LEARNING MATTERS

EDITION 25
DECEMBER 2025

IN THIS EDITION

Effective early treatment of infective corneal keratitis in contact lens wearers can prevent corneal scarring and vision loss 1

Ingestion of Caustic Soda 2

Operation carried out on wrong site due to inadequate documentation 3

Identification of a Small Bowel Obstruction 4

Recognising Necrotising Fasciitis 6

Transfer of patients on intravenous (IV) fluids/medication 9

Reminder - Topiramate (Topamax®): Safety Measures Should Now Be In Place, Including A Pregnancy Prevention Programme 10

Welcome to edition 25 of the Learning Matters Newsletter produced by the System Learning, Transformation and Governance Team, PHA. Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in its care. We recognise the need to utilise a variety of methods to share learning, therefore the purpose of this newsletter is to complement the existing methods by providing staff with short examples of incidents where learning has been identified.

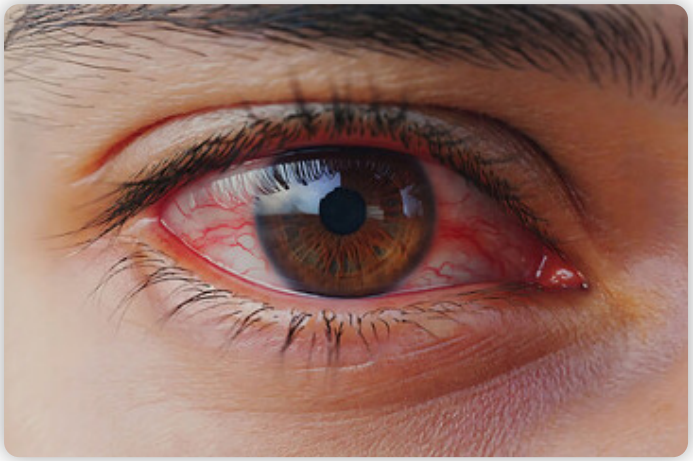
HSC Health and Social Care

QUALITY 2020

Effective early treatment of infective corneal keratitis in contact lens wearers can prevent corneal scarring and vision loss

Summary of event

A patient who was a **contact lens** wearer developed a significant pseudomonas keratitis causing dense anterior stromal central corneal scarring, possibly due to the delay in the appropriate treatment commencing when they presented for health care. Earlier commencement of treatment for **infective keratitis** may have reduced the risk of scarring and visual loss.



KEY LEARNING

Emergency Departments are advised:

- If a contact lens wearer presents with a history of keratitis with a painful red eye the contact lens should be removed.
- The patient should be commenced on a course of Levofloxacin or Ofloxacin to achieve optimal corneal treatment.
- All Adult Emergency Departments across Northern Ireland should maintain an accessible stock of Levofloxacin or Ofloxacin eye drops at all times.

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Ingestion of Caustic Soda

A child presented to the emergency department after drinking what was believed to be lemonade from a bottle in their home. The liquid was in fact a highly toxic and corrosive chemical mix which had been made up for cleaning purposes and kept in a previously used plastic fizzy drinks bottle.

After initial assessment locally, the child was found to be well on presentation, no evidence of airway compromise but had evidence of a burn on the tongue.

The child required transfer to another hospital with specialist services for further investigations and management.

The unfortunate incident highlights the dangers posed by leaving potentially lethal substances in unmarked and poorly secured containers within the sight and reach of children.

KEY LEARNING

All staff need to be aware that presentations of caustic soda ingestion are increasing. The twin dangers are an immediate/impending airway obstruction plus medium-term oesophageal injury with stricture formation.

If a child presents to an emergency department, they should be assessed promptly at Triage for any signs of an airway burn. If present:

- Immediate transfer to resuscitation room for senior assessment including anaesthetic staff to ensure airway is secure
- Utilise TOXBASE® for advice
- If in a District General Hospital liaise with the Royal Hospital Belfast for Sick Children (RBHSC)

If there is no evidence of an airway burn the child should have:

- Prompt admission to paediatrics and a robust history taken
- Observation and liaison with RBHSC

www TOXBASE .org

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A patient with a diagnosis of squamous cell carcinoma (SCC) with a number of Actinic Keratotic lesions on the scalp, was red flagged for removal of a lesion on the **RIGHT** side of the frontal scalp. Unfortunately, a lesion on the **LEFT** side of scalp was removed.

The specific anatomical area of the SCC that was curetted had been poorly defined/documented at various consultations with the General Practitioner (GP), Dermatology teams and on pathology forms.

KEY LEARNING

- Ensure all relevant notes and documentation are available prior to surgical intervention and that the correct anatomical site is clearly defined.
- Ensure all references made to site of surgery are recorded in relation to patient's side, not operator's side.
- All patient notes should be clearly laid out in chronological order and complete. The relevant information should be readily accessible in defined sections within the patient chart, to include relevant clinical consults and investigations/pathology. This is particularly important when treating red flag/cancer patients.
- Patients should be assessed by the operating surgeon well in advance of the date of the surgical procedure. Where this is not possible or practical, patient notes, photographs, an accurate location of the area and all other relevant information should be in place, for the operating surgeon to review on the day of surgery.
- If there is any unresolved query or area of ambiguity, a procedure should not proceed until the issue is resolved (unless, for some reason, it is essential to do so).
- Ensure access to all relevant documentation including the Electronic Care Record is available for all clinicians
- Ensure use of clearly marked standardised photographs of the area in question to be provided with referrals.

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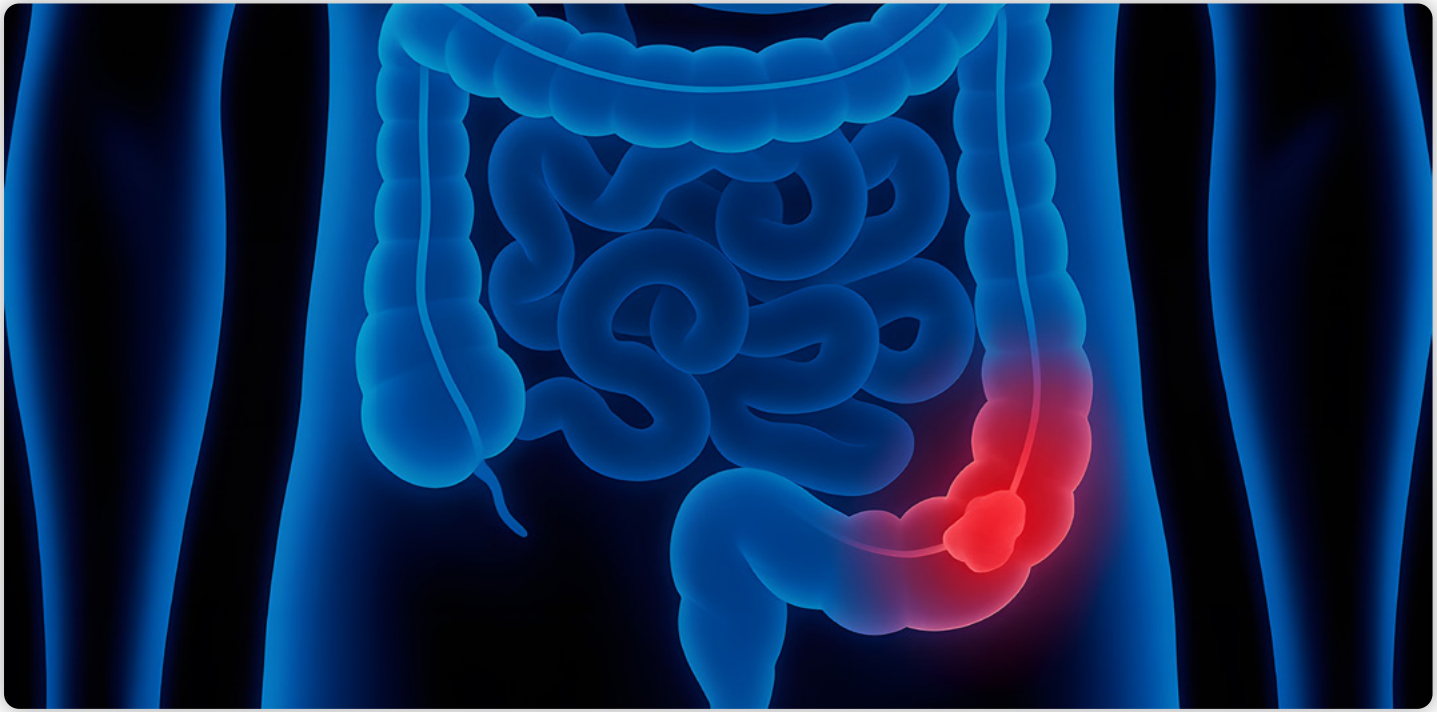
Identification of a Small Bowel Obstruction

A patient with a history of a longstanding abdominal hernia presented to an Emergency Department (ED), complaining of acute onset shortness of breath and reporting a three-day period of vomiting, which had ceased 48 hours prior to attendance at ED. There was no report of abdominal pain and the patient noted normal bowel and urine function. The patient was admitted under the care of the Medical Team with sepsis, hypotension, and tachypnoea, which was considered within the differential diagnosis either to be of respiratory origin or secondary to a suppurative ulcerative lesion on the right calf. During initial examinations, the para-umbilical hernia was noted to be present and although usually reducible, was not on this occasion. Analysis of the patient's venous blood gases revealed a high lactate concentration. The patient was commenced on oxygen, intravenous (IV) fluids and IV antibiotics and a urine catheter inserted. Following further review by a member of the Medical Team six hours after arrival in ED, the patient was referred to the Intensive Care Unit (ICU) with a diagnosis of septic shock with multiple organ failure, against a clinical picture of metabolic acidosis, oliguria and increasing lactate. Surgical review was recommended by the ICU Consultant, who then assessed the patient and referred for a Computed Tomography (CT) scan of the abdomen and pelvis due to the presence of abdominal distension. This occurred eight hours after the patient's arrival in ED. On return from the CT scan, the patient vomited and arrested. Resuscitation was attempted but unsuccessful and the patient passed away. A small bowel obstruction secondary to para-umbilical hernia was noted on the CT scan.



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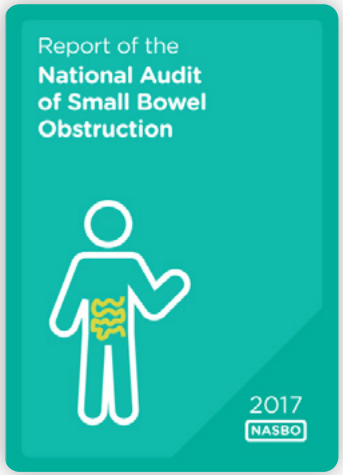
KEY LEARNING

- Small bowel obstruction can present in a variety of ways, presenting challenges for diagnosis in the absence of specific signs and symptoms (abdominal pain, distension, regurgitation and constipation) and the presence of distracting features which may initially suggest an alternative diagnosis.
- In the presence of a history of regurgitation, an irreducible hernia and a raised lactate, bowel ischaemia secondary to obstruction should be considered in the top differential diagnosis. The presence of significant physiological derangement, acute renal failure or shock, may also raise suspicions.
- Resources, for example, laminated posters highlighting the triad of symptoms which should raise suspicion of bowel obstruction (hernia, regurgitation, raised lactate) should be displayed in ED, medical and surgical areas to prompt consideration of this condition within a differential diagnosis and enable the undertaking of appropriate investigations.
- If bowel obstruction is suspected based on the clinical features noted, abdominal imaging, preferably a CT scan of the abdomen and pelvis with contrast, should be carried out early in the patient's journey and a surgical opinion sought. An abnormal plain abdominal film undertaken in a patient presenting with the clinical features described should trigger a subsequent referral for a CT scan and surgical review.
- Patients diagnosed with a small bowel obstruction typically require IV fluids for resuscitation, urinary catheters to measure urine and guide fluid balance and the placement of a naso-gastric tube with continual drainage and intermittent aspiration.
- An assessment of suitability for transfer to the Radiology Department should be undertaken for all acutely unwell patients in ED, while doctors accompanying patients to the Radiology Department should have appropriate experience to deal with any potential emergencies which may arise.
- The National Audit of Small Bowel Obstruction (NASBO, 2017) produced a series of recommendations guiding the management of patients with small bowel obstruction, including the following which is relevant to this SAI:
  - Early use of CT scanning in patients with small bowel obstruction offers both confirmation of diagnosis and prognostic information as to which patients may benefit from emergency or early surgery.



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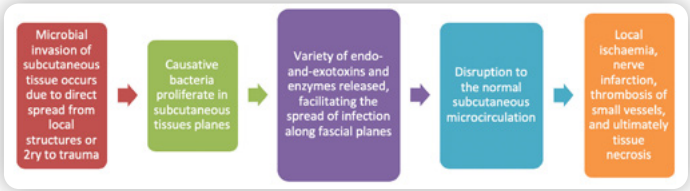
Recognising Necrotising Fasciitis

Necrotising fasciitis is a life threatening rapidly progressing soft-tissue infection. The most critical factors for reducing mortality in necrotising fasciitis are **early recognition** and **urgent surgical debridement.** Necrotising fasciitis can be easily missed because the patient may present early in the disease process with non-specific signs and symptoms[1,2,3]. The diagnosis is clinical. Typical signs are as follows:

Local signs	Systemic signs
Oedema	Fever
Erythema	Tachycardia
Severe and crescendo pain out of proportion to clinical findings	Hypotension
Skin bullae or necrosis (late stage)	Shock
Swelling or tenderness	
Crepitus	

(**Source**: Sartelli, M., Guirao, X., Hardcastle, T.C. et al. 2018 WSES/SIS-E consensus conference: recommendations for the management of skin and soft-tissue infections. World J Emerg Surg 13, 58 (2018). https://doi.org/10.1186/s13017-018-0219-9)



Source: https://www.rcemlearning.co.uk/reference/necrotising-fasciitis/#1570706791784-95e25097-695a

Two recent SAIs were reported where there were delays in recognition of necrotising fasciitis.

Summary of event

CASE 1

A patient fell from a ladder outside the home and suffered head and knee injuries. At ED in Hospital A, a CT scan was carried out of the patient's head, neck and spine and x-rays were taken of both knees, hands, and right forearm. The CT scans and x-rays showed no abnormalities. A ragged laceration on the right knee was cleaned and sutured. A tetanus vaccine and oral antibiotics were provided for the knee wound. The patient was also treated for a urinary tract infection. Patient A was discharged to a relative's care, with wound care, head injury advice leaflets and antibiotics. The following evening the patient contacted GP Out of Hours (OOH) complaining of increasing pain in their right knee. Advice was given regarding analgesia.

Later that evening, the patient presented to the Emergency Department complaining of pain in their right knee and thigh, discharge from the knee and was unable to weight bear. Bloods and x-rays were taken. The leg x-ray indicated there was no fracture but showed subcutaneous gas in the soft tissue of the thigh. The patient's thigh was warm to touch and purulent discharge was noted from the knee laceration. National Early Warning Score (NEWS) was zero at this time. Blood testing did show signs of infection with increased C-reactive protein (CRP) and White Cell Count (WCC). As a result, the patient was given Intra venous (IV) antibiotics and a discussion took place with Trauma and Orthopaedics in Hospital B who advised a blue light transfer. The patient was taken to theatre the following morning for debridement and washout of the wound. As a consequence of the rapid spread of the infection at this time, surgeons in Hospital B had no option but to amputate the right leg and some of the surrounding buttock tissue in order to preserve the patient's life. The formal report of the x-ray noted 'appearances suspicious for **necrotising infection**.'

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CASE 2

A patient presented to ED in the afternoon complaining of a right swollen arm, following a fall the previous day. It was noted that a blood pressure (BP) reading could not be obtained. Staff noted swelling/oozing blisters to arm, no neurological deficit (beyond pre-existing). There was no mention of blood pressure or haemodynamic parameters in the notes at this time. X-ray taken showed possible gas in tissues. Multiple calls between in-patient teams without a review of the patient caused delays.

Trauma admission notes that evening also mentions BP unrecordable as well as a heart rate of 130, capillary refill time of 4 secs, respiratory rate of 30, and oxygen saturation of 70% on room air (i.e. a rapidly deteriorating patient). The patient was moved to resus, an arterial line was inserted and first recorded BP was 68/45 after fluid resuscitation. The patient was escalated to ICU and taken to theatre in peri-arrest for debridement of **necrotising fasciitis** of arm and then back to ICU. The patient continued to deteriorate overnight and died the following morning.

In both these cases the patient had soft tissue swelling and blistering and x-ray showed gas in the tissue planes.

KEY LEARNING

- Suspect sepsis where a patient presents with signs and symptoms of infection and implement the **sepsis 6 bundle within 1 hour**.
- Always suspect necrotising fasciitis in a patient with a rapidly progressing soft-tissue infection and any of the following:
  - severe pain (disproportionate to the clinical findings) or
  - anaesthesia over the site of infection;
  - oedema and erythema (oedema will typically extend beyond the erythema);
  - systemic signs of infection[1]
- Disproportionate pain is a serious sign that warrants urgent surgical referral and intervention[3]
- Identification of gas in soft tissue from radiology findings should be a trigger to the clinical teams managing any patient and call for prompt escalation to a consultant surgeon.
- If you suspect necrotising fasciitis, immediately refer the patient for urgent surgical debridement; do not wait for the results of investigations before referral[1].
- Initial treatment requires coordination between surgeons, intensive care staff, and microbiology. Treatment consists of radical debridement, broad-spectrum antibiotics and haemodynamic support.[1,2,3]

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Current guidance

- Suspected sepsis: recognition, diagnosis and early management. NICE NG51 (2016) https://www.nice.org.uk/guidance/ng51
- Sartelli, M., Guirao, X., Hardcastle, T.C. et al. 2018 WSES/SIS-E consensus conference: recommendations for the management of skin and soft-tissue infections. World J Emerg Surg 13, 58 (2018). https://doi.org/10.1186/s13017-018-0219-9

Useful resources

Royal College of Emergency Medicine (RCEM) Learning on Necrotising Fasciitis available at the link below:

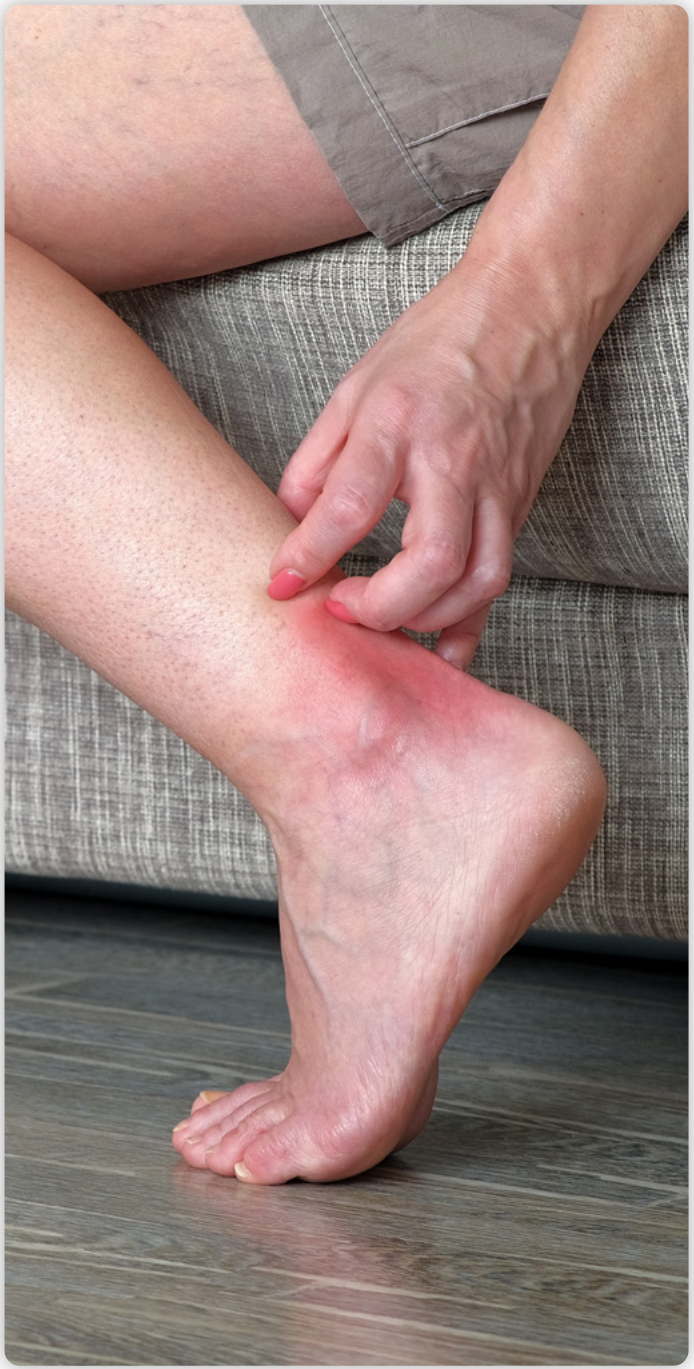
- https://www.rcemlearning.co.uk/reference/necrotising-fasciitis/

References

1 Jenkins-Welch, M., Angus, B. Necrotising fasciitis. BMJ Best Practice (2024) https://bestpractice.bmj.com/topics/en-gb/3000241

2 Sartelli, M., Guirao, X., Hardcastle, T.C. et al. 2018 WSES/SIS-E consensus conference: recommendations for the management of skin and soft-tissue infections. World J Emerg Surg 13, 58 (2018). https://doi.org/10.1186/s13017-018-0219-9

3 Diab J, Bannan A, Pollitt T. Necrotising fasciitis BMJ 2020; 369 :m1428 doi:10.1136/bmj.m1428 https://www.bmj.com/content/369/bmj.m1428



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Transfer of patients on intravenous (IV) fluids/ medication

Two serious adverse incidents (SAIs) identified in relation to the transfer of patients who had IV Fluids/medication in progress.

CASE 1

Patient A arrived with a double lumen connector attached to a cannula, with an insulin syringe attached to one lumen. Maintenance fluid as per diabetic variable rate insulin intravenous infusion was attached to the other lumen, but neither were infusing through pumps. Both infusions were checked by receiving nurses and put into relevant pumps.

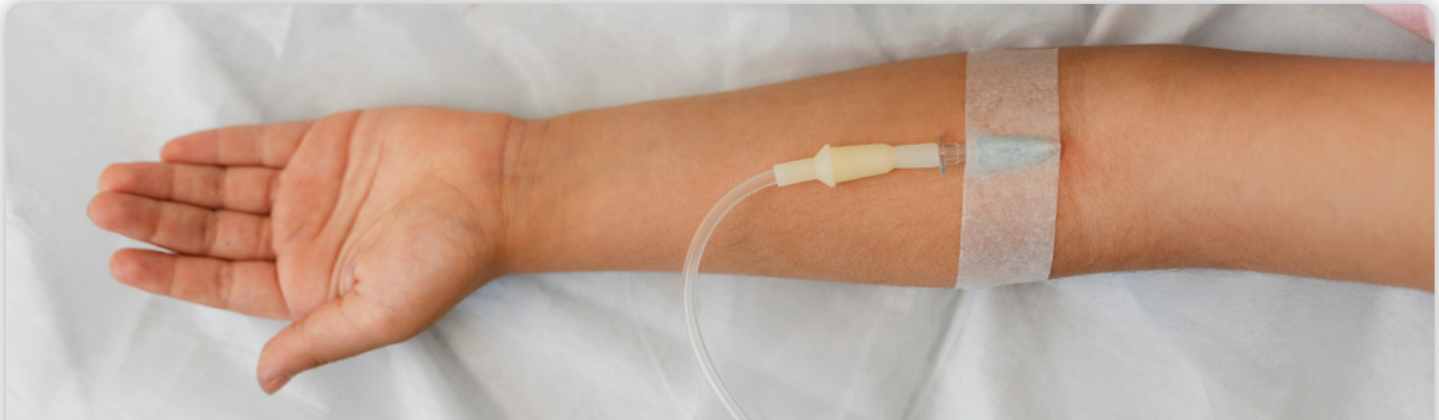
Patient A should not have been transferred from Hospital X with a syringe of insulin disconnected from the relevant pump. Rather, this syringe of insulin should have been disconnected for the transfer and discarded.

CASE 2

Patient B was transferred to theatre for scheduled surgery. On arrival into theatre from the anaesthetic room, the anaesthetist found a syringe in the patient's bedding. On inspection, it was identified as a pre-filled syringe of 50 units of human soluble insulin in 50mls of saline. The syringe was attached to the patient via an intravenous cannula; however, the administration set was not clamped nor connected to an infusion device.

KEY LEARNING

- All administration of intravenous fluids should be in accordance with Trusts Medicine Codes and Nursing and Midwifery Council (NMC) guidance
- While in both of these cases the infusion in question was insulin, the learning applies to any infusion. If a patient has an intravenous infusion and requires transfer from one area to another (either another department or another hospital) the patient should either be transferred with the infusion attached to a pump at the appropriate rate, or if this is not possible the infusion should be discontinued and detached from the patient prior to transfer.
- Rationale for non-administration, including amount that has (and has not) been infused, should be documented in the patient's notes.
- Handover between transferring and receiving staff needs to include a record of infusion pumps and rate of infusions.



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REMINDER – TOPIRAMATE (TOPAMAX®): SAFETY MEASURES SHOULD NOW BE IN PLACE, INCLUDING A PREGNANCY PREVENTION PROGRAMME

It is important to note that the implementation of these safety measures differs depending on the indication:

- For **migraine prophylaxis**, ongoing patient management, including annual reviews, completion of Risk Awareness Forms, and ensuring compliance with the Pregnancy Prevention Programme, will primarily be the responsibility of **GP practices**.
- For **epilepsy**, while similar safety requirements apply, ongoing management and specialist oversight will largely fall under **Trust services**. If a patient has comorbid epilepsy and migraine, epilepsy guidance takes precedence, and referral to the epilepsy specialist team is required.

Summary

The Medicines and Healthcare products Regulatory Agency (MHRA) issued a Drug Safety Update (June, 2024), available at the following link

Topiramate (Topamax®) is now contraindicated in pregnancy and in women of childbearing potential unless the conditions of a Pregnancy Prevention Programme are fulfilled.

Topiramate is indicated for the prophylaxis of migraine and for the treatment of epilepsy. It is available as tablets, a liquid oral solution and as capsules that can be swallowed whole or sprinkled on soft food. The brand name of topiramate is Topamax®, and so this may also appear on the box.

A review by MHRA concluded that the use of topiramate during pregnancy is associated with significant harm to the unborn child. Harms included a higher risk of congenital malformation, low birth weight and a potential increased risk of intellectual disability, autistic spectrum disorder and attention deficit hyperactivity disorder in children of mothers taking topiramate during pregnancy.

All healthcare professionals involved in the prescribing or supply of topiramate should be aware of the regulatory requirements as set out below:

General advice for healthcare professionals:

- topiramate should **not** be used:
  - in pregnancy for prophylaxis of migraine
  - in pregnancy for epilepsy unless there is no other suitable treatment
- topiramate should **not** be used in women of childbearing potential unless the conditions of the Pregnancy Prevention Programme are fulfilled. This aims to ensure that all women of childbearing potential:
  - are using highly effective contraception
  - have a pregnancy test to exclude pregnancy before starting topiramate
  - are aware of the risks from use of topiramate
- please see specific **advice for prescribers** and **advice for dispensers**

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- ensure women of childbearing potential sign the Risk Awareness Form, you should have received materials including the Risk Awareness Form by post to use in the implementation of the Pregnancy Prevention Programme
- report suspected adverse drug reactions associated with topiramate to the **Yellow Card** scheme

Unplanned Pregnancy

Epilepsy: Women presenting with an unplanned pregnancy should have their treatment switched. Urgent referral to specialist services is required for this to take place.

Migraine: Women with migraine (without epilepsy) presenting with an unplanned pregnancy should have their treatment discontinued.

For further information on:

- advice for healthcare professionals to provide to patients
- the review of harms of topiramate use during pregnancy
- new safety measures
- materials to support the Pregnancy Prevention Programme please refer to the **link** to the drug safety update.

See table below with links to all materials to support the Pregnancy Prevention Programme

Migraine	
Patient Guide for Migraine	https://www.medicines.org.uk/emc/rmm/3082/Document
Guide for Healthcare Professionals for Migraine	https://www.medicines.org.uk/emc/rmm/3079/Document
Risk Awareness Form for Migraine	https://www.medicines.org.uk/emc/rmm/3084/Document
Epilepsy	
Patient Guide for Epilepsy	https://www.medicines.org.uk/emc/rmm/3081/Document
Guide for Healthcare Professionals for Epilepsy	https://www.medicines.org.uk/emc/rmm/3080/Document
Risk Awareness Form for Epilepsy	https://www.medicines.org.uk/emc/rmm/3083/Document
All Patients	
Patient Card	https://www.medicines.org.uk/emc/rmm/3078/Document
Patient Guide for Migraine	https://www.medicines.org.uk/emc/rmm/3082/Document https://www.medicines.org.uk/emc/rmm/3081/Document

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Anne-Marie Phillips
Denise Boulter
Dr Jackie McCall
Joan Melanophy
Brendan Forde
Shannon Magee