

## Welcome to our first issue of Learning Matters newsletter

**T**he Public Health Agency and the Health and Social Care Board are committed to improving the quality of services in Northern Ireland by disseminating learning from incidents, reviews complaints and patient experience. The quality of our services is everyone's business. We need to use a variety of ways to ensure learning is shared with everyone throughout the region such as learning letters, alerts and reports. The purpose of our newsletter is to complement these by providing staff with access to important learning. We hope also to include innovative solutions others may have developed in response to local learning and we would encourage organisations to contact us to share their local learning with others in Northern Ireland.

Our newsletter will also be available on  
[www.publichealth.hscni.net/publications](http://www.publichealth.hscni.net/publications)  
[www.hscboard.hscni.net/publications/index.html](http://www.hscboard.hscni.net/publications/index.html)

We believe it is important to listen to patients, carers, health practitioners and partners and welcome your views and feedback on this issue.

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## The Emergency Care Summary: What medicines are not included?

The Emergency Care Summary (ECS) is used routinely by doctors, pharmacists and other healthcare staff across Northern Ireland e.g. in out-of-hours (OOHs) settings, emergency departments and during hospital admissions. It lists patient's current medication and allergy history. On a number of occasions, the ECS medicines summary has not listed the full medication history and as a result, medicines have been omitted on admission to hospital. The ECS only includes those medicines issued by the GP practice during the last six months and therefore should not be relied upon as the 'complete' list of a patient's medicines and allergies. See Box 1 for examples of medicines that may not be included in the ECS.

### Key Learning Action

ECS users should always confirm current medicines and allergies with the patient or carer.

### Please note:

The new Electronic Care Record (NIECR) currently being rolled out across Northern Ireland contains the same medicines and allergy information as ECS.

### Box 1

#### Medicines included in the ECS:

All medicines prescribed by the GP practice in the previous six months.

#### Medicines that may not be included:

- Medicines supplied by hospital e.g. specialist medicines or following recent discharge
- Medicines prescribed during a home visit
- Medicines prescribed by another service e.g. GP Out of Hours
- Medicines prescribed less frequently than every six months due to their pack size and/or infrequent use e.g. contraceptive pill, some inhalers

## Consider the diagnosis of Abdominal Aortic Aneurysm in Emergency Department (ED)

Any patient over 50 years old who presents with abdominal, back or flank pain, especially when associated with syncope or hypovolaemic shock should have an abdominal aortic aneurysm (AAA) excluded. Progressive symptoms will be of particular concern. Any patient who has these symptoms and a known AAA should have a presumptive diagnosis of ruptured AAA.

A rapidly expanding or ruptured AAA can be difficult to diagnose. There have been a small number of cases over the past few years where the diagnosis has either not been made; or not made early enough in patients presenting to ED. Patients have presented with back pain, groin pain and/or flank pain. Some have also had a history of collapse. They have been diagnosed as suffering from a variety of conditions, including musculoskeletal pain, an acute abdomen or a urinary tract

infection. Ruptured AAAs can also be misdiagnosed as renal colic, pancreatitis, bowel ischemia, diverticulitis, cholecystitis, bowel obstruction and myocardial infarction.

The classic presentation of a ruptured AAA is the triad of:

- severe abdominal, back or flank pain (which can radiate to the chest, groin or leg);
- hypovolaemic shock or hypotension; and
- a pulsatile abdominal mass.

Only a minority of patients with a rapidly expanding or ruptured AAA present with this classic triad. The most consistent presenting feature is pain, followed by hypotension. However, the blood pressure may be normal. A high index of suspicion is required and a differential diagnosis of expanding or ruptured AAA considered in patients with any of the symptoms or signs of AAA.

## The Card Before You Leave Scheme: Learning from evaluation

In 2010 the Card Before You Leave Scheme was introduced to ensure that all patients who attend an Emergency Department, with self harming behaviours or thoughts of suicide, have the opportunity to have an assessment by a specialist mental health practitioner. The majority of patients who attend hospital with self harm or thoughts of suicide are seen by a specialist mental health practitioner before they leave hospital. The CBYL scheme is specifically aimed at a smaller group of patients where it has been assessed that the patient poses no immediate risk to themselves or others. The scheme ensures patients are given a next day appointment

with a member of the mental health team who will assess how they are doing and arrange any on-going care and support they may require.

The Health and Social Care Board has carried out an evaluation of the Card Before You Leave (CBYL) scheme in Emergency Departments and its findings are now available at [www.hscboard.hscni.net/publications/index.html](http://www.hscboard.hscni.net/publications/index.html)

The evaluation report makes a number of other recommendations to improve the scheme further and also some wider recommendations about services for people who self harm.

### Key Learning Action

#### Key learning points emerging from the evaluation include:

#### Health and Social Care Trusts should:

- Give a duplicate appointment card to any person attending with the patient.
- Hold regular joint Emergency Department and Mental Health service planning meetings to help identify and care for those who repeatedly

self harm and/or those who are hard to engage in follow-up services.

- Seriously consider an assertive outreach approach by mental health teams for patients who fail to engage with follow-up services.

Please note: **Self harm is known to be one of the strongest predictors of subsequent suicide.**

## Learning from Complaints Section

### Remember... Stop and Check - Right Patient, Right Drug!

Recently, a patient was accidentally administered her husband's medication instead of her own by domiciliary care staff. This resulted in an adverse effect on her blood sugar levels and a subsequent admission to hospital.

#### Key Learning Action

Learning from this complaint resulted in the development of a new training programme in HSC Trusts for domiciliary care staff which has been devised in partnership with pharmacy staff. This programme will concentrate specifically on the Safe Assistance and Administration of Medication Policy. This training has recently commenced and will continue as a rolling programme into the future.

For further information on this training programme please contact Frances Bradley at the Health and Social Care Board via email at [frances.bradley@hscni.net](mailto:frances.bradley@hscni.net) or direct dial 02890 553 752.

For further safety information on medicines visit the MHRA website at [www.mhra.gov.uk](http://www.mhra.gov.uk).

## NEVER Adapt Medical Equipment

Medical equipment is designed to meet the very specific needs of patients. Adapting equipment for uses other than those for which it has been developed may impact on your patient's safety.

In a number of reported incidents patients have been harmed when equipment was used for a purpose which it was not designed for. For example, oxygen tubing should never be used to vent naso- gastric tubes, this resulted in serious harm when the tubing was accidentally attached to the oxygen supply.

### Key Learning Action

Be a champion for your patient's safety. NEVER use equipment for a purpose it has not been designed for. If you are aware of this happening, bring it to the attention of the manager in your ward or department.

For further information on the safe use of medical devices and equipment please visit the Northern Ireland Adverse Incident Centre (NIAIC) website or the National Patient Safety Agency (NPSA) website at:

[www.dhsspsni.gov.uk/index/hea/niaic.htm](http://www.dhsspsni.gov.uk/index/hea/niaic.htm)  
[www.nrls.npsa.nhs.uk/resources](http://www.nrls.npsa.nhs.uk/resources)

## Right Patient Right Care

Failure to verify patient identity can have implications that are devastating to the patient/client, their families and in addition can have medical, legal, and emotional implications for patient/clients and healthcare staff.

A review of serious adverse incidents has highlighted that patient identity and documentation are not routinely re-checked throughout the entire episode of patient care as can be seen in the examples below:

### Example One

'An invasive procedure was performed on the wrong patient'

'Patient A', who had a hearing loss, came forward when staff called out 'Patient B's' name in a Day Procedure Unit. Expecting to see a patient of the same gender and age, staff **presumed** that this was the correct patient and did not confirm their name. This error was not detected until midway through the operating procedure when the patient's arm band was checked against specimen bottle labels.

### Example Two

'Misidentification of the patient can occur at every stage in

healthcare from the checking in at reception to the delivery of care'

The receptionist in the Emergency Department searched on patient C's last name **but did not input** their full double barrelled first name to the Emergency Department Admissions System (Symphony).

By using only the surname and patient's date of birth the system located patient D who had a similar name.

***The care for Patient A was planned using Patient B's history resulting in the wrong medication being prescribed and administered.***

### Key Learning Action

#### You should always

- Ask the patient to confirm their name before any intervention, treatment or medication.
- Ask a family member or carer to confirm the patient's name if the patient is unable to do so themselves.
- Check the patient's verbal confirmation against their name band and all documentation.
- Remember patient verification is **everyone's** responsibility.

## Contact Us

If you have any comments or questions on the articles in the newsletter please get in contact by email at [learningmatters@hscni.net](mailto:learningmatters@hscni.net) or by telephone on **028 9032 1313** ext:2497.

 Health and Social Care

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