LEARNING MATTERS

EDITION 20

EDITION 20 APRIL 2022 - THIS EDITION SUPERSCEDES MARCH 2022

IN THIS EDITION

Link below to previous Learning Matters:
Learning Matters Newsletters | HSC Public Health Agency (hscni.net)

Welcome to Edition 20 of the Learning Matters Newsletter. Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in its care. We recognise that we need to use a variety of ways 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

STOP Before you Block

A patient received a nerve block to the wrong site.

A nerve block was administered to a patient by the Consultant Anaesthetist in theatre to facilitate surgery and recovery. Following this, the surgical site was exposed and the anaesthetist identified that the surgical site was **not** the site the nerve block had been administered to; the block had been administered to the left side, instead of the right side.

The Consultant Anaesthetist notified the surgical team immediately and it was clarified that the nerve block had indeed been administered to the incorrect site. The surgery was able to go ahead and local anaesthetic was subsequently infiltrated into the correct surgical site at the end of the surgery.

On subsequent investigation it was found that no **"STOP BEFORE YOU BLOCK"** pause or surgical site check had been undertaken immediately prior to administration of regional anaesthesia.

After the surgery the Consultant Anaesthetist made the patient aware of the mistake and the need for investigation into the events.

The patient was monitored as an inpatient for a number of days and suffered no ill effects.

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STOP Before you Block *(continued)*

KEY LEARNING

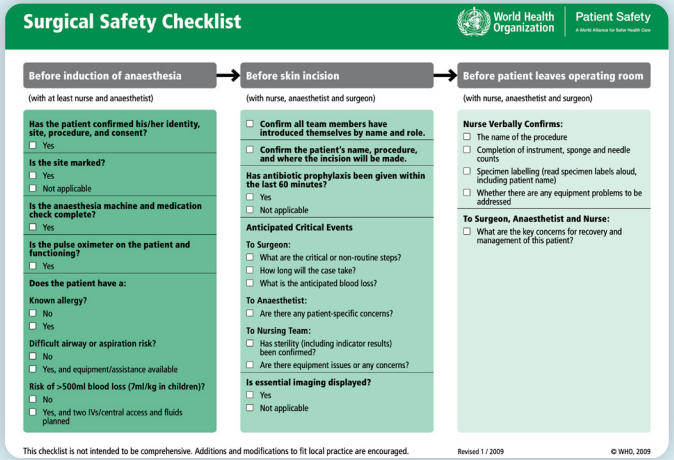
- The World Health Organisation (WHO) Surgical Safety Checklist must be performed. It is a simple tool designed to improve communication and teamwork by bringing together the surgeons, anaesthesia providers and nurses involved in care to confirm that critical safety measures are performed before, during and after an operation.
- IMMEDIATELY before needle insertion in the nerve block process the correct site is confirmed again. This involves:
  - Visualising the surgical arrow indicating site of surgery
  - Asking the patient to confirm the side of surgery (if conscious)
  - Double checking the consent form for operative side (if patient unconscious)
- The "STOP BEFORE YOU BLOCK" moment can be instigated by any member of the anaesthetic team (anaesthetist, anaesthetic nurse, operating department practitioner or anaesthetist's assistant).

  Success of the campaign will rely upon all team members being aware of, and trained in the process.
- Times to be vigilant:
  - Where there has been a prolonged duration of primary anaesthetic or long time since WHO surgical pause
  - After turning the patient
  - Busy anaesthetic room
  - Lower limb nerve blocks where surgical site arrow may not be immediately visible
- "STOP BEFORE YOU BLOCK" posters should be made visible in all theatres.
- Further information available:

  Stop Before You Block (ra-uk.org)

  CSQ-PS-sbyb-posterA4.pdf (ra-uk.org)

  Microsoft Word - Stop before you block Accompanying Information Final Version.doc (ra-uk.org)



Surgical Safety Checklist — World Health Organization | Patient Safety

Before induction of anaesthesia (with at least nurse and anaesthetist)

Has the patient confirmed his/her identity, site, procedure, and consent?
- ☐ Yes

Is the site marked?
- ☐ Yes
- ☐ Not applicable

Is the anaesthesia machine and medication check complete?
- ☐ Yes

Is the pulse oximeter on the patient and functioning?
- ☐ Yes

Does the patient have a:

Known allergy?
- ☐ No
- ☐ Yes

Difficult airway or aspiration risk?
- ☐ No
- ☐ Yes, and equipment/assistance available

Risk of >500ml blood loss (7ml/kg in children)?
- ☐ No
- ☐ Yes, and two IVs/central access and fluids planned

Before skin incision (with nurse, anaesthetist and surgeon)
- ☐ Confirm all team members have introduced themselves by name and role.
- ☐ Confirm the patient's name, procedure, and where the incision will be made.

Has antibiotic prophylaxis been given within the last 60 minutes?
- ☐ Yes
- ☐ Not applicable

Anticipated Critical Events

To Surgeon:
- ☐ What are the critical or non-routine steps?
- ☐ How long will the case take?
- ☐ What is the anticipated blood loss?

To Anaesthetist:
- ☐ Are there any patient-specific concerns?

To Nursing Team:
- ☐ Has sterility (including indicator results) been confirmed?
- ☐ Are there equipment issues or any concerns?

Is essential imaging displayed?
- ☐ Yes
- ☐ Not applicable

Before patient leaves operating room (with nurse, anaesthetist and surgeon)

Nurse Verbally Confirms:
- ☐ The name of the procedure
- ☐ Completion of instrument, sponge and needle counts
- ☐ Specimen labelling (read specimen labels aloud, including patient name)
- ☐ Whether there are any equipment problems to be addressed

To Surgeon, Anaesthetist and Nurse:
- ☐ What are the key concerns for recovery and management of this patient?

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged. Revised 1 / 2009 © WHO, 2009

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Ophthalmology

Three patients pre-covid had life changing visual deterioration as a result of delayed appointments.

Patient A presented to their optician and was subsequently diagnosed with Central Retinal Vein Occlusion (CRVO). They had a direct electronic referral to the Retinal Vein Occlusion (RVO) clinic marked **Urgent**, and was triaged as **Urgent**; however there was a significant time delay of 7 months for the patient's appointment, the clinically agreed timeframe is 9 weeks. During this serious delay Patient A's vision deteriorated to light detection only and once reviewed was diagnosed with Rubeotic Glacucoma & Rubeosis Iridis with predicted poor prognosis.

Patients B and C were on the Wet Age-Related Macular Degeneration (AMD) Review pathway. They were both due for review at 8 weeks (clinically indicated time) – neither were seen for 23 weeks, a time delay of 15 weeks. This delay led to a loss of vision below driving standard for both patients, with patient C also developing a serious secondary pathology causing extensive vision loss.

The following factors have been identified in these delays:

- A lack of available staff and delays in filling vacant posts led to a reduction in clinic services.
- An increased demand on service is causing an increased amount of patients on the waiting list as well as delaying current patient reviews – some of whom have time critical pathologies.

The Royal College of Ophthalmologists recommends that CRVO should be seen within 2-4 weeks from referral for optimisation of outcome.

KEY LEARNING

- Screening protocols for patients who have high risk ophthalmology disorders must include comprehensive risk assessment to ensure new appointments and review appointments are allocated within the accepted timescales.
- Urgent review appointments should be prioritised with waiting list structures amended to allow easy identification.
- Where there are long/unacceptable delays in patients waiting for treatment – trusts should escalate to the commissioner to determine if regional intervention is required to expedite relevant interventions.
- Ensure patients can access a point of contact within Multi-Disciplinary Team if concerned or notice changes in their vision.
- Protocols for appointment allocations should be agreed and communicated with all members of the team.
- Trusts should consider a macular tracker role.

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The HSC Hospital Passport

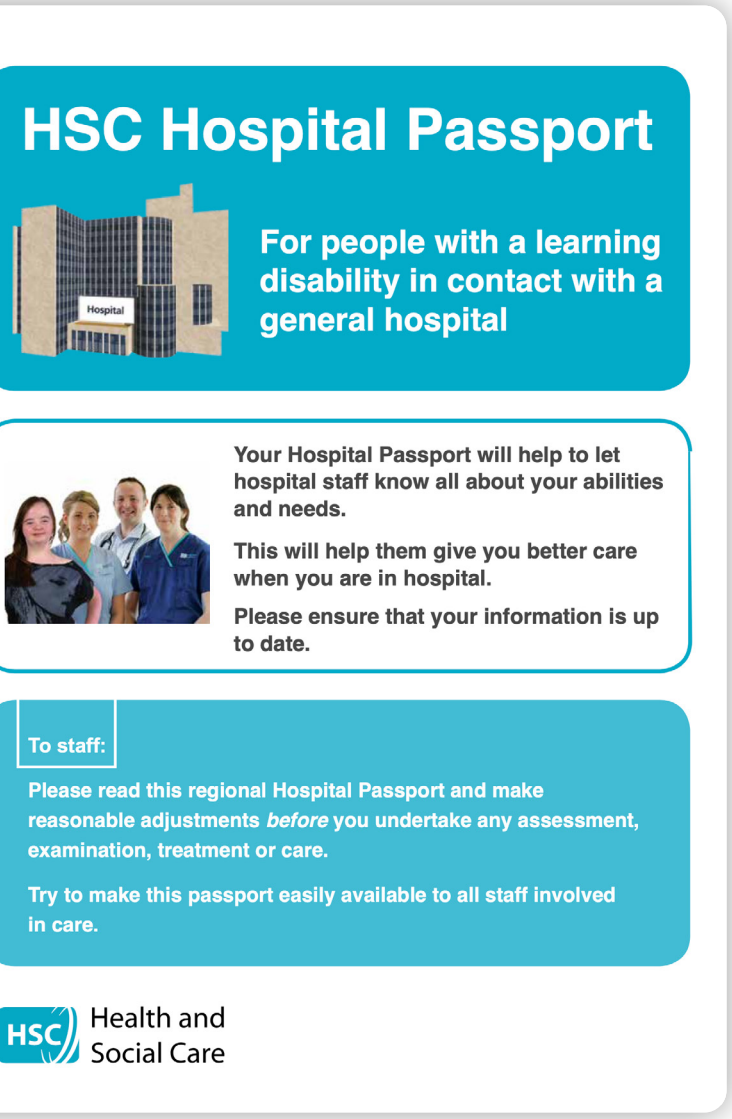
This HSC Hospital Passport has been developed by the PHA and the Regional General Hospital Forum for Learning Disability for people with a learning disability to complete (with or without help) and present to staff every time they have contact with a general hospital.

It gives staff important information on the person and how they prefer to communicate, their medical history and any support they might need while in hospital. Staff can then make any reasonable adjustments in order to provide the best possible care for people with a learning disability.

The electronic version of the Hospital Passport allows patients or carers to type details directly into the document before saving, printing off and bringing to hospital.

Guidance notes to help those completing the HSC Hospital Passport can be found at the link below.

https://www.publichealth.hscni.net/publications/hsc-hospital-passport-and-guidance-notes



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The use of the Electronic Care Record (ECR) and Relevant Patient Checks prior to Patient Discharge

A patient attended the Emergency Department (ED) with shortness of breath. The patient denied having chest pain or cough; the past medical history included hypertension, a Deep Venous Thrombosis (DVT) and bilateral pulmonary emboli (PE). The patient didn't volunteer any further information and Northern Ireland ECR was not checked. At the time of the PE there was also moderate pericardial effusion under cardiology review.

During triage in ED the clinical observations were within the normal range, however a temperature was not recorded and the patient was noted to have pleuritic pain, with a pain score recorded of 5 out of 10 with no analgesia given.

The patient spent two and a half hours in the department and during this time a clinical examination, chest x-ray, ECG and blood tests were performed, and the patient was discharged home with oral steroids. The chest x-ray documented by the Doctor was reported as small bilateral pleural effusions, cardiomegaly and prominent vascular markings; these were suggestive of pulmonary oedema. Prior to discharge, there were no repeat clinical observations undertaken; these would have provided further evidence of the patient's physiological status and if there had been any deterioration or change in the patient's condition.

The following day the patient died. Due to death occurring within 24 hours of attending the ED the patient had a post mortem which reported cause of death as pulmonary oedema caused by heart failure.

There was no documentation that the patients medical history had been reviewed by the clinician. If the past medical history had been reviewed there may have been further understanding and further investigations performed.

KEY LEARNING

- Triage is a process where patients are sorted according to their need for care and the likely benefit that care will provide in order to determine what order in which to treat them. A complete set of clinical observations, including a temperature recording and pain score should be included as part of the triage process.
- Pain should be addressed at the initial stages and analgesia offered for any complaints of pain.
- National Early Warning Scores (NEWS) must be undertaken according to the frequency as noted in the NEWS trigger thresholds and prior to discharge from ED.
- Review of the patient's ECR record should be documented.
- Clinicians assessing a patient in ED should make a careful review of a patient's NI Electronic Care Record to ascertain important information about past medical history, comorbidities and information about previous radiological investigations and ECGs. This may require a thorough review however could add useful information about clinical context and therefore a particular patient's level of risk.

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Multidisciplinary Meeting (MDM)

A patient was admitted for investigation of ongoing respiratory issues and as part of their management plan imaging was done which included a Computed Tomography scan (CT) of chest and abdomen.

The report found enlarged para-aortic nodes and was further discussed at the radiology MDM where it was recommended that the patient should have a further CT in 6 months' time as well as an ultrasound scan. The report of the follow up CT, generated by a telemedicine company, showed persistent enlarged nodes, however failed to highlight bilateral ovarian masses.

This was later added to the report as an addendum, but not communicated directly to a consultant; causing a delay in treatment. At the follow up MDM, one year from the initial meeting, it was discovered that the ultrasound had not been acted on. The patient was later confirmed to have a diagnosis of 'high grade serous cancer'. The patient was referred to oncology and underwent surgery.

Had the initial management plan been adhered to it may have had a different outcome for this patient.

KEY LEARNING

- Attendance at radiology MDMs is essential for all relevant staff.
- A formal record of decisions and actions should be maintained and entered onto the Electronic Care Record (ECR).
- The ECR Action plans for patients should be reviewed at every MDM.

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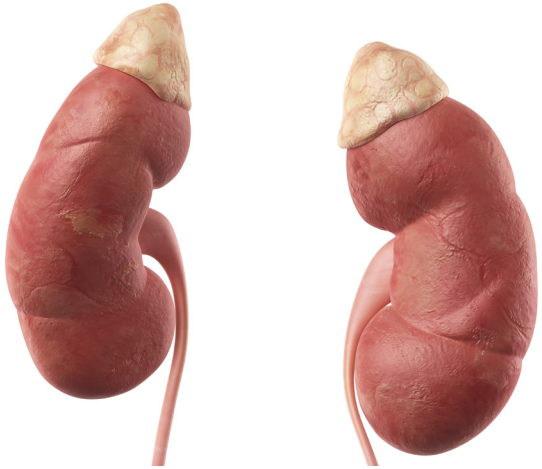

Renal Stones

A patient had a Computerised Tomography (CT) Urogram examination as a follow-up to a different medical condition which showed an incidental finding of a right lower pole stone. A referral was made to Urology.

The patient was reviewed annually by telephone. A year later a further x-ray to include kidney, ureter, and bladder (KUB) was performed and 'no calculi seen' was recorded. The following year a further x-ray was performed and reported that the abdominal x-ray was not clear due to faecal loading and gas, but no KUB x-ray was carried out. At the telephone consultation three years from initial review, the patient was discharged from Urology as no symptoms were noted.

Following a history of recurrent Urinary Tract Infections (UTIs) and weight loss, the patient was referred by the GP to hospital services and had a CT of chest, abdomen and pelvis. This CT showed staghorn calculi with hydronephrosis. An urgent outpatient appointment and an urgent nephrostomy were arranged due to loss of kidney function in the affected kidney. The patient had a nephrectomy.

On review of the previous x-ray images the calculi were identified. This delay in identification of the calculi may have contributed to the loss of function of the kidney and eventual outcome for the patient.

KEY LEARNING

- CT KUB is the preferred choice of diagnostic exam to identify first presentation of renal stones.
- It is the responsibility of a clinician who makes a referral for investigations to read and act on the report as appropriate.
- When there is uncertainty in relation to the findings of an x-ray it should be repeated.
- NICE guidelines regarding management of suspected renal stones are available at the following link:

https://cks.nice.org.uk/topics/renal-or-ureteric-colic-acute/management/management/

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Nasogastric (NG) Tubes

Three incidents occurred in which patients suffered aspiration pneumonia due to incorrectly positioned nasogastric (NG) tubes

In the first incident Patient A was admitted due to a decline relating to Parkinson's disease and noted by Speech and Language Therapists (SLT) to have an unsafe swallow.

It was recommended that Patient A be made nil by mouth (NBM) and an NG tube be inserted to allow feeding. This NG tube was dislodged one day after being inserted. It was subsequently re-inserted and required confirmation of position by X-ray. Unfortunately, the X-ray was not ordered. On reviewing the imaging system a Foundation Y2 (F2) Doctor looked at the most recent x-ray **from the previous day** and incorrectly informed nursing staff that the NG tube was in the correct position and feed could be commenced.

Three hours after feeding had been commenced Patient A developed symptoms of aspiration and a chest X-ray (CXR) confirmed the NG tube was situated within the right lung. Patient A deteriorated and required transfer to ICU and intubation due to respiratory distress, the patient continued to deteriorate and unfortunately died.

In the second incident Patient B was admitted following an unwitnessed fall at home. They were diagnosed as having a cervical fracture, disruption of the anterior longitudinal ligament, frontal hematoma and chest sepsis. Due to a drop in Glasgow Coma Scale (GCS) they required intubation and ventilation and needed feeding through an NG tube.

Patient B had ongoing issues with aspirate readings over pH 5 and so required several CXRs during the course of their admission to ensure correct positioning of NG tube.

On one occasion an x-ray had been ordered but not completed and the doctor reviewed the imaging system from the previous day. In addition an agency nurse did not adhere to the trust guidelines and administered a feed, following a documented aspirate pH of 6.0 despite guidance stating, **"If pH is greater than pH 5.5 do not commence feed."**

The patient subsequently developed symptoms of an aspiration and medical staff commenced intravenous (IV) antibiotics for suspected aspiration pneumonia. It was noted at the time of deterioration that NG feed was leaking from the patient's mouth. Patient B continued to deteriorate and required escalation of antibiotic therapy and chest physio. They recovered well with seven days of treatment and were medically fit to be discharged shortly after having sustained no long-term ill effects from the episode as confirmed in a follow-up outpatient appointment.

In a third case, the patient had a NG tube in place following a laparotomy and repair of an incisional hernia. The post-operative instructions identified the patient was at high risk of developing an ileus therefore the NG tube was to remain on free drainage, the patient was to remain nil by mouth and intravenous (IV) fluids were prescribed.

Later that day, the staff nurse noted that the patient used the call button to alert staff that the NG tube had accidentally dislodged, and they had drunk approximately one litre of fluid and were now feeling sick. The patient subsequently vomited approximately 100mls. It was agreed that an NG tube was to be passed if vomiting continued. The patient vomited a further 100mls later that evening however an NG tube was not passed as the patient settled after this episode. No further vomiting or nausea was observed by / reported to nursing staff.

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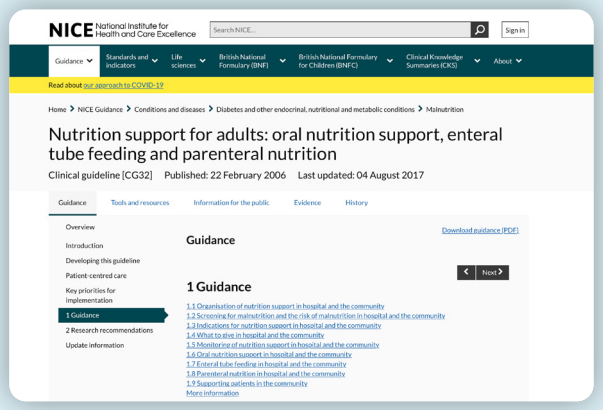
Nasogastric (NG) Tubes *(continued)*

The following morning the patient was found on the floor of their room unresponsive. Cardiopulmonary resuscitation (CPR) was commenced however the patient sadly passed away. Cause of death was aspiration due to or as a consequence of post-operative ileus due to or as a consequence of a surgery to repair a bowel obstruction.

KEY LEARNING

- Correct placement of an NG tube is essential to ensure patient safety and nutrition. Local policy for the insertion and confirmation of position of NG tubes in adults must therefore be followed at all times.
  - All patients receiving NG feeding require an aspirate to be obtained prior to commencing feed. **If pH is greater than pH 5.5 do not commence feed.**
  - Staff must ensure the NG position check chart is fully and accurately completed in all circumstances.
  - CXR date and time must be checked to ensure that the correct CXR is being reviewed. This is especially important when a patient has had multiple NG tube changes throughout admission.
  - The measurement and accurate recording of the external length of the tube is critical to the placement of the NG tube tip and any differences in this respect should raise staff index of suspicion for a potential complication. This specific issue should also be reinforced as part of staff induction and training.
  - When a NG tube tip becomes dislodged in a postoperative patient, a doctor at ST3 level or above must be consulted.
- Patients with ongoing NG feeds should be highlighted at the daily safety brief.
  - All nursing staff, particularly agency staff should be competency assessed prior to caring for patients on NG feeding regimes.
  - The risk associated with not following advice on the importance of fasting should be discussed with patients.
- Staff should be reminded of their professional responsibilities in relation to accurate record keeping.
- National Institute for Health and Care Excellence (2006). Overview | Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition | Guidance | NICE



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Patient ID / The Importance of Identification Checks

Two patients received incorrect treatment or investigations following identity checks not being properly undertaken.

In the first incident Patient A attended for Ultraviolet light B (UVB) phototherapy and was received by staff nurse 1. This staff nurse did not check the patient's identification and subsequently the patient received phototherapy in accordance with that planned for a different patient. Patient A **incorrectly** received 1 minute and 33 seconds of UVB phototherapy instead of the planned 16 seconds, five times the planned exposure time.

Staff Nurse 1 made an entry into Patient B's medical notes, for whom this treatment and exposure time was planned, stating receipt of 1 minute and 33 seconds of treatment with no ill effect. When entering the details of Patient A's attendance and treatment into the computer system Staff Nurse 1 realised they had administered the incorrect dose to Patient A.

Staff Nurse 1 then retrospectively amended the entry made in Patient A's notes stating the correct dose of 16 seconds had been administered despite the true time being 1 minute 33 seconds. Staff Nurse 1 did not inform the dermatologist or senior staff on duty.

Patient A re-attended for further treatment two days later and advised Staff Nurse 2 they thought they had been exposed to phototherapy for too long on the previous day. Staff Nurse 2 assessed the patient and observed E3/E4 erythema to Patient A's trunk, buttocks, upper thighs and groin. When Patient A enquired how long he had been exposed to UVB phototherapy for, Staff Nurse 2 could only advise that the time had been recorded as 16 seconds. Patient A stated he had been in the machine for longer than 1 minute.

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Patient ID / The Importance of Identification Checks *(continued)*

Staff Nurse 2 contacted the Dermatology consultant by telephone who advised application of dressings and steroids and to review Patient A again the next day. No UVB phototherapy was given on that day due to presenting skin damage. Patient A attended the dermatology unit and had dressings and steroid creams applied over several days and recovered.

In a second incident, Patient C was referred for an Magnetic resonance cholangiopancreatography (MRCP) by a Consultant Rheumatologist.

Patient D on the same ward, who shared the same surname, was mistakenly sent for MRCP. In the MRI department a full three point identification check was not undertaken and Patient D was scanned in Patient C's place. Incidentally a right lower aortic and common iliac aneurysm was found. This required urgent assessment and onward referral to the vascular service. Unfortunately, this referral was made for Patient C, whom the consultant assumed had had the scan.

When reviewed by vascular service Patient C had a CT angiogram which showed no evidence of aneurysm.

Concerns were raised with the rheumatology consultant that the MRCP was not in keeping with other scans for this patient and the clinical director of radiology for the trust was notified. An investigation was initiated.

By this stage Patient C had been informed they had an aneurysm and an unnecessary dose of radiation. An urgent MRCP was arranged for Patient C and contact was made by the vascular team with Patient D.

KEY LEARNING

- All staff should adhere to checking procedures for treatment received and all clinical interventions, as outlined in their respective professional codes of conduct, Trust Policies, guidance and follow checklists.
- Phototherapy doses entered into a machine should be checked by a second registrant prior to therapy commencing.
- All staff should strictly adhere to their professional standards in relation to documentation and record keeping.

If you have any comments or questions related to this Edition of Learning Matters please get in contact by email at learningmatters@hscni.net

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