LM Learning Matters

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Issue 9: July 2019

Interaction of Selective Serotonin Re-Uptake inhibitors (SSRIs) with Monoamine-oxidase Inhibitors (MAOIs)

Selective Serotonin Re-Uptake inhibitors (SSRIs) are contraindicated with concomitant use of monoamine-oxidase inhibitors (MAOIs). Their coadministration can lead to increased serotonin levels, which could cause serotonin syndrome – a rare but dangerous clinical condition.

A recent SAI reported the admission of an elderly patient to ICU due to serotonin syndrome, triggered by a simultaneous prescription of a MAOI and SSRI. The patient was on a MAOI prior to and during hospital admission. During admission the depressive state of the patient was reviewed, and SSRI was prescribed and administered for two days. The combination of these two medicines caused serotonin syndrome and the admission of the patient to ICU.

Serotonin syndrome presents with a spectrum of clinical findings ranging from benign to lethal that arise from an excess of serotonin in the Central Nervous System (CNS). The diagnosis of this syndrome is clinical and classically involves a group of symptoms including mental changes, agitation, confusion, myoclonus, hyperreflexia, rigidity, tremor, sweating, diarrhoea with abdominal cramping, malignant hyperthermia, hypotension, coma and even death.

MAOIs are used much less frequently than tricyclic and related antidepressants because of the dangers of dietary and drug interactions. They can interact with a number of common substances including decongestant cough medications and some foods such as mature cheese, salami, Oxo and Marmite. Therefore, care must be taken when these antidepressants are prescribed to counsel patients appropriately.

Since the effects of both MAOIs and SSRIs may persist for some time after their discontinuation, a wash out period will be required if switching from SSRI to MAOI or vice versa is considered. It should be noted

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Introduction

Welcome to the ninth issue of the Learning Matters Newsletter. Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in it's care and we recognise that we need to use a variety of ways to share learning. The purpose of our newsletter is to complement the existing methods by providing staff with short examples of incidents where learning has been identified.

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that when switching from individual antidepressant drugs, the washout period may vary and thus the British National Formulary (BNF) should be consulted before final decisions are made. Appendix 1 of the BNF lists drugs that are known to interact with each other. The concomitant use of drugs involved in potentially serious interactions should be avoided.

Key Learning

- Serotonin syndrome is a rare but serious risk when any two medications which increase serotonin are co-prescribed.
- SSRIs and MAOIs should not be co-prescribed. If intentionally switching from SSRI to MAOI or vice versa a wash out period will be required, in the order of weeks depending on switch. https://bnf.nice.org.uk/treatment-summary/antidepressant-drugs.html
- Prescribers should consider interactions with current medications when commencing any new therapy, check Appendix 1 of BNF if unsure.

Risks of Nasogastric (NG) Tube Insertion

A critically ill patient developed a pneumothorax due to misplacement of a nasogastric tube. The tube was in situ for feeding and delivery of important medications. The NG tube became blocked and had to be reinserted. Following insertion the patient became short of breath and unwell. At no stage was any fluid or food introduced via the NG tube. The chest x-ray confirmed the presence of the NG tube in the right lung and a right pneumothorax. The NG tube was subsequently removed and a chest drain inserted. A number of patient safety alerts have been issued relating to misplacement of NG tubes in the respiratory tract.

Key Learning

- Trusts should ensure that there are clear protocols and procedures for NG tube insertion.
- NG tubes should be inserted by healthcare professionals with the relevant skills and training.
- Healthcare professionals should refer to the relevant guidance and protocols for placement and monitoring of NG tube and ensure that patients and carers are aware of the risks of NG tube insertion.

Nasogastric tube insertion is a common procedure in hospitalised, particularly critically ill patients. In spite of the apparent simple insertion technique, nasogastric tube placement can have serious complications which need to be anticipated and carefully assessed. These complications may be exacerbated by delays in recognition or poor monitoring. Training, monitoring, and confirmation techniques help to prevent or at least minimise the complication and maximise safe practice. NHS Improvement has developed a set of resources to support staff in conducting initial placement checks for nasogastric and orogastric tubes.[2]

1. NPSA 2016: https://improvement.nhs.uk/news-alerts/nasogastric-tube-misplacement-continuing-risk-of-death-severe-harm/
2. NHS Improvement 2016: https://improvement.nhs.uk/resources/resource-set-initial-placement-checks-nasogastric-and-orogastric-tubes/

Blunt Trauma to Superior mesenteric artery

An elderly patient was brought to Emergency Department (ED) following a Road Traffic Collision (RTC). Initial assessments and radiological investigations did not indicate any significant concern for intra-abdominal pathology. The patient was admitted to Critical Care for observation; however the patient's clinical condition deteriorated further and after a few days the patient passed away due to multi-organ failure. Post –mortem examination concluded that death was ultimately the result of small and large bowel infarction secondary to probable thrombosis of the superior mesenteric artery (SMA) following the recent RTC.

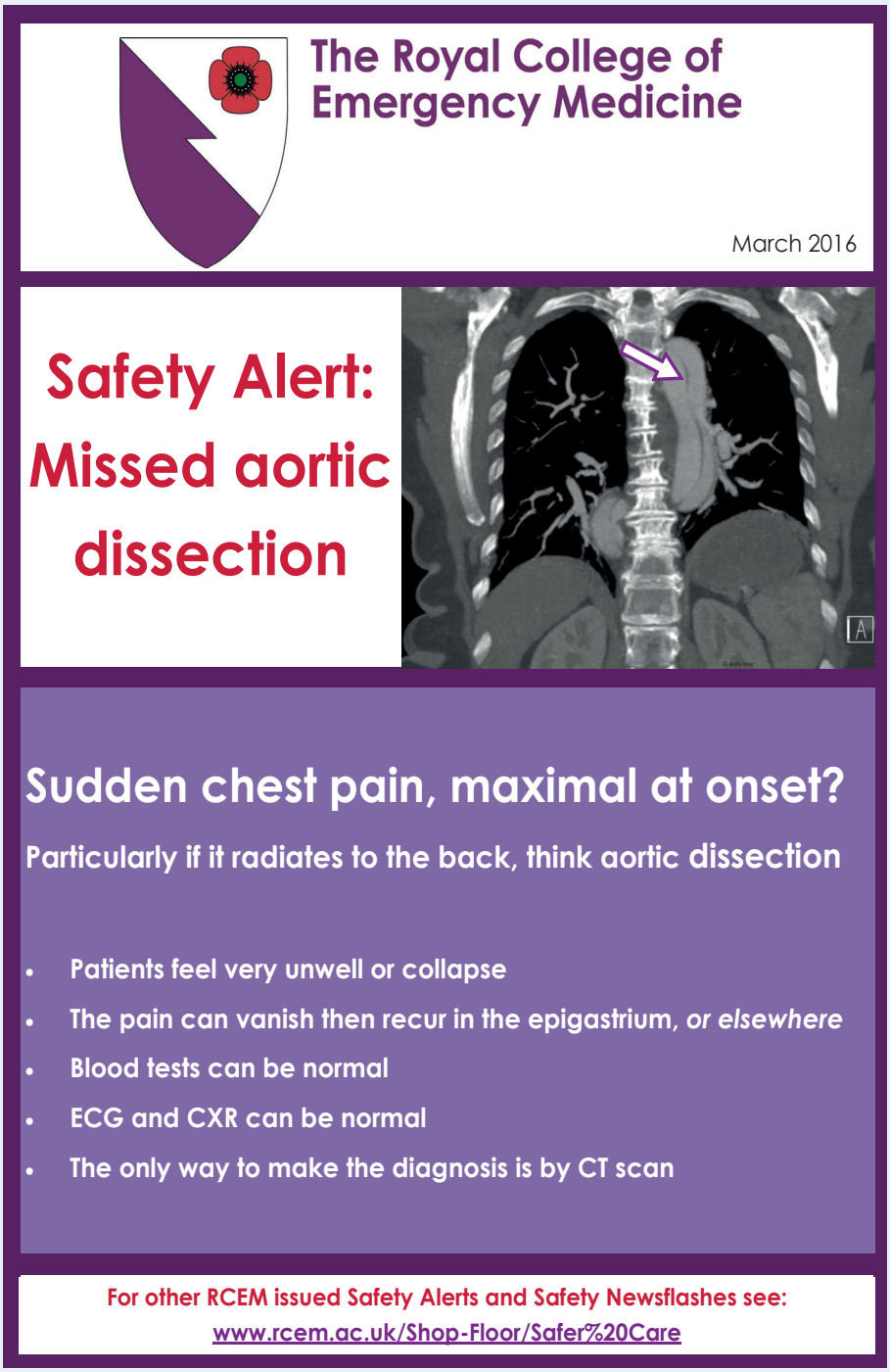
Blunt or penetrating trauma to the proximal SMA is unusual. SMA injuries may present with haemorrhage, intestinal ischemia, or arteriovenous fistula. Management of trauma to the SMA presents unique clinical challenges and is usually associated with high mortality rates.

Key Learning

Healthcare professionals need to be aware that superior mesenteric artery injuries are rare and difficult to diagnose. The use of computerized tomography (CT) scanning in blunt abdominal trauma is the primary modality for imaging stable patients. However radiological signs can be subtle and should be regarded as complementary to meticulous clinical assessment.

Delays in diagnosing Aortic Dissection

There have been several cases reported where there have been delays in diagnosing aortic dissection. Dissecting aortic aneurysm is a notoriously difficult diagnosis to make. Clinical teams should consider the diagnosis and the poster below is a good simple reminder.



Sepsis article

A regional Sepsis Collaborative was established by the Safety Forum/HSCQI. They have agreed the following definitions of sepsis to be used by the region:

Sepsis clinical definition: "Sepsis is defined as life threatening organ dysfunction caused by a dysregulated host response to infection."

Sepsis public facing definition: "Sepsis is organ malfunction due to infection which may be life threatening". Remember sepsis is not present in a localised infection in the lung, skin etc without evidence of new organ failure.

According to the UK Sepsis Trust, if a patient looks sick with infection as the likely cause, consider implementing the 'Sepsis 6' if one or more of the following 'Red Flags' are present, indicating organ dysfunction:

- Responds only to voice or pain/unresponsive
- Acute confusional state
- Systolic BP <90mmHg (or drop >40 from normal)
- Heart rate > 130 per minute
- Respiratory rate >25 per minute
- Needs oxygen to keep SpO2 >92%
- Non-blanching rash, mottled/ashen/cyanotic
- Not passed urine in last 18h/UO <0.5 ml/kg/hr
- Lactate >2 mmol/l
- Recent chemotherapy

Sepsis 6:

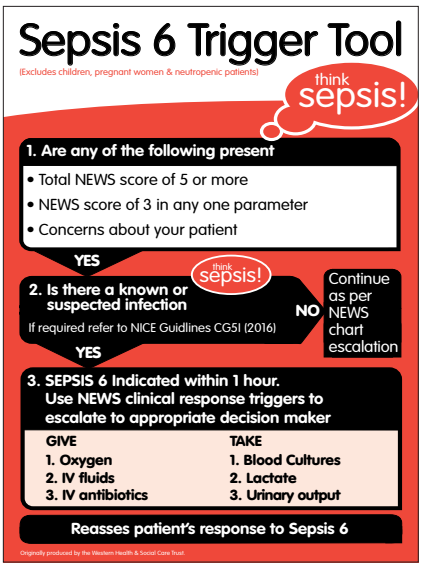
- Administer oxygen to target saturation
- Take blood cultures
- Give IV antibiotics
- Give IV fluids
- Check serial lactates
- Measure urine output

Antibiotic prescribing should be based on locally approved guidelines, the patient's history of colonisation/infection with antimicrobial resistant organisms and the site of infection as determined locally. Antibiotics should be reviewed after 48-72 hours by a senior clinician and rationalised based on culture results and clinical response as outlined by the PHE 'Start Smart, Then Focus' guideline. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/417032/Start_Smart_Then_Focus_FINAL.PDF

Trust antibiotic policies are free to download via the Microguide® app (see QR code above) and also available in individual Trust intranets.

Excessive or inappropriate antibiotic use is associated with increased antimicrobial resistance, C. difficile infection and adverse drug reactions. It may be helpful to discuss empirical antimicrobial therapy choices with a clinical microbiologist/infectious diseases physician.

It is important to document the diagnosis of sepsis in the patient's notes and discharge letter, in order to enable accurate clinical coding.



Evidence has shown that completion of the "Sepsis 6" within 1 hour of presentation/identification reduces mortality. Left untreated, sepsis can progress to severe sepsis and septic shock, having a mortality rate of 30% and 50% respectively.

Right patient, Right drug: Intravenous infusions

In two separate SAIs, two patients were administered intravenous infusions incorrectly.

In the first case a patient received an infusion of Amiodarone in error. The infusion, containing 900mgs in 1 litre 5% Dextrose had been prepared for another patient, who was taken to theatre before the infusion was commenced. The infusion bag was not discarded at the time and was placed back in the fluid store.

The infusion bag was then selected for administration to another patient who was prescribed 1 litre 5% Dextrose, 3 days later. Although there was an additives level on the fluid bag, this was missed when checks were being carried out.

In the second case an intravenous infusion containing the anticonvulsant drug Levetiracetam (Kepra) was found to be attached to the peripheral intravenous cannula of the wrong patient.

Key Learning

- All administration of Intravenous fluids should be in accordance with Trusts Medicine Codes
- Intravenous fluids with additives must be administered to the correct patient immediately after preparation, using all the appropriate checks
- Administration of intravenous drug infusions must be completed and not discarded without discussions with the patients' medical team
- If an intravenous fluid infusion is no longer required or not administered to the patient it must be discarded immediately
- Rationale for non-administration, including amount that has (and has not) been infused, should be recorded in the patients notes.
- Intravenous infusion stands should not be shared between two patients

The infusion had previously been disconnected from the patient in an adjacent bed, who was taken to theatre, and the infusion bag was left on the drip stand between both beds. The patient, who was taken to theatre, did not receive the complete dose of a critical medicine.

The same drip stand was being used to infuse intravenous therapy to both patients. Approximately half of the 1 gram dose of Kepra was infused into the wrong patient. A registered nurse noticed that the infusion was attached to the wrong patient and immediately discontinued the infusion and sought urgent medical review.

Both incidents highlight the need to ensure that intravenous fluids are administered according to the correct procedures.

Cerebral empyema - a rare complication of sinusitis

A previously healthy patient attended the Emergency Department (ED) with a one week history of headache followed by a seizure. Inflammatory markers were raised and a Computerised tomography (CT) showed almost complete obliteration of the frontal sinuses. The patient was admitted to a medical ward, commenced antibiotic treatment and was referred for Ear, Nose and Throat (ENT) assessment. The patient was discharged 2 days later, at their request, following a telephone discussion between the on call consultant and a junior doctor. The consultant was not made aware of ongoing pyrexia and persistently raised inflammatory markers. ENT assessment was arranged as an outpatient.

Key Learning

- Be vigilant for signs of neurological involvement in a patient who is systemically unwell with sinusitis.
- Family concerns about the degree of deterioration in a previously well person should always be acted upon.
- Accurate clinical records are needed to ensure correct clinical decision making.

The patient re-attended ED 5 days later complaining of slurred speech, lethargy and vomiting. Inflammatory markers had improved and there were no focal neurological signs. The symptoms were considered to be due to a Urinary Tract Infection (UTI) and after Intravenous Fluids (IV) and oral antibiotics the patient was discharged without senior review.

The patient was referred back to ED by their General Practitioner (GP) one week later as their family were concerned by memory problems, confusion, erratic behaviour and one-sided facial weakness. The GP considered a space-occupying lesion a possibility. The patient was admitted and on the following day referral for both CT and Magnetic Resonance Imaging (MRI) was considered, but neither test was ordered. The family were very concerned at the deterioration in the patient's condition. Two days after admission the patient developed unilateral weakness. CT showed a subdural empyema and cerebral abscess with early herniation of the cerebral hemisphere. Despite urgent transfer and emergency neurosurgery the patient died 2 weeks later.

Missed fracture of femoral shaft

A patient attended ED following a fall, complaining of right hip and shoulder pain. Their right leg appeared to be shortened and rotated. The patient was unable to mobilise / weight bear. Plain X-rays of the shoulder and a CT scan of the hip showed a fracture of the humerus but no hip fracture. The patient was admitted to a ward and in due course transferred to a community hospital. On arrival the patient's leg was noted to be shortened and externally rotated. An x-ray showed there had been a mid-shaft fracture of the femur.

Key Learning

- A patient should be reassessed and re-examined when clinical findings are not in keeping with radiology findings, such as when in pain and non-weight-bearing despite no fracture on the x-rays taken to date.
- X-ray the joints above and below the site of the pain – especially if no injury was detected where expected.
- A shortened, externally rotated leg can occur due to a fracture of the distal femur and is not just associated with hip fracture.
- Escalate a case to a senior member of staff for advice or review if there is a discrepancy in clinical and radiological findings.

Contact the haematology doctor on call at the Belfast City Hospital (BCH) if a patient, with congenital bleeding disorders under the care of the NI Haemophilia Comprehensive Care Centre BCH, presents acutely out of hours

In a recent incident a patient was brought to an Emergency Department (ED) overnight via ambulance following a fall at home which had resulted in a head laceration with associated loss of consciousness.

As this patient had a bleeding disorder diagnosis of Von Willebrand Disease they required immediate, emergency replacement of Von Willebrand factor and subsequent CT imaging of brain. ED staff contacted the Haematology Helpline at 08:00 to advise of the patient's presentation to ED "as a courtesy." This information was not escalated to the Haematology on-call doctor as per established policy.

The overnight Helpline nurse handed over this information to the in-hours Helpline nurse who was coming on shift. The Haemophilia Centre was informed of the patient's presentation to ED at 09:06. Haemophilia Centre staff contacted ED immediately, liaised with the medical team and ascertained that Patient A was undergoing a CT scan and had not yet had factor replacement administered.

Patient A subsequently received von Willebrand factor after CT Scan of brain was performed. The scan was normal and the patient was discharged and followed-up with no further issue.

Key Learning

- Head injury, or suspected head injury, in a patient with an inherited bleeding disorder requires treatment, firstly and urgently with factor replacement products. This should be given before any further assessment or diagnostic procedures following consultation with a member of the Haematology Medical Team at Belfast City Hospital (at Specialty Doctor Level or above)
- The patient was exposed to risk of extended cerebral bleeding due to a delay in von Willebrand factor replacement
- The Haematology Helpline is not an appropriate method of referral for inter departmental advice. Referrals should be made via switchboard to the Haematology doctor on-call
- The communication pathways outlined in the policy for the Out of Hours care for patients with congenital bleeding disorders under the care of the Northern Ireland Haemophilia Comprehensive Care Centre at Belfast City Hospital should be followed at all times

Always check the allergy box on the Kardex before prescribing or administering any medication

A number of incidents have been reported recently where a patient is documented as being allergic to a particular medicine and that medicine is then prescribed and administered. For example:

1. A patient with an allergy to penicillin was prescribed and administered a dose of a penicillin based antibiotic.
2. A patient with an allergy to amlodipine was prescribed and administered this medicine as a stat dose.
3. A patient with a penicillin allergy was prescribed and administered a dose of piperacillin/tazobactam.
4. A patient with a trimethoprim allergy was prescribed and administered a dose of trimethoprim.

Whilst these patients were monitored following these incidents and did not come to harm they did have the potential to do so.

Key Learning

It is essential to:

- Ask the patient if they have any allergies.
- Ensure allergies are clearly documented on the medicines Kardex.
- Always try to determine the nature of previous reactions whenever possible and record this.
- Always check the allergy box on the Kardex before prescribing or administering any medication.

Management of Risk for Patients with Mental Health Conditions in the General Hospital Setting

A patient died following a non-accidental fall within an acute hospital facility. The patient attended the emergency department and was admitted to the Acute Medical Admission ward. The patient left the immediate vicinity of the ward and whilst still within the hospital the tragic incident occurred. The patient was also known to Trust Mental Health Services.

Key Learning

There should be:-

- A parallel process of physical care and mental health needs of a patient considered together where indicated. This means seeking input from Trust 'liaison psychiatry' services as soon as possible: (these services may not be available in all Trust locations on a 24/7 basis).
- Clearly documented medical and nursing assessments to evaluate both physical and mental health risks.
- A clearly documented joint management plan agreed between medical and nursing staff to minimise physical and mental health risk, and an escalation plan to include the transfer to a mental health unit if necessary.
- An agreed process by both general and mental health staff outlining how a patient can be transferred in a timely manner from the general setting into the care of mental health services when assessed as a priority.

The process for managing this case focused on the patient's physical needs rather than mental health needs. The Mental Health Key Worker communicated the potential risk of self-harm, however this information was not considered by the general hospital staff in the context of the patient's overall presentation.

Use of Adrenaline in Anaphylaxis

HSCB has received a notification of an incident where 1 in 1000 adrenaline was administered intravenously (IV) to a patient being treated for anaphylaxis. In this case the patient recovered and did not suffer any long term ill effects.

However, administration of adrenaline via the intravenous or intraosseous route has the potential to cause a range of serious adverse effects including cardiac dysrhythmias.

Adrenaline is also used as part of the cardiac arrest algorithm at a lower strength of 1 in 10,000. In this setting administration is IV but at a much lower concentration.

Key Learning

- Adrenaline is part of the recommended treatment algorithm to manage anaphylaxis. To treat anaphylaxis, adrenaline at a strength of 1 in 1000 should be administered intramuscularly. It should not be administered IV or intraosseous at this strength.

  https://www.resus.org.uk/search/?q=ALGORITHM+FOR+ANAPHYLAXIS

Delay or Omission of medicines

Administration omission and delay is the most commonly reported medication incident type in Northern Ireland. In 2010, DHSSPS issued a Rapid Response Report from the National Patient Safety Agency on Reducing harm from omitted and delayed medicines in hospital. A copy of the report is available at http://www.dhsspsni.gov.uk/hsc_sqsd_3_10.pdf

Factors such as a lack of communication and awareness of critical medicines where timeliness is crucial can often lead to omission or delay of medicines.
This can compromise patient treatment, be potentially harmful and may lengthen hospital stay. This is also a common theme from complaints.

Key Learning

- Antiepileptic medicines are critical medicines where timeliness of administration is crucial.
- Follow trust guidelines for obtaining a supply of critical medicines to avoid dose omissions or delays.
- Review the Kardex at each medicine round to ensure all doses have been administered or where a dose is intentionally omitted or delayed that the reason for omission has been documented and appropriate action taken.

In a recent SAI, a patient with a history of epilepsy which was well controlled on drug therapy was admitted to a surgical ward following a minor surgical procedure. Multiple doses of the patient's usual antiepileptic medication were omitted and patient developed seizures which required input from intensive care.

Resources to assist with the prevention of omitted or delayed doses of medicines are available at the following link: http://www.medicinesgovernance.hscni.net/secondary-care/safety-documents/safety-toolkits/omitted-and-delayed-medicines-material/

Focus on Falls

In this edition we are focusing a section on Falls Learning. A Regional In-Patient Falls Prevention Group, led by the PHA, provide multidisciplinary advice and support across the HSC in preventing harm to patients who fall whilst in hospital, undertake surveillance of falls and share regional learning across Northern Ireland.

The reasons why patients fall are complex with numerous contributing factors such as physical illness, mental health, medication, age and environmental factors. It is important that we learn from the information and feedback from the adverse/serious adverse incidents and complaints related to falls.

Whilst not all falls can be prevented, any preventative intervention must be tailored to meet the needs of the individuals concerned. It is also important to note that many of the incidents reviewed are complex and don't necessarily relate to one discipline or one factor. The success of falls prevention interventions are dependent on a multidisciplinary approach.

The recent analysis from the Falls regional group, reported SAIs and Complaints has identified a number of key themes, the learning from these has been identified below:

Patient Factors – lack of mobility, lack of assistance or supervision of patients with physical or mental health needs, confusion and/or medications. The factors that appear to be most prevalent in hospital are:

- Confusion
- Being physically weak or having unsteady gait
- Being incontinent or requiring the toilet frequently
- Having a history of fall
- Having taken sedation or sleeping tablets

Key Learning

- Encourage the patient to wear the following: correct glasses, hearing aid (where required) and safe footwear.
- Advice the patient not to wear long or silky nightwear as this will increase the risk off slipping of furniture or tripping.
- Advice the patient to firmly tie dressing gown prior to walking about ward.
- When assisting the patient from their bed, chair or toilet encourage them to use the correct technique, with their feet on the floor before they stand.
- To build up exercise tolerances persuade the patient to sit out of bed for short periods each day.
- Orientate any confused patient regularly to time, place and person.

Focus on Falls continued

Risk assessment – A number of adverse incidents over the past year identified a lack of a co-ordinated approach for risk assessment including deficiencies in updating of risk assessment in conjunction with changing needs of patient/resident and poor documentation.

Key Learning

- The patient's Falls Risk Assessment should be completed within 6 hours of admission.
- The Falls Risk Assessment should be reviewed and completed if the patient's condition deteriorates or when the patient is transferred between wards.

Environmental and Equipment Factors

Some of the identified environmental and equipment factors identified by many of the adverse incident learning reports include issues relating to lighting, assistive devices, hoists, furniture, clinical alarm systems, housekeeping, properly fitted shoes.

Key Learning

- Orientate new patients to the ward, including to the toilet, and provide regular reorientation for patients with cognitive impairment
- Maintain and promote a safe, clutter free environment around bed spaces.
- Ensure the call bell; bedside table and walking aid if necessary are all within easy reach.
- Provide easy access to objects according to patient's needs and preferences, for example the TV control, glasses, magazines
- Lock wheels on the bed and other equipment
- Ensure the patient puts on appropriate, good fitting footwear and clothing
- Ensure adequate lighting – especially at night time
- Keep hallways clear, provide safe seating opportunities.
- Ensure all equipment is well maintained and in working order e.g. alarm bells hoists etc.
- When considering assistive technology always consider the right technology for the right person with the right support. This should be used to assist prevention of falls and not to replace supervision.

Medicines and Falls

The analysis of these incidents identified falls relating to medications, most commonly these involved sedatives, sleeping tablets, opiates and cardiac drugs such as beta-blockers.

Key Learning

- Medications should be reviewed for those patients who are at higher risk of falling.
- The FallSafe care bundle advocates those patients who are 65 years and older are to have their medications reviewed.
- If you feel that any medication, which a patient is taking, may increase their risk of falling, highlight this to the medical team.
- Try to avoid prescribing new night sedation for any inpatients as this could increase their risk of a fall.

Post Fall

Analysis of the adverse incidents indicates that a number of patients with falls resulting in fractures after a fall in hospital experienced some failure of aftercare. Problems included:

- Undiagnosed or delayed diagnosis of fractures;
- Undiagnosed or delayed diagnosis of head injury;
- Inadequate or delays in observations
- Movement of patients despite signs or symptoms of limb fracture.

Following a fall there is the opportunity to reduce the degree of harm by promptly detecting and treating injuries.

Key Learning

- Before moving a patient off the floor, stop and think if there are serious injuries, including checking for signs or symptoms of limb fracture, head injury and potential for spinal injury
- Ensure that all patients with features of serious injury, and those who are more vulnerable to serious injury, are rapidly assessed by a doctor
- Ensure that all patients receive a detailed and documented medical review within an appropriate timescale.
- After suspected head injuries, ensure neurological observations are commenced. Abnormal findings such as lateralising signs, seizures, or a drop in the Glasgow Coma Scale should trigger prompt action.
- Carefully document a history of the fall, collected from any witnesses as well as the patient, as this may point towards underlying causal factors. Report all falls and investigate these via local systems, and where applicable inform relatives and carers of the fall
- Assume that a patient who falls is at high risk of further falls, triggering action on secondary prevention and consideration of bone health

National Patient Safety Alerts

Patient Safety Alerts (PSAs) are issued centrally by the Safety Policy Branch of the Safety Strategy Unit by email, containing a Department of Health (DoH) Northern Ireland Patient Safety Alert Circular.

All PSAs that have been issued to date are available to view or download from the Department of Health (DoH) website or via the following links.

DoH Ref No	Title of Alert	Link to DoH Website	Date Issued
HSC(SQSD) 61/16	Resources to support the safety of girls and women who are being treated with valproate	https://www.health-ni.gov.uk/sites/default/files/publications/health/HSC-SQSD-19-17.pdf	24.04.17
HSC(SQSD) 3/17	Health Technical memorandum (TTM 01-06- management and decontamination of flexible endoscopies	https://www.health-ni.gov.uk/sites/default/files/publications/health/HSC-SQSD-03-17.pdf	27.02.17

Reminder of Best Practice Guidance (SQR) Letters

Reference	Title	Date Issued
SQR-SAI-2019-049 (AS)	Cardiac Arrest Protocol for Patients with LVAD	May 2019
SQR-SAI-2019-046	Mismatched Incompatible Components	Feb 2019
SQR-SAI-2019-048	NI Flowchart for management of suspected ST Elevation or Acute Posterior MI in a hospital setting	Jan 2019
	NI Flowchart for Suspected Primary PCI Activation	Jan 2019
SQR-SAI-2019-047	Endometrial Thermoablation	Jan 2019
SQR-SAI-2019-045 (AS & MCH)	Misdiagnosis of DKA in children	Jan 2019
SQR-SAI-2018-044	Management of Risk For People With Mental Health Conditions in the General Hospital Setting	Nov 2018
SQR-SAI-2018-042	Staff (Paid and Voluntary) And Access NI Checks	Nov 2018
SQR-SAI-2018-043 (AMH)	Recommendation From Independent Inquiry	Oct 2018

Reminder of Best Practice Guidance (SQR) Letters continued

Reference	Title	Date Issued
SQR-SAI-2018-041 (AS, MH, MCH & PHC)	Prescribing Dispensing And Administration of Oromucosal Midazolam	Sept 2018
SQR-SAI-2018-040	Prescribing of liquid and other sedative medications for children and Reducing the Risk of over use	July 2018
SQR-SAI-2016-009	Prescribing and Dispensing High Risk Drugs eg Immunosuppressants such as Tacrolimus	July 2018
SQR-SAI-2018-039 (PCC AS)	Serious Prescribing Error Due to Milligram Confusion At Primary Care – Secondary Care Interface	June 2018
SQR-SAI-2018-038	Recruitment and Selection	May 2018
SQR-SAI-2018-037	Doctors Ordering Investigations Have Responsibility to Follow Up Results	May 2018
SQR-SAI-2018-036	Arterial Line Blood Sampling Preventing Hypoglycaemic Brain Injury	May 2018
SQR-SAI-2018-035	Development of Diabetic Keto-Acidosis DKA As An In-Patient	May 2018
SQR-SAI-2018-034 (OPS)	Provision Of Services For People In Their Own Homes Final	March 2018
SQR-SAI-2018-033	Fire Risk Associated With Use of Hedrin	March 2018
SQR-SAI-2017-031	Risk of Accidental Overdose of IV Paracetamol	Jan 2018
SQR-SAI-2017-032	Acute Hospital Accommodation For Patients With Learning Disability	Dec 2017
SQR-SAI-2017-030	Management of Needlestick Injuries in ED	Oct 2017
SQR-SAI-2017-029	Acute Management of Diarrhoea Related to Cancer Treatment	Sept 2017
SQR-SAI-2017-028	Blood Transfusion (TACO)	June 2017
SQR-SAI-2017-026	Reducing the Risk of Throat Packs Being Retained After Surgery	June 2017
SQR-SAI-2017-027	How to Examine Newborns for Red Reflexes	June 2017
SQR-SAI-2017-025	Risk of Genital Tract Sepsis During Pregnancy And in the Postnatal Period	March 2017
SQR-SAI-2017-023 (MCH, PHC)	Sepsis Due to Untreated Urinary Tract Infections in Pregnancy	March 2017
SQR-SAI-2017-022 (AS & MH)	Prescribing of Methadone	March 2017

National Patient Safety Alerts continued

Safety and Quality Learning Letters

Reference	Title	Date Issued
LL-SAI-2018-034	Use of Standard (Male) Length Catheters in Female Pregnant Patients	Nov 2018
LL-SAI-2018-033 (MH)	Use of plastic bags on mental health in-patient wards	Oct 2018
LL-SAI-2018-032 (AS)	The administration process within the Breast Family History mammograph appointment service	Aug 2018
LL-SAI-2018-031 (MH)	Appointment Letters to Service Users with Literacy Problems	June 2018
LL-SAI-2015-030 (MCH)	Emergency Call Arrangements in Obstetric Units	Feb 2018
LL-SAI-2014-029 (AS, PHC)	Systems to Check The Integrity Sterility of Packs of Instruments Prior to Use	Feb 2018
LL-SAI-2014-02 (MCH)	Monitoring of Twin Transfusion Syndrome	Feb 2018
LL-SAI-2014-026 (PHC, AS)	Dispensing Beta Blockers – Selection Errors	Feb 2018
LL-SAI-2014-025 (AS)	Head Injury in Patient's on Warfarin	Feb 2018
LL-SAI-2013-024 (OP & AS)	Safe Management of Lower Bowel Dysfunction Including DRE and DRF	Feb 2018
LL-SAI-2013-023 (AS)	Learning Letter Safe Use of Intravenous (IV) Magnesium Sulphate	Feb 2018
LL-SAI-2013-022 (MH)	Care Planning for Adult Mental Health Patients	Feb 2018
LL-SAI-2013-021	Revised Communication of Patients Risk Status for CJD	March 2017
LL-SAI-2013-020 (FCC)	Child Centred Decision Making	March 2017
LL-SAI-2013-019 (AS)	Know the Massive Haemorrhage Protocol	March 2017
LL-SAI-2013-018 (AS)	Haemolysis During or after Haemodialysis	March 2017
LL-SAI-2013-017 (FCC)	Management of Data is Community Services	March 2017
LL-SAI-2013-016 (CS)	Loss of Data from the Twinkle Paediatric Diabetic Database	March 2017
LL-SAI-2013-015	Regional Learning from SAI – Appropriate Communication	March 2017

Safety and Quality Learning Letters continued

Reference	Title	Date Issued
LL-SAI-2013-014 (AS)	Management of Head Injury Complicated by Alcohol Ingestion	March 2017
LL-SAI-2012-013 (MCH)	Patient Selection and Intrapartum Care in Maternity Units	March 2017
LL-SAI-2012-012 (AS)	Wrong Procedure Performed	March 2017
LL-SAI-2012-011 (AS)	Importance of Taking Action on X-Ray Reports	March 2017
LL-SAI-2012-010 (AS)	Inadvertent Attachment of Oxygen Nasogastric Tube	March 2017
LL-SAI-2012-009 (MH)	Use of Telephone Messaging Service in Mental Health Service	March 2017
LL-SAI-2012-008 (PHC)	GP MH Referral Forms to Secondary Care	March 2017
LL-SAI-2012-00 (PHC)	Regional Learning from SAI Flushing of a Central Line with the Incorrect Strength of Heparin Sodium	March 2017
LL-SAI-2012-006 (AS)	Rare Case of Fatal Scalp Haemorrhage	March 2017
LL-SAI-2012-005 (MCH)	Newborn Hearing Screening Incident	March 2017
LL-SAI-2012-004 (MCH)	Induction of Labour	March 2017
LL-SAI-2012-00 (MCH)	Learning From Recent Adverse Incidents in Maternity Services	March 2017
LL-SAI-2012-002 (MCH)	Obstetric Anaesthetic Incidents	March 2017
LL-SAI-2012-001 (AS)	Regional Learning from A SAI Patients Enrolled in a Clinical Trial	March 2017
LL-AI-2014-028	Prescribing Dispensing Incidents Involving Buccal Midazolam Products	Feb 2018

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HSC Health and Social Care

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