LEARNING MATTERS

Welcome to Learning Matters Special 'Complaints' Edition 16 March 2021

Health and Social Care

QUALITY 2020

Introduction

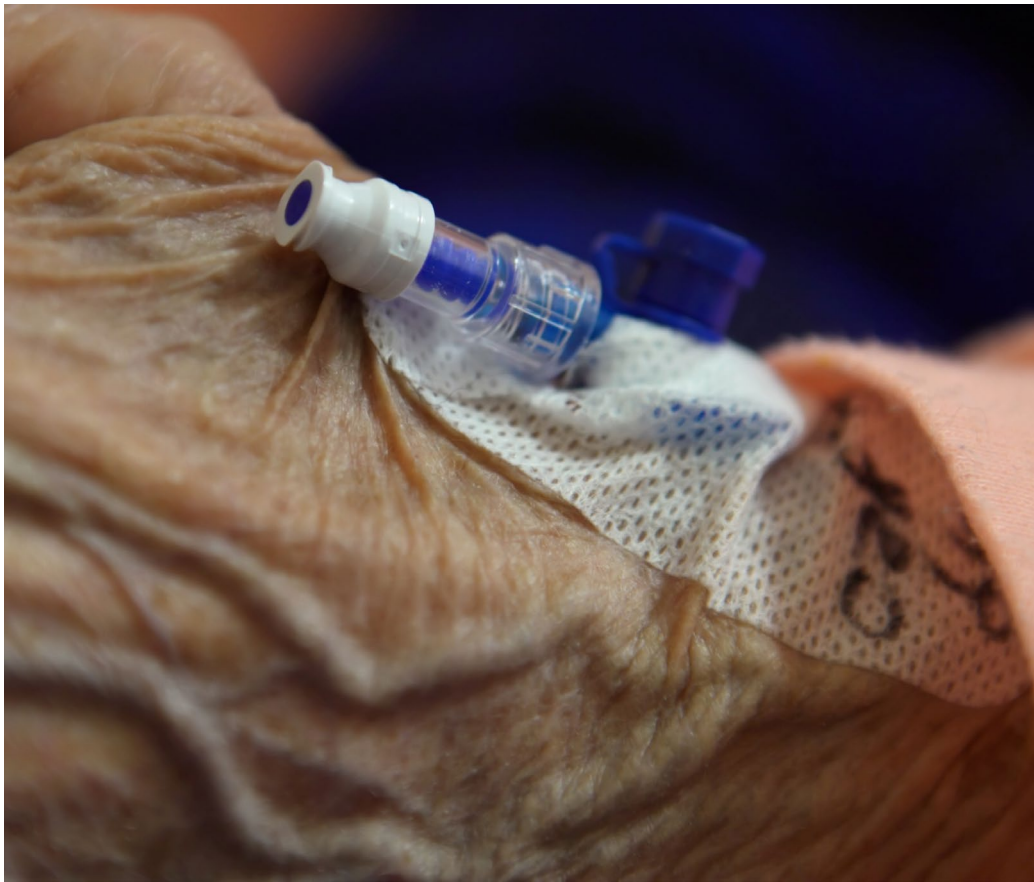
Welcome to this special 'complaints' edition of Learning Matters. All cases presented in this edition have been dealt with through the various Trusts complaints departments. Following resolution of all complaints within Trusts they are forwarded to the Health and Social Care Board (HSCB) complaints department to be reviewed by HSCB and Public Health Agency (PHA) professionals, who ascertain if there is any regional learning from cases or if there are recurring themes, patterns or trends in relation to complaints; that are important to highlight and learn from, so that improvements can be made in relation to patient safety, quality of care and the patient experience.

IN THIS EDITION

Safe Discharge: Remember to check the peripheral intravenous (IV) cannula has been removed

Across the HSC there have been an increasing number of complaints generated, i.e. at least 7 in the past 18 months, in relation to patients being discharged from the hospital setting with a peripheral intravenous cannula still in place because the healthcare professional has omitted to check it has been safely removed prior to discharge. Although none of these complaints resulted in any patient coming to harm, it is however a patient safety issue and should not happen if robust, safe person-centred discharge is undertaken.

A common finding following analysis of these complaints is that this type of incident occurs most frequently following discharge from the Emergency Department (ED).

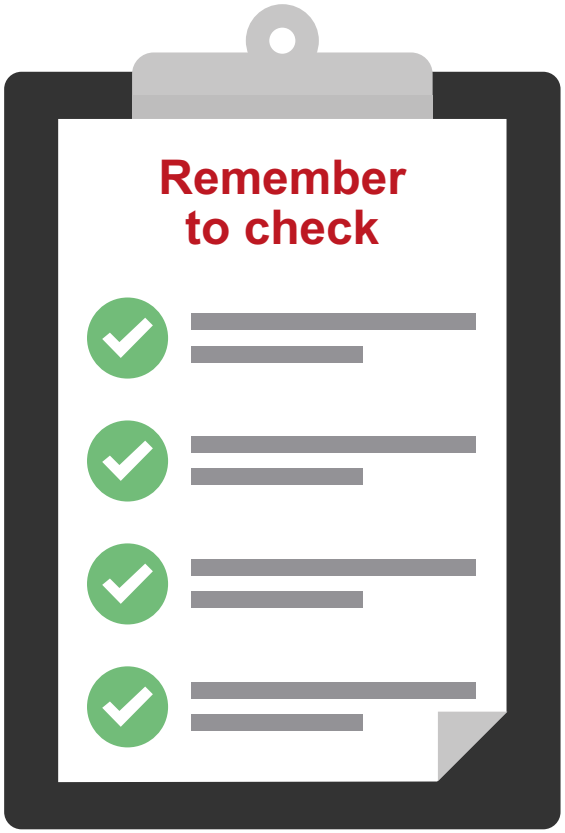


LEARNING MATTERS

Welcome to Learning Matters
Special 'Complaints' Edition 16
March 2021

HSC Health and Social Care

QUALITY 2020



KEY LEARNING

HSC Trusts should have robust processes in place for safe patient discharge, including documentation that details the IV cannula check has been undertaken to ensure it is removed if one is in place.

There are several strategies to avoid accidental discharge with IV cannula in situ including:

- A **clear and simple discharge checklist** that includes a check for cannulas.
- Regular reminders at team meetings/safety briefings for staff to always check for IV cannula in situ and complete the necessary documentation, when the patient is being discharged.
- As part of the insertion procedure healthcare staff should always **inform the patient** (and family members) that it ***must*** be removed on discharge and advise them to flag with a staff member if this has not occurred.
- Regardless of setting, a peripheral IV cannula observation chart must **always** be completed on insertion, as this will also be another prompt for removal on discharge.
- In the ED or primary care setting, beware of the patient that enthusiastically re-dresses themselves prior to discharge, as it is very easy for long sleeved shirts etc. to obscure that visual cue of the cannula still in situ.

The date, time and reason for removal of cannula should always be documented in the patient's nursing and/or medical notes.

LEARNING MATTERS

Welcome to
Learning Matters
Special 'Complaints' Edition 16
March 2021

HSC Health and Social Care

QUALITY 2020

Importance of considering flexor sheath infection in any patient presenting with signs of soft tissue infection in the fingers/hand

A patient presented to the Emergency Department with a red, swollen, tender finger and feeling unwell. The patient had a history of a thorn foreign body in the left middle finger, which they had attempted to remove. On presentation the patient looked pale and was complaining of feeling shivery and nauseated.

The patient was triaged appropriately and bloods were taken which did not indicate any significant systemic infection. The assessing doctor did consider the possibility of flexor sheath involvement but felt there was no evidence of this at the time of assessment. The doctor administered a single dose of intravenous antibiotics and discharged the patient with a course of oral antibiotics and safety net advice to seek further medical review should their symptoms worsen.

The patient's pain did not improve and the swelling in the hand worsened, so they had to urgently re-attend hospital for emergency surgery, due to an **infection of the flexor tendon sheath** of the finger.

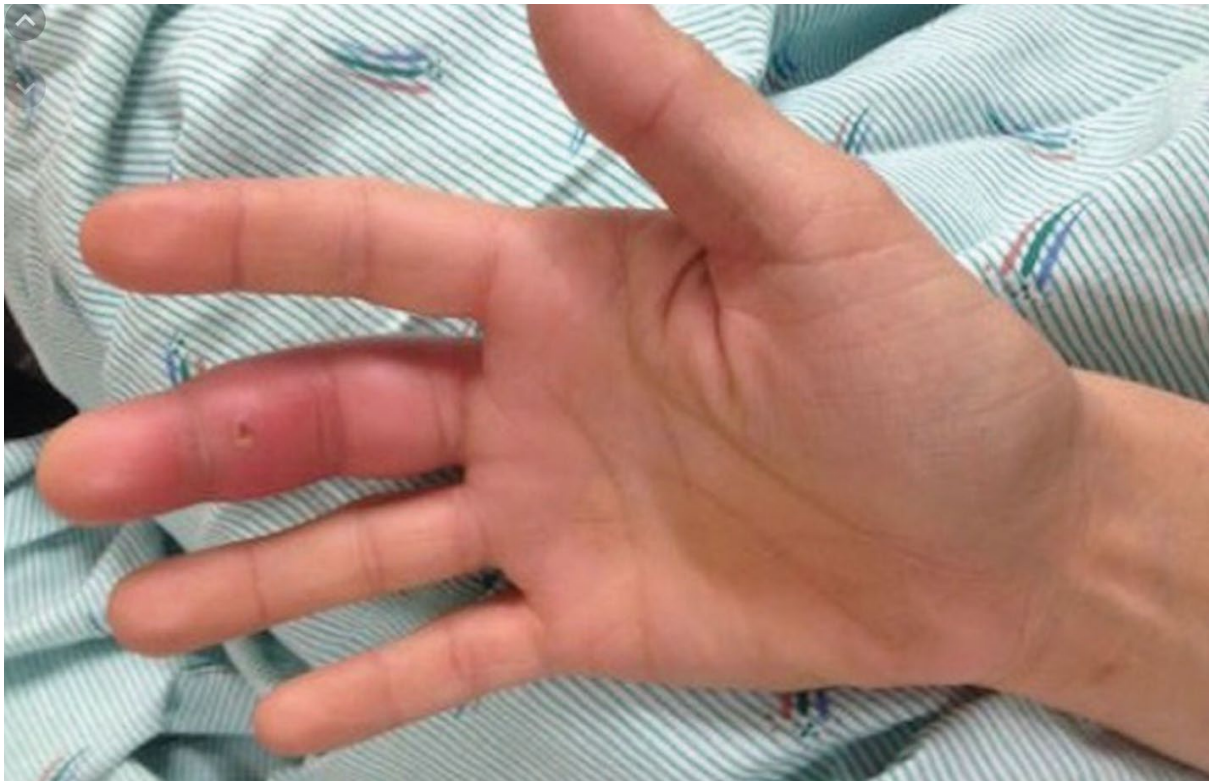


Figure 1. Flexor sheath infection of the right middle finger from a patient with a drill puncture wound.
From: Chan E, Robertson BF, Johnson SM. Kanavel signs of flexor sheath infection: a cautionary tale. Br J Gen Pract 2019; https://bjgp.org/content/69/683/315

LEARNING MATTERS

Welcome to Learning Matters
Special 'Complaints' Edition 16
March 2021

HSC Health and Social Care

QUALITY 2020

KEY LEARNING

Flexor tendon sheath infection or pyogenic flexor tenosynovitis is an aggressive, closed-space bacterial infection that can lead to significant morbidity if not effectively managed. The purpose of presenting this case is to raise awareness amongst all staff of the importance of thorough history taking, examination and documentation in relation to this important diagnosis.

- Pyogenic flexor tenosynovitis accounts for 2.5-9 % of all hand infections.
- Treatment typically consists of intravenous (IV) antibiotics and surgical drainage of the sheath with open or closed irrigation.
- Despite advances in antibiotic therapy, pyogenic flexor tenosynovitis remains a clinical challenge that requires prompt diagnosis and management.
- Patients present with one or more positive Kanavel's cardinal signs:

  1. Exquisite pain on passive extension of finger
  2. Exquisite tenderness along course of tendon sheath
  3. Fusiform swelling of entire digit
  4. Digit with semi-flexed posture

- Treatment is usually IV antibiotics if the injury is less than 48 hours old. If this is unsuccessful within 12-24 hours then surgical intervention is recommended.
- If the patient presents after 48 hours, then surgical intervention is recommended.
- Healthcare professionals should be aware of the importance of considering the diagnosis of a flexor tendon sheath infection when patients present with a history of injury to the finger, a deep cut, or penetrating trauma, ensuring that they are referred to Plastics at the earliest opportunity.

LEARNING MATTERS

Welcome to
Learning Matters
Special 'Complaints' Edition 16
March 2021

HSC Health and Social Care

QUALITY 2020

Headache: Assessment in the Emergency Department (ED)

A patient attended their GP with a history of increasing headaches, vertigo and tiredness, causing disturbed sleep particularly due to nocturnal headaches with vomiting. Following eye assessment by the GP, the patient was advised to attend the ED immediately with a GP letter of referral suggesting a CT brain scan was required.

At the ED the patient was assessed by medical staff. All clinical observations were within normal limits. The doctor noted that the patient had a moderately severe unilateral throbbing headache with nausea and vomiting; that there was a known history of migraine headaches and that this episode had woken the patient from their sleep. Clinical examination revealed the patient was alert, orientated and coherent, with a Glasgow Coma Score (GCS) of 15/15. There were no cranial nerve deficits, no motor or sensory deficits and pupils were equal and reactive to light. There is **no documentation** that a fundoscopy examination was undertaken.

The doctor did consider a "space occupying lesion" such as a Meningioma in their assessment, but did not consider that it was likely enough to require an emergency brain CT scan on the night of attendance, nor did they ask the patient to return the next day for this investigation. The patient was subsequently diagnosed with migraine headache and on discharge from the ED was provided information regarding adequate hydration, analgesics, and safety net advice to return if symptoms worsened.

One week later, following review by the optician and complaining of worsening vision, the patient was urgently referred to the regional centre with raised intracranial pressure. A CT brain scan showed grade 1 parasagittal meningioma attached to superior sagittal sinus which required urgent surgery.

KEY LEARNING

Headache is a common presentation to the ED and assessment can be complicated. Headaches waking patients from sleep, as in this case, is suggestive of a more serious cause.

The purpose of presenting this case is to raise awareness amongst all staff of the importance of being alert to features suggestive of a serious cause of headache and the importance of seeking advice from **senior colleagues** at the earliest opportunity. Senior advice was **not** sought in this case.

As per NICE guidance - assessment for a person attending with headache should include:

- A detailed history, being alert for features suggestive of a serious cause of headache including: progressive or persistent headache, headache with vomiting
- Check: Vital signs including fundoscopy

NICE guidelines available here

Also applicable to the learning from this case is The Royal College of Emergency Medicine Consultant Sign-Off (June 2016) which states: *'there are many other presentations that carry important risk (e.g. headache), and individual departments may wish to add these and other conditions locally when staffing allows.'* Full detail of the Consultant Sign-Off is available here to read for context and completeness in relation to how it may relate to this complaint.

LEARNING MATTERS

Welcome to Learning Matters Special 'Complaints' Edition 16 March 2021

HSC Health and Social Care

QUALITY 2020

Recognising Ovarian Torsion

A young girl presented to the Emergency Department (ED) with sudden onset abdominal pain and associated vomiting. A history of recurrent abdominal pain was noted. Examination was normal and she was discharged with a diagnosis of non-specific abdominal pain and advised to return if any further concern.

The patient re-presented to the ED the next day with worsening symptoms of abdominal pain. The pain was now associated with anorexia and radiation to the right thigh. Examination revealed a soft abdomen with mild right iliac fossa tenderness and bowels were moving normally.

Vital signs and blood results were normal. Urinalysis was positive for leucocytes, but there were no features of urinary tract infection (UTI). The patient was diagnosed with constipation and discharged. The patient's mother was asked to attend the GP to consider referral to Paediatrics if the issue continued.

The patient re-presented to the ED later the same day with worsening of abdominal pain, making this the third ED attendance in 48 hours. The patient was examined by the ED Consultant. Abdominal examination was unremarkable, however she was admitted to hospital, as this was the third attendance with the same presenting complaint.

The following morning she was reviewed by surgeons who considered taking her to theatre to rule out atypical presentation of appendicitis, however an ultrasound scan of abdomen and pelvis, ordered by ED the evening before was performed, which confirmed the diagnosis of **ovarian torsion.**

KEY LEARNING

Ovarian torsion is rare in children but accounts for 3% of all cases, in the child who presents with acute abdominal pain. Importantly it requires immediate surgical intervention. The presence of vomiting, short duration of abdominal pain, and elevated CRP level has a predictive value for the diagnosis of ovarian torsion in children (Bolli et al., 2017).

Re-attendance to the ED with an ongoing issue should prompt review by a senior ED doctor. The Royal College of Emergency Medicine (RCEM) recommend consultant sign-off for patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. RCEM standard is available here.

Important to note:

- Blood markers should **not** be solely relied upon as an indicator of significant pathology or as criterion for admission. Normal inflammatory markers can be falsely reassuring.
- Ultrasound abdomen is the first line imaging modality for suspected appendicitis in paediatric patients, but as demonstrated in this case is useful for detecting other pathology.

References

Bolli, P., Schädelin, S., Holland-Cunz, S. and Zimmermann, P. (2017). Ovarian torsion in children. *Medicine,* 96(43), p.e8299.

www.rcem.ac.uk. (n.d.). *RCEM Standards - Consultant Sign-off.* [online] Available at: https://www.rcem.ac.uk/RCEM/Quality-Policy/Clinical_Standards_Guidance/RCEM_Standards.aspx?WebsiteKey=b3d6bb2a-abba-44ed-b758-467776a958cd&hkey=0c1979a4-cd10-4592-babd-9a76d8000d2f&RCEM_Clinical_Standards=2 [Accessed 26 Feb. 2021].

LEARNING MATTERS

Welcome to Learning Matters Special 'Complaints' Edition 16 March 2021

Health and Social Care

QUALITY 2020

DURING 2019/20:
- HSCTs received 6105 complaints.

The top three categories of complaints were in relation to:
1. Treatment and care (1399 complaints)
2. Staff attitude and behaviour (1021 complaints)
3. Communication (948 complaints)

'Focus on' Professionalism

A family member of a child attending a chemotherapy appointment raised a complaint with the respective Trust, after witnessing staff 'laughing and joking' inappropriately and 'being on mobile phones'. A further complaint was made by the family member in relation to a staff member they had encountered who was 'rude'.

We should be aware of our surroundings at all times, while working in health and social care, particularly when interacting with work colleagues or patients and be sensitive to others who may witness or overhear our conversations. It is important to consider how interactions or behaviours which may hold no ill-intention, such as joking with colleagues or looking at your phone, is perceived from the point of view of a service user or their family members.

Complaints relating to poor patient experience concerning staff professionalism; namely attitudes and behaviour are not uncommon within the NI health service. This is clearly evident from the complaints information below, where **1021** complaints were received by HSC Trusts in 19/20, that related to **staff attitude and behaviour.** It is therefore **essential** this pattern and trend is highlighted and most importantly improved for those who use our services, often at a very vulnerable and uncertain time in their life.

KEY LEARNING

Professionalism is integral to delivering high quality, safe and effective person centred care across the HSC system in N. Ireland. Being an inspiring role model and working in the best interests of people in our care, regardless of what position we hold and where we deliver care, is what really brings practice and behaviour together in harmony.

In N. Ireland the four Health and Social Care Values provide clarity for all HSC staff, including prospective staff, on the values we should live every day, and the behaviours expected of us, regardless of the HSC organisation we work for. These values and behaviours will send a clear message to patients, service users, families, and carers about the care and support they should expect, and how this should be delivered.

LEARNING MATTERS

Welcome to Learning Matters
Special 'Complaints' Edition 16
March 2021

HSC Health and Social Care

QUALITY 2020

For all **nursing staff** the following key information is applicable to learning from this complaint and others of similar nature: Enabling professionalism in nursing and midwifery practice is available at the link below:
Enabling professionalism in nursing and midwifery practice.

NMC Code available at the link below:
Nursing and Midwifery Council (2018).

For all **medical staff** the following key information is applicable to learning from this complaint and others of similar nature: The General Medical Council (GMC) **'Good medical practice'** guidance which is available at the link below:
Good medical practice - GMC (gmc-uk.org)

For all **AHP staff** the following key information is applicable to learning from this complaint and others of similar nature: The Health and Care Professions Council (HCPC) **Standards of conduct, performance and ethics** available at the link below:
HCPC Standards.

All pharmacists are expected to abide by the Pharmaceutical Society NI Code
https://www.psni.org.uk/psni/about/code-of-ethics-and-standards/

Another useful resource for all Health and Social Care staff in relation to learning from complaints on attitudes and behaviour is the link below to the Cleveland Clinic video on Empathy:
Cleveland Clinic Empathy - Cleveland Clinic Annual Report 2012

In summary, health and social care staff should be aware of the large volume of complaints generated across the HSC in relation to professionalism concerning staff attitudes and behaviours. HSC staff must act at all times in a polite and courteous manner and with the highest of professional standards and behaviours as set out in guidance by their professional regulatory body.

Contact Us
If you have any comments/feedback or questions on the articles in the newsletter please get in contact by email at learningmatters@hscni.net

Learning Matters is available on:
https://www.publichealth.hscni.net/publications/learning-matters-newsletters