it says:

"This example would be appropriate for a new admission. Variable doses and first and second line choices should be reviewed by the patient's own team."

Can you explain that concept of first and second line choices?

A. So the prescribing clinician would decide which was the most appropriate medication to be given first if a patient is experiencing some form of agitation or aggression. This will give the nurse, the administering nurse direction as to which medication to chose. The second line would be the choice that they

would like them to use once the first line has been exhausted and has shown no clinical outcome for a patient.

67 Q. And that would then be written up on the left-hand side of the Kardex. I think if we could zoom into one of the entries, Lorazepam please. You can see there under "Special instructions", the third column, it says "First line agitation". So you would expect that question of whether something is first line or second line to be noted by the prescriber on the Kardex, is that right? 10:55

A. That's correct.

68 Q. And aside from that note about what is first line and what is second line, what guidance does the prescriber give those who may be administering this, as to when it is appropriate to administer first line and then second line? 10:55

A. I wouldn't be the best person to ask that information of. That would be between the medics and the nursing team. As far as the role of the pharmacist goes, it's to ensure that doses are adhered to, frequency is adhered to, the right route is adhered to and there is a maximum dose in 24 hours provided for the nursing staff. 10:55

69 Q. But in terms of this Kardex, there's nowhere on the sample Kardex that allows a prescriber an opportunity to give that more narrative note, is that right? 10:56

A. No, there isn't.

70 Q. And by its nature, PRN is prescribed in advance of the

time that it might be needed, isn't that right?

A. Yes.

71 Q. So it's described on the left-hand side. And in the learning disability context, is there a usual time that PRN would be considered for prescription? 10:56

A. It would be, on admission, all their medicines, their normal, their regular medications are transcribed from their ECR or from their GP record onto a Kardex, and it's up to the prescribing clinician to decide which medications would be appropriate also to be 10:57 administered when required. And they're all completed at the time. That's not to say that's a static prescription. If a patient is not suitable for certain medication or the nursing team felt that it wasn't appropriate any more, that something else was indicated 10:57 better, then the prescription can be changed.

72 Q. Who would be involved in those sorts of discussions about what is an appropriate medication?

A. The clinicians and the nursing team. I would also be involved as part of an MDT to assure that appropriate 10:57 doses are adhered to.

73 Q. What about families, do they have an involvement, families of patients?

A. I know that our families would. Some parents would say that they don't feel a medication is appropriate for 10:58 their child, and I'm sure that the clinicians take that all into consideration.

CHAIRPERSON: Could I just ask. This is again my ignorance, but even though there's no room on the

Kardex to give a narrative as to why a drug has been administered, would you expect that to appear elsewhere in the patient notes?

A. Yes.

CHAIRPERSON: Thank you. 10:58

74 Q. MS. KILEY: And then if -- So the left-hand side shows us what is prescribed in advance and if ultimately PRN is administered, then that ought to be filled out on the right-hand side, is that right?

A. Yes. 10:58

75 Q. So we can see then the items that need to be recorded are date, time, dose, route and given by, who has given it.

A. Yes.

76 Q. When, at what point in time is it expected that that part of the Kardex would be filled out? 10:59

A. After the administration of the medication.

77 Q. And is there a timeframe between the administration of the medication and the completion of the note that is acceptable? 10:59

A. No, it should be immediately. All depending on how the ward is functioning, the administering staff should fill that in immediately.

78 Q. As they are administering then or shortly after?

A. After. They would need to go -- These Kardexes are kept in a clinical room, they are not kept at the end of a patient's bed, so once the medication has been administered, the nursing staff should go back to the clinical room and complete the Kardex. 10:59

79 Q. You referred there, and have referred earlier, to multidisciplinary team meetings and I want to talk a little bit about that, because at paragraph 54 they are mentioned. So if we turn that up for context please, page 17. So it is said there: 11:00

"In the context of MAH, although the prescribing clinician ultimately must make the prescribing decision, this is done within a framework of regular multidisciplinary team, MDT, meetings and review." 11:00

And you have referred to those, whenever we were looking at the Kardex, and your involvement in those. There is reference within the statement to those multidisciplinary team meetings having occurred at 11:00 Muckamore Abbey since 2018, and I think that coincides with whenever you became the clinical pharmacist, is that right?

A. That's correct.

80 Q. Are you aware of what happened before 2018? 11:00

A. No.

81 Q. So is the Panel to take it that the weekly MDT meetings only involved a pharmacist after 2018?

A. Yes. I do know that they had meetings obviously, but I wouldn't have known what was discussed at those 11:01 meetings. I didn't attend them.

82 Q. And there was no other clinical pharmacist attending?

A. No, they didn't have a pharmacist from maybe at least 10 years before I came.

83 Q. Okay. There's reference -- If we just scroll over to the next page please and just pause there. There's some reference to what happens at the MDT meetings. So it says:

"Each MDT meeting involves a review of the individual's care plan and drug Kardex by at least one or all of a consultant psychiatrist, senior house officer and from 2018 the clinical pharmacist. This includes review of all prescribed medication and all medication that has been administered in the preceding week, including both oral PRN deescalation and intramuscular rapid tranquillisation." 11:01 11:02

In terms of the type of information that the MDT receives about medication that has been administered in the preceding week, what type of information do you receive? 11:02

A. The nurse would give a review of the patient's journey that week, that previous week. They would report if and how many times PRN first and second line had been administered. I would have checked the Kardex to see that it actually matches what the prescription - you know, when they make a note to the right-hand side of the prescription, what has been administered as what they have reported. Sorry, what was your question again? 11:02 11:03

84 Q. You're answering it. I wanted to understand the type of information that you receive. You were talking

about information being provided by the nurse. Is that something that's provided orally or is it a written report?

A. Oh, yes, it's a written document. They read from their notes. I then -- We all listen to what they have to say. The doctor has look at the Kardex, I have a look at the Kardex and if there's any comments to be made with -- 11:03

85 Q. You refer to getting a report on, I think, the number of times PRN had been administered in the preceding week, is that right? 11:03

A. Mhm-mhm.

86 Q. Do you get any further information about the circumstances in which it was administered?

A. Yes, there's a narrative on how the patients presented and then they will say, 'First line was administered following the incident'. 11:03

87 Q. Do you get any information on the effect that the medication had on a patient?

A. Yes, they will say that, and it's something that we would discuss quite often. The patient was settled then after or there was no effect after first line, therefore they proceeded with another line. So they will give us a detailed account of how the patient presented. 11:04 11:04

88 Q. And if, having had that presented, another member of the MDT was concerned about the amount of oral PRN deescalation medication that a patient was getting, how would that be dealt with?

A. There would be no reason why anyone would hold back any information to that account. If you felt like that, that's what you should say. I haven't been involved in that scenario, so I can't account for anyone else.

89 Q. You mentioned there that the information that the MDT receives is oral from the nurse and it's then discussed. What record is then made of the MDT meeting? 11:05

A. There is always an admin assistant there and they make notes on changes that are made or any information that the team feels appropriate. 11:05

90 Q. Returning then to the statement.

DR. MAXWELL: Sorry, can I just ask, where are the minutes of the MDT meetings kept, because obviously they won't be in the patient's notes because they refer to a whole group of patients? 11:05

A. If you contacted the team, I'm sure someone could direct you to that. It should be in the PARIS notes under case conference.

DR. MAXWELL: Okay, so it would be electronically in the PARIS system? 11:06

A. Yes.

91 Q. MS. KILEY: And that's relating to individual patients?

A. Yes.

92 Q. So turning then to paragraph 56 of the statement. There's reference to the nature of medication used for oral PRN deescalation, and it says: 11:06

"It is important to highlight that not all medication

prescribed for the management of behaviour by oral PRN deescalation is sedation medication. We are aware that there are patients at MAH for whom the first line medication prescribed for agitation is Paracetamol. This may be because such patients often complain of or indicate pain. Further and for the avoidance of doubt, where sedating medications or potentially sedating medications are used, the aim of oral PRN deescalation and intramuscular rapid tranquillisation is not to achieve a state of sedation but to achieve a state of sufficient calm so there is minimal risk to the individual patient, staff members and others where the patient is displaying acutely disturbed behaviour." 11:06 11:07

There's reference there, Ms. Murray, to Paracetamol being prescribed for agitation. If that is administered and that successfully does deescalate a patient's behaviour, how is that flagged for further investigation as to the source of the pain that has been complained of? 11:07 11:07

A. A doctor would be called for review if the nurse in charge felt that the patient required a review, medical review.

93 Q. So it's down to the nurse in charge to ask for a review in those circumstances? 11:07

A. Yes, yes.

94 Q. But this would be a circumstance that PRN, Paracetamol for PRN would be prerecorded on the Kardex?

A. Mhm-mhm.

95 Q. Is that something -- Is the administration of that something that would be reviewed at the MDT meeting?

A. Yes, all administrations are reviewed for the week.

96 Q. So is that not something that you would expect to be picked up at the MDT meeting then, the fact that Paracetamol had been successful in deescalating and then that be flagged for further investigation? 11:08

A. I don't know if it would warrant further investigation. Not every time it would warrant further investigation. If the patient was indicating that they had mouth pain or a headache and the nurse in charge felt that they needed review, that would be reviewed at that stage. But at the MDT meetings, the use of Paracetamol, being an over counter medication, wouldn't necessarily flag that up. 11:08

DR. MAXWELL: Would you not be aware that Paracetamol was being used regularly? Would that not flag a concern?

A. Oh, yes, the review of the amount of administration, we can see the date and the time that it was used, so if something was being used quite often, that would be discussed. If there's more than seven times administration within that week, then there would be a discussion. Is this necessary, do we need to do any further investigation, should we have the patient reviewed, should it move to regular and take it off the PRN section. 11:09

DR. MAXWELL: In sticking with Paracetamol, how - what would flag to you -- How many times would

Paracetamol be administered to flag to you that perhaps there was some unresolved pain that needed further investigation?

A. There's not too many spaces left available on that Kardex for one medication. So if I saw five, five to seven times within a week, then I would question whether -- what was the use for, were they reviewed, should we move it to regular? And that would all be discussed with the whole team then. So the nurse in charge would be the best person to know how the patient was that week. 11:10

DR. MAXWELL: Thank you.

MR. GUY: Can I add a supplementary there?

97 Q. MS. KILEY: Yes.

A. MR. GUY: I think there's two scenarios around -- You know, I haven't direct experience of Paracetamol in learning disability but I do have in care of the elderly wards where using - they're not able to vocalise pain and you give them pain relief and their behaviour improves. But there's another scenario where you may have someone who has just a temporary thing like a broken tooth so you're getting short sporadic use for an acute pain or someone who's got a longer underline problem, and it's that one you need to investigate more than the acute dental pain or a headache or a fever. 11:10 11:10 11:11

DR. MAXWELL: But you can see from the chart that it was being used?

A. Yes, yes. There's only, there's 14 spaces for

administration of each PRN before it needs to be re-prescribed. So, you know, a doctor would have to rewrite that after that recording space is used up. So if you see something very quickly within -- If you're giving four doses in 24 hours, that space is going to run out very, very quickly. So that would indicate that the doctor would need to sort of think why it's suddenly starting to being used.

98 Q. MS. KILEY: Okay. Returning to the statement then at paragraph 57. There's reference to the mode of administration of prescribed medication, so I want to look at that. At paragraph 57 it is said: 11:11

"A number of the medicines used in this area are available in both oral and intramuscular injectable form." 11:12

And then it's said that:

"You are advised that the administration of intramuscular rapid tranquillisation was comparatively rare..." 11:12

That's at Muckamore Abbey Hospital.

"...and where it was prescribed, the prescription was often for the same type and dose of medication as the oral PRN deescalation medication." 11:12

I wanted to ask you, Mr. Guy, about that phrase "comparatively rare". Compared with what?

A. MR. GUY: I don't know why the phrase "comparatively" is there. I think that could be dropped. I think it is rare. We would, either looking at this in a wider context, and Deirdre can give her own impression of the number of times that PRN IM medication is administered in Muckamore, my experience would be more within acute adult mental health in-patient units and psychiatric intensive care and there would be higher incidents of IM medication use in those environments than there would be in Muckamore. So you could look at it comparatively in that sense but I think overall in Muckamore, the use of IM medication is rare. 11:12 11:13

99 Q. Ms. Murray, does that accord with your understanding of Muckamore since 2018 when you commenced there? 11:13

A. MS. MURRAY: Yes. I know that we could identify how many patients have had intramuscular first or second line administered through the Datix system, but currently that data hasn't been pulled yet. 11:13

100 Q. Yes, and I'm going to come on to that, because later on in the statement there's reference to what must be recorded on Datix and what mustn't, so I'll come to ask you about that.

DR. MAXWELL: Can I just ask, do you get -- You can get information from Datix. Is it pushed to you? Do you get a regular report from Datix saying this is the number of times -- 11:14

A. No.

DR. MAXWELL: -- parenteral. So you don't?

A. You have to --

DR. MAXWELL: You would have to go and ask for it?

A. Yes.

DR. MAXWELL: Rather than it being sent to you? 11:14

A. And it would be something that would be discussed at live governance and I don't attend those meetings. But, yes, it's given. But if I wanted it, I would have to ask for it.

101 Q. MS. KILEY: You referred there to the live governance 11:14
meeting and, again, we'll come on to look at that, but in general terms, is the actual administration of oral PRN medication more generally monitored by the Trust?

A. It is now. There is a template that the nursing staff complete and it is verified by two nurses. We also 11:14
have introduced calm cards to remind, just as a reminder to the administering nurses of other ways of deescalating the patient, and they use this newer template now to record how the patient has responded to the administration of oral PRN. This was something 11:15
initiated in 2022. Previous to that, no.

102 Q. It's only in 2022 that that practice commenced?

A. Yes.

DR. MAXWELL: And is this specific to Muckamore?

A. It is, yes. 11:15

DR. MAXWELL: Or is it used in other mental health settings?

A. No, this is --

DR. MAXWELL: So it's something bespoke?

A. MR. GUY: We have used calm cards in adults in-patient units as well.

DR. MAXWELL: But the idea that two registered nurses have to consult before administering oral medication, deescalation medication, does that happen in other mental health settings? 11:15

A. MR. GUY: No, not to my knowledge.

DR. MAXWELL: So this is a specific response to concerns at Muckamore?

A. MS. MURRAY: Yes, this is used since 2022. 11:16

103 Q. MS. KILEY: Is this the process referred to at paragraph 83, page 27? If we could bring that up please. You can see there, Ms. Murray, there's reference to:

11:16

"Since the summer of 2022, as part of the recent audit and quality improvement project referred to above, an additional process has been introduced within MAH for the completion by two registered nurses of a specific form recording that PRN medication has been given after 11:16 discussing other agreed alternatives, including that deescalation techniques have been unsuccessful. This requirement essentially instigates a critical conversation between two registrants prior to the administration of PRN medication and act as an 11:16 additional safeguard in relation to the decision to do so."

That's the process?

A. Yes.

104 Q. And if we turn up page 655 please. Is this the means of recording that process?

A. It is, yes.

105 Q. And was there any equivalent before 2022? 11:17

A. No.

106 Q. So from 2022 onwards, two nurses need to discuss and agree a rationale, is that right?

A. Yes.

107 Q. But before then, one nurse could make the decision themselves, is that right? 11:17

A. Yes.

DR. MAXWELL: And going back to the point about using oral Benzodiazepines for other use. That wouldn't cover that, that wouldn't cover giving something to somebody who was going out and was socially anxious? 11:17

A. Recording it on this sheet?

DR. MAXWELL: Yeah. This is just for deescalation or violent or aggressive behaviour?

A. Yes. 11:17

DR. MAXWELL: So similar drugs might be given but not using this chart?

A. Any --

DR. MAXWELL: This is context-specific to deescalation? 11:18

A. No, this is for any medication that has been used, that has been prescribed as required medication. The nurses would record every medication, whether it was Paracetamol, whether it was -- They then describe under

"rationale" why.

DR. MAXWELL: But we discussed earlier a potential scenario where a patient was going on an outing and was anxious and might be given some Lorazepam, and that wouldn't be considered deescalation? 11:18

A. Yes.

DR. MAXWELL: Would that be recorded on this form since 2022 or not?

A. There's no reason why it couldn't be recorded on the form. 11:18

DR. MAXWELL: But I'm asking what the practice is rather than whether it could be.

A. Well, I haven't been involved in that scenario where someone has went out on an outing, on a bus, so I can't testify to that. There would be no reason why the 11:18 nurse couldn't record it on there.

DR. MAXWELL: But they may not record it?

A. They may not. But perhaps that question would be better asked to the nursing staff that would be involved in those decisions, but there's nothing to say 11:19 that they can't.

CHAIRPERSON: And it wouldn't be part of your role to review these forms?

A. No.

CHAIRPERSON: Right. Okay, the witnesses have been 11:19 going for about -- They probably haven't noticed the time, but you've been going about an hour and 20 minutes, which is quite a long time for any witness to give evidence for, so I wonder if that would be a

convenient moment for a break?
MS. KILEY: Yes, Chair.
CHAIRPERSON: Alright, we'll take 15 minutes. Thank you very much.

11:19

AFTER A SHORT BREAK THE HEARING CONTINUED AS FOLLOWS:

CHAIRPERSON: I'm just wondering if the Trust lawyers are coming back or not?
MS. KILEY: I haven't seen them, Chair. I think the 11:38
secretary has gone to alert them to that, that you're back.
CHAIRPERSON: I didn't hear a word of that. Could you say that again, sorry!
MS. KILEY: I think the secretary has gone to alert 11:39
them to the fact that you're back.
CHAIRPERSON: Oh right, thank you. Right, okay.
108 Q. MS. KILEY: Thank you, Chair. Ms. Murray, Mr. Guy, before we broke we were talking about the multidisciplinary meeting and how that acts as one of 11:39
the processes by which a prescription and administration of PRN can be reviewed. I want to look at some other processes for review which are set out in the statement. So another is listed at paragraph 58. If we could bring up page 19 please. It says there: 11:39

"Outside of the regular framework of MDT review, there are also times where, in response to behavioural presentation such as an escalating incident, it is the

opinion of ward nursing staff that there may be a need to consider the prescription of further PRN medication in order to manage the incident. That scenario could lead to a consultation with a doctor for a decision to be made as to whether it is safe and necessary to prescribe further medication. A prescription may thereby be issued live as a stat dose. This would be written up on the individual's Kardex as a one-off prescription to be administered immediately." 11:40

Ms. Murray, I wanted to just clarify, could that parenteral deescalation be prescribed verbally in an emergency situation?

A. MS. MURRAY: I am not the best person to ask that question to. That would be something you would need to ask the nursing team. 11:40

109 Q. Have you seen that happen?

A. No.

110 Q. You haven't?

DR. MAXWELL: Does the Trust have a policy? 11:40

I certainly know from my experience in England that different trusts have different policies on verbal prescriptions.

A. MR. GUY: I can answer that for you. Yes, it's in the Trust's medicines code that in an emergency situation, a medicine that has previously been prescribed can be re-prescribed or the dose can be offered, and is confirmed by electronic means to the nurse, so a text or email if that's required. But it wouldn't normally 11:41

apply to a new medicine, a medicine that had not previously been prescribed.

DR. MAXWELL: So if there was a conversation on the telephone between the nurse and a prescriber, that would be confirmed by a text or an email? 11:41

A. That's what the Trust policy says.

DR. MAXWELL: Before the drug is administered?

A. I would suspect -- I would say, yes, it should be done before the drug is administered.

DR. MAXWELL: And that would be in the Trust medicines policy? 11:41

A. It's in the Trust medicines code, yes.

CHAIRPERSON: And could I just ask, are all these types of drugs controlled drugs?

A. No, not in the sense that you're asking in terms of like an opiate is a controlled drug, no. Benzodiazepines are a controlled drug but they're subject to very low levels of control. They don't have to - they're not subject to the safe custody rule so they don't have to be kept in a controlled -- They have to be kept in a locked medicines cupboard, not in a controlled drug cupboard. 11:42 11:42

CHAIRPERSON: Right.

A. And there is no requirement to make a record of the administration in a controlled drug register. 11:42

CHAIRPERSON: So there's no extra hurdle, as it were?

A. No.

CHAIRPERSON: And that's what I was thinking.

A. No.

A. MS. KILEY: Mr. Guy, thinking back to the process that you referred to for the verbal prescription of medication in an emergency, are you aware of what the process is for the recording of that, after it happens verbally? 11:42

A. I'm not directly aware of the recording, but my interpretation of it would be that they would make a record of that in the patient's notes, that there had been a verbal order to administer a medicine and to record the conversation which had been had with the 11:43 doctor that was prescribing that medicine. But my experience of verbal orders is they're not that common.

DR. MAXWELL: Would you expect it to be entered on the medication record as well?

A. Yes, the medication chart is supposed to be signed as a 11:43 stat dose at a later point.

DR. MAXWELL: And would you expect the doctor to come at a later date and countersign that?

A. Yes.

111 Q. MS. KILEY: A further review is noted at paragraph 59. 11:43 It says there:

"Further, where intramuscular rapid tranquillisation is used, the Belfast Trust policies over time have provided that a senior doctor must review all 11:43 prescribed medication every 24 hours, and so the prescribing decision is also revisited in those circumstances."

Mr. Guy, I just wanted to clarify that use of the word "used" -- So it says there:

"...where rapid tranquillisation is used..."

11:44

and then it goes on to explain the process required. Does that review happen every time intramuscular rapid tranquillisation is prescribed or does the word "used" there mean administer?

A. It means, I think that means administered. 11:44

112 Q. So that process that's described at paragraph 59 only happens after the rapid tranquillisation is actually administered?

A. Yes.

113 Q. Where is the senior doctor's review recorded? Are you 11:44 aware of that?

A. I'm not directly aware of that, no. That would be a question to ask the medical team.

114 Q. Yes. Ms. Murray, are you aware of that, in working at the hospital, where the senior doctor's review would be 11:44 recorded?

A. MS. MURRAY: No.

115 Q. I want to move on now and consider the role of a non-medical prescriber. We heard reference to that briefly earlier in our exchanges. It's addressed 11:44 further at paragraph 62 of the statement and you can see there that the role of a non-medical prescriber is set out. Mr. Guy, are you able to explain to the Panel in general terms what the non-medical prescriber is?

A. MR. GUY: A non-medical prescriber is a healthcare professional from a list of allowed groups. Pharmacists, nurses, podiatrists, physiotherapists and other professions can become non-medical prescribers. It's a post-graduate qualification, although in some professions it's coming into undergraduate, it's coming into undergraduate in pharmacy in a couple of years. They have to do a post-graduate course in terms of prescribing to become a non-medical prescriber. They have the same rights of prescribing as a doctor. They can prescribe any medication but they're expected to prescribe within their area of competence. So if they've trained for example in an asthma environment, they're supposed to prescribe medicines only within that environment. I am a registered non-medical prescriber within mental health so I would be expected to practice only within the mental health area and if something else came up in terms of cardiology, I would not prescribe for that. 11:45 11:45 11:46 11:46

The Trust then has a register of non-medical prescribers to which you have to apply to become a prescriber within the Trust. So once you have the non-medical prescribing qualification and you have that noted on your professional register as a non-medical prescriber, you can then apply to the Trust to have that recognised as a Trust prescriber. There's a form to complete within that, within the non-medical prescribing policy which you've referenced here, 11:46

in which you have to outline your area of practice and a general overview of the types of medication that you will prescribe as a non-medical prescriber.

116 Q. How long have non-medical prescribers been operating in the Belfast Trust? 11:47

A. Non-medical prescribing has been going for more than 10 years. I couldn't give you an exact number, exact figure.

117 Q. There is reference to a non-medical prescriber operating at Muckamore Abbey Hospital. At paragraph 42 11:47 it says:

"Currently, there is one nurse registered as an NMP at MAH. That individual has been registered since 28th of February 2020. However, we are advised by colleagues 11:47 that this individual is not actively prescribing so there is no NMP function at MAH currently. To the best of our knowledge, there have not previously been any active NMPs prescribing at Muckamore Abbey Hospital."

11:47

Do you have any understanding of why there weren't NMPs at Muckamore before that time?

A. I don't directly have any knowledge of that, no.

118 Q. And do you have knowledge of why the current NMP isn't currently prescribing? 11:48

A. I don't have that knowledge, no.

119 Q. Ms. Murray, are you able to assist on that?

A. MS. MURRAY: No, and I actually don't believe that to be true any more. I think that person has since left

Muckamore Abbey Hospital.

120 Q. Okay. So they were registered since 28th of February 2020. Are you able to give a time that they left?

A. Ehm, maybe October last year, if that is the person who I'm thinking of. 11:48

121 Q. Okay. That then is the prescription of medication. I want to focus now on who can actually administer the medication.

DR. MAXWELL: Can I just ask a question please. So in some of the policies it refers to special considerations in the choice of prescription for people with dementia, older people. Are there any particular considerations that need to be made in regard to people who have learning disabilities? 11:48

A. MR. GUY: I can't see that there are any particular reasons for that other than the person may have a physical condition, which someone who doesn't have a learning disability may equally have, and that would be considered by the prescriber when they were writing the medication. To give an example. If they had a cardiac complication, then that might preclude the use of Haloperidol for example. But I don't know if that would be any different from a person without a learning disability. 11:49 11:49

DR. MAXWELL: So I'm wondering why older people in dementia gets a special mention in the policy? 11:49

A. Because people with dementia are at higher risk of stroke with the use of anti-psychotics and also they're probably at the higher risk of delirium when some

medications like benzodiazepines are used. So they need to be used more carefully and more cautiously in that group to avoid precipitating delirium.

DR. MAXWELL: We have heard that a number of people with learning disability have epilepsy. Are there particular issues about prescribing these deescalation rapid tranquillisation medications in relation to somebody with epilepsy? 11:50

A. Again, I would have to say that's a clinical decision by the prescriber who's making the choice of medication at the time, because people without -- There are a lot of people who have epilepsy who do not have learning disability and we don't have an exclusion or separate section of the policy for epilepsy. There is a risk, antipsychotics do have a small increased risk of causing seizures, so that would be taken into consideration by the prescriber when they're deciding whether to do that. Benzodiazepines are often used in the treatment of epilepsy. That might actually mean they can't be used for that person because they're already on a Benzodiazepine. So again, I think that is not something that's unique to a person with learning disability. I think that would apply to anybody with epilepsy and the same clinical judgment would have to be applied. 11:50 11:50 11:51 11:51

DR. MAXWELL: So there's some quite complex pharmacological considerations with people who have co-existing conditions --

A. Yes.

DR. MAXWELL: -- and prescriptions?

A. Yes.

DR. MAXWELL: Thank you.

122 Q. MS. KILEY: Can we turn up page 23 of the statement please. At paragraph 70 and 71, Mr. Guy, you explain who can administer medication. It is said there: 11:51

"Within the Belfast Trust in a hospital setting, medication must be administered by a registered nurse. Whilst there may be some medical wards in the Belfast Trust where doctors also administer medication, this is rare in the mental health and learning disability context. Healthcare assistants and other ward staff may not administer medication. The above position applies equally to both oral PRN deescalation and intramuscular rapid tranquillisation. 11:51 11:52

In practical terms, oral medication may be taken personally by an individual patient or service user. However, the decision as to its administration at a particular time is a clinical decision which must be made by the registered nurse. The nature of a PRN prescription, whether for oral deescalation or intramuscular rapid tranquillisation, is that its administration is at the discretion of the nurse. Its very purpose is to ensure that there is, within appropriate bounds, flexibility based on patient need." 11:52 11:52

So it's clear there that only registered nurses can

administer medication, but does that include agency nurses too?

A. Yes, it would include agency nurses.

123 Q. There's reference there to the decision to administer being a clinical one -- 11:53

A. Yeah.

124 Q. -- and that being taken by the nurse. Where would the nurse record their clinical decision-making?

A. You would have to confirm with the nursing staff to be certain because it's not something that I would be 11:53 directly involved with, but I would expect that to be recorded in the patient's notes.

125 Q. Yes. And we have seen then the process since 2022, which you described, Ms. Murray. Is that the type of document where we would see clinical decision-making 11:53 being recorded in the present day?

A. MS. MURRAY: Yes.

126 Q. And are you aware of what process took place for that sort of clinical recording before 2022?

A. No. Again, that would be something that would be 11:53 clarified by the nurses.

127 Q. Turning then to paragraph 72 to 75 of the statement, the link between the clinical decision to administer PRN and other deescalation techniques are emphasised and I just want to look at paragraph 75 please. 11:54 It says there:

"Module 7 of the safety intervention training addresses decision making. It introduces a decision making

matrix, which is a tool for assessing risk behaviour and assists staff to determine the safety intervention which meets the criteria of reasonable proportionate to the risk and the least restrictive intervention. Further, the emergency content of the course also covers a specific holding skill for the administration of intramuscular rapid tranquillisation as well as the considerations to be taken into account prior to the administration and in relation to post administration monitoring." 11:54

Are you aware, Mr. Guy, of when that decision-making element was introduced to safety training?

A. MR. GUY: I am not aware of that. You would need to address that to the Safety Intervention Team. 11:55

128 Q. The Panel have heard from Mr. Warren from the Safety Intervention Team, generally, about the safety intervention training. But keeping with that issue of training, if we just scroll down to paragraph 96 please. There's specific reference to specific training on rapid tranquillisation. Yes, just pause there please. Are you familiar with that, Mr. Guy? 11:55

A. I'm familiar with -- Exactly what are you asking am I familiar with?

129 Q. Are you familiar with the specific training that exists in respect of rapid tranquillisation? 11:55

A. Yes, in the context that pharmacy were asked to deliver rapid tranquillisation training as part of the five-day MAPA course based at Knockbracken.

130 Q. Yes.
A. And that is sort of on a rolling basis and we attend whenever we're asked to attend to do that.
131 Q. So is it pharmacy that deliver this element then?
A. It's pharmacy that deliver that part of it at the request of the Safety intervention Team. 11:56
132 Q. Okay. And there is reference just further on in that paragraph, if we scroll down please. Just scroll up so we can see the whole paragraph. Yes, there's reference in the third line to the rapid tranquillisation course having not been delivered as part of the MAPA SI course delivered at Muckamore Abbey Hospital, and the Panel have already heard from Mr. Warren about the two types of safety intervention training. 11:56
A. I've seen that transcript. 11:57
133 Q. Yes. So are you aware as to why pharmacy weren't asked to deliver this training at Muckamore?
A. I don't have any awareness as to why, no.
134 Q. Okay. I want then to move on to the processes which are in place for assurance in relation to PRN, which is a further section of your statement. And in fact at paragraphs 100 to 105 there's a summary. If we could bring up page 33 please and just pause there. So I won't go through all of this, but those paragraphs explain some of the processes that we have already discussed in fact, so for example the review of medicines administration, post administration monitoring of rapid tranquillisation and the multidisciplinary weekly review that you have referred 11:57 11:57

to also, Ms. Murray. Those are all referred to there as "processes of review" which provide assurance in respect of PRN. I do have one question in respect of paragraph 103, if we could scroll down please and pause there. You will see in the latter half of that statement there's reference to the MDT review meeting. Half way down there it says:

"A Datix incident form is also completed where there has been an incident of acutely disturbed behaviour and this has been managed with oral PRN sedation.
By contrast, a Datix report is not completed where PRN sedation is administered to a patient other than in the course of an incident of acutely disturbed behaviour or psychological escalation." 11:58

Ms. Murray, you referred earlier to the recording on Datix. So just to clarify: Is it right to say that there's no requirement to record every administration of oral PRN deescalation medication on Datix? 11:59

A. MS. MURRAY: To maybe clarify that a bit better. There is always an incident form filled in at the point of an incident, and whether they use medication for that should be recorded within the Datix.

135 Q. Yes. So that is associated with the requirement to fill in a form relating to an incident rather than the requirement to do it because oral PRN deescalation has been administered? 11:59

A. Yes.

136 Q. There's reference there to the Datix report being needed for circumstance in which rapid tranquillisation is used in the context of acutely disturbed behaviour. You referred to that term earlier, Mr. Guy.

A. MR. GUY: I've actually raised this with the Trust team, that that statement is mildly ambiguous in the sense that it's suggesting that an incident form is used after any incident of acutely disturbed behaviour, when I think what that is actually referring to is that it should be after IM medication. And as Ms. Murray has already said, there could be an incident which occurs which requires an incident form to be completed and as part of the management of that incident, the person receives oral medication as PRN medication, but it was not the trigger, the giving of the oral medication was not the trigger for completing the incident form, but it would appear then on the incident form as oral medication being administered. You would have to look at the rest of the circumstances of the incident to maybe determine as to what was the trigger for completing the incident form. 11:59 12:00 12:00 12:00

137 Q. Yes. And rapid tranquillisation is different then, is that right?

A. Rapid tranquillisation is different. That is a trigger for completing an incident form on its own. 12:00

138 Q. Okay.

A. The person may still require restraint for the administration to be given, so there's obviously almost two reasons for completing an incident form within

that, but that would be recorded as part of that incident form. But there's no automatic, certainly within the Trust policy there's no automatic requirement to complete an incident form after giving oral medication as part of a deescalation strategy. 12:01

139 Q. Yes. And where does the requirement to complete the form after rapid tranquillisation emerge from?

A. That's in the Trust policy.

140 Q. The policies that we have looked at?

A. Yes, yes. 12:01

141 Q. The rapid tranquillisation policies?

A. Yes, yes.

142 Q. Okay.

A. And that comes from the NICE guideline.

143 Q. And do staff receive further guidance on what 12:01 constitutes acutely disturbed behaviour?

A. You would have to speak to the nursing staff about that. I can't comment on that because I don't know.

144 Q. But does the policy itself give that sort of guidance?

A. It gives an outline, you know, a very broad outline of 12:01 acutely disturbed behaviour in sort of the scope of the policy.

145 Q. Yes.

A. But as I've actually already discussed earlier on, it's a very, very complex area to try and - it's very 12:02 nuanced - to try and provide a very clear definition of what is and what isn't acutely disturbed behaviour and what is just normal agitation/irritation, for want of a better ward.

146 Q. Yes. And are you aware of when the use of Datix recording commenced?

A. It's been around for as long as -- Well, there has definitely been something in the Trust for as long as I can remember. I couldn't comment as to how far back it goes. 12:02

147 Q. And what about the requirement to record after a rapid tranquillisation? Are you aware of when that commenced?

A. We can definitely pin that back at least to the 2012 Trust guideline, and I would suspect it goes back before that as well. 12:02

148 Q. Ms. Murray, in the list of assurances that are provided in this section, a third assurance is noted at paragraph 106. And that is something said that you have been responsible for, a review of all patient Kardexes at MAH every six months. 12:03

"This is part of a review of physical health monitoring to comply with physical health monitoring guidelines. Further, at least once per year Ms. Murray meets with the ward manager to undertake a review of the agreed stock holding of medications kept in the ward." 12:03

When did those practices commence, Ms. Murray? 12:03

A. MS. MURRAY: I'm not sure of the actual date. I would say around 2020 for the review with Dr. Kingsley. The top-up, which is the stock holding of medications on the ward, that would have been one of the first

elements of my role, so I would say 2018 for that.

149 Q. Was anyone else fulfilling those roles or carrying out those functions before you did in 2018 and 2020?

A. I'm not sure of that answer. Perhaps Mr. Guy would know that. 12:04

A. MR. GUY: There wouldn't have been a role with Dr. Kingsley or his equivalent before that and the top-up reviews would probably have fallen to me or to some of the other pharmacy team.

150 Q. Okay. How long would they have or how often would they have taken place? 12:04

A. The Trust policy is that it should be reviewed annually but I can't -- And that's not something I prepared to look at, so I couldn't comment as to whether that happened or not. 12:04

151 Q. Okay. But if it did happen, it's likely that that would have been by the wider pharmacy team?

A. Yes.

152 Q. Okay. And if we scroll down to paragraph 107 please. We'll see a fourth assurance mentioned as the governance structures within Muckamore Abbey Hospital and the Belfast Trust, and there's reference there to the "live governance" meeting which you referred to earlier, Ms. Murray. It says there: 12:04

12:05

"For example, the administration of oral PRN deescalation and intramuscular tranquillisation is tracked weekly per patient and per ward, forming part of the weekly live governance for the ward that is

considered at weekly live governance calls and reviewed as part of individual ward rounds based on the purposeful in-patient admission model."

When was that live governance process commenced? 12:05

A. MS. MURRAY: I'm not sure of that actual date. I suppose we could refer back to the team and get that clarified for you.

153 Q. Has it been in place since you have worked at Muckamore, since 2018? 12:05

A. I would say so. I am aware of it, however I don't attend those meetings.

154 Q. Okay. If we scroll down to 108 please. There's reference there to: 12:06

"The data collected and reported is also collated and trends are identifiable through graphs prepared on a ward basis, which in turn feed into a monthly safety dashboard for the MAH site as a whole. By way of an example, behind tab 7 of the exhibit bundle is a recent 12:06 example of the datasets prepared for the weekly clinical improvement meetings as well as a copy of the 2023 safety dashboard report to MDAG."

The Panel has heard previously about the safety 12:06 dashboard. Are you aware of when that commenced?

A. No.

155 Q. Again, is that something that you're familiar with from your practice at Muckamore?

A. No, that's not part of my practice.

156 Q. Okay. What about the clinical improvement meetings, are you involved in those?

A. No.

157 Q. There are some -- It refers to datasets being prepared for the weekly clinical improvement meetings. Are you aware of who prepares those? 12:06

A. The governance team would prepare those.

158 Q. And does pharmacy have any input into those?

A. No, no. 12:07

159 Q. I want to move on then to paragraph 109. There's reference to audits, and it's that:

"Audits provide an assurance process in relation to the prescription and administration of medication for behavioural management." 12:07

Then at paragraph 111, if you scroll down, there's reference to a list of service level audits carried out at Muckamore Abbey Hospital. That list appears at page 798, if we could turn that up please. So you can see there a list of various audits, which it is said have taken place, which provide assurance in relation to prescription and administration of medication for behavioural management. Now, the documents themselves haven't actually been exhibited. Mr. Guy, are you familiar with these audits? 12:07 12:08

A. MR. GUY: I can give you some background on that and I can give you some background on where the list has come

from.

160 Q. Yes, please.

A. The list came from the auditing standards, the Standards and Quality Audit Department, but only included the title of the audits and it didn't include the actual details of the audit. So the Trust is attempting to contact the named person from the audit to try and get details of the audit background, and they're still working on that to try and track that down. I can highlight some information on the audits that are there. I don't know anything about Audit A, I can't comment on that. Audit B is actually - and if you look forward to the page afterwards, page 114, it mentions POMH. 12:08 12:08

161 Q. Yes, this is paragraph 104 of the statement. 12:09

A. Yes. If I want to describe what POMH is, POHM is the Prescribing Observatory for Mental Health and it's a quality improvement initiative run by NHS England. They commissioned the Royal College of Psychiatrists to run the organisation and it's run through their quality improvement programme. It's a subscription membership service where trusts pay for an annual subscription to be part of POMH and they provide a number of audit topics, usually three or four audit topics a year, and it allows trusts the opportunity to benchmark their prescribing against other participating trusts in the UK. And there's usually about 69 or 70 mental health trusts across all of the UK who participate in the POMH audits. The members have a small say in the direction 12:09 12:09

the audits go. They're involved in the -- The POMH managing board generally tend to pick what the audit topic will be, but then they will consult with members on how practical that audit may be to conduct and they will consult on the audit collection tool and then they'll call that an "audit topic". They will then run a number of re-audits on a sort of a two or three-year cycle. That Audit B is actually one of the POMH prescribing audits and it was run actually -- 12:10

162 Q. And when you say Audit B, just to make sure we're looking at the same thing, that's B at paragraph 111, an audit registered in October 2009? 12:10

A. Correct.

163 Q. Antipsychotic monitoring?

A. Yeah. That audit was actually Topic 9A, which was antipsychotic monitoring in learning disability. It did not actually look at PRN medication, it was looking at the physical health monitoring of patients prescribed regular antipsychotic medication. So the audit team, the group have - the Trust has picked this up from a list without actually having the details of the background of it. That audit has been repeated in 2009, 2015, 2020. It also included community based patients but, again, it did not look at PRN use. 12:10 12:11

164 Q. Okay. Are you aware if any of those audits listed at page 798 would have looked at PRN use? 12:11

A. No, the only other one that I'm aware of was Audit D, which again was another POMH audit and it was prescribing high dose in combination in acute adult

wards. And POM has inclusion criteria for their audits, at which service groups are included, so they're comparing like with like across trusts, and that did not include learning disability.

165 Q. How long has the Belfast Trust taken part in the POHM audit scheme? 12:12

A. More than 10 years, but I think we were an early member, I think one of the sort of -- For quite some time we were the only Trust in Northern Ireland that was a member, but just in the last two or three years the other trusts in Northern Ireland have joined POMH as well. I think we've been a member for 12/13 years, possibly longer. 12:12

166 Q. So is that all you can tell us for now about those audits? 12:12

A. Yes.

167 Q. I want then to turn to paragraph 113, page 37 please. There's a reference to an audit which you undertook, Ms. Murray, in 2020. It's said that you undertook a baseline audit of drug Kardexes at MAH in 2020, and some of the data which you collected is provided to the Inquiry. What was the reason behind conducting the audit at that time? 12:12

A. MS. MURRAY: This was a Kardex completion audit, not a clinical audit, so questions in the audit that I had to complete was, were handwriting up to standards, was everything signed and printed by a doctor, was the correct drug name there, dose, directions. 12:13

168 Q. Yes, and in fact just for your aid, I think we can

bring up page 832 which notes the type of information that you were recording. So if we just scroll in. Are those the items in the left-hand column the type of thing that you were looking at?

A. Yes. So it was a completion exercise rather than an audit of any clinical administration, to ensure the safety of the Kardex itself. 12:13

169 Q. And was there a particular reason for conducting it at that time?

A. MR. GUY: It was a baseline. 12:14

A. MS. MURRAY: Just a baseline.

A. MR. GUY: It's called a baseline. It was just to get a --

A. MS. MURRAY: Just to see where they were in reflection to anyone else, you know, to get -- That was my first audit there, so it was to see -- 12:14

A. MR. GUY: Sorry.

A. MS. MURRAY: Sorry.

A. MR. GUY: I can just maybe clarify a wee bit. I think that was around the time that you started, Deirdre, and I was trying to get you sort of up to speed with the site, up to speed with the processes, and this audit tool that you have on the screen here was designed by the governance lead in the Belfast Trust to audit the Kardexes that were used in the rest of the Trust, because the Kardexes are slightly different. The rest of the Trust uses a Kardex which only has recording space for 14 days and it doesn't have a separate section for long-acting injection medication. 12:14 12:14

And it's not practical to use that Kardex within a longer stay setting, so a longer stay Kardex was developed which allows recording space for up to eight weeks to be used in units that have a longer period of stay. Not just mental health, it's used in some of the 12:15
care of the elderly units as well. And I adapted, I think with one of the senior nurses - we looked through the tool that had been developed by the Trust governance lead for the acute Kardex, and we adapted it for the -- They've got sections on antibiotic 12:15
prescribing and stuff which we didn't have, so we've adapted it to mirror the Kardex which was being used there. And I had suggested it to Deirdre as one of her initial actions, whenever she started working in Muckamore, to get a feel for the site. 12:15

DR. MAXWELL: Can I clarify because, ironically, this form hasn't been filled in properly, it hasn't got the name of the auditor or the site. The tool was designed by you in 2014. Is that what it's telling me at the bottom? 12:16

A. MR. GUY: That was my variation of the tool in 2014.

DR. MAXWELL: Yes, so this version was created by you in 2014. The data that we're seeing, when was it collected?

A. MS. MURRAY: 2020. 12:16

DR. MAXWELL: Right, okay. So this was two years after you started?

A. MS. MURRAY: Yes.

DR. MAXWELL: Okay.

170 Q. MS. KILEY: Can I ask you about one of the specific entries. Half way down the left-hand column there's a number 2:

"Weight documented (where relevant to medication), yes or no." 12:16

So what was that assessing?

A. MS. MURRAY: Whether the medication, any medication prescribed would require a weight for the appropriate dose to be given. So some medicines were, some medicines weren't. 12:17

171 Q. And were you checking whether, where required, the weight was recorded on the Kardex?

A. Yes. 12:17

172 Q. So there are references along that line then to N. Presumably that stands for No, does it?

A. Mhm-mhm.

173 Q. And Y yes?

A. Mhm-mhm. 12:17

174 Q. So we can see that there are -- in fact half are recorded as no and half are recorded as yes. So does that mean half the Kardexes that you reviewed that ought to have recorded weight didn't?

A. No, that means that half the Kardexes had no weight documented. 12:17

175 Q. Yes, but is that in circumstances where it was necessary to document it, that they ought to have recorded that?

A. No, I've put there at the side, "no weight related medication".

176 Q. So the fact that there are a number of nos there, is that a cause for concern?

A. No, the question is a little bit ambiguous on the data form, but if there a "no" was put, that was the answer to "weight documented yes or no". 12:18

A. MR. GUY: Can I interject?

177 Q. Yeah.

A. There are very, very -- I actually struggle to think of any medicine in a mental health setting that requires weight-related dosing. 12:18

178 Q. Okay.

DR. MAXWELL: I thought it was established that a number of antipsychotic drugs could lead to weight gain? 12:18

A. Yes, but it doesn't alter the dose of the medication that's prescribed and that's a separate monitoring.

DR. MAXWELL: Oh, I see, so this is about knowing somebody's BMI -- 12:19

A. Yes.

DR. MAXWELL: -- to determine the dose?

A. Yes.

DR. MAXWELL: It is not about monitoring the impact of the medication on their weight? 12:19

A. MS. MURRAY: No.

A. MR GUY: No, no.

DR. MAXWELL: But would you agree that there are a number of drugs --

A. Yes.
DR. MAXWELL: -- which that can profoundly affect people's weight?
A. Yes, and that is the review that Ms. Murray undertakes with Dr. Kingsley. That is the purpose of that review, to look at the physical health and the cardiometabolic risk factors of antipsychotic medication. 12:19
DR. MAXWELL: So does -- Even though it's not on this chart, do we know whether patients' weights are regularly recorded when we know there's a risk that the medication will increase their weight? 12:19
A. MS. MURRAY: The hospital does record weight at any given chance they can. It's very impractical sometimes to get the weight of the patient and record it consistently, some patients don't comply, but they do have days such as wellness Wednesdays where they would record weights. 12:19
DR. MAXWELL: And is that audited to your knowledge?
A. No, not that I'm aware of, no.
DR. MAXWELL: So it would be hard to come across some data to say whether the weight was being regularly recorded? 12:20
A. Yes.
179 Q. MS. KILEY: And just to be clear. If it was recorded, you're not talking about it being recorded on those instances on a Kardex, it's recorded somewhere else, is that right? 12:20
A. There is space on the front of the Kardex, on the long stay Kardex, to record a patient's weight, so if --

A. MR. GUY: In some ways this question actually probably could have been removed from the audit of the longer stay Kardex because there's very, very - there's very few mental health medicines where weight is actually required in terms of calculating the dose, which was really what the intention of that question was to pick up. There are some physical health medicines that might be used, but very rarely within the mental health setting. 12:20

180 Q. I want to turn to one of the final assurances that is noted in the statement. This is at paragraph 117, page 38 please. So having referred to internal processes of assurance, which we've just discussed, there's reference at paragraph 117 to: 12:21

"External processes have also provided a degree of assurance as to the use of PRN at MAH."

And at paragraph 118: 12:21

"First, there is a three-month review of the treatment plan of every detained patient at MAH. This included a review of all prescribed medication, both regular and PRN. Until 2005 this was completed by another doctor within the hospital, known as a Responsible Medical Officer or RMO. From in and around 2015, the RQIA became more closely involved in this process. RQIA appointed a visiting psychiatrist to provide this review and second opinion of the individual's treatment 12:21

plan."

Prior to 2005 then it says that a responsible medical officer, another doctor within the hospital, would have conducted that review. Are you aware, Mr. Guy, of where the findings of that review would be recorded? 12:22

A. MR. GUY: I'm not.

181 Q. Ms. Murray, are you able to assist with that?

A. MS. MURRAY: No.

182 Q. What about then the position after 2015, when RQIA became more closely involved and they appointed a visiting psychiatrist to provide that review, are you aware of where that's recorded? 12:22

A. MR. GUY: I'm not aware if that was recorded in a direct sense, but I know there are -- When those reviews were done, they were done on forms within the Mental Health Order and those forms would be kept in the patient's notes. But for full details of that, I think you'd need to address that question to the medical team. 12:22 12:23

183 Q. Yes. And then to be clear that what is being conducted is a review of prescribed medication but, as part of that review, Pharmacy didn't have input into it, is that right?

A. No. My understanding of the review is that it's a review of consent to treatment, and that's my own limited understanding of the Mental Health Order review, and Pharmacy are not involved within that review. But you'd need to seek complete clarification 12:23

with the medical team for that.

184 Q. Yes. But just to be clear, Pharmacy weren't involved before 2015 or after?

A. No.

185 Q. Okay. Those are all the questions that I have for both of you on the matters arising from your statement. The Panel may have some additional questions. 12:23

MR. GUY AND MS. MURRAY WERE THEN QUESTIONED BY THE PANEL AS FOLLOWS 12:23

186 Q. DR. MAXWELL: Yes, I wanted to ask you a question about one of the appendices on page 788, which is the safety dashboard. This is from 2023 and it appears one of the graphs is - it has been sort of cut off. The bottom second in is: 12:24

"The percentage of staff who have completed enhanced safety intervention training including management of escalating behaviours." 12:24

And it seems to be quite a low percentage. This is 2023. It seems to be around 50%. And obviously you're not responsible for the training, but my question is: If people haven't had enhanced safety intervention training, are they still allowed to prescribe and administer drugs in relation to deescalation? 12:24

A. MR. GUY: I don't think that's a question that we can answer. I think you'd have to address that to the

Safety Intervention Team.

187 Q. DR. MAXWELL: So there's no mention of that in the policy on rapid tranquillisation?

A. MR. GUY: No.

188 Q. DR. MAXWELL: So potentially -- Well, yes, as you say, I have to ask what the operational policy is. But as Ward Pharmacist, are you aware if this is ever discussed? 12:24

A. MS. MURRAY: No, I'm not aware of any discussions of this matter at all. 12:25

DR. MAXWELL: Okay, thank you.

CHAIRPERSON: No, I think we're all done. Can I thank you both very much for your evidence. You've obviously both been well prepared and you've answered very frankly, so it has been very helpful to the Inquiry. 12:25 So thank you both very much, thank you.

Tomorrow we are I think sitting at 12:30 for Mr. Dawson, so what we'll probably do is, we'll sit through lunch. So can I suggest everybody gets some 12:25 food in if they need it before we start. And then I'll -- At the end of that I'll have some remarks to make about where we've got to so far and the future progress of the Inquiry. Alright, thank you very much everybody. 12:30 tomorrow. 12:25

THE INQUIRY ADJOURNED UNTIL 12:30 P.M. ON WEDNESDAY, 28TH JUNE 2023